University of Nottingham

UNDERSTANDING CARE HOMES SAFETY: CULTURE AND SAFETY IN NON-MAINSTREAM CARE SETTINGS

By

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PhD in Business and Management

2021

A thesis presented in part consideration for the PhD in Business and Management

Word Count (whole document): 98,285
Word Count (excluding abstract, contents, references and appendix): 78,521

Acknowledgments

Before you read this thesis, I would like to say that this work really has been a labour of love over the past years. It has challenged my thinking and has been both an enlightening and humbling experience. I would like to give my greatest thanks to Justin Waring and Stephen Timmons who have both been outstanding supervisors on my journey. They have given me trust and encouragement and always pushed my thinking in a positive way. The quality of this work would not have been possible without their guidance and support. I would also like to thank Cheryl Crocker who has been an exceptional expert and guide through my journey. Her networks helped me to gain access for this study, and she has given great guidance to keep my work grounded in current policy and practice for care homes. I must also give great thanks to Adam Gordon who has been another critical expert throughout my PhD and has always been an enthusiastic sounding board for my ideas during this PhD journey.

To all of the residents, relatives and staff that took part in this study I give great thanks for your participation and openness. The insights and value that I have gained from my experiences with you have been both inspiring and enlightening, which I hope will go forward to make a difference to future changes in care home policy and practice. Without you all this would not have been possible.

I would finally like to give thanks to all of my family and friends who have supported me, with late nights and long hours I have always been encouraged and cannot thank you all enough. The most thanks has to go to one of my best friends David. Thank you for taking one for the team and letting me bounce my ideas off you and for supporting me in proofreading what is a very long, hopefully interesting book that captures the complexity of work I have completed over the last few years!

Thank you everyone, and reader, I hope you enjoy ☺

Abstract

Background

The care home sector provides 24-hour residential care or nursing care to more than 450,000 vulnerable older people in the UK with complex needs and high levels of dependency. These services face many challenges in relation to funding, increasing demand, staff shortages and relying on an unregistered workforce with almost 40% possessing no qualifications. Care homes present a unique setting that provides care to individuals at significant risk of harm but has received little attention or research. Care homes provide a particularly rich context in which to study safety, as they are inherently complex organisations that have historically suffered many catastrophic failures and scandals and continue to struggle to achieve safety goals.

It was widely accepted that organisational culture was important for patient safety. Both the organisational culture and patient safety literature have been dominated by the positivist assumption that organisations are part of an external reality that can be both measured and manipulated. Many scholars now argue that positivist approaches do not reflect the complexity of contemporary organisations as they only capture the very surface of organisational cultures. The deeper levels of organisational culture and its impact upon safety have received little exploration in the patient safety literature and have not before been explored in the context of care homes.

Aim

The thesis aimed to empirically explore organisational culture and how this related to safety in care homes. The thesis focused on how residents, relatives and staff in this context made sense of their reality by investigating the basic underlying assumptions that underpin human perception and behaviour, specifically in relation to quality and safety. Through this exploration the thesis also captured how different groups contributed to and negotiated quality and safety.

Research Question

The thesis addressed the central research question:

- How do employees, residents and relatives give meaning to and value issues of safety in care homes?

Methodology

The thesis aligned with the interpretive paradigm and adopted an ethnographic case study approach within the care home sector. Over 200 hours of observations and interviews with 50 participants took place across two care homes between January – December 2018. Inductive thematic analysis was used to analyse both interview and observational data.

Research Gaps and Intended Contribution

This study adds to the limited evidence base through its interpretive, ethnographic approach, accepted as a method suited to achieving a deeper level of cultural analysis. The approach taken has not previously been used to address safety in the care home sector, which presented a setting that was theoretically and empirically

distinguished from mainstream care settings. Due to the under-researched nature of this care setting the study also enabled theoretical contribution to the patient safety literature. The findings from this study make a contribution to current debates around care home policy and practice, which was of particular relevance given the recent impact of the COVID-19 pandemic upon the care home sector.

The thesis makes a new contribution to the literature around patient safety by presenting a conceptual understanding of how culture relates to safety in care homes that comprises of Uncertainty, Identity and Role, Responsibility and Relationships. My study argues that within care homes there was a disconnect between the formal culture and approaches, and the informal culture within the care home. The study has highlighted that traditional patient safety orthodox approaches being used within care homes may be inappropriate due to the unpredictability and the assumptions that underpin how people give meaning to and value safety in care homes. Moreover, my study has shown that safety in care homes was achieved through attempts to get to know residents, focusing on their identity, building relationships and the importance of promoting resident autonomy and responsibility for their own safety.

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CHAPTER 1- Introduction

BACKGROUND

Organisational culture has been widely recognised as important for achieving patient safety (Hutchinson, Cooper et al. 2006, Singer, Meterko et al. 2007, The Health Foundation 2011, Morello, Lowthian et al. 2012, The Kings Fund 2014, Agency for Healthcare Research and Quality 2016). Since the early 2000s the importance of patient safety across both health and social care has risen on international agendas and steps have been taken to improve patient safety (Institute of Medicine 1999). One such approach has been to focus attention on understanding and implementing interventions to address the safety culture within health and social care organisations. The term safety culture is highly contested, for this thesis it is broadly defined as how organisational culture relates to and influences safety. Within healthcare the term patient safety culture has also been commonly used and focusses on the safety of patients and service users within the healthcare sector.

Patient safety has been dominated by orthodox approaches that aim to standardise and control practice in order to achieve safety (Bosk 1979, Rosenthal 1995, Waring, Allen et al. 2016). However, in recent years it has been recognised that orthodox approaches are largely inappropriate for the complex health and social care systems that are subject to many more sociological influences (Waring, Allen et al. 2016). It has therefore been argued that more interpretive approaches to patient safety are required in order to address the complexity of health and social care today.

The organisational culture literature has also been dominated by positivist assumptions, assuming that culture can be manipulated and controlled in order to improve organisational performance (Ouchi 1981, Peters and Waterman 1982, Deal and Kennedy 1988). Schein (2010) argued that historical approaches to organisational culture do not address the essence of organisational culture, and suggested that interpretive approaches are required to capture the deepest level of organisational culture. There has therefore been a call for interpretive approaches to look at the deepest level of organisational culture (Parker 2000)

When looking at patient safety, a particularly neglected setting is that of care homes (Gordon, Logan et al. 2012, Morley, Caplan et al. 2014, Goodman, Sharpe et al. 2017). Care homes are a social care setting that are inherently complex due to fragmented funding models, privatisation and great variance across the sector (Competition & Markets Authority 2018, CQC 2017, Competition & Markets Authority 2018, Blakeley and Quilter-Pinner 2019). In terms of patient safety, this setting has attracted lots of negative attention and has been of particular concern in terms of achieving patient safety (Berwick 2013, CQC 2013, NHS England 2014, CQC 2015). Moreover, this setting has received little investment in improvements in comparison to the health sector and consequently many approaches to address safety in care homes were simply lifted from the NHS and applied to care homes (Mody, Krein et al. 2015, Mody, Meddings et al. 2015, Buljac-Samardzic, van Wijngaarden et al. 2016, Lim, Anderson et al. 2016). This setting therefore presents an interesting case study for investigating organisational culture and how this impacts on safety. No previous studies have been undertaken that specifically look to capture the deepest level of organisational culture within care homes.

RESEARCH GAPS

The thesis aims to empirically explore how organisational culture influences safety in care homes. The thesis focuses on how residents, relatives and staff in this context give meaning to and value issues of safety by investigating the basic underlying assumptions that underpin human perception and behaviour, specifically in relation to quality and safety.

This thesis specifically looks to address some specific gaps in the research evidence surrounding these topics. It uses an ethnographic approach to explore safety culture in care homes and uses interpretive methods to explore organisational culture and how this impacts on safety. The thesis makes a contribution to the literature around patient safety and organisational culture. By undertaking this research within care homes, it also makes a unique contribution to policy and practice for care homes.

During this study the research question is addressed:

- How do employees, residents and relatives give meaning to and value issues of safety in care homes?

Data was collected using an ethnographic case study approach across two UK care homes. The core datasets were therefore observational and interview data, analysed using inductive thematic analysis.

CONTRIBUTION

This thesis offers unique findings that have not before been presented around organisational culture and safety in care homes. The findings are presented as a conceptual understanding of culture within care homes through four key themes: Uncertainty, Identity and Role, Responsibility and Relationships. Each of these themes are explored in their own right and then drawn together to make an overall comment on the organisational culture with care homes and how this relates to safety. My study makes an important contribution to the patient safety literature by highlighting the inappropriateness of formal orthodox safety-I approaches within care homes. It also argues that there is a disconnect between the formal and informal culture in care homes. As such, the overall contribution of this thesis is to critique current approaches to safety within care homes, which often take a safety-I and orthodox approach. The thesis suggests that there is a need for sociocultural approaches to safety that are tailored to the care home sector.

LAYOUT

The thesis starts by reviewing the patient safety literature (CHAPTER 2) and organisational culture literature (CHAPTER 3). It then moves on to specifically explore gaps in the literature through the use of an integrated literature review (CHAPTER 4). The last literature review explores care homes as the study context, and gives details on important and interesting areas of the care home sector (CHAPTER 5).

The methodology is then discussed to cover aims, research question and key areas of data collection and analysis (CHAPTER 6).

I then moves on to present four data chapters, each of these covers in depth each theme using a mixture of vignettes, observations data and interview data to support my analysis and interpretations. These chapters cover the following key themes: Uncertainty (CHAPTER 7), Identity and Role (Chapter 8), Responsibility (CHAPTER 9), and Relationships (CHAPTER 10).

The thesis then presents a discussion to situate my findings within the wide literature and make comment on how my findings extend and make a contribution to the wider literature (CHAPTER 11).

Finally, the conclusion brings together and pinpoints the key findings and contribution of my thesis (CHAPTER 12).

CHAPTER 2- Review of Patient Safety Literature

INTRODUCTION

The literature review chapters of this thesis will build an argument for exploring safety using sociological interpretive approaches and will highlight care homes as an important site for this study. This chapter will begin by providing a detailed history and analysis of the patient safety literature. By doing this, the chapter identifies fundamental flaws in previous approaches to patient safety and offers sociological approaches as a potential solution to studying patient safety within complex organisations such as care homes. The chapter will set the foundations for the thesis that will attempt to address criticisms of previous approaches to patient safety research by taking a sociological approach to exploring patient safety in care homes.

THE HISTORY OF PATIENT SAFETY

INTRODUCTION

Over recent years, major service scandals and failures in care have highlighted quality and safety as fundamental principles at the heart of healthcare services (Kennedy 2001, Smith 2005, DH 2012, Berwick 2013, Francis 2013, Kirkup 2015). However, the current policy impetus on quality and safety was a relatively recent phenomenon. Patient safety became an international priority in the early 2000s, and has since risen to the forefront of healthcare research and policy (Waring, Allen et al. 2016). Over the last two decades, quality and safety research has moved on from blaming individuals (Smith 2005, Francis 2013), to acknowledging the wider organisational factors that influence quality and safety (Waring 2009, Swinglehurst, Emmerich et al. 2015).

THE RESPONSIBILITY OF PROFESSIONS

The Institute of Medicine report "To Err is Human", highlighted a critical realisation of the importance of improving patient safety (Institute of Medicine 1999). Prior to this, the term patient safety was unrecognised as a concept. Adverse events, or patient harm, were viewed as an unfortunate but inevitable part of healthcare (Freidson 1975, Bosk 1979, Rosenthal 1995). The medical profession, who were claimed to have expert knowledge and clinical autonomy, held complete responsibility for instances of adverse events or negligence (Rosenthal 1995, Freidson 1975, Bosk 1979).

Instances of adverse events, or error, were considered acceptable as long as the individual clinician did not regularly repeat errors, and that they displayed honesty, remorse and learning (Bosk 1979). Bosk (1979), found that the response taken to errors did not correlate to the amount of patient harm. Instead, the adverse event, or error, was judged on if this had breached moral principles, which was considered unforgivable. Whereas, if a technical or judgemental error had occurred this was considered less serious with little to no repercussion (Bosk, 1979). The reality of substandard care and patient harm was dealt with purely through professional regulatory processes (Freidson 1975). This self-regulated nature of the medical profession resulted in a lack of wider awareness and responsibility around patient safety issues (Bosk, 1979) and elicited specific challenges of self-interest, shared vulnerability, and an assumption that clinicians' professional judgements should not be criticised (Rosenthal 1995).

THE PATIENT SAFETY REVELATION

In the early 1990s, patient safety was realised to be beyond the responsibility of professions, and was acknowledged as a 'service level' problem. The findings from the Harvard Medical Practice Study (Brennan and Leape 1991, Leape and Brennan 1991), and the subsequent publication of the Institute of Medicine (1999) report, served as the catalyst for the growing attention on improving patient safety. Death due to medical error was discovered to be a leading cause of death, above motor vehicle accidents and breast cancer (Institute of Medicine 1999). Following this revelation, a number of studies on medical error and adverse events were undertaken; reaching the consensus that approximately 10 per cent of patients admitted to hospital would experience an adverse event that resulted in prolonged care, disability or death (Wennberg 1984, Wilson, Runciman et al. 1995, Vincent, Neale et al. 2001, Baker, Norton et al. 2004, Vincent 2006).

The early 2000s signified a period of crisis, with international recognition of the extent of preventable harm to patients. Due to the lack of attention patient safety had received, there were few established approaches to deal with patient safety issues. The answer to this dilemma was to adopt and implement successful solutions from other industries, primarily aviation and occupational health (Institute of Medicine 1999). These solutions were based on a linear cause-and-effect component model, which was simply lifted from other industries and saw humans seen as a source of potential error (Hollnagel and Wears 2015).

In a "fire-fighting", rapid response to the colossal problem of patient safety, there was no robust evaluation of the appropriateness of the solutions taken from other industries. In fact, at the time when these models were adopted in healthcare, in industry they were being scrutinised as inadequate for the new complex working environment (Hollnagel and Wears 2015). Such linear cause-and-effect models have since been criticised as unable to explain the complexity of organisations (Hollnagel and Wears 2015). As such, new approaches to explaining patient safety have been taken (Hollnagel, Woods et al. 2006). However, it was important to note that despite decades of political attention and investment, progress in patient safety from this point has been exceptionally slow. In fact, many of the solutions adopted form other industries in the early 2000s still make up the majority of our efforts to improve patient safety.

THE ORTHODOX PARADIGM

The revelation in patient safety soon became internationally recognised with multiple landmark reports calling for change in the way patient safety, the training and credentials of healthcare professionals, and regulation of healthcare was approached (Institute of Medicine 1999, Donaldson 2000, Runciman 2000, Institute of Medicine 2001). The developments in patient safety research, policy, and practice have largely been dominated by an orthodox paradigm (Waring, Allen et al. 2016). It became widely recognised that threats to safety rarely stemmed from individual fault, inability, or negligence, but arise through wider organisational and practice factors (Reason 2000), such as "task design, communication patterns, teamwork, the availability of resources, time pressures, and work stresses" (Waring et al. 2016, p.203). This paradigm has seen a national commitment to improving quality and safety.

Although many safety solutions originated outside of healthcare, there has been notable advancement in the standardisation of safety practices, the application of health technology, and interventions (Waring, Allen et al. 2016). Now largely embedded across hospital services, practices include alert systems, standardised communication tools (NICE 2007), early warning scores (Royal College of Physicians 2015), incident reporting, and risk management (House of Commons Public Administration Select Committee 2015). Moreover, with capturing safety issues through local and national error reporting, there was a continued drive for new innovations and initiatives.

Despite technological advancement and increasing vigilance around safety, organisational cultures have been found to resist widespread adoption (Wiener 2000). This was explained by McDonald et al (2006) as a conflict between the opposing perspectives of clinicians and managers (McDonald, Waring et al. 2006). Managers are seen to seek standardisation of practice through adherence to national guidelines, error reporting and other structures. In contrast, clinicians have been found to oppose standardisation and instead rely on clinical judgment and expert knowledge, staying true to the fundamental principle of clinical autonomy and self-regulation (Freidson 1975, Bosk 1979, Rosenthal 1995). Due to patient safety being historically led by the medical profession, advancements in patient safety have largely focused on medical practices, particularly in the hospital context (Allen 2009). Allen (2009) highlighted that there was much less evidence available that explores patient safety from the perspective of other professions, such as nurses and allied health professions. Although the orthodox view has provided substantial advances in the patient safety arena, it was apparent that robust evidence was still not available for certain workforces and settings.

THE SOCIOLOGICAL PERSPECTIVE

A shortcoming of the dominant orthodox paradigm was that it can be seen to not give a full picture of safety practice, with safety largely being seen from the medical professions' world-view (Allen 2009). Waring et al

(2016) have criticised the widely seen medical perspective for concentrating predominantly on micro-systems and often not considering the influence of wider social, cultural, and organisational factors on healthcare practice. To explore these factors, a sociological perspective could be taken to achieve a deeper understanding of patient safety. Sociological contributions to quality and safety have the potential to offer a deeper understanding of the social, political, and cultural complexity of our current healthcare climate (Waring, Allen et al. 2016).

Although external guidelines, regulation, and reporting provide some control over safety, this was often complex and influenced by sociological factors, such as how errors, mistakes, and poor practice are conceptualised at the frontline (Illich 1976). In healthcare, the categorisation of faults, errors, and mistakes has been argued to be relative to the social and cultural context in which these are constructed (Hughes 1951). Therefore, the way that safety risks are identified and reported was dependent on wider sociological factors and cannot fit within universally set criteria. This work has largely been corroborated by findings from major scandals that have indicated normalisation of poor standards, failures in communication, and a lack of accountability across professions (Kennedy 2001, Hindle, Braithwaite et al. 2006, Francis 2013, Kirkup 2015). The influence of perceptions of risk in safety practice has been further emphasised by discrepancies seen across professional groups, with different occupational training and socialisation related to conflicting priorities, poor integration, and inefficient communication of safety (Waring 2009, Swinglehurst, Emmerich et al. 2015).

This sociological perspective reflects the realisation that the linear cause-and-effect models widely adopted in patient safety are not appropriate for addressing the complex interplay of sociological factors that influence safety (Hollnagel and Wears 2015, Waring, Allen et al. 2016). Improving patient safety should move beyond seeking and addressing causation of adverse events. When looking at safety through the sociological lens there was an appreciation that the concept of safety in itself was socially contracted, and therefore the influence of organisational culture upon how actors attribute meaning and value to safety may offer great insight into the safety practices. It was essential that patient safety research and practice moves beyond the orthodox paradigm and instead use sociological perspective to find new ways to improve patient safety, which account for the complex social, cultural, political and organisational influences on healthcare.

SAFETY-I VS. SAFETY-II

SAFETY-I

Overview

Reflecting on the history of patient safety it was often asked, why was progress moving so slowly despite political attention and investment? To answer this question the basic assumptions that underpin the dominant orthodox safety practices adopted in healthcare must be considered. The following section summarises and explores the debate from the report “From Safety-I to Safety-II: A White Paper” which explored this key issue (Hollnagel and Wears 2015).

The widely accepted definition of safety is the absence of accidents or harm, whereby as few things as possible go wrong (Hollnagel and Wears 2015). This perspective is called “safety-I”. Hollnagel and Wears (2015) explain that this approach assumes that when things do go wrong there is always an identifiable failure related to a specific component, which can then be found and rectified. As such, the basis of safety-I approach is a linear cause-and-effect model, whereby investigations are used to identify the causes of adverse events, and risk assessments are used to determine the likelihood. The premise of safety-I is to learn from what goes wrong, and through analysis of incidents and near misses we can avoid future harms (Edmondson 2011, Carson-Stevens 2018). This approach assumes that every failure is the consequence of a factual and set cause that should be identified and mitigated, aligning with the positivist paradigm (Hollnagel and Wears 2015).

Decomposable and bimodal systems

The safety-I approach could perhaps explain the slow progress we have seen in improving patient safety. This approach was adopted from other industries and has been criticised as unfit for new complex organisations (Hollnagel and Wears 2015). The foundation of this approach is that systems can be decomposed into separate components. In this way, the complex healthcare system is being treated as if it is the parts of a car, whereby if you can find the broken part and fix it, then the car will function. Moreover, it is also based on the assumption that these components are bimodal; they either fulfil their function and work, or they have failed. Specifically for healthcare, the functions of healthcare services are not so simply deconstructed into constituent parts and do not fit this bimodal model. Hollnagel and Wears (2015) described these assumptions as convenient, as it allows us to assume that every problem can be “fixed”. However, this is insufficient for use in the world today where there is a complex interplay of social, cultural, political and organisational factors influencing healthcare practice (Waring, Allen et al. 2016).

A negative approach

Hollnagel and Wears (2015) continue to criticise the safety-I approach for its focus on things going wrong. In healthcare it is estimated that adverse events happen in up to 10 per cent of patients in hospital settings (Wennberg 1984, Wilson, Runciman et al. 1995, Vincent, Neale et al. 2001, Vincent 2006). As such, our patient safety efforts are disproportionately focusing on the minority of cases where care goes wrong, rather than the 90 per cent of times that we get it right.

Hollnagel and Wears (2015, p.12) describe that the safety-I perspective is based on “a global predominant belief that adverse outcomes (accidence, incidents) happen because something goes wrong, hence that they have causes that can be found and treated”. Therefore, there is a focus on “how to stop things going wrong” rather than “how to make sure things go right”. This negative approach to patient safety is reinforced throughout healthcare and can be seen in national and local error/incident reporting, regulation and risk assessments (Woodward 2019). Organisations are called upon to account for harm and errors, and these are publicly available as a measure of care quality, for example the Safety Thermometer (NHS Safety Thermometer 2013). The same attention is not given to good practice, showing the negative approach to safety. There is consequently much less available data about good practice, and much fewer models and methods based on getting things right.

This inverse definition of safety means that we define safety to be a lack of harm. A perfect level of safety would be no adverse events or error, which means there is then nothing to be measured. As a result, Hollnagel and Wears (2015) note that this makes it extraordinarily difficult to assess if our efforts to improve safety are working and to argue for continued investment. Moreover, this approach to safety makes it particularly difficult to see what “good safety” looks like as we only try to achieve a lack of harm. This is a possible explanation for why progress in improving patient safety has been so slow.

The human component

In the safety-I approach, the human actor is seen as a constituent of the system, and human action is often regarded as a clear part that is susceptible to error. Technological advances in safety have therefore attempted to “replace ‘fallible’ humans with ‘infallible’ technology” (Hollnagel and Wears 2015, p.16). For example, digital early warning score systems are used to automatically alert other staff groups, rather than relying on the individual clinician to escalate according to the policy. Although this has benefits of increased standardisation, Hollnagel and Wears (2015) argue that technology can only be relied on in set circumstances with no unexpected variability, which is simply not possible in today’s complex healthcare system. They argue that humans are not a problem to be solved, but are instead an adaptive solution to many patient safety issues.

Other attempts to standardise practice have been to implement strict national and local guidelines and policies, used to prescribe practice. However, performance can never be fully prescribed. Human actors offer an adaptive solution allowing a flexible and adaptive response in order to make our healthcare system function. Without this our system would not be able to function (Hollnagel and Wears 2015).

SAFETY-II

Overview

Approaches to safety have seen a shift towards adopting a more proactive, rather than reactive, position on safety (Ball and Frerk 2015, Chan 2016). The growing complexity of healthcare has been argued to make it no longer possible to adopt a purely safety-I approach, as easily identifiable solutions to errors cannot be generated amongst such complexity (Ball and Frerk 2015, Chan 2016). Hollnagel and Wears (2015) have suggested the safety-II approach as a possible solution, which focuses on the positive instances of care, and defines safety as "everything going right" (Hollnagel and Wears 2015, p.24).

Hollnagel and Wears (2015) explain that the safety-II approach is based on the understanding that healthcare today is highly complex and full of uncertainty, requiring humans to make adjustments in order for healthcare to function. It is now widely acknowledged that healthcare has become inherently complex, with growing complexity of comorbidities, patient conditions, treatment pathways, integrated care and technology (Plesk and Greenhalgh 2001). Complexity science has evolved to acknowledge and support understanding of what makes complex adaptive systems and how these work (Woodward 2019). This notion of complexity theory fits with the safety-II approach as it is based on the premise that complex adaptive systems involve the interplay of individual agents who have the freedom to act in unpredictable ways and that these actions are all interconnected with others and the broader organisational context (Plesk and Greenhalgh 2001). Unlike the safety-I approach, complexity science and safety-II approaches see boundaries as blurred and context dependent, making problem solving difficult due to unexpected and unintended consequences of actions (Woodward 2019, Plesk and Greenhalgh 2001). The key areas of complexity science are the acknowledgement that; boundaries are blurred, agents actions are based on internalised rules, systems and agents are adaptive, inherent uncertainty and non-linearity (Plesk and Greenhalgh 2001). All of which relate closely to aspects of the safety-II approach which will be further explored in this section.

A key challenge in the approaches taken to safety interventions is related to appropriate solutions. In many ways, the safety-I approach can be seen to attempt to apply simple solutions to what are in fact significantly complex problems (Woodward 2019). This could explain the limited success of dominant safety-I solutions within healthcare, as the solutions implemented were perhaps inappropriate for the level of complexity (Woodward 2019). Complexity theory is therefore an important consideration for safety in healthcare, and it is essential to acknowledge healthcare as a complex adaptive system (Plesk and Greenhalgh 2001). By aligning complexity science with Hollnagel's safety-II view on safety it is possible to see how taking a broader, context dependent and appreciative approach to safety allows complexity to be captured and explored (Woodward 2019).

Overall, focusing on rare cases of 'human error' does not explain how human performance goes right nine times out of ten, nor does it show us the direction we can take to improve safety. Safety-II offers the solution that we should "look at the many cases where things go right and try to understand how that happens" (Hollnagel and Wears 2015, p.20). The core focus of safety-II is the study of success, and the main adoption of the safety-II approach can be seen in the growing attention given to "Resilience engineering" (Ball and Frerk 2015, Chan 2016, Fairbanks et al 2014). Resilience engineering is the ability of resilient systems to respond effectively to growing demands, pressures and threats to safety (Fairbanks et al 2014). In establishing resilient systems, there are four related aspects: "monitoring or exploring the system's function and performance; responding or reacting to events or conditions; anticipating or foreseeing future events and conditions; and learning or reorganizing system knowledge" (Chan 2016, p137). Such approaches have shown promise within healthcare, with Anderson and Watt (2020) reporting that use of such safety-II and resilient healthcare concepts can increase quality of safety approaches, and is particularly useful for strengthening adaptive systems.

The safety-II approach therefore offers an appreciative approach to safety, which focuses on positive practice and accommodated for the inherent complexity of healthcare systems (Woodward 2019). Rather than focusing on standardisation and constraints, safety-II acknowledges the vital need for practitioners to make adjustments and be adaptable in order to achieve good safety and quality (Hollnagel and Wears 2015).

Performance adjustment and variability

As I have discussed, safety-I used a bimodal systems approach that was adopted from other industries outside of healthcare. On the other hand, safety-II has attempted to reflect healthcare today. It recognises the sheer complexity of healthcare that is forever changing and expanding. As such, it also recognises the vital place of performance adjustments and variability. Hollnagel and Wears (2015) describe adjustments as "increasingly important for effective performance and therefore present both a challenge and an opportunity for safety management" (Hollnagel and Wears 2015, p.21).

Hollnagel and Wears (2015) explain that in the safety-II approach adverse events should not be treated as individual "failures", but are instead seen as part of everyday performance variability, which in most cases does not negatively affect safety. Healthcare is not seen to be the functioning of bimodal systems that either "work" or "fail", but instead performance is both flexible and variable. This performance variability should not be seen as a negative aspect, as this allows for both acceptable and adverse outcomes, and the majority of times the outcome is positive.

Emergence, not causality

The safety-II approach is based on the foundation that performance is variable, making it impossible to apply a linear model of cause-and-effect (Hollnagel, Woods et al. 2006, Hollnagel and Wears 2015). Although it may be appropriate to apply this in some cases, in most cases outcomes are seen to be "emergent rather than resultant"

(Hollnagel and Wears 2015, p.24). Therefore, causality cannot be used to adequately explain most safety incidents, or adverse events, due to the influence of multiple factors in our complex systems. This means that often no single cause can be found for an adverse event, due to the transient nature of the many sociological factors that influence care.

THE WAY FORWARD

The safety-II approach offers a new outlook on safety that accounts for the complexity of healthcare today. As patient safety research has focussed on the 10 per cent of times things go wrong, there is massive potential that by using this approach we can learn from the wealth of good safety practice taking place. Through looking at the context and considering the complex interplay of sociological influences it may be possible to find new solutions to the ongoing safety problems faced in health and social care today.

Due to the complexity of healthcare today, the notion of a single approach to safety solutions should be rejected (Woodward 2019). Hollnagel and Wears (2015) therefore suggest that safety-II approaches should not simply replace that of safety-I. Instead they propose that we should now be looking at what goes right and what goes wrong in a way that is proportionate and does recognise that failures can still happen. Multiple scholars have supported this claim and support that safety-I approaches, such as incident reporting and risk assessment remains an essential part of safety in healthcare, but must be supported by wider adaptive systems to use such information and also learn from positive instances of safety (Carson-Stevens 2018, Woodward 2019, Woodward 2019a, Anderson and Watt 2020). Woodward (2019a) calls that now is the time to consider balanced and nuanced approaches to safety that are able to get underneath the surface of patient safety issues today. This chapter therefore suggests a need for patient safety research to adopt an approach that looks at the full context of safety, inclusive of when things go right, and when things go wrong.

CONCLUSION

Patient safety continues to be an important consideration within health and social care. The orthodox and safety-I approach has come to be dominant in healthcare today. For example, the notion of “do no harm” continues to be a central part of practice today, and we regularly see policymakers, managers and regulators emphasising that we need to make sure that patients are protected from harm. It is argued that the cause and effect assumptions underpinning these approaches are fundamentally flawed and are therefore unable to capture the complexity of health and social care organisations. Moreover, the chapter has highlighted that patient safety research and interventions often adopt a medical lens with far less research available outside of acute medical contexts. Overall, It is clear that safety-I has many limitations, and that advances in patient safety should move away from positivistic and orthodox perspectives.

The safety-II perspective offers many solutions through its focus on learning from high quality and safe care, as well as embracing the individual autonomy of human actors. However, safety-II has much broader potential if used alongside a sociological approach to understanding safety. Specifically focussing on the aim of this thesis, the safety-II perspective offers a means of exploring how organisational cultures promote safety, rather than looking at how safety may go wrong (Waring, Allen et al. 2016). Moreover, the focus of safety-II on the broader organisational context enables the consideration of the complex interplay of social, ethical, cultural and political factors that may influence upon safety. Overall, this chapter has clearly indicated the need for patient safety research that takes an approach that accounts for sociological factors such as cultural, social and organisational influences upon health and social care

CHAPTER 3- Organisational Culture Literature Review

INTRODUCTION

Chapter 2 has outlined the importance of considering sociological factors, such as culture, when investigating patient safety. The purpose of this chapter is to offer a critical insight into the dominant views on organisational culture and offer an alternative perspective that will underpin this thesis. The chapter will first briefly highlight culture as a concept and critically address how culture is contested within the literature. Organisational culture will then be explored to show how culture has been operationalised within organisational theory. The chapter criticises the dominant positivist lens that underpins much of the literature and suggests the interpretive paradigm as an alternative perspective that would allow the use of the sociological approach advocated in Chapter 2. Moreover, it is noted that to truly understand an organisation's culture it is necessary to explore this at the deepest level of 'basic underlying assumptions', which is only possible through an interpretive perspective. Finally, the chapter deconstructs the notion of safety culture, which has become a widely accepted concept within high-risk organisations, and more recently, health and social care. Overall, the chapter builds an argument for the topic of this thesis exploring organisational culture and safety within non-mainstream healthcare settings. It also lays the foundations for the interpretive methodology chosen within this study.

CULTURE

'Culture is one of the two or three most complicated words in the English language' (Williams, 1983, p.87) .

Exploring the concept of 'culture' is no easy task, due to the complex and varied history of this term across distinct disciplines and schools of thought (Williams 1983). The term has been used with varying meanings, including physical, metaphorical, symbolic and even in a romantic manner in relation to art and literature (Williams 1983). This has resulted in overlapping positions and fundamentally opposed stances on the understanding and exploration of 'culture'.

Within British and American social theory, 'culture' is conceptualised through a 'pluralist' view (Jenks 2006). Broadly 'culture' can be seen to encompass the action, understandings and motivations of behaviour within a group, often measured through looking at regular, or common, behaviours (Markus 1990). It is common that 'culture' is used to refer to social patterns, and has therefore been related to shared meaning, reality, rituals and objects that guide the collective action of individuals (Markus 1990, Alvesson 2002, Hirschfeld, Atran et al. 1982). However, the concept of 'culture' again becomes more complex with acceptance that the overall collective 'culture' is defined by the division of work and interplay of smaller social units and their 'subcultures' (Jenks 2006).

It is clear that definitions of culture are theoretically dependent, and that there is no fixed or agreed meaning of the term ‘culture’ (Williams 1983, Borowsky 1994). Although the meaning of ‘culture’ is complex and highly contested, this thesis focused on the use of ‘culture’ to explain social action and human society. It is important to note that ‘culture’ may still have varied meanings across disciplines, such as anthropology, sociology, economics, organisational theory, and across different theoretical and philosophical underpinnings. ‘Culture’ was used as a concept to encompass the importance of symbolism and rituals and the individual interpretation of events, ideas and experiences, all of which is shaped by the groups within human society (Frost et al 1985). Moreover, the term ‘culture’ has been used to encompass the underpinning assumptions, norms and values of the social reality, as this has been seen to be the essence of culture (Schein 1988). Organisational theory has been used to operationalise this concept, and the meaning and exploration of ‘organisational culture’ critically discussed.

ORGANISATIONAL CULTURE

INTRODUCTION

Organisational performance has been widely accepted as a reflection of the underlying organisational culture. However, like the concept of ‘culture’, the term of ‘organisational culture’ remains varied and contested (Alvesson 2002). The variation across this body of literature is particularly noticeable due to the contrasting views and theoretical underpinnings across the scientific disciplines that contribute to this field (Alvesson 2002). Generally, it is associated with a shared understanding of reality, including cognition, attitudes, beliefs, values, ideologies, norms and behaviours that shape individual, group and organisational activities (Schein 1988, Alvesson 2002) The term ‘organisational culture’ has been described as a ‘tricky concept as it is easily used to cover everything and consequently nothing’ (Alvesson 2002, p.3).

Although organisational culture was first explicitly discussed as a defined entity in the 1970s, Parker (2000) argued that many of the themes raised by organisational culturalists are not new, but rebranded previous themes and ideas already discussed in the study of organisations, such as climate, personality, atmosphere and institutionalisation. The work of both Weber and Taylor can be seen as a precursor to the advancement of organisational culturalism (Taska 1992). It is therefore challenging to ascertain when ideas of culture became a part of organisational theory, as arguably these themes were within the literature without being specifically called ‘organisational culture’ (Parker 2000, Onday 2016). In the late 1970s, modern organisational culturalism was born (Parker 2000). Early work on organisational culture (Ouchi 1981, Peters and Waterman 1982, Deal and Kennedy 1988) explicitly recognised this to be a key quality indicator that organisations should have.

PERSPECTIVES ON ORGANISATIONAL CULTURE

This next section attempts to capture the main perspectives on organisational culture and position them within distinct sociological paradigms. Burrell and Morgan's (1979) influential typology of sociological paradigms draws on four distinct stances on organisation (functionalist, structuralism, interpretive and radical humanist). Parker (2000) used this typology to group different historical stances and approaches to organisational culture, which will be used to explore two of these dominant approaches; structural functionalist and interpretive (Please see Table 1).

Table 1: Parker's (2000) approaches to organisational culture (reproduced in full)

Sociological Paradigm	Approach to Organisational Culture
Structural Functionalist	Widely adopted across organisational culture studies. Positivist worldview, reality, facts and truth. Focus on the ability of managers to manipulate and control people's actions. Use of human factors approaches.
Radical Structuralism	Little research into this approach. Positivist worldview, reality, facts and truth. Focus is on structural conflicts that generate societal change through political and economic crises. Relates to higher levels of structure and society, rather than the local level actors that may influence culture.
Interpretive	A growing approach, not widely adopted. Interpretive worldview, social construction between actors. Focus is on local level symbols, languages and actions related to individual actors. Sociological perspectives.
Radical Humanist	Little research into this approach. Interpretive worldview, social construction between actors. Focus on power and power relations in relation to local level actors.

Structural functionalist

The first emergence of organisational culture was termed 'Managerial Culturalism', aligning with Burrell and Morgan's (1979) structural functionalist paradigm. Managerial culturalism focused on the ability of managers to manipulate and control people's actions through the use of scientific management and human factors approaches (Parker 2000, Waring 1992). This early understanding of organisational culture took a distinctively positivist stance whereby organisational culture was seen as a variable that could be theoretically, methodologically and pragmatically analysed and controlled to improve organisational performance (Denison and Mishra 1995, Ouchi 1981, Peters and Waterman 1982). The functionalist perspective assumes that culture is the sharing of values, norms and symbols (Hollis 1994) which if understood, can empower management and elite staff to exercise control over workers (Ouchi 1981, Peters and Waterman 1982, Deal and Kennedy 1988, Parker 2000). It has therefore been argued that this approach aligns with dominant management approaches that focus on control and coerce as primary tools to achieve 'culture' (Smircich 1983).

The dominant structural functionalist paradigm has historically been argued to be an effective organisational approach, giving organisations a competitive performance advantage (Lim 1995). Owoyemi and Ekwoaba (2014) have suggested that organisational culture can be used as a tool to enhance organisational performance, but describes this as a "double edged sword" and therefore may be either an asset or liability. Attempts to control and manipulate organisational culture can provide benefits in terms of outcomes, but has suggested to reduce employee autonomy and result in job dissatisfaction, absenteeism and lower productivity (Owoyemi and Ekwoaba 2014).

This first emergence of organisational culture has been argued to not demonstrate the complexity of organisational culture, and instead presented culturalism as a quick fix and a strategy that could be followed by managers to achieve excellence (Parker 2000, Sulkowski 2014). It is not surprising that many attempts to change organisational cultures using such approaches have been found to be unsuccessful. A particular criticism of this stance is the focus on facts and truth, whereby culture is seen to be a tool that can be identified and fixed, in the same way we find a fault with a car and fix it (Parker 2000). This is a flaw in the fundamental assumptions of the functionalist perspective that tends to describe reality as a fixed, stable and balanced state, thus making it difficult to apply this approach to organisational culture which is arguably a dynamic phenomenon (Sulkowski 2014). Organisations are widely accepted to be rapidly changing environments due to both internal and external influences, and more dynamic approaches to organisational culture are required to gain solutions from situations of conflict, incoherence and contradiction that are commonplace in organisations (Coser 1956, Dahrendorf 1969).

The cause and effect model that underpins functionalism has further been criticised as inappropriate for exploring organisational culture. Key components of culture from this perspective are seen to be bimodal, either working or not working, and limits the depth of this paradigm in exploring the complex interplay of culture within organisations (Coser 1977, Sulkowski 2014). This view is therefore flawed, due to being unable to capture the complexity of the deeper levels of culture (Schein 1988). Overall, this functionalist argument accepts culture as a tangible and measurable trait that an organisation has, and remains the dominant argument within the study of organisational culture (Burrell and Morgan 1979, Parker 2000).

Interpretive

An alternative school of thought aligns with the interpretive paradigm (Burrell and Morgan 1979). This lens directly contrasts the positivist view described above, and instead believes that the social realm should not be subject to the same methods as the natural world (Hollis 1994). From this perspective culture is not seen to exist as an explicit entity or 'social facts', but is instead an ongoing social construction between individual actors (Smircich 1983, Smircich 1985). Culture is not something the organisation 'has' but is something the organisation 'is' (Parker 2000).

The interpretivist view on organisational culture is more local in nature, with culture studied through symbols, languages and actions related to individual actors, instead of focusing on the organisational structures (Rhodes 2000, Sulkowski 2009). This is seen to provide deeper understanding of culture, rather than looking at surface level structures and artifacts (Schein 1988). The interpretive perspective therefore provides a more 'holistic' account of culture, which accounts for the oversimplification of the complexity of organisations provided by the positivist paradigm (Turner 1990). The central assumption of this view is that all interactions are symbolic. Culture is seen to not be a defined set of traits, but instead can only exist through meaningful action and understanding of individual actors (Parker 2000). As such, this perspective captures the complexity of understanding culture and denies that this can be easily controlled and manipulated due to the socially constructed nature of organisational culture.

A further distinction of the interpretive paradigm is the methods adopted (Babones 2016). The functional/structuralist paradigms have looked to measure culture through the development of measurement tools and surveys; quantitative tools (Parker 2000, Schein 2010). These have often been used within the leadership and management level of organisations, and have been criticised for the subjective nature of management responses. Research on organisational culture has be criticised for focusing on top-level management and capturing just the macro level of an organisation (Parker 2000). Moreover, the functionlist paradigm has been criticised for its etic perspective and dominance of quantitative survey methodology that have been argued to not provide depth when exploring organisatioanl culture (Sulkowski 2014). Parker (2000) has argued that organisational culture should not be understood at just a top level, but "should be understood as involving both the everyday understandings of members and the more general features of the sector, state and society of which the organization is a part – both the 'micro' and 'macro'" (Parker 2000, p.1).

The Interpretive paradigm offers a solution for these prominent criticisms of the functionalist approach and is emic in its nature (Headland et al 1990). Interpretive approaches are arguably far more methodologically diverse and capture a range of qualitative methods to immerse the researcher in the field, including both anthropology and ethnography (Denzin and Lincoln 2005). Interpretivism therefore offers the potential to explore the complexity of organisational culture through the use of qualitative approaches, such as ethnography, participant observation and document analysis (Turner 1988, Parker 2000, Babones 2016).

Why are these perspectives important?

To understand the different views on organisational culture provided by the positivist and interpretivist lens it is important to understand their underlying assumptions. Distinctly, is culture something an organisation 'has', or is this something that the organisation 'is' (Parker 2000). From the positivist perspective culture is seen as something an organisation 'has' and it is therefore something that can be identified and controlled to improve outcomes. However, the interpretivist stance instead sees culture as something that the organisation 'is'. Culture is seen to exist within the organisation but cannot be controlled as this is a socially constructed entity made up by the complex interplay of actors situated within the social, ethical and political context of the organisation. From the interpretivist perspective, culture is something that we can seek to explore and understand in all of its contextual complexity, but it is not something we can seek to manipulate or control. These two standpoints are vastly different, and have parallels between the distinctions we saw in Chapter 2 when looking at the orthodox and sociological perspectives on patient safety.

Positivist views on organisational culture have dominated UK healthcare and can be seen within regulatory frameworks that explicitly look at leadership and culture (Care Quality Commission 2015, Care Quality Commission 2015). Moreover, various surveys and tools have been used to attempt to measure and change organisational culture within healthcare settings, predominantly related to "patient safety culture" (Hutchinson, Cooper et al. 2006, Singer, Meterko et al. 2007, The Health Foundation 2011, Morello, Lowthian et al. 2012, The Kings Fund 2014, Agency for Healthcare Research and Quality 2016). However, these surveys have a clear methodological flaw, as through focusing on the subjective opinions of top-level management they are unable to capture the everyday assumptions or practices of individuals at the frontline who deliver safety (Parker 2000). The focus of this position on the macro level, elite staff is therefore a prominent criticism, which can be argued to not give a true representation of the organisational culture (Schein 1988). The assumption that organisational cultures exist as a measurable and controllable entity can be seen as fundamentally flawed, and theorists are now advocating more interpretive approaches (Parker 2000, Sulkowski 2014). These would enable sociocultural influences on organisational culture to be captured.

The interpretive paradigm offers a distinctly different approach to understanding organisational culture within health and social care. The holistic nature of this approach resolves many of the criticisms of previous approaches to studying organisational culture (Turner 1990). Through the use of interpretive methods it is possible to explore what the culture 'is' amongst the frontline staff and service users of the organisation (Parker, 2000). Moreover, the understanding of culture as a social construction enables this approach to truly capture the complexity of sociological factors influencing health and social care organisations (Smircich 1983, Smircich 1985). The interpretive paradigm therefore offers a convincing alternative approach to exploring organisational culture, and offers the possibility to do this embracing a safety-II perspective that considers not only how safety goes wrong, but also how this works.

LEVELS OF ORGANISATIONAL CULTURE

The dominant positivist approaches seen within healthcare can be further criticised due to the level of analysis achieved through the use of scientific methods. Schein (1988, 2004, 2010) identified three levels for analysing organisational culture, with changing degrees of visibility to the observer (Please see Table 2).

Table 2: Schein (2010, p.24) Three Levels of Culture (reproduced in full)

Level of Culture	Description
1. Artifacts	Visible and feelable structure and processes Observed behaviour - Difficult to decipher
2. Espoused Beliefs and Values	Ideas, goals, values, aspirations Ideologies Rationalizations - May or may not be congruent with behaviour and other artifacts
3. Basic Underlying Assumptions	Unconscious, taken-for-granted beliefs and values - Determine behaviour, perception, thought, and feeling

Schein's well-known model has distinct areas of synergy and overlap with Parker's (2000) dominant sociological paradigms. The dominance of structural functionalism, has led to organisational culture within healthcare being predominantly explored through the use of positivist scientific methods (Mannion, Davies et al. 2005). Through positivist methods, such as the culture tools and surveys commonly used within the functionalist paradigm (Parker 2000), only the more superficial levels of culture can be explored. The functionalist perspective adopts a cause and effect approach whereby culture can be analysed, controlled and manipulated. Schein (2004) criticises these more surface levels as subject to interpretation. Through surface level artifacts, values and behaviours it is possible to capture what is, or is not, working within an organisation (Sulkowski 2014). However, as this aligns with the functionalist paradigm it does not allow for the depth required to explore the complex interplay of social actors (Parker 2000), meaning that the surface levels of analysis “often leave large areas of behaviour unexplained” (Schein 2004, p.30). This debate is similar to that seen in the above section between functionalism and interpretivism, with interpretive approaches again offering a solution to provide depth of insight into organisational culture.

The third level, “Basic Underlying Assumptions”, represents the deepest level for analysing culture, which is often taken for granted and aligns closely with Parker’s (2000) interpretive paradigm. Schein (2004, p.36) stated that “the essence of culture lies in the pattern of basic underlying assumptions, and once one understands those, one can easily understand the other more surface levels”. The deep unconscious assumptions of individuals and the group therefore represents the most important level for understanding culture. It is only at this level that differences in perceptions, understanding and subsequent behaviours or conflicts can be analysed. Despite the acknowledged importance of this deeper level of culture, it has had relatively less successful exploration within the study of organisational culture (Schein 2010).

Although Schein (2010) emphasised the importance of the deepest level of culture, his central argument was that you must capture all of the levels of analysis to truly understand the interplay of culture within an organisation. It is therefore essential to explore the sociological factors that underpin the level of artifacts, values and behaviours. As such, the methods used should capture the deepest level of organisational culture. As Parker’s work outlined, the interpretive paradigm offers a perspective that values the exploration of complex sociological factors (Hollis 1994, Parker 2000). This approach can therefore be used to provide deeper understanding of culture, rather than looking at surface level structures and artifacts (Schein 1988). Through this lens it is possible to use in-depth qualitative methods to explore culture at the micro and macro levels of the organisation, and provide a ‘holistic’ account of culture. The interpretive method addresses the oversimplification of the complexity of organisations provided by the positivist paradigm (Turner 1990). Specifically for this thesis, interpretive methods were appropriate for exploring how actors attribute meaning and value to safety by looking at their basic underlying assumptions. By doing this it was possible to explore the deepest level of organisational culture (Schein 2010).

RECURSIVE RELATIONSHIPS

In the discussion of organisational culture, a further contested point is what groups of individuals should be included as part of the organisation. This is a particularly relevant point for healthcare settings, which are often large, multifaceted and involve complex working across occupational groups, organisational boundaries and with patients and service users. Mannion, Davies et al. (2005) have argued that it is important to consider the place of service users and patients when studying organisations. Specifically, Mannion et al (2005) noted that "recursive relationships" (Mannion 2005, p.55) exist within healthcare organisations, whereby patient behaviour can impact on how staff interact and respond to patients within a service. As such, when studying organisational culture within healthcare, patients or service users are also an important group to consider. Investigations into organisational culture should also look at patients' deep underlying assumptions, as this has the potential to account for conflicts or success in interventions, communication, quality and safety.

SUMMARY

Overall, in the study of organisational culture it is essential that interpretive approaches be taken which explore the complexity of contemporary healthcare organisations. It is also important that comprehensive ethnographic approaches are taken which consider both micro and macro levels of the organisation, whilst also involving all relevant groups, including the recursive relationships that exist with patients and external stakeholders. Finally, to truly understand culture, the deep underlying assumptions of people within settings should be analysed.

SAFETY CULTURE

THE HISTORY OF SAFETY CULTURE

The concept of "safety culture" first originated as a specific part of "organisational culture". This concept was first discussed in 1988, following the Chernobyl nuclear energy disaster. Safety culture has since become a commonly used term and has received varying definitions. This is broadly seen to be "the product of individual and group values, attitudes, perceptions, competencies, and patterns of behaviour that determine the commitment to, and the style and proficiency of, an organization's health and safety management" (Health and Safety Executive 1993, n.p).

The concept of safety culture has been particularly influential in settings which are considered to be high-risk (Perrow 1984, Vaughan 1996). This resulted in a widespread call for high-risk organisations to have a 'safety culture' that fosters shared attitudes, values and behaviours that uphold organisational quality and safety (Health and Safety Executive 1993). Within high-risk areas such as nuclear power, space exploration, chemical plants and the aircraft industry, 'safety culture' is achieved through safe systems that make up an authoritarian, rigidly disciplined and error-free organisation (Perrow 1984). However, it has also been argued that simply standardising practice through such restrictions can hinder safety rather than promote it, especially in the present complex world that does not fit this simplistic view (Hollnagel and Wears 2015).

Patient safety culture

In Chapter 2, I discussed how patient safety came onto the international agenda and the dominant orthodox approaches taken to address patient safety concerns. Specifically in relation to culture, policymakers and experts called for a culture that "instils awareness of safety issues, openness about the potential threats to safety and shared values and behaviours that continually promote safety and learning" (Waring and McDonald 2014, p.119). Similar to the adoption of patient safety approaches generally, patient safety culture approaches were also lifted from other industries and were underpinned by positivist assumptions.

A significant shift in the culture of healthcare organisational has been the acceptance that adverse events are rarely the fault of individual or group behaviours, but are instead influenced by upstream or latent factors that make the conditions where these adverse events happen (Waring and McDonald 2014). "Systems thinking" came into existence and was essential for challenging the previous "blame culture" inherent in healthcare organisations (Leape 1999, Wiegmann and Shappell 2003). This shifted the attention away from blaming individual clinicians for adverse events or errors, and instead looked for the 'root-cause' of problems that were often outside of the clinician's control (Hollnagel and Wears 2015).

However, it has been argued that this 'systems approach' was insufficiently adapted, and was inappropriate for the application to complex healthcare organisations (Hollnagel and Wears 2015). As was seen in patient safety, the systems approach was also adopted from other industries and has been since considered unable to capture the complex interplay of social, cultural, political and organisational factors influencing healthcare practice (Waring, Allen et al. 2016). However, these systems approaches (like orthodox patient safety approaches) remain embedded within healthcare today for example in risk assessment, national reporting, audit etc.

CREATING A "SAFETY CULTURE" IN HEALTHCARE

Although adopting a 'safety culture' was seen to be a specific solution to safety issues within healthcare, the exact nature of a 'safety culture' and if this can be created within organisations is still widely debated (Rowley and Waring 2012). Broadly, safety culture is described in terms of the values, attitudes and behaviours that characterise a certain individual or groups' safety behaviour (Waring and McDonald 2014). The overall consensus is that individuals and groups should have a commitment to ensuring optimally safe healthcare. As such, if an organisation has a positive safety culture, it will have "enhanced awareness and attention to safety issues, openness and communication about the potential threats to safety, shared values about the importance of safety and behaviours to promote learning and embrace safety enhancing interventions" (Waring and McDonald 2014, p121).

However, the concept of a 'safety culture' remains widely debated, and is often poorly defined (Guldenmund 2000). There are therefore opposing views of 'safety culture' from different disciplines and philosophies. The term 'safety climate' is also commonly discussed and debated against 'safety culture' as either a similar or distinct idea (Guldenmund 2000).

As was discussed earlier in the literature review, the vast majority of advances in organisational culture have reflected a positivist approach. Meek (1988) argued that organisational cultures are socially constructed, and it was being wrongfully accepted that an organisational culture was a tangible entity that existed within organisations (Meek 1988). The main body of literature exploring safety culture is therefore based on foundational assumptions about knowledge and reality that have now been debated as inherently flawed. However, by taking an anti-positivist viewpoint culture is seen as socially constructed between actors, and therefore is not a device that can be used to manipulate and control workers. In fact, it could even be argued that this cannot be changed at all, which would explain why attempts to change safety culture have been largely unsuccessful (Waring and McDonald 2014).

Waring and McDonald (2014) explain that cultures themselves are complex and deeply embedded within organisational norms, cognition and regulation. As such, they show that it is difficult to change cultures, and changes in action may therefore not mean that the underlying meanings, values and assumption will have changed. Waring and McDonald (2014) recommend that we think more deeply about culture change and what this involves, particularly as there are inconsistent results from attempts to change culture, whereby failed attempts may result in poor morale and patient harm (McDonald, Waring et al. 2005).

Overall, the concept of 'safety culture' remains largely contested. Indeed, even the assumption that an organisation can have a 'safety culture' aligns with positivist assumptions that culture is something an organisation 'has', rather than what this 'is'. As this thesis aligns with the interpretive paradigm and views culture as what the organisation 'is' (Parker 200), I will be focussing on exploring organisational culture as this relates to safety. In doing so, I will explore the culture within the organisations by specifically looking at actors basic underlying assumptions and how they attribute meaning and value to safety. Moreover, to be able to explore the interplay between actors I will be looking at how the organisational culture influences negotiation of responsibility for safety between actors.

CONCLUSION

This chapter has framed the concept of organisational culture as relevant to this thesis and has highlighted the limitations of dominant positivist approaches to exploring organisational and safety culture. This chapter has also highlighted the significance of studying organisational culture and safety culture within organisations and the need for an approach that is interpretive and captures the basic underlying assumptions of all groups involved. As such, this chapter lays the foundations for the topic and methodology chosen within this thesis, which aims to explore organisational culture and safety using an interpretive methodology. As this thesis aims to explore the deeper levels of organisational culture, analysis will focus on how actors give meaning and value to safety. Furthermore, it will specifically focus on frontline actors and will involve residents and relatives to enable recursive relationships to also be captured.

CHAPTER 4- Gaps in the Evidence

INTRODUCTION

Chapters 2 and 3 have positioned this thesis within the literature surrounding patient safety, organisational culture and safety culture. This chapter will now move on from these debates to undertake an integrated literature review to pinpoint where the gaps in the patient safety culture evidence base lie. This chapter will also draw on findings of a further scoping review I have undertaken which has subsequently been published (Gartshore, Waring et al. 2017). The chapter will conclude by outlining the gaps in the evidence that this thesis will address.

INTEGRATED LITERATURE REVIEW

The purpose of this literature review was to provide a detailed overarching examination of the healthcare safety culture literature at the outset of the study. Applying systematic principles, an integrated review was used as this gathers and systematically categorises primary research (Ganong 1987). This strategy was chosen to allow for past research in patient safety culture to be summarised and to highlight specific areas for future research (Cooper 1989).

REVIEW QUESTION/OBJECTIVE

The objective of this integrated literature review was to provide an overview of health and social care safety culture literature, specifically highlighting:

- The health and social care setting
- Theoretical underpinnings
- Research method and measurement of culture
- The level of analysis (Schein 2004)
- Micro or macro level of the organisation (Parker 2000)
- Whether they included patient or service user groups in their analysis

INCLUSION CRITERIA

The review considered primary studies that investigated “Safety Culture” or “Safety Climate”, as these terms are often used interchangeably (Mannion, Davies et al. 2005). The studies had to have taken place in a health or social care setting. The studies had to have collected primary data and be written in the English language.

EXCLUSION CRITERIA

Papers were excluded if they: a) were not primary research b) were not written in English c) had a lack information related to the specified inclusion criteria.

LITERATURE SEARCH

Studies were identified by searching the databases: SCOPUS (Elsevier) 2003-Jan 2017, MEDLINE (Ovid) 1946-Jan 2017, CINAHL (EBSCO) 1937-Jan 2017, PsychINFO (Ovid) 1806-Jan 2017 and Web of Science (Thomson Scientific) 2008-Jan 2017. The dates of this search are up to Jan 2017, as this is when the integrated review was undertaken at the outset of the PhD study.

Search Terms Included:

Safety culture* OR safety climate* OR culture of safety* OR sense-making*

AND

Healthcare* OR social care OR hospital* OR long term care* OR nursing home* OR care home* OR homes for the aged OR residential home* OR home care OR community*

AND

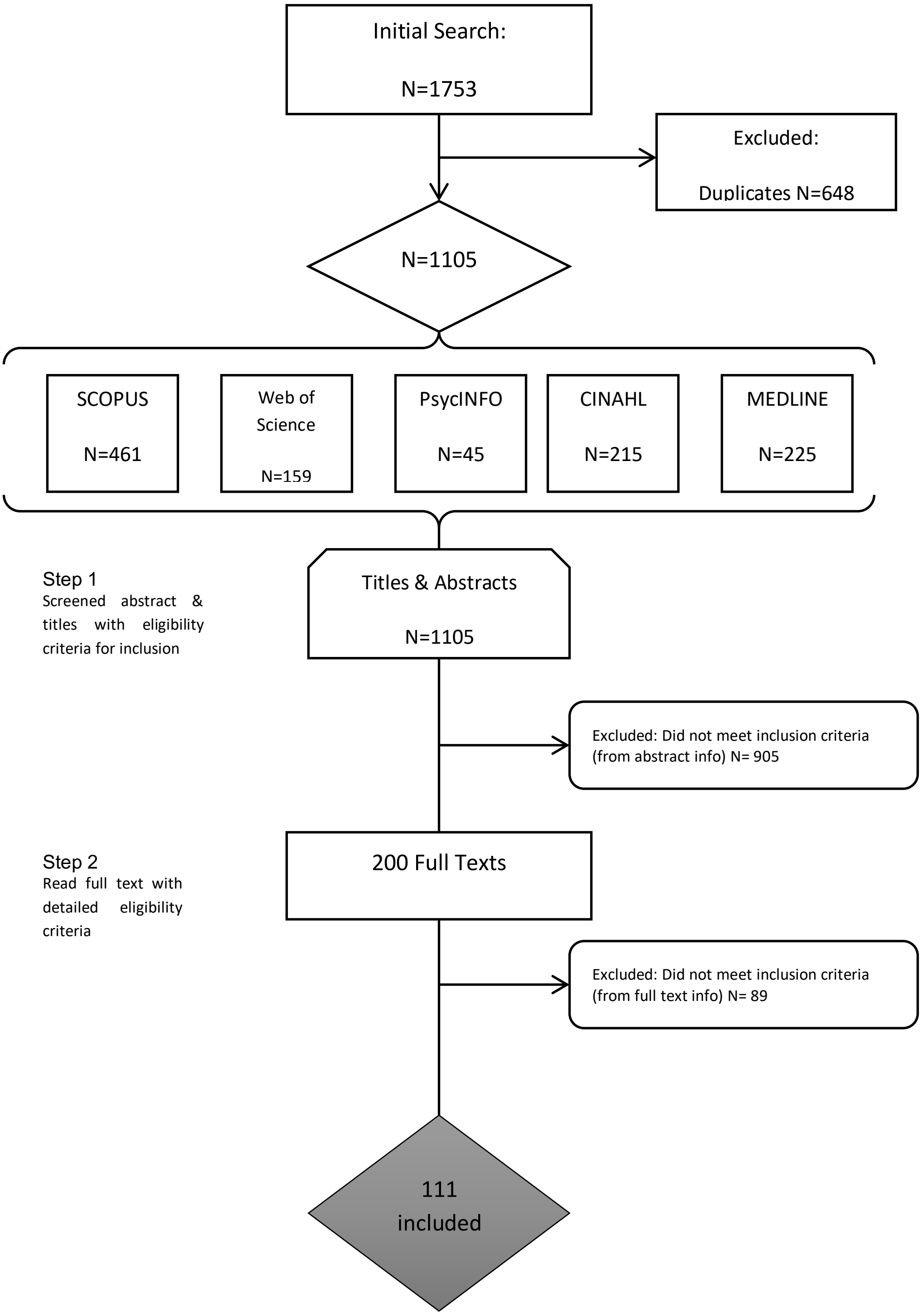
Patient safety*

All terms were exploded within each database to ensure all relevant terms were included as both key terms and MESH headings.

SELECTION PROCESS

The final search produced 1753 articles. After 648 duplicate articles were removed, this left a total of 1105 to be reviewed. All of the remaining articles had the abstract reviewed against the eligibility criteria; if the abstract was unclear then the full-text paper was be retrieved. 905 abstracts were rejected as they did not meet the inclusion criteria. The result was 200 retrieved full-text papers. Following full-text review, 111 texts met all eligibility criteria and were included in the literature review (see Figure 1 for a flow diagram of this process, see Appendix 1 for details of each included study).

Figure 1: Flow diagram of search strategy and selection process



REVIEW METHOD

The integrated review was undertaken following a systematic search strategy (Cooper 1989), as is outlined in the selection process. During the screening of papers two reviewers were used, the PhD candidate (EG) and supervisor (ST). EG undertook all initial screening of titles, abstracts and full texts. This was then reviewed by ST who provided challenge and a second opinion on which papers did and did not meet the eligibility criteria. The iterative double sifting process used ensures higher reliability and rigour for this review (Archer et al 2015). A data extraction table was designed by EG and the supervisory team prior to data collection to ensure this contained the relevant information and categories for the review. Data analysis was undertaken by EG at the outset who read each full text and pulled out the relevant information into the table in Appendix 1. This was reviewed in detail by ST to ensure the rigour of data extraction and analysis. The finding were discussed with the whole supervisory team to establish the key themes outlined below.

RESULTS

Following integrated literature review principles, a descriptive approach to synthesis of findings was used; common themes and content were identified and analysed. The 111 identified texts came from a variety of countries; most texts were from the United States (n=50, 45.0%). The remainder of the texts were predominantly from Asian (n=26, 23.4%) and European countries (n=32, 28.8%). A mere n=7 (6.3%) were based in the UK.

Health and social care setting

This review found that there was a prominent disparity in the chosen health and social care settings within the patient safety culture. There is a clear difference in the number of primary studies undertaken in a healthcare setting (n=99, 89.2%), in comparison to the number in a social care setting (n=9, 8.1%), with three outlier papers (n=3, 2.7%) that looked across both health and social care. This is a particular gap, as social care services make up a significant part of UK provision, with care homes alone reaching over 450,000 older people (NICE 2015). It is apparent that although some research has taken place within social care, there is still need for further exploration of safety culture within these non-mainstream care settings.

Theoretical underpinnings

The majority of the identified literature (n=101, 91.0%) sat within a functional/structuralist paradigm. This supports discussion from Parker (2000) and Mannion et al (2005) who identified that this approach underpinned most investigation into organisational culture. Far fewer studies sat within the interpretive paradigm (n=7, 6.3%), which again reflects the dominance of the functional/structuralist paradigm within the safety culture literature. In light of my earlier argument, in Chapter 3, this finding signifies the importance that research into organisational culture adopts more interpretive approaches, as these methods have the potential to capture the essence of organisational culture (Schein 2010).

Research method and measurement tools

Across the identified studies, there were a variety of research methodologies, which aligned with the theoretical underpinnings. The most common methodology was quantitative, through the use of surveys/questionnaires (n=100, 90.1%). This finding could be seen as expected, given that we know most studies adopted a functional/structuralist approach. All studies within the functional/structuralist paradigm used a quantitative survey method.

The interpretive articles (n=7, 6.3%) used a qualitative methodology, with the adoption of various methods. The qualitative methods included interviews, focus groups, reflective diaries and participatory action. Although a range of methods were seen in these studies, it is interesting that the literature review identified no ethnographic studies, particularly as Parker (2000) saw interpretive ethnographic approaches as essential for providing insight into the complexity of organisational cultures at both micro and a macro level. It is therefore apparent that there is a gap within the healthcare literature in the use of interpretive ethnographic approaches that aim to capture both micro and macro levels of safety culture.

Level of analysis

Overall, 96.4% of the studies analysed safety culture at the superficial levels of artifacts, beliefs and values (Schein 2010). This appears to be due to the predominant functional/structuralist approaches taken across the literature. Positivist approaches do not lend themselves to exploration of deeper meaning and can therefore only capture these more superficial levels (Parker 2000). Although this provides insight into safety culture across healthcare organisations, Schein (2005) explains that we can only truly understand organisational culture if this deeper level of culture is explored. Moreover, the findings align with Schein's acknowledgement that there has been relatively less successful exploration of culture at Level 3 (basic underlying assumptions), with only 3.6% (n=4) of the studies attempting to explore participants underlying assumptions.

The literature review highlighted a significant gap in the exploration of what Schein (2004) calls 'the essence of culture'. Particularly when looking at the healthcare safety literature, exploration of these deeper levels of culture is required. Moreover, all of the texts identified to be exploring level 3 were within a mainstream healthcare setting (e.g. hospital, primary care), as such research should focus on these non-mainstream care settings, particularly that of social care.

Micro/ macro

The texts were analysed to see if they were exploring the micro level (clinical and non-clinical frontline staff and direct ward level management), macro level (senior level management above ward level to executive team) or both. Parker (2000) identified that organisational culture literature has predominantly looked at the macro level, with little exploration of frontline workers. The findings from this review show a distinct advance in exploring organisational culture, as the majority of the literature was instead looking at the micro level (n=90, 81.1%). This may be unique to healthcare contexts and the frontline nature of patient safety culture. As such, studies looking at the macro level accounted for 4.5% (n=5) of the texts identified.

Moreover, Parker (2000) reflected that approaches needed to be taken to capture both the macro and micro level. This was seen to be the best way to achieve high quality research into organisational culture. Within this literature review some studies (n=13, 11.7%) were identified that attempted to explore both micro and macro level safety culture. Within the search there were three (2.7%) that did not define their population sufficiently to ascertain the level within the organisation.

More exploration is needed that covers both the micro and macro influences and aspects of culture. Parker (2000) suggests that the best way to achieve this it through ethnographic approaches that elicit a methodology that is tailored to meeting this aim.

Patient/service user inclusion

The final category for this literature review looked at if service users or patients were included in the study of safety culture. Mannion et al (2005) highlighted that it the importance of including patients and service users, due to the implications of recursive relationships. However, this literature review only identified three studies (2.7%) that included patient perspectives in the exploration of patient safety culture. This therefore highlights that the inclusion of patients/service users is a final gap within the health and social care safety literature. This could be particularly important for non-mainstream social care settings, such as long-term care, where patients, service-users, residents and their families make up a central part of the organisation.

Summary

The integrated review has demonstrated the predominant focus on medical and hospital services, and revealed the gap in evidence for non-mainstream care settings, particularly within social care. Moreover, there was relatively little evidence that adopted an interpretive approach to explore the deeper levels of culture. As organisational culture can only truly be understood at this deeper level, it is essential that more research attempts to capture basic underlying assumptions. Finally, in terms of participants, the review identified a need for a more comprehensive understanding of both the micro and macro levels of organisation, including the recursive relationships with patients/service users.

Overall, there is a need for future research into safety culture within non-mainstream social care settings, which use an interpretive approach to explore the deeper levels of culture. Ethnographic approaches should be taken to provide a comprehensive analysis that looks at both the micro and macro levels of the organisation.

Moreover, as patients/service users are at the heart of healthcare, it is essential that they are included in the investigation of organisational safety culture.

SCOPING REVIEW

OVERVIEW

A further scoping review was undertaken to describe the availability of evidence related to patient safety culture within care homes, as an important example of a non-mainstream care setting. As this scoping review was published (Gartshore, Waring et al. 2017), this section will not cover the methods of this scoping review, but will focus on the key gaps in the evidence that have also guided the direction of this thesis.

The scoping review found 24 primary research studies and 1 literature review for inclusion. This therefore shows the limited availability of research looking at patient safety culture within the care home sector. Chapter 1 and Chapter 2 highlighted the dominance of medical and acute hospital research looking at both safety and safety culture, which offers a potential reason for this limited availability of research.

Many of the findings of the scoping review were relatable to what was found within the integrated review. This body of evidence was similarly positioned in the functional structuralist paradigm and used positivist, quantitative approaches. The measurement tools used were also dominated by survey tools, with only one qualitative study found. From what has already been discussed in Chapter 3, it is unsurprising that the majority of these studies consequently only addressed the more surface levels of organisational culture. With no studies available that explored the deepest level of "basic underlying assumptions" (Schein 2010). It was also found that all of the available research into safety culture in care homes was focused on staff in this setting, with no studies capturing the place of the residents or relatives within this safety culture.

The scoping review also offered some additional insights into gaps in the evidence specific to this research in care homes. The first is that by looking at all available evidence related to patient safety culture in care homes, I was able to comment that there were no available studies in the UK. Moreover, the literature was mostly undertaken in nursing homes, which are distinctly different to residential homes that make up a large proportion of UK service provision.

FROM 2017 TO 2020

As this scoping review was undertaken in 2017, the search from this scoping review was run again to update these findings with literature published between January 2017 and July 2020. The search found 16 additional papers (not including the scoping review paper: Gartshore et al, 2017), which highlighted the growing interest in the care home sector and patient safety culture (please see Appendix 2 for these additional papers).

Although this literature provides more up to date evidence related to safety culture in care homes, this body of evidence was found to follow the same trends of the original scoping review. The vast majority of the studies aligned with the functional structuralist paradigm and used a survey tool to analyse safety culture (n=11, 69%), or was a psychometric test of a culture survey tool within care homes (n=4, 25%). Just one paper sat outside of this dominant paradigm and adopted a mixed methods approach to explore safety culture and the feasibility of Manchester Patient Safety Framework (MaPSaF) in care homes (Marshall, Cruickshank et al. 2017). It is also clear that the available research within care homes remains focused on nursing homes (n=15, 93%), and does not commonly include service users within this exploration. Overall, the updated search reveals that the conclusions drawn by Gartshore et al. (2017) remain timely and relevant.

Overall, this scoping review (Gartshore et al. 2017) reaffirms the findings of the integrated review presented in this chapter and also offers additional conclusions useful to the direction of this thesis. There is a need for more evidence that investigate safety culture within care homes, particularly capturing both nursing and residential homes. Studies should use interpretive approaches to be able to investigate the deeper levels of culture, with ethnographic studies highlighted as most useful. Finally, the research should encompass the perspectives and place of service users within the research.

ARRIVAL AT THE RESEARCH QUESTION

Reviewing the literature around patient safety, organisational culture and safety culture has revealed key gaps in the evidence which will be used to generate the research question for this thesis. The areas that will attempt to be addressed by this thesis are highlighted below:

1. Organisational culture and safety should be explored through the use of an interpretive approach that accounts for the complexity of healthcare today through an approach that aligns with sociological and safety-II perspectives.
2. The approach to exploring organisational culture should attempt to capture Schein’s deepest level of analysis; “Basic underlying assumptions”.

3. Care homes were highlighted as a neglected setting that have received little exploration in terms of both patient safety and culture.
4. Research into organisational culture and safety should attempt to capture both the macro and micro level of the organisation, which for health and social care organisations should include the recursive relationships of others involved, such as service users.

In order to capture the first two key areas noted above the research question needed to be appropriate for an interpretive ontology and appropriate qualitative methods. To capture the sociological influences upon both good and poor safety practice, and to delve into the basic underlying assumptions of participants, it was decided that the question should to explore how actors gave meaning to and value issues of safety. Through doing this it is hoped that the interplay of sociocultural factors will become apparent through exploration of what influences participant perceptions of safety.

Care homes were clearly identified as a neglected setting within the safety culture literature. This setting was therefore the focus of the study. The following chapter will build the argument of why this setting is also an empirically interesting setting to explore organisational culture and safety.

To capture the final area outlined above, the research question was framed to include all employees within the care home. This was chosen to capture diversity of perspectives between frontline employees in a variety of roles and the management of the care home. Residents and relatives were also considered key participant groups to include due to the recursive relationships of these individuals and the nature of this care setting as the residents' home (Fleming, Kelly et al. 2015).

After consideration of each of these areas the final research question arrived at was:

How do employees, residents and relatives give meaning to and value issues of safety in care homes?

CONCLUSION

This chapter has highlighted that there is a need for further research into patient safety culture in non-mainstream care setting such as care homes. Due to dominant positivist approaches, this chapter suggests that interpretive methods should be used and an attempt made to explore the deepest level of organisational culture. Moreover, there is a particular call for research to explore safety culture in both UK nursing and residential care homes in a way that involved both staff and service users. The thesis will attempt to address these specific gaps within the evidence through undertaking an interpretive ethnographic study into the organisational culture and safety in care homes.

CHAPTER 5- The Study Context- Care Homes

INTRODUCTION

Care homes provide essential 24-hour care to the vulnerable older population. The safety and quality of care homes has remained a prominent concern over recent years due to reports of failing care homes (CQC 2016). Care homes face many pressing issues that may impact on the safety of residents. These challenges include prominent variation across the sector, privatisation, limited funding and workforce challenges, all of which contribute to a fragmented and potentially unstable sector. These challenges are becoming more important as services are placed under increased demand due to the aging population. Complex comorbidities and rising levels of dementia amongst the aging population has led to increased demand for social care provision. In the UK this need is currently met by the care home sector.

This chapter will provide an overview of the UK care home sector. The chapter will not attempt to provide a systematic review of the care home evidence and will instead present an overview of care homes as organisations generally and within the safety literature. Overall, the chapter will highlight important organisational and sociological factors that may influence safety and make care homes a novel setting to study organisational culture and safety.

THE CARE HOME CONTEXT

The care home sector provides care to approximately 4% of the UK population aged 65 or older and 16% of those aged 85 or over (Competition & Markets Authority 2018). Typically, care homes provide support for residents' everyday needs, including Activities of Daily Living (ADL) (e.g. mobility, washing, dressing, eating and drinking) and Instrumental Activities of Daily Living (IADL), which are often more complex activities related to living independently (e.g. managing medications) (Mlinac and Feng 2016). ADL decline is prevalent in older people with physical deterioration as a result of long-term conditions or falls (Cahn-Weiner, Farias et al. 2007). Whereas IADL functioning is more commonly affected by cognitive impairments such as dementia (Farias, Park et al. 2013), with more severe cognitive impairments affecting both IADL and ADL functioning (Cahn-Weiner, Farias et al. 2007). ADL and IADL dependence has been correlated with poorer quality of life, increased health care costs and increased risk of mortality (Ramos, Simoes et al. 2001, Millán-Calenti, Tubío et al. 2010). Care homes provide this essential 24-hour support for vulnerable older people with both physical and cognitive decline.

In 2017 the care homes registered with the Care Quality Commission (CQC) in England had over 450,000 beds (CQC 2017). This is three times the number of available NHS hospital beds (NHS England 2016), which demonstrates the size of this sector in terms of social care provision. Although long-term care services internationally are predominantly nursing homes, within the UK this comprises both care homes with nursing (nursing homes) and without nursing (residential homes). In this thesis the term care homes will be used to include homes with and without nursing. Despite the growing acuity and dependency of the older population, it remains that most UK care homes do not have any registered nurses on site (CQC 2017). Residential care homes (non-nursing) make up 73% of all UK care homes (CQC 2017). In terms of service provision, there are some distinct differences, particularly in the provision for nursing care. Medical and nursing care within residential care homes is given through external providers, such as the local General Practice (GP) and community nurses. Within nursing homes, registered nurses on site meet nursing care needs, with medical care provided by the GP.

Despite rising demand, care homes remain poorly understood sites for long term care. Care homes face many organisational challenges, which include increasing service demands, national cuts to adult social care budgets, a largely unregulated workforce and workforce shortages (Cavendish 2013, Age UK 2014, Association of Directors of Adult Social Services 2015, National Audit Office 2015). From an organisational safety perspective, care homes are empirically and theoretically significant because of factors such as workforce composition, influence of commercial pressures, and as a setting that is the resident's home. There remains, however, little exploration of culture in this setting, in particular the deeper levels of organisational culture, and therefore we do not know how stakeholders give meaning to safety, or negotiate responsibility for safety within this environment (Gartshore, Waring et al. 2017).

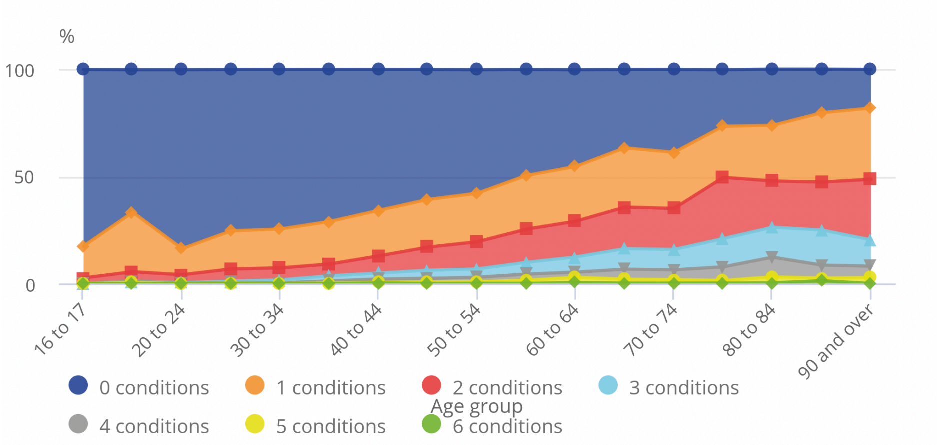
FEATURES OF CARE HOMES

In order to present an overview of the care home sector in the UK I have highlighted some distinguishing features of care homes and challenges that they face.

INCREASING ACUITY

Over the past 100 years the UK population has been steadily getting older and the Office for National Statistics (ONS 2018) predict that this trend will continue. By 2066 it is forecast that there will be 20.4 million people in the UK aged 65 or over, making up 26% of the total population (ONS 2018). These trends in the older population present a challenge for both health and social care services. As people age the number of complex long-term conditions they face increases (see Figure 2) (NHS Digital 2016).

Figure 2: Health Survey for England (NHS Digital 2016). Number of grouped health conditions by age, 2016, England.



This older population therefore have significant health and social care needs due to multiple long-term conditions, high-level functional dependency, and prevalent cognitive impairment (Coulter, Roberts et al. 2013, Gordon, Franklin et al. 2013, ONS 2011). Looking at the demographics of the typical resident, they are a female who is aged 85 or older, who has complex comorbidities including a cognitive impairment, frailty and high levels of dependency (ONS 2011, Baylis and Perks-Baker 2017, Dudman, Meyer et al. 2018). It has been suggested that this shift in demographics means that residents in nursing homes are now similar to what used to be cared for in community hospitals, and the residents within residential homes share the demographics of who was previously within nursing homes (Bebbington, Darton et al. 2001). People within the care home sector are now often very vulnerable people with high levels of depression and complex co-morbidities, immobility and subsequent dependency on others to meet care needs (Bebbington, Darton et al. 2001, Gordon, Franklin et al. 2013, Oliver, Foot et al. 2014). Among these complex conditions is dementia, which is a condition affecting older people, mainly those over 65. Globally it is estimated that 50 million people are living with dementia, and as the older population increases this is due to triple to over 150 million people by the year 2050 (Public Health England 2018).

Health and social care service in the UK have struggled to meet the growing demand of the older population who frequently require 24-hour care (Oliver, Foot et al. 2014) and are often at high risk of many safety hazards (Rowe and Kahn 1998, Crogan, Alvine et al. 2006, DH 2009, NICE 2015b). Recent statistics have shown a significant gap between people that need help with ADL (such as washing and dressing) and those who receive help, with 24% of people 65 and over reported to not receive the support required with daily activities (NHS Digital 2018). In the UK, people 65 and over account for 51% of adult social care expenditure (£8.8 billion) (Health and Social Care Information Centre 2014). As such, the increasing acuity of the older population presents both financial and service provision challenges for UK health and social care services.

The increased acuity within the care home sector is a significant factor to consider, as the majority of the workforce are unregulated workers, often with low levels of qualification (Cavendish 2013). This is an important workforce issue to consider and will therefore be covered under the section ‘workforce’ later in this chapter. As the UK care home market is dominated by residential homes, many services operate without a registered nurse on site even though the acuity of patients in these settings is what was historically seen in nursing homes. Moreover, the increased acuity and dependency of the older population in care homes has resulted in a prevalent medicalisation of care home care (Lievesley, Crosby et al. 2011). This can be seen within the approaches taken to both care and safety, which are often interventions and systems lifted from the NHS and adapted for care homes.

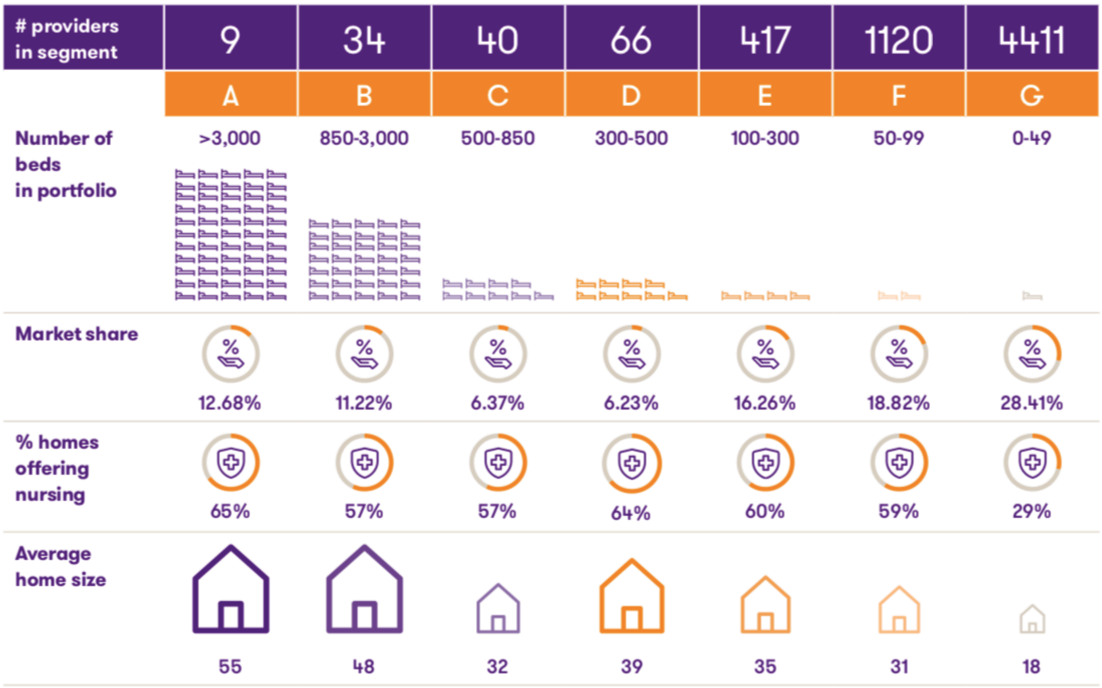
HETEROGENEITY OF ORGANISATION AND DELIVERY

The care home sector is not only vast, but has wide variation across the sector in terms of size, organisation, and governance processes (Coulter, Roberts et al. 2013, Competition & Markets Authority 2018), as well as disparity in the quality across the sector (CQC 2017) (see Figure 3). Historically, the majority of care homes were publicly funded and run by local authorities. In 1980, local authorities provided 63% of residential care home places, and the private sector just 17% (Lievesley, Crosby et al. 2011). One of the biggest changes since the 1980s is widespread privatisation of the UK care home sector. In 2019, this shift is evident with 84% of care home beds now run by the private sector, 3% of care homes run by local authorities and 13% by the voluntary sector (Blakeley and Quilter-Pinner 2019). This dominance of for-profit organisations in the care home sector continues to increase and has grown by 2% between 2015-2019 (Blakeley and Quilter-Pinner 2019).

The majority of these organisations are small, local entrepreneurs, often family-run businesses. However, in the late 2000s as UK property values increased this enticed large providers who were driven by potential profit and financial gains (Blakeley and Quilter-Pinner 2019). Looking at the care home market in 2018 it was found that the largest 30 care home providers supplied 30% of the overall capacity, and 80% of providers with only one care home supplying 29% of care home beds (Competition & Markets Authority 2018). It is therefore evident that the care home market is fragmented.

Across the sector, care homes are heterogeneous with wide variation between providers (see Figure 3). Some care homes are organised as single institutions or as small chains of providers without the considerable quality assurance and improvement infrastructure that underpins clinical governance in the NHS. Meanwhile, large-scale corporate providers adopt disparate approaches to quality improvement and assurance, which contribute to the inconsistency of approaches seen across the sector as a whole. Unlike the advances in patient safety that we have seen reflected across the medical profession and hospital services (Waring, Allen et al. 2016), UK care homes do not have standardised communication tools, alert systems, national reporting, or risk management. Consequently, safety practices, and developments across care homes are varied and rely on the individual organisations and settings to be responsible for managing safety and risk (Coulter, Roberts et al. 2013). Although this is an important point to consider, this doctoral study will be unable to capture the heterogeneity of organisations due to the small study size.

Figure 3: Overview of the care home sector in England (Thornton 2018)



# providers in segment	9	34	40	66	417	1120	4411
	A	B	C	D	E	F	G
Number of beds in portfolio	>3,000	850-3,000	500-850	300-500	100-300	50-99	0-49
Market share	12.68%	11.22%	6.37%	6.23%	16.26%	18.82%	28.41%
% homes offering nursing	65%	57%	57%	64%	60%	59%	29%
Average home size	55	48	32	39	35	31	18

PRIVATISATION

An important shift noted earlier in this chapter is that long-term care for older people has been transferred from the NHS to the care home sector. In the 1980s community care reforms saw the move of long-term care from community and geriatric hospitals to care homes. This formed part of policy reforms within the White Paper ‘Working for patients’ (DH 1989), which also highlighted the benefits of privatisation and the part independent providers had to play in health and social care. For the care home sector, this policy radically changed the political economy of care homes. The delivery of long-term care has moved away from the universal and state funded NHS to independent and private care home providers. It could be argued that the financial burden of long-term care has moved away from the state and onto providers and individuals. As such, the care home market is now largely dominated by financially motivated private providers.

The privatisation of the care home sector marks a significant cultural shift in the way care home services are run and the financial models that underpin them. Blakeley and Quilter-Pinner (2019) highlight that what has happened in the care home market is financialisation, whereby we have seen a rapid increase in financial motives, markets, actors and institutions within the care home sector. This mirrors the financialisation seen across the UK, whereby businesses invest in property by relying heavily on loans, bank lending and private finance. Blakeley and Quilter-Pinner (2019) propose that the care home market is a key example of finance shaping care delivery and services. The five largest care home providers, which account for nearly one-fifth of total care home beds (Competition & Markets Authority 2018), are private-equity backed organisations and have used the care home market to buy large amounts of land and real estate (Blakeley and Quilter-Pinner 2019). As a result, these organisations rely highly on funding from bank loans and financial markets. Many providers are now heavily indebted but continue to borrow money to buy further small care homes to expand their business. The cost of this debt is often pushed onto the residents as increased fees for care (Blakeley and Quilter-Pinner 2019).

The impact of this financialisation within the care home sector is that these financial interests have shaped service provision. Blakeley and Quilter-Pinner (2019) suggest that these companies are inclined to focus on maximizing shareholder value, rather than the quality of services. A key way to do this is to reduce costs, such as reducing costs of wages, and even tax avoidance. Blakeley and Quilter-Pinner (2019) outline that this has resulted in highly complex organisational structures often with multiple subsidiaries that may also be offshore.

Although privatisation is often pitched to be beneficial to quality of care, due to increase in services and competition, it has been found that for-profit providers with high levels of competition actually deliver a poorer quality of care (Rosenau and Linder 2003, Comondore, Devereaux et al. 2009, Forder and Allan 2011). Blakeley and Quilter-Pinner (2019) outline three areas that there appears to be an association between this ownership model and quality: workforce, instability and size. Private providers have been found to have a poorer quality workforce, with lower levels of staffing, higher staff turnover, lower rates of pay and lower levels of training (Dromey and Hochlaf 2018). This raises particular concerns for quality and safety, as evidence highlighted that these factors can lead to poorer quality and unsafe care (Eaton 2000, CQC 2017).

In terms of instability, the financial situation of some private providers has resulted in an unstable care home market. Over the past 10 years two of the largest care home providers have gone into administration, Southern Cross in 2011 and Four Seasons in 2019 following periods of financial difficulty. It is evident that the sector grows increasingly more volatile, with three-quarters of local authorities experiencing provider closure, up from two-thirds the year before (Association of Directors of Adult Social Services 2019). In 2018/2019, 250 care homes closed, equating to the closure of 3,000 beds (Bottery and Babalola 2020). The instability of the care home sector, as providers cease to be financially viable, is an important issue as closure of services puts our most vulnerable people in the UK at risk and is a prominent safety concern.

Finally, the size of care homes has been steadily growing, with large care homes taking a growing share in the market (Blakeley and Quilter-Pinner 2019). Trends have shown that the number of care homes continues to fall, however the number of available care home beds is continuing to increase, showing the growing size of care homes (CQC 2010, Lievesley, Crosby et al. 2011, Competition & Markets Authority 2018, Blakeley and Quilter-Pinner 2019). In 2004, the average size of a care home was 23 beds. By 2010 this had risen to 25 beds (CQC 2010). In 2018 care homes had 40 beds on average, with larger care homes having around 60 to 70 beds (Competition & Markets Authority 2018). This is of concern as evidence suggests that larger care homes provide poorer quality of care. In 2017, the CQC (2017) found that 89 per cent of small nursing and residential homes are rated as good or outstanding. However, large nursing and residential homes achieved just 65 per cent and 72 per cent respectively. Overall, the privatisation of the care home market raises many concerns for these organisation's stability, safety and quality of care.

FUNDING

The UK care home sector is worth around £15.9 billion a year (Competition & Markets Authority 2018). Although 97% of the UK care home market is provided by the independent sector (for-profit and charitable providers) (Blakeley and Quilter-Pinner 2019), the Competition & Markets Authority (2018) suggest that the current model of service provision in the care home sector is unsustainable without public funding. However, there continues to be substantial cuts to funding and since 2010 there has been a drop of £700m in adult social care funding (Bottery and Babalola 2020). The provision of care for local authority funded residents is unsustainable at the current rates that local authorities pay (Competition & Markets Authority 2018). The Competition and Markets Authority (2018) have reported that 49% of residents received support from only the local authority, with a quarter of these being 'topped up' by third parties, and 41% of residents were self-funding. It has been estimated that local authority funding is about 10% under the cost of care. This equates to a deficit of £200-£300 million across the UK (Competition & Markets Authority 2018). Overall, underpaying from local authorities has significant implications for the stability of the sector, particularly given the tenuous financial viability of some larger providers (Competition & Markets Authority 2018). As such, it is suggested that either the amount of funding available is increased to meet the increasing costs of care, or the financial model of the sector needs to change (Competition & Markets Authority 2018). The funding available to residents in nursing homes is different to that in residential homes, with the NHS commissioning nursing provision for approximately 10% of residents (Competition & Markets Authority 2018).

Across the sector, many homes attempt to alleviate this funding deficit by increasing the cost of care to self-funding residents (Competition & Markets Authority 2018). What this means is that those who are not eligible for local authority funding (those who have more than £23,250 in assets in England) end up paying more for the same care. As such, many care homes take both local authority and self-funding residents to be able to cover the running costs of the care home. The current social care funding model is therefore disadvantageous to people who have saved, as anyone who owns their property would not be eligible. Therefore in the care home sector there is disparity and inequality for residents. This presents many social challenges for residents, as those who self-fund often need to spend all of their savings and investments to cover costs of care that others get for free. These inequalities are often unseen and a further change in the market is many new care homes that open focus purely on the self-funding market, as this is where the most profit can be made (Competition & Markets Authority 2018).

The cost of care to self-funding residents is substantial. The average cost for a self-funding resident in 2016 was £846 per week, approximately £44,000 per year (Competition & Markets Authority 2018), with the exact fee varying substantially by geographical location. Multiple reports have found this to be substantially higher than what is paid by local authorities (LaingBuisson 2015, Mintel 2016). On average self-funders have been found to pay 41% more than local authority funded residents (Competition & Markets Authority 2018). It can therefore be seen that providers are cross-subsidising self-funders in order to cover for the low prices for local authority funded residents. The impact of this disparity and cost to individuals is that there is an increase in the unmet needs of older people, with people not accessing the care that they need. Age UK (2017) predicts that 1.2 million older people do not receive the care that they need.

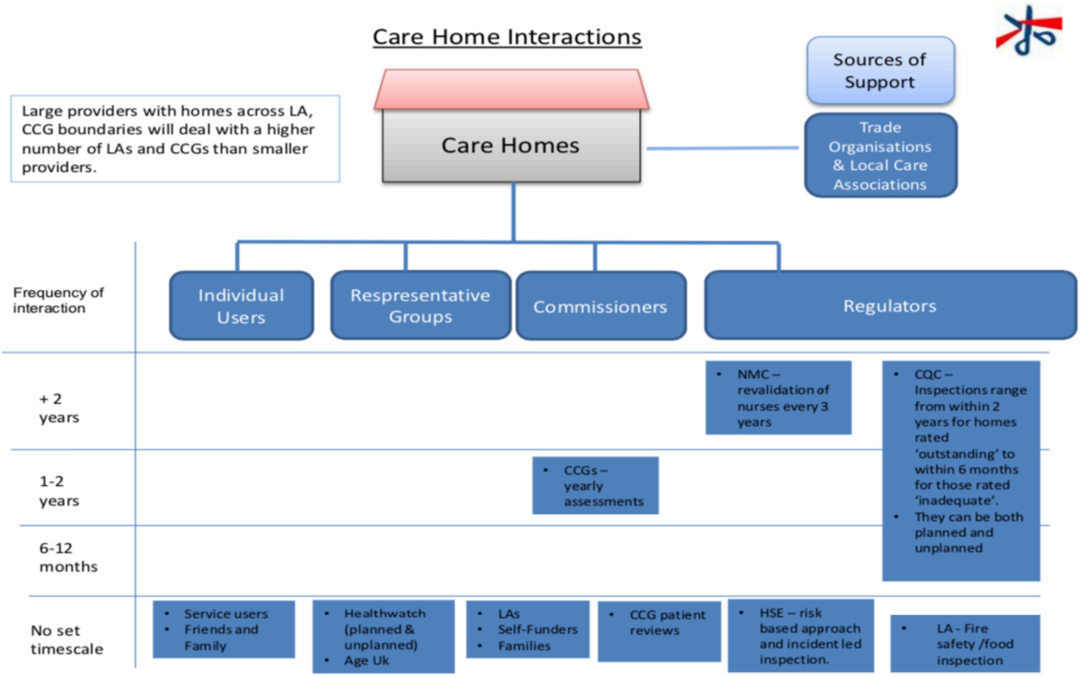
Overall, the funding of the sector contributes to many disparities across care home organisations and inequalities between residents in the same care home. As the dependency and care needs of our older population continue to increase so will care costs. These funding issues are specifically a safety concern due to measures to cut costs, such as staffing, training and resources. Moreover, these funding issues continue to raise concerns regarding the stability of the sector. This is an important concern and The Care Act (2014) highlights that the CQC holds market oversight and must assess the financial sustainability of these hard-to-replace care providers (Department for Business Innovation and Skills 2016). The Competition & Markets Authority (2018) highlight a need for change and reform to be able to stabilise the care home market.

REGULATION

The regulation of care home services is complex due to the funding landscape and multiple public agencies involved with this sector (see Figure 4). Health and social care services in England are primarily regulated by the CQC. For care providers to function legally they must first be registered with the CQC and meet their requirements. The CQC regulates across sectors and applies a standardised approach that relies on comprehensive inspection and ratings. This can be criticised as the current CQC inspection model is largely framed by the positivist paradigm and medical perspective that dominates the acute sector. Reviewing recent

CQC reports it is clear that although on re-inspection many services improve, a significant proportion of care home services drop in quality rating or remain the same. In 2017/18, 11% of adult social care services rated 'inadequate' did not improve on re-inspection (CQC 2018). For adult social care services rated 'requires improvement' 42% remained the same and 7% dropped to 'inadequate'. Of those rated 'good' 22% dropped to 'requires improvement' and 3% to 'inadequate'. Even looking at those rated 'outstanding' 27% dropped in ratings on re-inspection (13% good, 11% requires improvement, 3% inadequate) (CQC 2018). As such, the effectiveness of CQC regulation as a quality-enhancing tool for adult social care services can be called into question. Smithson, Richardson et al. (2018) have criticised the CQC's approach and found that this is less effective within the adult social care sector. It has been recommended that the CQC need to take a tailored approach to each sector (Smithson, Richardson et al. 2018), which has also been acknowledged in the CQC's recent strategy document (CQC 2016).

Figure 4: Care home map of interactions with agencies (Department for Business Innovation and Skills 2016).



The regulatory landscape of care homes does not stop at the CQC. Due to multiple sources of funding care homes are also accountable to the commissioners of services; the local authority who fund social care and local Clinical Commissioning Groups (CCGs) who fund nursing care. Local authorities have a vital role in the administration of state funded social care and this is reinforced by The Care Act (2014). Local authorities are not regulators, but as they fund 49% of care home places they have significant contact with care homes and hold them accountable to the contracts in place (Department for Business Innovation and Skills 2016, Competition & Markets Authority 2018). Local authorities hold responsibility for assessing eligibility and places for residents, but also have a role in shaping the market to ensure this meets the needs of residents and achieves value for money (Department for Business Innovation and Skills 2016). Local authorities will undertake visits and inspections on a regular basis, however each local authority operates differently. Local authorities also have an important role in the safety of care homes and have statutory duties for safeguarding for adults within the local area (Department for Business Innovation and Skills 2016).

CCGs take a lead for commissioning adult social care for those needing nursing provision and coordinate the local provision of NHS services. Local CCGs commission NHS continuing healthcare and funded nursing care within nursing homes. Similarly to local authorities, CCGs are accountable for the quality of the services they commission. They must have an ongoing relationship and undertake assurance visits within the care homes (Department for Business Innovation and Skills 2016). However, there is no standardised approach to quality assurance across CCGs, so all 209 CCGs may undertake their inspections differently (Department for Business Innovation and Skills 2016).

The regulatory landscape of the care home sector involves multiple public agencies and presents some key challenges for quality and safety in care homes. The Department for Business Innovation and Skills (2016) have found that many care home providers consider the burden of monitoring to have a significant negative impact on quality and safety within care homes. This has been reported to impact services across the sector as an excessive amount of time is reportedly spent on documentation for monitoring, which is felt to pull staff away from delivering care to residents. Moreover, with the interactions of these 3 public agencies, many providers are unclear on the roles and responsibilities of these organisations. It has been reported that there is overlap in the monitoring requirements, which results in duplication in work as well as variation in what is required between different local authorities and CCGs. Overall the monitoring activity that is supposed to enhance quality has been found to detract from quality and safety, causing an administrative burden to care home services and confusion among providers. The complexity of these systems makes quality improvement within care homes difficult to navigate and it has been recommended that steps need to be taken to coordinate monitoring and ensure this is effective (Department for Business Innovation and Skills 2016).

WORKFORCE

As residential care homes make up the majority of services in the UK, it is understandable that the workforce is predominantly unregulated staff (CQC 2017, Competition & Markets Authority 2018). By unregulated staff, this refers to the workforce that are not professionals registered with a professional body. This is of significance as in the NHS a high proportion of the workforce are registered professionals with the Nursing and Midwifery Council, General Medical Council or the Health and Care Professions Council, making up 53.1% (605,876 FTE) of the overall NHS workforce (NHS Digital 2020). For the care home sector the only professionally registered employees are often registered nurses. In 2019, registered nurses made up 6.4% (36,500 FTE) of employees within the care home sector (Skills for Care 2019) showing a significant difference between the nature of the NHS and care homes workforce.

The context of care homes has not been greatly explored in the patient safety culture literature (Gartshore, Waring et al. 2017), and as such little is known about how this workforce conceptualises, negotiates, or enacts patient safety. As a sector largely supported by unregulated and non-professional staff, it has been acknowledged that staff often do not have access to the support, training, and education required to deliver in their roles (Cavendish 2013). Almost 40% of non-professionals undertaking direct care roles have been found to possess no qualifications (Cavendish 2013), which may have an influence on individual understanding of safety. Moreover, due to varying structures and stakeholder relationships within care home organisations, access to external healthcare support often varies significantly across the sector (British Geriatrics Society 2011, Age UK 2017, Competition & Markets Authority 2018). This is of particular importance in England as the majority of care homes rely on a completely unregulated workforce with no medical or nursing provision (NICE 2015).

The average pay for care home staff is close to minimum wage, however those working in local authority run care homes were paid significantly more (Skills for Care 2019). Most carers working in the independent sector were on £8.21/£8.15 per hour or in senior carer roles were on £9.10/£9.05 (residential homes/nursing homes respectively) (Skills for Care 2019). Overall, the care home workforce is predominantly unregulated workers in low paid roles.

The demographics of the care home workforce show diversity across the sector. The average care home worker is a 43-year-old female (Skills for Care 2019). Broadly the nationality of the workforce differed within nursing and residential homes. Nursing homes had 74% British, 13% EU (non-British) and 13% non-EU, which showed more diversity than seen within residential homes, 85% British, 7% EU (non-British) and 8% non-EU (Skills for Care 2019).

The care home sector currently faces significant workforce challenges, including high staff turnover and difficulty in the recruitment and retention of staff (Centre for Policy and Ageing and Bupa 2012, Skills for Care 2019). Across the adult social care sector the vacancy rate is 8% and equates to 122,000 vacancies (Skills for Care 2019). However, turnover rates are particularly high within adult social care, reaching 30.8%, 440,000 leavers in a 12 month period (Skills for Care 2019). Looking specifically at nursing and residential care homes the turnover rate remains significantly high, 31.5% and 29.6% respectively. Within residential homes the turnover rate for care workers was even higher, sitting at 35.9% (Skills for Care 2019). This has particular implications for safety; with the CQC (2013) reporting a link between increased rates of staff turnover and notifications of death in care homes. The impact of staff turnover on safety was also found to be more prominent in care homes without any nursing provision (CQC 2013). Vacancy rates within nursing (6.3%) and residential (5.5%) care homes remain notable, equating to approximately 35,500 vacancies across the sector at any one time. These challenges present specific organisational factors in which individual perceptions of safety will be embedded (Brown, Colville et al. 2014).

HOMES AND PRIVATE PLACES

The complex environment of care homes is not only a care setting, but is the person’s home where they receive 24-hour care, often in the last years of life (Oliver, Foot et al. 2014). As a vulnerable group, with 80% cognitive impairment or dementia (Alzheimer's Society 2014), it could be argued that responsibility for safety has been passed over to the organisation and care home staff, in the same way that Hughes (1951) explains individual clients transfer responsibility to an expert. However, as this is the person’s home, should the person and their family have some responsibility for safety? Do they have the right to make decisions that put them ‘at risk’ or undertake activities that may be seen as ‘unsafe’? Or arguably, because these are a vulnerable group, should they be protected by organisational policy, risk assessments, structures, and the actions of staff providing care? In order for safety in care homes to truly be understood, we must attempt to comprehend these sociological challenges, and the impact of safety on the autonomy of individuals in their own home.

SUMMARY

Care homes are a novel social care setting that face many sociological challenges when delivering safe and effective care. Looking at the sector as a whole there is considerable diversity and many external factors influence upon care home performance. Multiple imperatives have placed pressure on care homes. In many ways it can be seen that although the sector aims to achieve safety and quality, care homes are often pulled in different directions, which can create confusion and a lack of coordination that is not conducive to improved safety practice. Overall, the care home sector can be considered unstable and fragmented. As such, it is important that safety within this setting is considered.

SAFETY IN CARE HOMES

This section will highlight important areas of the care home patient safety literature relevant to this PhD thesis. It will highlight relevant aspects of the literature including approaches to safety and key areas of safety practice and innovation.

Across the UK, care homes generally provide a good quality of care (CQC 2017). However, a number of CQC reports and high-profile scandals have raised significant concerns about the quality of care provided within this environment, with 10% of adult social care services rated as 'inadequate' for safety in 2015 (Berwick 2013, CQC 2013, NHS England 2014, CQC 2015). Although this has improved over the past 5 years, 20% of residential homes and 31% of nursing homes still require improvements in safety (CQC 2018). Care homes continue to be subject to negative publicity and are often criticised for delivering poor care, having a lack of funding, high turnover and inadequate training for staff (Eborall, Fenton et al. 2010, Cavendish 2013, Franklin 2014, Skills for Care 2019). A particular safety concern which has received recognition is the high prevalence of preventable harm within the care home sector, which includes falls, pressure ulcers and urinary tract infections (Mody, Krein et al. 2015, Stubbs, Denkinger et al. 2015, Marshall, Pfeifer et al. 2018).

Advances in patient safety research are predominantly led by medical and acute hospital settings (Allen 2009, Jha, Prasopa-Plaizier et al. 2010). As a result, the care home sector has not seen the same attention as the acute sector. Attempts to improve safety in care homes, often take initiatives and approaches from the acute sector and apply these care homes. Over recent years many interventions have taken place within care homes in an attempt to improve safety (Mody, Krein et al. 2015, Mody, Meddings et al. 2015, Buljac-Samardzic, van Wijngaarden et al. 2016, Lim, Anderson et al. 2016), however the outcomes have often been variable and ineffective due to poor intervention design and implementation (Jiang and Yu 2014, Marshall, Pfeifer et al. 2018). Arguably, the variable success of safety interventions in care homes may come from differences in organisational culture and a lack of understanding of the care home sector. Overall, there is a growing recognition of the need for care home specific research to inform and enhance safety practice within care homes (Gordon, Logan et al. 2012, Morley, Caplan et al. 2014, Goodman, Sharpe et al. 2017).

APPROACHES TO SAFETY

Approaches to safety in social care have historically taken a different approach to what is seen within healthcare. The Department of Health report 'No Secrets' (DH 2000b) highlighted institutional abuse as a prominent issue within social care. Following this report the focus on safety within social care took an individualised focus, centred on the steps people take to protect the individual from abuse or harm. As such, approaches to safety typically involved identifying people at risk and responding with appropriate interventions to promote safety and prevent harm (DH, 2007). Safety within care homes was subsequently bracketed under the broad umbrella of safeguarding, which remains commonly understood in the conceptualisations of safety within social care (Scott, Birks et al. 2017). Safeguarding processes involve the reporting and investigation of instances of abuse, and can include institutional abuse, physical abuse, psychological abuse, financial abuse and neglect. Safety concerns and harm within social care settings remains largely reported and investigated through these safeguarding channels. For example, if a resident had a wound or had a fall, this would be reported to the local authority safeguarding team who would investigate this as a potential instance of abuse.

What is of note here is that this approach to safety is greatly different to what is seen within the healthcare sector. As was captured in Chapter 2, patient safety in healthcare has involved the standardisation of practices across the NHS. Common practices are standardised policies and guidelines, risk assessments, care plans, incident reporting, root-cause analysis and more, all in an effort to control phenomenon and reduce harm within the NHS. However, care homes historically have not taken this approach. Instead care homes have largely been led by the individual organisation with limited guidelines to follow; as such there has been vast variation across the sector.

A further difference in the approach to safety within care homes is that unlike the hospital sector, staff within care homes often have not had the training and support required to put safety guidelines or recommendations into practice. Moreover, the variation across these organisations means many also lack the infrastructure required to apply theories of safety to their work. As such, the care home sector arguably requires more resources and investment to ensure the successful implementation of safety initiatives than acute settings that have a predominately registered workforce and a well-established infrastructure for safety.

SAFETY PRACTICE AND INNOVATION

Over recent years there has been a growing emphasis on innovation within care homes. The Academic Health Safety Network (2019) has published a recent report showing a wealth of safety practice innovations taking place in care homes across the UK. These span safety areas including safety culture, pressure ulcers, continence, pain, falls, nutrition, hydration, restraint, medicine optimisation, communication, infections, resident deterioration, dementia, monitoring, end of life care, workforce development and leadership (Academic Health Safety Network 2019). This can also be seen reflected across the academic literature with a growing body of evidence exploring these common areas of safety in care homes, most notably falls (Zubkoff, Neily et al. 2019, Glass, Mendelson et al. 2020, Schoberer and Breimaier 2020, Taylor, Parsons et al. 2020), pressure ulcers (Lavallée, Gray et al. 2019, Kwong, Chen et al. 2020, Palese, Zammattio et al. 2020, Parker, Finlayson et al. 2020), urinary tract infections (Gómez Belda, De la Fuente et al. 2019, Dowson, Bennett et al. 2020, Viner 2020, Wu, Pu et al. 2020), nutrition and hydration (Kuehlmeyer, Schuler et al. 2015, Lea, Goldberg et al. 2019, LagacÉ, Carrier et al. 2020, Salminen, Suominen et al. 2020), monitoring and deterioration (Sogstad and Tosterud 2018, Dugstad, Eide et al. 2019, Hall, Brown Wilson et al. 2019, Little, Rodgers et al. 2019). Although there is much more evidence available internationally than ever before due to the variability across the care home sector, it is often difficult to standardise interventions and approaches across the sector.

The NHS Patient Safety Strategy (NHS England and NHS Improvement 2019) focuses on improving patient safety across all sectors, and places emphasis on enhancing safety in care homes and reducing hospital admissions.

This national strategy is of note as it does attempt to standardise safety practice across the care home sector. Part of the NHS Long Term Plan (NHS England 2019) was to roll out the Framework for Enhanced Health in Care Homes across England by 2024. This is a programme of work that looks to embed a proactive and collaborative model of care within care homes (NHS England and NHS Improvement 2020). The framework sets out to set a minimum standard for NHS support to care homes and aims to bridge the divide between services. The 'Vanguard' projects, as part of this programme, have led the way on care home innovations to enhance 7 care elements, all of which are vital to quality and safety within care homes (NHS England and NHS Improvement 2020).

Attempts to standardise care across the health and social care sectors are also taking place, such as the National Early Warning Score (NEWS) 2 initiative (Royal College of Physicians 2017) which aims to standardise clinical monitoring nationally and has been trialled in care homes (Barker, Stocker et al. 2019). However, although it possible to roll out such initiatives in care homes, the approaches taken can be argued to not resonate with the understandings and practices of staff working in care homes. For example in the case of NEWS 2, it has been challenged that use of a track and trigger system may add no benefit to care homes, due to the more stable nature of the resident population and the limited avenues available for escalation (Hodge, Thompson et al. 2019).

A criticism of many safety innovations within the care home sector is that they have aimed to apply a standardised approach, many taking what has worked in the NHS and applying this to care homes. It is possible that unsuccessful initiatives may be due to the many organisational and cultural differences between care homes and the NHS. As such, the availability of evidence that explores the organisational culture within care homes may offer an answer to why these safety approaches have not worked, and may also offer a potential solution of how to ensure safety improvements in care homes are successful.

CONCLUSION

Care homes provide an essential service to meet the needs of the older population and are vital to the sustainability of the health and social care sector. In the UK, care homes have many distinguishing and varied organisational features due to the increasing acuity of residents, prominent privatisation, funding models, workforce factors and the regulatory landscape. All of these features situate care homes in a distinctly interesting cultural, social and political context with potential implications for the organisational culture within care homes.

There continues to be concern over the safety of care homes and approaches to safety innovation can often be varied and at times unsuccessful. However, no evidence is available that explores why such safety innovations have proven unsuccessful. From my arguments made in this thesis thus far, I would argue that may be due to the dominance of positivistic exploration of both organisational culture and safety. Therefore, the interpretive approach used in this thesis has the potential to reveal valuable insights about the distinct organisational culture within care homes and how this relates to safety.

Overall, safety in care homes continues to be an important topic and as explored in the last chapter (Chapter 4) there is no available evidence looking at the deepest level of organisational culture within care homes. By exploring the deepest level of organisational culture within care homes this PhD will offer an understanding of how people in care homes attribute meaning and responsibility for safety, providing vital insight to support future safety interventions and research within the care home sector.

CHAPTER 6- Methodology

INTRODUCTION

This chapter will start by reaffirming the aims and research question that were addressed by the thesis. The chapter will then position the thesis in terms of its ontology, epistemology and methodology. The ethnographic research design and methods adopted in the thesis will then be explored, providing details of data collection and experiences in the field, as well as approaches taken to data analysis. Key points of reflexivity during data collection will be highlighted for transparency. The chapter will finally outline the steps taken to ensure that quality has been achieved.

AIMS OF STUDY

The thesis aimed to empirically explore organisational culture and safety in care homes and make a significant theoretical contribution to the patient safety literature. The empirical evidence was used to explore the key themes identified as important to safety in care homes. The study aimed to achieve this by focussing on how residents, relatives and employees in this context attributed meaning and value by investigating the basic underlying assumptions that underpin human perception and behaviour, specifically in relation to quality and safety.

RESEARCH QUESTION

The thesis addressed the central research question

Question: *How do employees, residents and relatives give meaning to and value issues of safety in care homes?*

In order to understand safety in this setting the deeper levels of culture for staff, residents and relatives will be explored. The influence of sociological factors will also be considered.

ONTOLOGY, EPISTEMOLOGY AND METHODOLOGY

SOCIAL CONSTRUCTIONIST

Berger and Luckmann's (1967) seminal work proposed that people experience their own reality through social processes. Reality is considered "not distinct from one's own interpretation of reality" and is seen to be dependent on individual perception (Slater 2018; pg.1626). Knowledge was consequently the product of people making subjective judgements about social interactions, objects and facts (Slater 2018). According to this approach people understand the world through social relationships, experiences and dialogues, making reality construction continual, fluid and dynamic (Gergen and Gergen 2004, Gergen and Gergen 2012, Slater 2018). As such, research aligning with this ontology does not seek to find truth, but instead looks to explore the nature of these social processes (Slater 2018).

The thesis aligned with this ontological perspective, and considered the reality of the care home as socially constructed from the perspectives of, and interactions between, key actors. Through these interactions staff, residents and relatives were seen to socially construct a sense of shared meanings. The study took a practical social constructionist approach and presented theoretical possibilities based upon the social interactions captured within this study (Camargo-Borges and Rasera 2013). Moreover, the thesis did not seek to present findings as an absolute truth, but produced knowledge that was practical and context-dependent (Camargo-Borges and Rasera 2013).

Social constructionist perspectives have been used to support a variety of innovations in research and professional practice within healthcare (Gergen and Gergen 2012). Specifically, the social constructionist perspective supports research and practice which "focus on strengths and what is already working well, instead of on problems and how to fix them" (Camargo-Borges and Rasera 2013 pg.2). In line with this, the thesis attempted to explore the concept of organisational culture using an appreciative safety-II approach as has already been outlined within Chapter 2.

INTERPRETIVE

The literature review on organisational culture (Chapter 3) has highlighted that there was a need for more research that uses interpretative approaches to explore organisational cultures (Parker 2000). This thesis has therefore adopted an interpretive epistemology, and thus made a contribution to the limited interpretative research into organisational culture (Parker 2000).

Johnson (1984) described interpretivism as:

> "Hunger, pain and anger in the human world cannot be described without investigating how individuals use language and symbols to construct what such states *mean for them.* For it is only by understanding the individual experience of subjective interpretation that we will understand why human beings behave in the way they do." (Johnson 1984; p.75).

Interpretive approaches give value to, and seek to explore, the lived experiences of individuals and groups (Ormston, Spencer et al. 2014). Interpretive approaches to organisational culture were distinct in that culture was seen to be an ongoing social construction (Parker 2000). The thesis has therefore looked to understand the social world of care home organisations, seeing culture as constructed by staff, residents and relatives in this setting from symbols, languages and actions (Parker 2000). To gain a true understanding of the essence of organisational culture and safety, this study has used ethnographic interpretivism to shed light on the organisational culture and safety within care home organisations (Parker 2000, Schein 2010).

ETHNOGRAPHY

From both a social constructionist and interpretive viewpoint, organisations were considered “a potentially fluid field of meaning-making” (Gergen 2009; p.321), and therefore research into organisations require a methodological approach that allows exploration of complex social life. Ethnography presents a qualitative method that can be used to explore the nuances and meanings of the socially constructed world we live in, with particular attention on culture, power relationships and sociological factors (Geertz 1973). Moreover, ethnographic methods were recommended for exploring the deeper levels of culture (Weick 1995, Parker 2000).

The aim of ethnographic methods was to use an emic perspective to generate critical categories and themes as they emerge from understandings of multiple realities (Fetterman 2010). As I have already discussed, this method aligns with interpretivist assumptions that the world was socially constructed, and that facts and truths were not possible, only an interpretation of shared perspectives (Fetterman 2010). The emic perspective taken allows for the diverse understanding of multiple conflicting influences and complex situations (Hammersley and Atkinson 1995, Gubrium and Holstein 2008), moving away from the common bimodal, linear cause and effect models typically associated with patient safety (Hollnagel and Wears 2015). Ethnographic methods therefore offer a platform for exploring the complex and multi-faceted influences upon organisational culture in care homes.

Brewer (2000; pg.10) defined ethnography as “the study of people in naturally occurring settings or ‘fields’ by means of methods which capture their social meanings and ordinary activities, involving the researcher participating directly in this setting, if not also the activities, in order to collect data in a systematic manner but without meaning being imposed on them externally.” Ethnographic approaches have explored the study of social life in settings as they naturally occur, and do not attempt experimental manipulation (Brewer 2004). Taking an ethnographic approach this study sought to offer insight into the daily practices within the care home sites over the duration of this study. Ethnographic approaches require access into the social lives of the participants and therefore familiarity within the social setting was a vital part of data collection. Furthermore, ethnographic methods have been recommended for the study of complex patient safety issues (Finn and Waring

2006). To undertake ethnographic research this can combine a number of methods, for this study the ethnographic research design included interviews (King 2004), vignettes (Barter and Renold 1999) and participant observation (Waddington 2004). Across two care home sites, this methodology and the associated methods allowed for observations of interactions related to safety within these settings, providing insight into the social context (Gubrium and Holstein 2008). Through the use of ethnographic methods, a snapshot of organisational culture and safety in care homes was presented.

ETHICAL CONSIDERATIONS

For this study Health Research Authority ethical approval was sought. The study attained full approval from a Social Care Research Ethics Committee (see Appendix 3) prior to study commencement. Research and Development approval was sought from the care home sites, however as Site 1 was a small independent organisation, approval was sought from the owners/mangers of this care home. For Site 2, permission was sought from the care home manager, who then escalated the project for Research and Development approval which was granted. University of Nottingham research governance requirements were also met prior to study commencement. This study adhered to the principles of Good Clinical Practice (GCP) and the Research framework for Health and Social Care (Department of Health 2005).

As the thesis focuses on safety in care homes there was a risk that poor practice, neglect or resident harm could have been identified within the research study. During the identification of research care home sites, quality indicators were mapped to ensure that sites with significantly poor indicators, e.g. if the care home was identified as being under special measures by the Care Quality Commission, were not recruited. This was seen as an important measure to not place an additional research burden on already poor performing care home organisations.

During fieldwork, there was still a possibility that safeguarding concerns may be identified. This may have been something witnessed during the observation stage, or reported by a participant at interview. Due to my background as a nurse I received regular training on safeguarding and would be able to identify any concerns of harm. In the event that this happened, an expert advisory group was available for advice on all aspects of the study, and specifically if any ethical concerns arose. This expert advisory group included:

- Dr Adam Gordon, Clinical Associate Professor in Medicine of Older People, and Consultant Geriatrician
- Dr Cheryl Crocker, AHSN Network Patient Safety Director and Registered Nurse

Safeguarding was an important ethical consideration during this fieldwork with vulnerable people. If a significant safeguarding concern had arisen, this would have been discussed with the expert advisory group and PhD supervisors. Actions may have included raising the issue with the care home manager, raising a safeguarding concern, and if a severe ethical concern was identified, the research at that site may have been terminated. During the duration of the study no areas of concern were witnessed or raised by participants.

For this study, it was unfeasible to take written informed consent from all staff, residents, relatives and visitors involved. Murphy and Dingwall (2007) argued that bureaucratic ethics approaches that require strict informed consent were inappropriate for ethnographic research, and consequently may compromise the quality of ethnographic research studies. Written informed consent can be seen as particularly problematic due to the extended period of time associated with ethnographic approaches, during which people may have changing preferences in relation to being observed (Murphy and Dingwall 2007). Gaining informed consent was also made difficult by the emergent nature of this approach, where the research focus and the research design typically emerge during the course of the research (O'Neill 2002). It was therefore decided that a flexible approach that continuously sought consent from participants was more appropriate. This enabled verbal consent to be gained and reaffirmed throughout periods of observations, being flexible to the changing nature of staff, residents and relatives. Written informed consent was taken for those with full capacity taking part in the interviews.

Due to the nature of the care home setting, there were also residents that were assessed by the care provider to not have full mental capacity (Mental Health Act 2007). In this case consent was treated on an individual basis, with focus on the competency of the individual to make this decision (Mental Health Act 2007). As people with dementia often have fluctuating capacity, it was important to assess this for the individual decision. For this study, participation was considered low risk and some residents had capacity to decide if they wanted to talk to me. However, if this study was a clinical trial with many health risks these residents may not have been deemed to have capacity. In cases where individuals had fluctuating capacity, if a representative relative or friend was present they were asked, if a relative or friend was not available a member of staff was instead asked for their opinion on whether it was appropriate to involve the resident in data collection. If at any point it was felt by any person that observation was inappropriate for the resident, I would have left the room and not observed this interaction. If there were any indications, such as signs of discomfort among the participants or negative statements that were seen to be a doubt of consent, I would have stopped taking notes and left the area. During the time in the home there were no periods of observation that had to be ceased. This was likely due to the focus of my observations in the public and communal areas of the care home.

Finally, all steps were taken to protect the confidentiality and anonymity of the participants. The care homes involved in the study will therefore not be recognisable in any write up of this work. All participants were identified using anonymised codes and have been given a pseudonym for the write up of the thesis and any outputs

ETHNOGRAPHY IN ACTION

ACCESS AND RECRUITMENT

In order to provide sufficient depth when exploring organisational culture in care homes, two sites were used for this study over the 12-month study duration. Unlike positivist approaches that value quantity of data gained through multiple sites, ethnographic research typically focuses on providing depth and quality of data (Hammersley and Atkinson 2007). Two sites were therefore considered the optimum number for this study to allow for sufficient time to build relationships and delve into the deepest level of organisational culture. Moreover the use of two sites enabled important comparison, allowing identification of cultural differences between care home services and the consideration of localised similarities and differences.

Recruitment of UK care homes to research projects can be challenging due to variation in organisation across these settings that were run as independent services, and were rarely involved in research activity (Davies, Goodman et al. 2014). In response to this the National Institute for Health Research (NIHR) set up the Enabling Research in Care Homes (EnRICH) network. This was a “research ready” network of care home staff, residents and researchers, brought together to facilitate the design and delivery of research within care homes (EnRICH 2018). The recruitment strategy for this study therefore followed specific guidance from the EnRICH network, which highlights the importance of using gatekeepers and building relationships (EnRICH 2015; EnRICH 2015b).

First, EnRICH (2015) recommends to “identify care homes”. Following the EnRICH (2015) guidance, contact was first made with an expert from the local EnRICH network for advice on the study protocol and recruitment. Links with other key stakeholders were also made. This included the Care Home Quality Lead for local Clinical Commissioning Groups (CCG) and the Local Authority. From these meetings a matrix of care homes was made to guide site selection, which included details of the care homes status as a residential or nursing home, the number of residents, the provider, and selected quality indicators; CQC and Local Authority ratings, dementia status and if they were part of the EnRICH network. The EnRICH (2015) guidelines advise to not engage with “at risk” care homes, as participation in research may distract further from quality of care. The stakeholders I engaged with also echoed this concern. It was therefore decided that due to the appreciative focus of the thesis it would be more beneficial to focus on care homes that were indicated to be of medium-high quality. This would enable the exploration of how these care homes operate through the investigation of important aspects of organisational culture in care homes for delivery of safe high-quality care. The initial matrix of care homes captured over 100 care homes within the area, after discussion with local gatekeepers and review of the services quality ratings this was reduced to 25 care homes. The decision was made to have some diversity between the included providers, so that both nursing homes and residential homes were included. Guidance was again sought from local gatekeepers on the appropriateness and willingness of these services to be involved in the research study, this took into account more opportunistic factors, such as a recent change in management, known local difficulties or challenges, and the current workload and service pressure. Following this discussion

4 of these care homes were deemed appropriate to approach at the outset of recruitment. The rationale for approaching 4 care homes initially was based on EnRICH guidance that indicates the difficulty of recruiting care homes, so more care homes were approached to account for drop out.

The next step of recruitment was “approaching care homes,” which was another area where EnRICH (2015) offered guidance. The first step taken to approach the care homes was attending the national “Care Home Open Day” at each home during April 2017. I attended with the Care Home Quality Lead for the care homes, who therefore had existing relations and was able to introduce myself and the study to the respective managers. Whilst at the open day, I explained the study and was given permission and contact details to send the care home managers further information. Following this, I worked in line with the steps for approaching care homes as outlined by EnRICH (2015), this included:

- Sending out letters to the care home manager. This was done by post and email.
- After 2 weeks the letters were followed up by a phone call.
- Written consent to participate was gained via email for both sites.
- All correspondence was explicit about the amount of time, resource and involvement required, and highlighted the benefits of being involved, anonymity and confidentiality.
- No incentives were offered, however EnRICH (2015) recommend incentives for the care home and staff as a way to enhance recruitment to research. This was considered unnecessary by the stakeholders from the CCG and local authority.

During this initial contact with the care home managers, one care home did not want to be a part of the study due to service pressure. Another care home agreed to be a part of the study, but within one month had dropped out due to a change in management.

Furthermore, previous case studies of care home research have advised that throughout recruitment processes, being flexible was paramount (EnRICH 2015b). During recruitment I therefore conducted myself with the utmost flexibility, working around the care home managers preferences for correspondence, meetings and setting dates to commence data collection. Relationships with ‘gatekeepers’ was a vital part of recruitment (Hammersley and Atkinson 2007). Within healthcare research, being seen as an expert practitioner can improve researchers acceptance into the field (Hammersley and Atkinson 2007). As such, my dual identity as a nurse researcher may have allowed me to be regarded as a clinical ‘expert’ (Arber 2006, Hammersley and Atkinson 2007), which may have assisted in building relationships with care home managers. This appeared to be the case particularly when demonstrating an understanding of the demands of health and social care services and the need for flexibility. This was an aspect particularly important to the care home managers and aided recruitment of the care homes.

Finally, ongoing contact via email and telephone was required to keep the care homes on board with the study while it was gaining ethical approval. This was an important part of recruitment noted by previous care home researchers *“We’ve found you have to give people the information, and then give it to them again... you have to prompt and support the process, because you have to remember that your research is not top of the list of the manager’s priorities. Their priority is to run the home”* (EnRICH 2015b). From initially approaching the care homes to commencing the study took 9 months. During this time regular contact was successful with Site 1 who were on board to begin data collection as soon as possible. However, Site 2 was more challenging, as emails were not picked up and telephone calls proved difficult as the manager was often busy and unable to take the call. During Site 1 data collection I continued to attempt to engage with Site 2 with little success of confirming a start date. As Site 1 data collection was coming to a close I was able to arrange a face-to-face meeting with the Site 2 manager and data collection at Site 2 commenced only a few weeks later. This was an interesting finding as what I had been trying to achieve over many months of email and telephone calls, was able to be confirmed within just one contact face-to-face. For future studies engaging with care homes, the value of face-to-face contact should not be underestimated.

Site 1 was a nursing home with 30 beds, it had received consistently high-quality ratings, including an “Outstanding” rating by the Care Quality Commission (CQC) in 2016 and was rated in the highest banding (Band 5) by the local authority for the past 2 years (The sources of evidence related directly to Site 1 and Site 2 have not been referenced to protect the anonymity of the care homes). This nursing home was an independent provider and was a family-run business. The funding of this care home was provided by self-funders, the local authority and CCG. This site was selected as an example of good safety and quality in care homes and as a specialist home for dementia care.

Site 2 was a residential home with 39 beds, it had received medium-high quality ratings, rated as “Good” in its past 3 CQC reports and was rated again in the highest banding by the local authority over the past 2 years. This residential home was selected as it was part of a chain of care homes owned by a charity, providing care to over 5,000 older people in care homes throughout Britain. This care home was run by the voluntary sector and funding came from self-funders and the local authority. This site therefore offered a contrast in terms of organisational factors, and differences in clients as this home was for people with “residential” care needs and it did not specialise in dementia care.

OBSERVATION

The next two sections discuss in detail how observation and interviews were undertaken in the field. This reflected on data collection at Site 1 and Site 2 during the period January- December 2018. At the outset of the study it was decided that data collection at each site would take place separately, to allow myself to become fully immersed in each research setting. As such, Site 1 data collection predominantly took place from January – May 2018 and Site 2 took place June – December 2018.

In the period January-December 2018, 200 hours of observation were undertaken across Site 1 and 2 (100 hours per site). Throughout this observation period adopting a flexible and adaptive approach and being supportive and understanding about the demands on care home staff was essential for observing the daily practices within the care home (Arber 2006, EnRICH 2015b). The approach taken to both observation and interviews was tailored to meet the needs of each home and adapted on days when staff were particularly busy, had staff sicknesses or when an event was being held. This was discussed with the managers from the outset of data collection with managers highlighting particular days of the week and times of day when observation of interviews would be less appropriate for their individual service.

Observations initially started by "setting the scene" within the different areas of the home. The focus of these observations was on environmental features, atmosphere, and how staff, residents and relatives moved around these spaces and interacted within them. Keeping the aim of the study at the heart of data collection, aspects of quality and safety within each area were also considered in terms of the environment and the interactions between actors that promoted or detracted from quality and safety. These observations were often undertaken in close proximity due to the design of the care homes. However, observations could still be undertaken from a "distance" even in these small spaces, as the environment was often busy with various interactions happening at one time. This allowed for detailed observations that were captured through both close-up and distance vantage points without disrupting the flow of care delivery (Kusenbach 2003, Rivoal 2013).

At Site 1, the care home was composed of multiple communal "lounges", a garden area and a dining area. The corridors were in regular use, and there was also the space of the residents' rooms which were all positioned on the ground floor of the home. As well as these communal resident-facing areas, the care home also had "behind the scenes" areas such as the kitchen, medication room, laundry room, staff room, offices and storage, which all made up a series of spaces that would not routinely be occupied by residents. The spaces within Site 2 had a different layout with residents' rooms on the ground and first floor, however overall it had the same general spaces as Site 1. What was distinctly different in the use of spaces was that Site 2 had a dedicated "activities room" and the use of this lounge space was purely for group activities that took place in a structured way.

Observation then moved on to focus on individual workers within the care home. This was undertaken through shadowing key groups of staff; Carers, Nurses, Seniors, Activities Coordinators, Housekeepers, Catering Staff and Maintenance Staff. During the "shadowing" phase I was able to focus directly on the contribution of each staff group to quality and safety within each of the care homes. I examined the norms and physical tasks of each staff group, whilst paying particular attention to the relationships amongst staff, interactions within the home, how actors made sense of their surroundings, work and safety, perceived identity, emotions and attachments, and finally the tensions and power dynamics amongst staff, residents and relatives. Moreover, the process of "shadowing" adopted a "go-along" style of ethnographic method, where I was accompanying them with their everyday work (Kusenbach 2003). The environment and aspects of their work prompted discussion and encouraged explanations, discussions and sharing of stories. The narratives that unfolded as work was being undertaken was important to capture as this offered insight into the perceptions of these individuals, how they understood the task at hand, their reactions, emotions and the influences upon their response (Dervin 1983, Weick, Sutcliffe et al. 2005). This "go-along" style of observation allowed for detailed informal discussions of their role and how they understood their work and responsibility (Kusenbach 2003), particular attention was paid to recording these informal conversations that were not possible to capture through formal interviews.

Finally, observations focused back on the "hotspot" areas of the care home, to capture the focus point for activity. At Site 1, observation for this final stage of data collection was focused on the main lounge/dining area of the home. However, the movement within Site 2 was far more diverse through the day and this final stage took place between the activities room, corridors and the lounge/dining area. Specific attention was paid to how safety manifested itself and was maintained through the interactions of staff, residents and relatives with each other and the environment. Although observations may appear to focus on staff, observations of residents were constantly being captured within all of the data collection. During the final phase of observation, I participated in some individual and group activities to engage with and talk to residents. This was an effective way to observe the room in a non-intrusive manner. Relatives would come and go from the care homes at different times of day and in different areas. When they were present, detailed notes were taken on the interactions of relatives with residents and staff. The individual interactions between the resident and relative were at times not able to be captured, as many relatives would spend time alone with the resident in their private room space. During the study it was felt intrusive for observations to extend to this private space without express invitation.

The aim of the study and research question influenced all of the field notes taken during observations. As the study focused on how staff, residents and relatives attributed meaning and value to safety, all observation reflected the culture within the home and looked beyond the physical tasks associated with care and focused on how this demonstrated understanding or promotion of safety within care homes. Throughout the fieldwork the data captured included observations of the physical work in which quality and safety practices manifested. For example activities, moving and handling, meal times, prevention of falls and how deteriorating or aggressive residents were managed. However, a vital component of the observations was to capture the conversations and interactions between actors within the home, this was vital given the ontological and epistemological positioning of this thesis (Geertz 1973, Slater 2018). As such, during observation careful attention was paid to interactions between people within the care home and field notes were made on the dynamics and tensions between groups and the potential influence of sociological factors such as social identity (Jenkins 1996). Fieldwork therefore attempted to capture not only the physical, but the interactions and narratives which underpinned the functioning of the care home. Thus offering insight into how people in this setting construct meaning (Berger and Luckmann 1967, Weick, Sutcliffe et al. 2005), aesthetic knowledge (Ewenstein and Whyte 2007) and how this contributed to the shared reality of their socially constructed world (Geertz 1973).

Prior to commencing data collection at both sites, I met with the care home managers to discuss how this would work. I adopted a flexible approach and worked with them to outline a way of working that suited the care home and the research study. It was agreed that being flexible and adaptive was of the utmost importance at both sites, as well as being empathetic to the changing demand and needs of the care home (EnRICH 2015b). At Site 1 I was given permission to visit the care home at any date or time during the data collection period, however it was agreed that should there be days when the service was under significant pressure, I could be asked to leave and return on another day. At Site 2 it was asked to not undertake observations on a Monday, as this day was always particularly busy. It was also agreed that I could be asked to leave during high demand days.

At the start of data collection it was clear that staff at both sites were reserved and apprehensive of my presence within the care home. This can occur at the outset of fieldwork and was known as the “reversal of status” whereby the observed observe the observer (Bruni, Gherardi et al. 2004). During this time the participants may have been trying to decide if the researcher could be trusted (Bruni, Gherardi et al. 2004). Building trust was a continuous priority during fieldwork to prevent misconceptions from staff, residents and relatives in the care home. If participants perceived me to be a regulator or an outsider, this may have considerably influenced the data gained through the study. For example, people may not wish to take part, or may alter their answers based on their perceptions of me. Many scholars have explored the insider/outsider debate (Tedlock 1991, Davies 2008, Fetterman 2010) and advocate that ethnographic researchers were a part of the research and have a distinct influence on their participants and were them themselves part of the data (Gouldner 1972, Davies 2008). It was therefore important to note that the relationships between the researcher and participants, and how the researcher was perceived (as nurse, researcher, regulator, student) will directly influence the data collected (Flores 2016, Blee 2017).

During the first few weeks of data collection, staff enquired regularly about what I was there for and I took every opportunity to explain my research. During my initial observations, I consciously took steps to demonstrate that I was “helpful” and to find opportunities to talk to staff. At the outset of the study it was decided that my activity within the homes would be limited. This was decided because, as a nurse, I did not want my role or dual identity to be further blurred by taking part in personal care, or nursing tasks within the care home (Bruni, Gherardi et al. 2004). Steps were therefore taken to establish clear boundaries as a researcher (e.g. not working in clinical nurse capacity) and reduce potential conflicts in role (Pollner 1987). Nevertheless, fieldwork was inherently unpredictable with conflicts in role often unavoidable (Tedlock 1991). It was impossible to control how participants would perceive the researcher's participation (Coffey and Atkinson 1996). However, there were still many ways I could attempt to build relationships and trust within the home, whilst also maintaining my "researcher" hat and collecting observational data. Some of these activities included; doing the dishwasher, folding washing, making teas and coffee, setting up tables for dinner, doing activities with residents and helping during mealtimes.

Approximately a month into data collection at each site, I was on first name basis with all of the staff and routinely undertaking small tasks to help in the care home. Once these relationships were built I was able to significantly reduce the amount I "helped" with other tasks, and began to focus on "shadowing" staff groups and observations within the main communal areas. By assisting with menial tasks I was able to build a positive presence within the homes that allowed me to observe what else was going on around me. In doing this, I was also able to use my flexible approach to ensure my activities did not disrupt the normal activities within the care home (Bruni, Gherardi et al. 2004, Arber 2006).

From a practical perspective, observations were recorded using shorthand field notes in a small notebook. The recording of observational data could only be captured in note form due to the nature of this care setting and protecting the privacy and dignity within this home for vulnerable older people. Field notes were taken to capture key events and statements by staff, these were most useful as a tool to ensure that key details were not lost when writing up a more detailed account of the observational data (Hammersley and Atkinson 2007, Davies 2008, Gubrium and Holstein 2008). More detailed notes were written when leaving the site, and a dictaphone was also used to record my reflections on these observations while driving back from the site. This was found to be very useful for ensuring the data was captured in as much detail as possible. Reflections were also completed during fieldwork and following periods of observation.

The observational data was finally used to guide discussion during the interviews with staff, residents and relatives. In some instances I asked staff to reflect on an interaction or event I may have witnessed, for the most part the observations informed the themes and topics of discussion.

INTERVIEWS

As was noted earlier in this chapter, social reality was often largely invisible to its participants (Slater 2018). Moreover, Schein (2010) highlighted that to explore the deepest level of organisational culture we must investigate basic underlying assumptions, which again often remain subconscious to the people involved. As such, this presented specific challenges in how to approach ethnographic investigation of this subject. During fieldwork it may have been difficult for individuals to comment on events as they happen (Kusenbach 2003), with some scholars arguing that this was in fact a retrospective process whereby people only come to make sense of events after they have occurred (Weick 1993, Weick 1995). Weick (1993, p.635) argued that, "reality was an ongoing accomplishment that emerges from efforts to create order and make retrospective sense of what occurs". It was therefore seen that people made sense of their reality as a process of social construction (Berger and Luckmann 1967) where people use discourse to attribute meaning to cues from their environment. It was only through these discursive processes that individuals and groups were able to co-make sense of the world and co-construct "accounts", "narratives" or "stories" (Boje 2001, Brown 2004, Maitlis 2005). With this in mind, interviews were considered a useful method and were undertaken to accompany the observational data, allowing a space for individuals to make sense retrospectively through the discursive process of an interview. The aim of the interviews was to discuss with staff, relatives and residents their experiences and draw out how they understood reality, in this case the care home. Combining observations and interview data allowed for additional depth in the data collected (Hammersley and Atkinson 2007) and thus offered a deeper insight into the organisational culture.

When using interviews, it was essential that steps were taken to prevent the influence of the researcher's understanding onto the participant (Ancona 2012). For this study an initial topic guide was developed with specific questions undertaken in an unstructured manner to follow the flow of the conversations with participants. Questions were framed in a way that encouraged open discussion and did not restrict the responses of participants. Open-ended questions, such as "What do you think about x?" were instead used, as Ancona (2012, p.9) states that these were "more likely to uncover unanticipated and potentially valuable viewpoints and information." Another advantage of open-ended questions was that this allowed the participant to articulate what they felt was most important for their role or within the care home.

UNDERTAKING INTERVIEWS

A total of 40 interviews (with 50 participants) were undertaken between February- November 2018, reaching over 26 hours of interview data (see Table 3). At Site 1, the interviews made up over 17 hours of this time, whereas at Site 2 only 9 hours was spent in interviews, nearly half the duration. Reflecting on this, it was clear that the longer duration spent interviewing at Site 1 was influenced by the Care Home Manager interview, which contributed to 3 hours 46 minutes of this timing. As data collection at Site 1 took place first, I feel there were also two distinct explanations for this longer interview duration. The first was that as a researcher new to ethnography there was a period of refining my own technique and learning while in the field (Fetterman 1998), and as such it was likely that my interview technique became more refined throughout the study. The second possible explanation was the process of achieving data saturation (Faulkner and Trotter 2017), which was how the researcher reaches a point where they can be reasonable assured that further data collection will present no new findings. In light of this, the shorter duration of interviews at Site 2 was a product of reaching data saturation in the study, as this thesis combines the data from both sites to achieve the overarching findings.

The interviews were undertaken with staff members (n=30) these were individuals working within the care home, residents (n=10) who received care in the care home, and relatives (n=10) who were either friends or family to a resident in the home. The purpose of these interviews was to shed light on individual experiences within the care homes and their perceptions of safety. The interviews also offered further depth to the observational data on organisational culture. The interviews followed topics from the interview guide (Appendix 4), however, due to the focus on how people understood safety and quality within the care home, interview questions would also follow the thread of conversation and topics alluded to by the participant, even if this was not on the topic guide.

Table 3: Interview Participants and Interview Time

Site 1		
Pseudonym	Role	Time
Andy	Carer	0:25:29
Will	Maintenance	01:24:59
Isabelle	Carer	00:18:06
Anne	Nurse	00:31:07
Sally	Service Manager	00:51:15
Jim and James	Resident and Relative (friend)	00:50:05
Dorothy and Richard	Resident and Relative (son)	00:43:36
Josephine	Resident	00:10:31
Penny	Lead Auditor	01:17:16
Jill	Carer	00:40:28
Billy	Carer	01:04:18
Shannon	Nurse	01:19:04
Isla and Mel	Housekeeper and Housekeeper	00:41:50
Claire	Carer	00:15:04
Sarah	Carer	00:27:39
Gail	Carer	00:37:04
Joy	Resident	00:29:19
Kirsty	Carer	00:12:20
Paul, Diana and Briony	Resident and Relatives (daughter and granddaughter)	00:47:25

Laura	Hairdresser	00:13:45
Rosie	Care Home Manager	03:46:54
Site 2		
Pseudonym	Role	Time
Jean and Tina	Resident and Carer	00:31:26
Harry and Louise	Relative and Relative (son and daughter in-law)	00:15:47
Dee and Kate	Resident and Relative (granddaughter)	00:36:12
Jane and Stacey	Volunteer and Activities coordinator	00:22:09
Hilda and Barry	Resident and Relative (friend)	00:21:46
Stephen and Margaret	Resident and Relative (wife)	00:40:05
Leema	Carer	01:00:00
David	Chaplain	00:47:00
Gareth	Senior	00:28:20
Sophie	Catering	00:30:29
Jane	Domestic	00:10:39
Christine	Chaplain	00:49:37
Betty	Resident	01:01:18
Sue	Activities coordinator	00:07:46
Julie	Company Policy Manager	00:27:44
Emily	Relative	00:14:45
Maria	Laundry	00:31:40
Craig	Admin	00:16:57
Thomas	Carer	00:19:17

The approach taken in the interviews was tailored to each of the participant groups. For staff, interviews were focused on their work experiences and how they understood their role and responsibilities. Open-ended questions were used to guide discussion asking staff to explain what their role entailed, what was important, what was challenging, how did they keep residents safe, how did staff work with relatives and many other open-ended questions that were guided by the topics the participant covered. For example, in an interview when asked what was most important, they began to talk about promoting choice and independence. Follow-up questions were therefore centred around getting the participant to explain these concepts in more detail and share examples of when they do this in their work. These were undertaken as 1:1 interviews, but in some instances other staff walking through the care home would be drawn into the discussion by the person I was interviewing. At times this led to a small contribution, and at other times a full joint interview.

Four interviews were undertaken with the resident alone and six interviews were joint with a resident and relative. When undertaking these interviews, I followed guidance from EnRICH (2017). As part of these interviews, the participants were first approached by a member of the care home staff to invite them to be interviewed. However, due to the immersive nature of the study, this was not my first introduction and I was on first name terms with these residents prior to the interviews.

The resident interviews were vastly different, as residents had advanced dementia at Site 1, whereas at Site 2 many individuals had no cognitive impairment. As could be anticipated, the interview techniques required were very different with participants who had a cognitive impairment. As such, the resident interviews at Site 1 and then Site 2 were discussed seperately.

At Site 1, all of the residents interviewed had a cognitive impairment. When interviewing residents with dementia, it was sometimes challenging to draw out conversation, particularly as I did not have extensive knowledge about the history of these individuals. In one instance a resident with known dementia began to repeatedly ask, “Where am I? Why am I here?” I attempted to divert her by undertaking an activity during the interview, which I knew she enjoyed, pet therapy. However, the result of this was discussions about her life that kept diverting back to the activity at hand. In interviews with residents with dementia I was not able to directly discuss “safety in care homes” due to the residents not being oriented to where they were. Nonetheless, the data still revealed useful insight into the use of person-centred activities, the life narratives of these individuals and how they saw the world. When approaching people for interviews, relatives who were visiting their family member or friend in the home, often requested to do the interview with the resident and wanted to involve them within the conversation. Previous studies have recommended the use of joint interviews, particularly with carers and people with dementia (Foster 2011, McIntyre and Reynolds 2012, Singleton, Mukadam et al. 2017, Tolhurst, Weicht et al. 2017). This therefore offered a unique opportunity to undertake joint interviews that incorporated the relative and the resident, which proved a useful way to overcome some of the challenges of interviewing a person with advanced dementia (Foster 2011, McIntyre and Reynolds 2012).

Many of the residents at Site 1 had advanced dementia, and in many respects were unable to answer questions related directly to the care home, as for the most part they did not acknowledge that they were in a care home. My questions directed towards relatives and residents were able to capture detailed narratives of these individuals, asking questions about their lives, what they enjoyed and what was important to them in terms of their care. Residents were often able to be involved in this discussion, but the relatives were able to prompt memories through sharing stories or insights that the resident was not able to articulate. Moreover, I was able to ask relatives more direct questions about the residents' care, what was important, the challenges and how they, as relatives, contributed to this. Again, open questions were used throughout these interviews.

At Site 2 all residents interviewed were deemed to not have a cognitive impairment, as such these resident interviews were more focused and were able to follow the topic guide. As with the Site 1 interviews, questions also followed the flow of conversation from the residents with open-ended questions. At Site 2, joint interviews were also undertaken. The rationale for this was that some residents expressed a preference to be interviewed with their relatives.

From Table 3 it can be seen that joint interviews were used within the study with all groups. This was the product of the flexible approach taken in this research, which responded to the preferences of participants and also the opportunities for interviews. Overall, these joint interviews within staff groups and with relatives and residents added a further benefit of discussion amongst the participants. This allowed for the discussion to move beyond me asking questions and them responding to interactions between staff and between residents and relatives. These discussions offered greater insight into people making sense of situations through this socially constructed dialogue, whilst also demonstrating where individuals had agreement and disagreement. In terms of the interviews themselves, this helped to create a more informal and discursive interview style among the participants, allowing these stories and perceptions to unfold as co-constructed narratives (Geertz 1973).

At times it was difficult to be able to interview care staff due to the busy nature of the care home. At the start of the day I would speak to the care staff who had agreed to be interviewed and the staff member in charge. On days where they were particularly busy, I would conduct observation through the day while waiting for the care staff to be available. I found that it was important to maintain empathetic to the demands of the care homes and remained conscious of not interrupting the normal care going on within the care home (Kusenbach 2003, Arber 2006). I eventually overcame this by identifying the quieter times of day, and quieter days of the week and focused my efforts on these times. For example, I avoided early mornings and meal times.

All interviews were undertaken within the care home. Prior to the interview the participant was asked where they would like to be interviewed (Yeo 2014). Most participants opted to be interviewed in one of the quieter lounges and communal spaces. During these interviews others would use or pass through the space, including residents, relatives and staff. This was at times a distraction, but at other times prompted discussion and allowed short interactions to take place within the interview. A few people also opted to be interviewed in the main lounge, in an office space or in the resident's bedroom. When participants wished to be interviewed in a non-communal space, these were undertaken with multiple participants (such as a relative and resident) and the door remained open. Although participants opted to be interviewed in either a communal or a private space, this did not appear to influence the detail of the data, perhaps because the communal spaces used were often quiet and were often only occupied by myself, the interviewee and residents.

DATA ANALYSIS

DATA

All interviews were audio recorded with the consent of each participant and transcribed verbatim. The data also included hand written, audio and electronic field notes. The data was managed and stored in accordance with the Data Protection Act (1998). Personal data was removed from the files for confidentiality and anonymity purposes. Hard copies were stored in a locked cupboard and computer files on the university server. As per local policy, data will be stored for a period of seven years after the study was complete.

As part of the data analysis process, I undertook personal transcription of half of the interviews to aid familiarisation with the data. This was felt to be important to ensure that I did not misrepresent the data, or read out of context. The other half were outsourced to a university-approved transcription service. Site 1 interviews, were transcribed, read, and re-read, to identify points of interest that could be explored during Site 2 interviews.

ANALYSIS

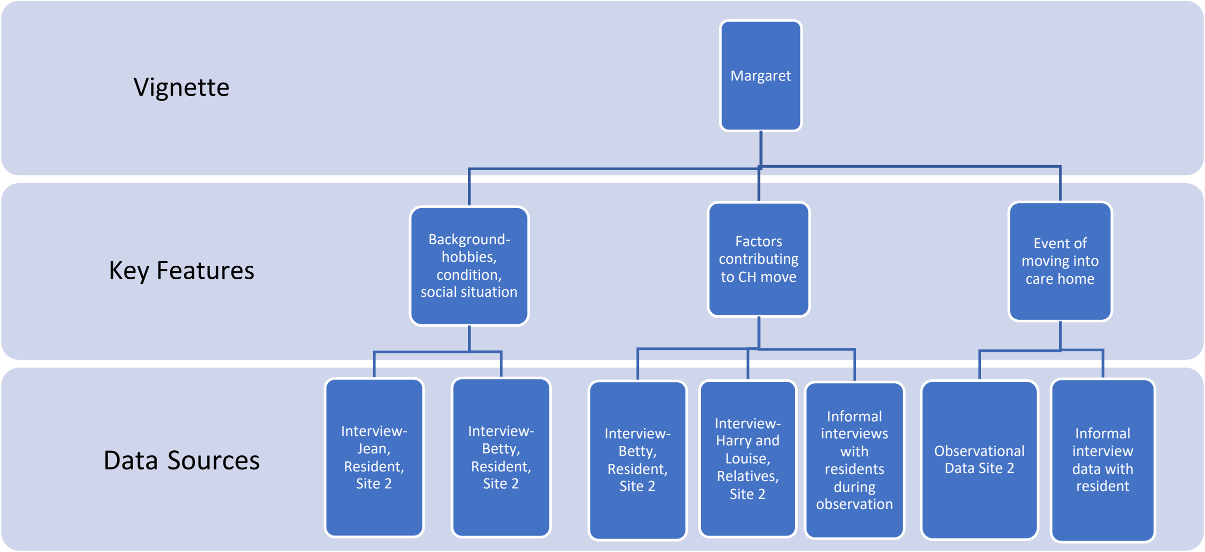
As an ethnographic study the boundaries of data analysis within this thesis were significantly blurred (Fetterman 1998, Fetterman 2010). This was to be expected in qualitative studies as analysis was a pervasive activity throughout the life of the research project (Silverman 2013). The thesis had taken a social constructionist and interpretive perspective while adopting an ethnographic methodology, all of which led towards the perspective that this research was an interpretation of the reality of the care home. As the researcher undertaking this study, it was my interpretations of both observational and interview data that made up the data of this study and as such, I lived through this data collection as an immersive experience. Therefore, data analysis cannot be pulled into a distinct process that took place separate from data collection. Instead this process took place from the outset of the study with me consciously and subconsciously analysing observations and interviews in real times as they took place, as well as in the more formalised attempt at data analysis.

The dataset used for analysis was large. This included the electronic written transcripts of over 26 hours of interviews, as well as detailed field notes that were captured during 200 hours of observation. As such, a great deal of time was needed for coding of this data. To manage the data NVIVO was utilised for electronic documents and paper analysis for field notes. The themes and subthemes drawn from these codes were captured both on NVIVO and in paper format.

Inductive thematic analysis was felt to be appropriate as this allowed me to generate data from the bottom up, with the analysis not following an existing theory (Braun and Clarke 2013). A complete coding technique was used to identify anything of interest or of relevance to the research question within the entire dataset (Braun and Clarke 2013). Doing this was challenging due to the volume of data, which remained large even once filtered for information that did not relate to the research question. This process was very labour-intensive and resulted in hundreds of individual codes, some related and others unrelated to the topic of focus for the theses. Following this process, both semantic (data-derived) codes and latent (researcher-derived) codes were identified (Braun and Clarke 2013). Once coding of field notes and interview data was completed, subthemes and themes were established. I triangulated the data by looking at where themes came up in various observations and interviews across stakeholders. I also looked at how these distinct themes and subthemes related as an overarching view of the organisational culture and safety within the care home sites. As this thesis aimed to answer two distinct research question, during theme generation Site 1 and Site 2 data was combined. In doing so, this offered two perspectives and both similarities and differences in how these themes presented. One of the most important parts of this data analysis process was cutting down the mass volumes of data to the clear and direct themes related to the research question.

Another level of data analysis was considering how to present these findings in a way that was articulate and appropriate to show the depth and complexity to the concepts observed. Following thematic analysis, observations and interview data were used to create vignettes to help explain and capture the complexity of the data (Barter and Renold 1999). This pulled together multiple observations and stories into a cohesive vignette. In doing this, details about the staff and residents were altered to ensure anonymity. An example of how the vignette of Margaret was constructed was given in Figure 5. These vignettes were shown to care home staff and relatives and felt by both to be representative of life within care homes and also a useful tool for demonstrating the many factors at play within the care homes.

Figure 5: Vignette Construction



The data analysis phase of the study extended into the write up of this thesis. This was supported by Silverman (2013) who notes that analysis cannot be separated from the write up phase of a thesis. The presentation of this data required extended thought about how to articulate these concepts while providing representative data and explanations that flowed and unfolded. Overall, the approach taken was to present the data in a way that talks the reader through four important areas of organisational culture, in doing so vignettes, interview data and observations were used to paint a picture of the care homes within this study.

REFLEXIVITY

The first area I wish to reflect on was the unseen. This was an unexpected area of data collection that I felt was noteworthy to explain and provide some possible interpretation. During data collection it was intended that triangulation of data would involve observations that were further explained by interviews to gain additional insight into the perceptions of the individuals involved. However, what was not expected was that triangulation would highlight interesting areas where observations and interviews did not fit together, and in the topics not seen in observation or not talked about in interview. An example of this was the tension between relatives and staff. At both care home sites my observations and informal conversations captured a tension between staff and relatives. Often this was associated with opinions on the care of the resident. Arguments were observed between staff and relatives and informal discussions captured staff talking about “difficult” relatives and people “interfering”. However, when these topics were approached in formal interviews with staff and relatives, even with those observed to be involved in these tensions, participants were hesitatant to discuss challenges. I feel that this example was important as it pinpointed a key consideration for qualitative research, the influence of myself as a researcher. It was obvious to me that this data was not discussed in formal interviews as the staff members knew they were in a formal and recorded interview and this did impact on what they were willing to disclose. However, what was also important here was to note the advantage of the ethnographic methodology used, which enabled for gaps to be seen, and also that observation over an extended period of time allowed for a considerable amount of observations and also for staff to become more comfortable with me as a researcher (Fetterman 1998, Fetterman 2010).

The other important area of reflexivity I wanted to highlight was some observations related to my acceptance into the field, potentially touching on the ‘insider/outsider’ debate (Mason 2002). At the outset of the study at both sites, I distinctly felt like an outsider to the organisation. I did not have relationships with these people, I did not understand the normal routine and processes taking place and that made me feel uncomfortable and like an intruder within the care home. In the first month at both sites I was consciously aware of my need to establish rapport with the participants, to gain their trust and enable them to also feel more comfortable with me during observation and interviews. What I found was that to establish these relationships I would make a lot of small talk, tell people about me and my life in order to come across as more human, and ask them about their lives. I was trying to consciously get to know them, and for them to know me too. This made me reflect on ethnographic methods and the emotional investment you must place from yourself as a person with your participants in the field. I was given the honour of looking into the lives of these people living and working within the care home, and getting to know these people as part of the study required investment from myself on a human level. As my time within the care homes progressed, I would be on first name terms with all of the participants and would commonly talk about areas of our lives outside of the study throughout my time during observation. I feel that this investment of my own self as a person enabled me to become more of an insider than my initial outsider positioning.

To explore this move from an outsider to potentially an insider in more detail I will mainly focus on Site 2 as an example of this, although similar experiences did take place at Site 1. Initially I found that people kept me distant to them, especially staff within the care home. During my first weeks I found it difficult to engage with staff and also staff were reluctant to let me shadow their practice. However, as time progressed this appeared to change, in handover there was a day when staff members notably began to instead ask me to work with them. What was also notable was a change in the expectations of myself as a potential “insider”. At the outset of the study I was a quiet observer and in terms of involvement in the activities of the home this was limited. However the longer I spent in the home, the more staff involved me and at times gave me work to do- with some jesting I needed to “pull your weight around here.” Examples of such activities were leading a game with the residents, making beds, folding laundry and helping to push people in wheelchairs to the dining room. All of which I took for granted as this had gradually increased during my time in the care home. However, there was a day when a regional manager was on-site within the care home. The care home manager told me before she arrived and stated that while she was here I was only to observe and I was not to help with activities or to push patients in wheelchairs. It was this moment that led me to really reflect on myself being seen as an insider and trusted by the care home staff, as they had clearly let me get involved in activities to a level that was past what they were comfortable the senior manager seeing.

ACHIEVING QUALITY

Quality in qualitative research cannot be measured against positivistic assumptions, as these value the validity and reliability of quantitative methods that seek to report on facts from an objective reality (Bergman and Coxon 2005). However, Mason (2002) argues that these concepts can still be useful to consider, moving away from the terms validity and reliability and towards the accountability and rigour of qualitative methods. Quality can therefore be demonstrated through clearly articulating the methodological, theoretical and practical/pragmatic steps taken within the study and showing transparency about the decisions made throughout the research process (Mason 2002). This chapter has therefore set out the theoretical background to this thesis, alongside the practical steps taken in the field to ensure quality in data collection and respond to the needs of the organisation being investigated. This section will continue to outline some other key points of consideration to ensure quality.

This thesis was situated within a social constructionist ontology and sought to explore organisational culture and safety. An essential aspect of quality was therefore to accept subjectivity and the influences upon how individual participants understood their reality (Weick 1995). The use of interviews was advantageous in this study, as this allowed for added depth to the observational data. However, it was important to maintain that interview data was not a substitute to observations, but could instead be used to understand what may have influenced some of the behaviours seen (Silverman 2013). The interviews offered insight into the experiences of participants, which was treated as their own perception shared through a socially constructed narrative of a recounted experience, rather than a description of an actual event (Silverman 2013). It was only through the amalgamation of vast amounts of observational and interview data that a picture of culture can be drawn.

Another crucial element of quality in this thesis was reflexivity (Mays and Pope 2000, Kitto, Chesters et al. 2008). As a qualitative study, interpretation sat at the heart of this thesis. As an ethnographic study I, as the researcher, experienced and interpreted all data, and therefore my own identity as a white female and professional identity as a nurse will have been a perceptual filter that has shaped what I saw and understood (Weick, Sutcliffe et al. 2005, Davies 2008). Reflexivity was essential to maintaining self-awareness on the role and influence of the researcher on the data (Arber 2006). It was important for me to acknowledge the pre-determined assumptions, values and beliefs that I held as a nurse researcher coming into this study, particularly when getting the balance as an ‘insider’ or an ‘outsider’. It was plausible to assume that my own prior assumptions and nurse experience would act as a perceptual filter that shapes the way I construct the 'field' (Mason 2002). Although this was an important point of reflexivity, the influence of the researcher was not a new concept for ethnography, which was often regarded an 'embodied experience' that was shaped by the researcher's choices during data collection and analysis (Hammersley and Atkinson 2007). As a clinician, my views of the field would be different to someone without a clinical background. However, I do not have clinical expertise in long-term care, which at the outset allowed to me remain open to the unknown and unfamiliar setting of care homes. A challenge of my prior experience was the risk that I would simply 'compare' the findings to hospitals, as this was the setting I was familiar with. Being aware of these assumptions was advantageous at the outset of the study, as this allowed me to reflect on how I would capture the culture of 'people in the field' without simply reflecting my own perceptions of the situation. The use of interviews assisted with this, as it allowed participants to openly articulate their experiences and influences upon them. This enabled me to back up all of my ideas and themes with 'evidence' from both observational and interview data. It was for these reasons that reflexivity was essential for reflection on what I found relevant and what I may have sub-consciously omitted from the data (Mason 2002). A way that I attempted to address this during fieldwork was to make notes initially on all interactions and events witnessed, attempting to capture all data in as much detail as possible- rather than just what I perceived of note. By doing this a wealth of data was captured and thematic analysis of these field notes and triangulation honed this into the key themes presented.

My dual identity and role as a researcher also required careful consideration and reflexivity as it was impossible to control how I was perceived by participants during fieldwork (Coffey and Atkinson 1996). Conflicts in identity were a particular issue for healthcare professionals undertaking research (Arber 2006). I was a registered nurse and as a result could have found that I was the most qualified individual on site. This presented a conflict in role, as participants at times regarded myself as a clinical expert and therefore looked to myself for clinical support and advice, even though my clinical background was not in long-term care. An example of this was me being asked to participate in medication administration, which was well outside of the scope of my role as a researcher and was explained to the participant. This was the case for Arber (2006), who found she was held in position of presumed expert knowledge outside of her clinical field. Steps were taken during fieldwork to establish clear boundaries as a researcher (e.g. not working in clinical nurse capacity) and reduce potential conflicts in role (Pollner 1987). Some benefits of my dual identity appeared to be enhanced recruitment and acceptance into the field (Arber 2006). However, it was important to also remain aware of the associated challenges, which included unclear boundaries, and the influence this had on the information participants may have decided to, or not to, share with me as a nurse researcher. Conflicts and challenges like this demonstrate the importance of reflexivity to ensure that the data collected was of high quality, transparent, trustworthy and reliable (Mays and Pope 2000, Bergman and Coxon 2005, Kitto, Chesters et al. 2008).

A further area of quality considered was my own interpretations of events and if my field-notes were an accurate representation of the care homes studied. In order to address this, towards the end of data collection at both sites I asked a member of staff in the care home if they would like to read my field diary and comment on if this was an accurate capture of the day's events. This was undertaken with a few participants and feedback was that this captured their own views on the day's events. Moreover, I was concerned about the interpretive nature of the study and if my own interpretations resonated within the care homes. As such, interim finding reports were written highlighting my key points of analysis. This was fed back to care home staff who disseminated to staff and residents and fed back to me that these greatly resonated. The care home manager at Site 1 stated that the findings put into words important aspects to care home safety that she had always struggled to articulate to external organisations. This was seen to be reassuring that the data was authentic to the two care home sites and therefore was an important aspect of quality.

The data analysis method used in this thesis was appropriate, but can be seen to have its limitations. Although I did not base coding on an underpinning theory, these codes may have been influenced by my own sociocultural and historical context (Anders and Lester 2015). In light of this, I was only able to identify codes and concepts that were in the realm of my understanding. Consequently, the findings were all framed within my own knowledge, perspective, and nursing background (Arber 2006). Other studies have found that data analysis changes across disciplinary backgrounds; if other researchers interpreted my findings; it was likely that they would have varying interpretations (Anders and Lester 2015).

CONCLUSION

This study aimed to explore organisational culture and safety in care homes and make an empirical and theoretical contribution to ongoing debates. The ethnographic approach to data collection has allowed for immersion into the field and insights into the deepest level of culture (Schein 2010). This was only possible through the use of these in depth qualitative methods, situated in the interpretive paradigm (Parker 2000), and was something that has not often achieved in studies of organisational culture (Schein 2010). Interviews with staff, residents and relatives have added valuable insight into the influences on how these individuals make sense of the social world of care homes and construct their reality. Observational and interview data has allowed for triangulation of data and helped to establish themes in answering the research question. This methodology and method has therefore enabled vital insight into the complex interplay of factors and influences upon organisational culture and safety in this setting.

The thesis will now highlight the findings from the ethnographic study. Each chapter presents a distinct overarching theme from this study. Interview data, observational data and vignettes have been used to explore the dimensions of each theme and highlight important aspects of culture. The findings of this thesis were made up of four interlinking themes; Uncertainty (Chapter 7), Identity and Role (Chapter 8), Responsibility (Chapter 9) and Relationships (Chapter 10). Each of these has been explored in turn, but within each chapter elements of the other themes were evident. Finally, the Discussion (Chapter 11) draws these findings together.

CHAPTER 7- Uncertainty

INTRODUCTION

In this first data chapter I have shared a series of vignettes. These were composite stories drawn from the individual narratives of residents, relatives and staff that have been constructed from the data to protect confidentiality. This chapter has interweaved these vignettes with actual accounts from interview data in order to demonstrate typical interactions and experiences within this setting. The chapter sets the scene of care home experiences and focuses on the perspectives of three key participant groups, residents, staff and relatives. Through doing this the chapter situates safety within the context of these care homes and actors' experiences of uncertainty. The chapter starts with the decision for a resident coming into a care home and then follows through the experiences of people working and living in care homes, while considering how identity, responsibility and relationships shape experiences and perceptions of safety from different actor perspectives.

"THERE WASN'T ANYWHERE ELSE FOR ME TO GO"

To explore care home experiences, the first area that will be considered is how people come to live there, the reasons why and the negotiations that happen as part of this process. When someone comes to live in a care home, it presents a time of uncertainty and relates closely to individual perceptions of safety in relation to physical and cognitive decline.

In this study, residents and relatives discussed the negative stigma that they had towards care homes. This opinion was reinforced by the negative media portrayal of care homes (Miller, Tyler et al. 2013, Miller, Livingstone et al. 2017) and hearing stories of negative experiences within care homes. Both observational and interview data revealed that coming to a care home was considered a last resort, it was viewed as something people did not want to happen, but there was no other choice. This was not a new narrative, as many studies have previously highlighted this theme regarding older peoples' residential care (Oldman and Quilgars 1999, Campbell-Enns, Campbell et al. 2020). The lack of choice when made by the resident, was due to feeling unsafe, a lack of support, or feeling a burden to others. When the choice was made by relatives, this lack of choice stemmed from feeling they could not cope with caring for their loved one and feeling unable to keep them safe. Two vignettes have been used to illustrate and explore the uncertainty and feelings of loss and change that typically occurs in peoples' lives when deciding to live in a care home.

> *Margaret was a 87-year-old women, who was moving into a residential home. She spent her career as an Engineering Lecturer and prides herself on her career and her passion for Art. She met her husband, Ron, through a local Art club. They have no children. 25 years ago they retired together to travel the world. For the past 10 years Margaret has suffered worsening Parkinson's, her husband has been her*

> *carer for all of this time. They lived in their 4-bedroom house, Margaret had to stop painting as she could no longer hold a paintbrush. They had a camper van and still travelled the UK. For the past 25 years they have been inseparable, but last year Ron died suddenly and unexpectedly from a stroke. Since then Margaret has been unable to cope at home, she was unsteady on her feet and cannot drive. She has fallen a couple of times and was struggling to remember all of her different medications. She was scared of falling so no longer leaves the house, not even to collect her post from the post box at the end of her drive. With no friends or family that live nearby, she feels she has no other choice but to move into a residential home. Her niece suggested Margaret could move up north to live with her, but Margaret did not want to be a burden to her niece and her young family.*
>
> (Vignette)

Margaret represented a typical example of many of the residents within the care home. This journey through retirement, the loss of a significant other, significant physical decline and no longer feeling safe in her own home marks an experience shared by many residents in care homes, a time of significant change and uncertainty (Barclay, Froggatt et al. 2014, van Wijngaarden, van der Wedden et al. 2018). The underpinning feature of this choice was that of 'safety' and feeling there was 'no other choice' due to physical risks such as falls and managing medications.

> *"… I realised what I'd have to do, go into residential care. I knew that was coming, because there wasn't anywhere else for me to go."*
>
> (Betty, Resident, Site 2, Formal Interview)

To illustrate this further I have used the vignette of John and his children, Victor and Sarah. John represented the typical journey into a care home for many residents following a diagnosis of dementia.

> *Victor and Sarah were both in their mid 50s and were the son and daughter of John, a 91-year-old gentleman who was being assessed today for a care home. Victor and Sarah have been looking after their dad at home for the past year, following the death of their mum. Their dad John was a carpenter and had been married for 60 years to their mum, Joan. They had a typical family life, their mum raised them and their other 3 siblings, while their dad went out to work. He was a 'workaholic' and loved keeping busy doing work on their house or on his car when he wasn't at work. John was diagnosed with dementia 3 years ago, but had been struggling with his memory for many years before this. When Joan died, it became clear that their dad's dementia was far worse than they thought and that their mum had been caring for him. Just a week after their mum died, Victor visited his dad and it became clear that John was not able to cope at home. He had lost weight, he was wearing dirty clothes and the neighbour reported that John had kept leaving his doors and windows wide open. Victor moved closer to their home town, and Sarah moved her dad in with her and her family. But,*

> *over the last year John was becoming more confused and kept looking for Joan. There had been two occasions of him wandering off while everyone was at work and not coming home. The police found him miles away from home in a field, and on the second occasion he was wandering the streets in the rain with no coat or shoes. Victor and Sarah had always said they would never let their dad go to a care home and before he deteriorated John had made them promise they never would, but he was so unsafe and they worried something bad could happen to him when they weren't there. Eventually they decided there was no choice but to put him in a care home.*
>
> (Vignette)

This vignette reinforced 'safety' concerns as a central reason for coming into a care home, in this instance the risks associated with cognitive decline and confusion. For residents with physical or cognitive decline, 'safety' was the key driver for coming to live in a care home. This physical or cognitive decline influenced not only a change in living circumstances, but represented a period of drastic change in the lives and social identity of the residents and their family, such as loss of work, hobbies and significant others alongside uncontrollable physical and/or cognitive deterioration.

A distinct feature of these two vignettes was the level of involvement of the resident in decisions about their safety. On one hand we have Margaret who was able to make this decision independently. Whereas, for John, this appeared to have been an autonomous decision made by his children. This was a common theme for residents with cognitive decline who were considered unable to make this decision for themselves. Cognitive deterioration often resulted in an inability to identify and make judgements on personal safety, and these residents consequently had reduced involvement in decisions about their own safety, this responsibility instead fell to their family or carers, such as children or partners.

The start of this story was a changing phase in people's lives, one marked by loss and the impact of physical and/or cognitive decline upon the individual's living situation and social identity. It marked a time of dependency on others and prevalent uncertainty. All of this catalysed by the individual no longer being perceived as 'safe' in their current home environment, and the perception that a care home was the 'last resort' in an attempt to achieve safety. This related closely to the wider themes of this thesis, in particular the notion of identity and that such change and uncertainty may cause an identity crisis, which will be expanded on in the next chapter.

"IT'S A SEPARATE STORY FROM THE REST OF MY LIFE"

Once someone, or someone on their behalf, had made the decision to live in a care home, what happens next? Although this was felt to improve safety, there was still a sense of loss and failure, that living in a care home signified the end of good things in life, and was instead making the best of a bad situation. This transition was once again marked by change and uncertainty. Interviews and informal discussions with residents and relatives highlighted that this part of their lives was one of the unknown, something that was not planned for and represented loss of purpose.

> *"I have no goals and no purpose. So that's the end of the road. "*
>
> (Betty, Resident, Site 2, Formal Interview)

Alongside the common theme of uncertainty, people would often refer to this in a military sense or refer to care homes as being like a prison, constructing a picture of a loss of independence and freedom.

> *"I wasn't quite sure to be honest. I'd never had much to do with it (care homes) you know, I thought it (the care home) might be a lot stricter and I've heard other people say 'be careful it's just like prison, they don't let you out your rooms very often'."*
>
> (Jean, Resident, Site 2, Formal Interview)

I will now go back to the stories of Margaret and John to highlight common experiences of uncertainty and change during this transition into care home life.

> *Today was moving day. Margaret had arrived with a carload of her belongings. After an hour of shuffling things about Margaret felt a sinking feeling, she would have to sell even more of her things. The home she had been in for 45 years was now on sale, and she was left with just a few boxes of a lifetime of things. What would Ron think if he could see me now? All she had kept of Ron's was some photos and his paintings she hung on the wall.*
>
> *A lady in a uniform stepped into her room and said*
>
> *"I just wanted to let you know that breakfast is between 8am and 10am, lunch we serve at midday, and tea at 4.30pm. I know you have come into the care home after having three falls at home. So, here is your buzzer to press for us to help you walk to dinner." For as long as Margaret could remember she had eaten breakfast as soon as she woke up, about 6am, as for lunch and dinner, well she ate that when she was hungry.*
>
> *At 4pm Margaret pressed her buzzer, but in 10 minutes nobody had come, and she could see staff helping to take people in wheelchairs past her bedroom door. She used her frame and started walking down to the dining room. A member of staff, she assumed these were carers, walked past and said "Mrs Wheeler, why didn't you wait for us? We need to help you." They continued on and took people*

> *in wheelchairs down the hall towards the dining room. When was the last time I was called Mrs Wheeler? I have never needed help to walk before, and I certainly don't now.*
>
> *Margaret was looking forward to meeting some other people, maybe they would understand how odd this all felt. At the door the lady from earlier pointed to a chair "You can sit here". She sat down and introduced herself, the lady at the table couldn't hear her as she spoke "What? What? I'm a bit deaf." The gentleman to the left was in a wheelchair. When she said hello, he looked at her and didn't reply. Eventually Margaret gave up trying to make conversation, they couldn't hear her, or they couldn't reply, she wasn't sure. Dinner reminded her of school dinners, not many choices and very cliché having fish on Friday. As they finished their meal, the man beside her went to stand, "Stephen sit down, its dinner time," shouted the staff from the next table across. Are we not allowed to leave until everyone has finished? She thought, and remained sat for another 30 minutes in silence while others finished eating and she could see other people starting to leave the table. After dinner, she waited until a staff member walked with her to her room. She lay down trying to remember the last time she slept in a single bed. Every time she started to drift off a loud buzzer sounded for what felt like forever and she could hear the bustle of people talking and moving all around her. After living in a quiet country home for all of her life, how would she ever get used to so much noise?*
>
> (Vignette)

Margaret's story highlighted a noteworthy change in lifestyle. This vignette presented change in a physical sense for residents, loss of their home and belongings and changing environment physically to the care home. But, alongside this came significant uncertainty as people entered this socially constructed environment with unknown social norms, beliefs, values and rules which all contribute to the functioning of the care home. Like Mondaca, Josephsson et al. (2018) and Andersson, Pettersson et al. (2007), this vignette showed that moving to a care home can result in a loss of autonomy and a change from independent life to one of adjusting to routine and restrictions. This adjustment related to their changing perception of self, as they adjusted to their own physical decline and increasing dependency. It also captured their adjustment to the socially constructed organisation and the culture that comes with this; "the way it works around here" and the "way things are".

For a resident with dementia, the transition to a care home was different and was characterised by confusion. This journey was different for all residents and their individual circumstances, but common across the narratives from this study was a period of transition and adjustment for the resident, as well as changing relationship and identity for residents and relatives. I will take you back to John's story to further illustrate these themes.

> *Today Sarah received a phone call from the care home. The nurse called to ask if she could come in to try and calm her dad down as he wasn't letting any of the staff help him to have a wash. Her dad John had been in the care home for a week now and he wasn't settling in well. When she arrived at the care*

> *home, John was in his room refusing to get out of bed. His face lit up when he saw her. She spoke to him and tried to calm him down. She asked the carers to make him a coffee and gave this to him.*
>
> *Sarah left her dad sipping his coffee in bed and went to talk to the nurse. She hadn't met this nurse before and explained that her dad was quite stubborn, but he responded better to routine. Even at home he would always refuse to get up if he didn't have a coffee in bed before getting ready, he had done that since she was a child. The nurse explained that yesterday he started to rearrange the furniture in the dining room, and was flipping over the chairs, nearly flipping one a lady was sitting on. He got very distressed when the staff had tried to stop him. Sarah explained that John used to be a carpenter, and that sometimes he thinks he is back at work and tries to fix things that are made of wood. She explained to the nurse that at home they had managed this by getting smaller items for him to sit and tinker with.*
>
> *Sarah went back to see her dad, he was still drinking his coffee. Sarah told him that the carers were there to help him get ready because mum wasn't here. He sat up and let the carers help him. Sarah left and walked back through the lounge, she saw a lady with a frame, she had dropped her bag and was leaning to pick it up. Sarah helped the lady to her seat, passing her the bag. Once the nurse had finished helping another resident, she asked "He seems to be very upset and confused, more than he was at home. Has he been seen by the doctor?" The nurse explained that the doctor's round happens tomorrow morning and that he was on the list. As she left, Sarah told the nurse, "If he starts telling you that he is at work, try telling him he is late for his break and that he needs to rest, that normally works."*
>
> (Vignette)

This vignette presented uncertainty and change from different perspectives, and related closely to the wider theme of 'Responsibility' in this thesis. The way people make sense of the situation and varying perceptions of safety, will shape how people respond. These varying perspectives contributed to complex and multifaceted safety situations and can cause tension between actors who perceive the 'right' action to be different to others, which could pose difficulty in negotiation of responsibility for safety. Looking to the perspective of the resident with dementia, what was significant here was the loss of familiarity associated with this change. Moving to a care home meant a new physical environment, new people who did not know the resident and a new routine. All of which was something unfamiliar and that was not understood by the resident.

> *"Where am I? Why am I here? You're looking after me. Why are you looking after me, why can't I look after myself, or why can't I be in with somebody I know?"*
>
> (Joy, Resident, Site 1, Formal Interview)

The impact of this change was what staff and relatives commonly called an “adjustment period” or a period of “settling in”.

> “*One resident needed loads of time to adjust. She used to throw her stuff at you. If she wasn't getting out of bed, she wasn't getting out of bed and that was end of story. She used to be a handful… But, she just settled in… you wouldn't believe that was her when she first came here. You really have to give them time to settle.”*
>
> (Billy, Carer, Site 1, Formal Interview)

This transition was marked by confusion and agitation often reported to get worse before it got better, and was considered to be due to the staffs’ unfamiliarity with the resident and needing to “get to know” them. This process involved staff building relationships with residents through working with them. The importance of these relationships was notable in this study and will be expanded on further through the wider theme ‘Relationships’. The vignettes captured this transition and knowledge sharing for someone with dementia, which also involved the relatives (or carer) providing information about the residents’ life, likes, dislikes, behaviours, routine, and all information about them as an individual.

> *“We have a new lady in and we have to figure out her needs and what she is capable of doing and what she needs help doing. It is a process of us getting to know her, and her getting to know us.”*
>
> (Claire, Carer, Site 1, Formal Interview)

> *“The more we know about them the more we can actually tap into them, and make their lives as happy as possible…. We are the ones that are here seven hours a day, and we spend more time with them than probably anybody else, we are their next closest.”*
>
> (Sarah, Carer, Site 1, Formal Interview)

Relating this back to the theme of uncertainty and change, for staff every new resident presented new uncertainty, and required them to build relationships and facilitate getting to know their varying abilities physically and cognitively, as well as getting to know them as an individual. The care of this resident also could not be looked at in isolation, and was influenced by other residents, relatives and the care home generally. For example, many staff reported that a new resident would completely change the dynamics of the care home.

Another distinction for residents with close relatives, was the change that also occured for relatives in this unfamiliar setting and adjusting to no longer caring for the resident. The transition was not only in relationships, but also a shift in responsibility for the residents’ care as this transitioned into the realm of the care home staff. However, the adjustment and continued input of relative’s was also an aspect that changed over time and was different depending on each resident and their family and friends.

Adjusting to life in a care home overall represented a time of change and uncertainty for all actors involved. For residents this change was physically, cognitively, environmentally and socially, linking directly to a sense of loss of their past lives and sense of identity. This important theme of ‘Identity’ shaped how individuals perceivd themselves and the world around them and therefore was a key theme used to explore how perceptions of social identity influenced organisational culture and safety in care homes. The change for relatives also signified an alteration in identity, particularly their relationships and perceived responsibility for the residents’ care and supporting transition through this adjustment period. Ericson-Lidman (2019) described moving to a care home as a struggle between belonging and alienation, marking the significant impact this can have on residents emotionally and socially. For staff, there was uncertainty and the unknown of working with new residents with individual needs physically and cognitively. They attempted to navigate the tensions around responsibility for safety, which marked the period of “getting to know” the resident. The wider theme of ‘Responsibility’ captures the different actor perceptions of safety, varying priorities and how negotiation of responsibility for safety takes place within care homes. A resolving feature throughout this thesis was that of ‘Relationships’, with this theme presenting how interpersonal relationships empowered and enabled both safety and quality of care, upholding vital aspects of individuality and independence for residents. Linking back to the last section, living in a care home symbolised that safety no longer sat solely in the domain of residents and their family, but was influenced by the organisation which they were now a part of.

ROUTINES AND UNCERTAINTY

This chapter will now go on to explore uncertainty, change and ambiguity through everyday experiences of care and safety. The purpose of this was to demonstrate how routines were used as a structuring device to address uncertainty. However, it was also apparent that variability amongst residents and the fluctuating nature of working and living in a care home setting continued to contribute to prevalent uncertainty, even within what was largely a structured and routinised day.

Across observation at both sites, many aspects of care were centred around a routine at set times of the day. Aspects of routine will be explored in more depth in Chapter 8. The excerpt from my field notes below outlines the general routine for Site 2, which was broadly similar to that of Site 1.

Site 2 Daily Routine

0700-0730	Handover
0730-0930	Personal care, washing/dressing and taking residents to the dining room
0800-1000	Breakfast

0800	Medication round
1000-1200	Group Activity
1030	Drinks round
1200-1230	Personal care and taking residents to the dining room
1230-1330	Lunch
1300	Medication round
1330-1530	Group Activity
1330- 1530	Visitors
1400	Drinks round
1530-1600	Personal care and taking residents to the dining room
1600-1700	Dinner
1700	Medication round
1730-1900	Personal care and getting residents into bed
1800	Drinks round
1900	Handover
1930	End of shift

In the care homes there were a number of activities that structured the day; personal care (I use this term to include all activities related to personal care and hygiene, which includes support in using the bathroom, getting washed and changing clothes), mealtimes, activities, visitors, and medication rounds. Staff and residents were able to consistently tell me this routine and it appeared to be valued by residents in terms of knowing when these events were taking place, providing consistency in their daily lives. I have explored how uncertainty and unpredictability manifested during the daily routine, specifically using mealtimes as an example. Uncertainty was a key theme that underpins the understanding, interaction and behaviours of residents, relatives and staff in this setting in relation to safety and quality of care and it was therefore important to contextualise uncertainty within the routine practices of the care home.

MEALTIMES

Mealtimes were a common occurrence within care homes and happen three times a day at set times. In between the set mealtimes were drinks rounds where the residents were brought hot drinks, fortified drinks and snacks. These activities form a vital part of the daily routine to meet the nutritional and hydrational needs of the residents. Mealtimes could be argued to be the most important structuring device, as the rest of the routine was centred around these mealtimes. For example, the residents needed to be up and receive personal care in time for breakfast, and the activities that took place were be scheduled in between mealtimes. Another example was that visiting times were planned around mealtimes. At Site 2 no visitors were allowed in the dining areas during mealtimes. As such, mealtimes not only provide a vital source of nutrition and hydration for residents, but also were the focal point of the structured routine that underpinned the daily lives of people living and working in care homes. The structure provided by these mealtimes evidently influenced the work routine of the staff in terms of the pattern of their tasks. For residents, this stability and consistency in the day appeared to influence the cognition of residents. For example, even when confused some residents appeared more oriented during mealtimes. One example of this was that a number of residents at Site 1 who would normally be restless and pacing, at mealtimes would appear calmed and be able to sit and feed themselves with or without support from staff.

Within the care homes residents were given meal options that accommodated for nutritional needs, such as a special diet, or allergy, as well as food consistency. On the surface, mealtimes have a clear purpose (to meet the nutritional and hydrational needs of residents) as well as some clear risks (allergies, swallowing difficulties, malnutrition). However, looking at mealtimes in more depth, there were many intricacies and challenges in this social scenario that brought together nearly all of the residents and staff in the care home into one room three times a day. Watkins, Goodwin et al. (2017) highlighted that mealtimes were important for providing structure and familiarity to residents, whilst also allowing them to meet their emotional and psychological needs through interacting with other residents. However, although this was a structured activity, the level of uncertainty and unpredictability during mealtimes remained a prominent safety challenge.

I will continue to use vignettes to present a typical example from observations of many mealtimes over the period of 1 year of data collection. In the vignette you will be able to draw out many aspects of unpredictability and safety, which I will then go on to identify and explore.

> *Annabelle was a carer and at 1230 it was time to get everyone into the dining room. Dorothy had just arrived in the dining room and begun to shout. “You are in my seat. This is my table”. The other resident, Joan, replied “No it’s not, I don’t see your name on it”. Before anyone could intervene Dorothy was tugging on the chair Joan was sat on shouting, “Get off!” Two carers quickly intervened and tried to calm Dorothy down and find a solution of who would sit where. While this was going on, another carer asked the residents what they wanted and explained to one gentleman that he needed the soft option; but he was still adamant that he wanted to have breaded chicken and salad for his lunch. Annabelle scanned the room and noticed that the new resident John had stood from his seat and was picking up*

> *his chair to put it onto the table. She rushed to him and convinced him he was not at work and to sit for his dinner.*
>
> *The dining room began to feel more settled and Annabelle took a meal to Joan and sat with her, helping her to eat her dinner. The other residents at the table were talking about the activity from the morning while they ate. On another table, Annabelle noticed Geraldine was asking the other residents, "I am lost. Do you know where Stevens Drive is?" This was normally a sign that Geraldine was getting upset, but when her food was placed in front of her she began to eat and appeared more settled. As dinner was coming to an end, Annabelle helped take plates from the table and give out tea and coffee. On one table, Dorothy was helping another resident to put down their cup, as they had been nodding off while holding it. "That is a hot tea, best put it down if you are sleepy." Dorothy said.*
>
> *People had mostly finished their desserts and tea and the nurse had now started to hand out medications to residents who were still at the dining table. Some of the more able residents were leaving, and staff were helping to hoist residents out of wheelchairs and help others walk back to the lounge. Joan called her over and said she needed the bathroom. Just as Annabelle was taking her, a relative approached, "My mum needs to go to her room, she told me she has been waiting for 20 minutes at that table."*
>
> *Annabelle replied, "I'm sorry, we are helping everyone to go to their rooms and the lounge, I can come and help her once I have helped this lady."*
>
> *"Who can I speak to? Someone needs to help her now." The relative seemed very angry and Annabelle pointed out the nurse who was still at her medication trolley doing the drug round. She knew the senior carer wasn't meant to be disturbed, but she was also the one in charge today. Ten minutes later, dinner was over and all of the residents had been helped to get down from the dining table.*
>
> (Vignette)

The vignette gives a snapshot of events from the carer's perspective and highlights many quality and safety considerations taking place during this activity. From observing countless mealtimes this vignette was designed to show the wealth of disruption and uncertainty that can take place. The vignette portrays how something organised and on paper (a simple activity, routine, the meal, a seating plan), in fact led to prevalent uncertainty and unpredictability.

A key factor here was unpredictability in resident behaviour, and this was not confined to those with dementia but was prevalent across all of the residents. Mealtimes were a social activity, something promoted at these sites through seating plans to encourage the social experience of a meal. However, with thwas comes uncertainty with residents themselves building relationships, or having collapses in relationships and conflicts between residents during mealtimes. The social nature of mealtimes as well can cause disruption due to these residents being together in this space. These findings were supported by Gibbs-Ward and Keller (2005) who found that each mealtime was unique and influenced by residents' actions and how they respond to both internal and external influences during the meal.

A further risk was that of falls. With the residents being mobilised to the dining room and while the meal was taking place many residents at risk of falls may attempt to stand, or push back away from the table, potentially resulting in a fall. Many observations of mealtimes saw staff responding to residents at risk of falls who attempted to mobilise during mealtimes. Mealtimes also present other risks that were evident in this vignette, swallowing difficulties require the staff to be vigilant of the consistency of food and the residents' ability, with hot food and drinks there was the potential for accidents such as scalding. What was clear from this vignette was that although mealtimes were a vital part of the structured day, they do present a time of uncertainty and unpredictability.

What we see in this example was a complex interplay of social actors, and the unpredictability and uncertainty that comes alongside this in terms of safety in what was often considered a simple and routine activity. However, it was important to note that what was presented here was a mealtime with lots of disruption, whereas the same group of people, sat in the same place, with the same food, on a different day can result in a mealtime with no disruption. This was something strongly suggested by staff in the care home, the unpredictable nature of working in this setting.

> *"It's very unpredictable. You've got to expect the unexpected, so to speak. Like driving, you've really got to keep your wits about you because you never know when the next person is going to fall or throw something or try to hit you. You've really got to know what you're doing."*

(Billy, Carer, Site 1, Formal Interview)

On an individual level, residents may respond and act differently in the morning to the afternoon, or to a different member of staff, or when relatives visit, or indeed act differently during mealtimes. The result was a lack of consistency and staff suggesting that most of what they do was deal with the unknown. What I will go on to consider later on in this thesis was how individuals deal with "the unexpected" through social identity, interpersonal relationships and negotiation of responsibility.

SAFETY AND UNCERTAINTY

In this section, I will briefly outline some of the core safety issues that have become apparent during data collection and elucidate how uncertainty and unpredictability within care homes impacts on these safety areas.

ADMINISTERING MEDICATION

Safe medication administration was vital to the treatment and wellbeing of residents, with medication errors a prominent safety concern within care homes (Barber, Alldred et al. 2009, Fahrni, Franklin et al. 2014). Across the two sites, there were distinct differences in the administration of medications. At Site 1 the medication rounds were undertaken by the nurse in charge of the shift. They did not have a medication trolley, but administered the medications from lockers in each of the resident's bedrooms. Whereas at Site 2, the senior carer undertook the medication round, whilst similarly being in charge of the shift. At Site 2 the medications were administered from a single medication trolley that was taken with the senior carer while doing the medication round. The following vignette will give a brief example of some of the typical unpredictable situations faced when administering medications.

> *At 830 am the nurse, Sarah, was undertaking her medication round. As the residents were still getting up, some were still in their rooms, while others were in the dining area. She went to the first bedroom and started to get the medications out of the locker. As she was doing this, a carer came to her and asked her where the hoist was. She answered and continued. The resident was not in their room, so she went and find them in the dining room, helped them to take their tablets and then went to the next resident bedroom. The resident was in the middle of getting washed, so she left this one and went to the next. She got out the next resident's medication, and documented this on the medication administration record. This resident was also not in her room, and liked to wander. Sarah walked to the dining room and could not see the resident. A resident was trying to stand from the table. The nurse intervened and got the resident to sit back down. Another resident appeared to have fallen asleep at the dining table, she woke them and told them it's breakfast and handed them their spoon. She continued to go and find the resident whose tablets she was still holding. As she walked down the corridor, she noticed a resident holding faeces in their hands. She placed the tablets on the windowsill and guided the resident by the arm towards the dining room. Sarah asked a carer to take over and help the resident to get cleaned up. She collected the medication from the windowsill and finally found the resident in another lounge and gave them the tablets. During the medication round there was no checking of names or details with the resident, the nurse said that this wasn't needed as she knows all of the residents.*
>
> (Vignette)

This vignette shows the first 15 minutes of a medication round and captures how uncertainty and unpredictability can influence the safety of medication administration. Medication errors were a significant safety issue across health and social care, and the frequency and severity of such errors has been associated with distractions during medication rounds (Barber, Alldred et al. 2009, Westbrook, Woods et al. 2010, Fahrni, Franklin et al. 2014). The nature of the care home setting meant that there were a lot of distractions during medication rounds, which could impact on the safety of administration. These distractions were from residents, the environment, staff and relatives depending on the time of day. Moreover, these distractions were always unpredictable.

In this vignette there were many distractions during the preparation and administration of medication which could result in an error. During the medication round there were other risks the nurse needed to respond to, in administering just two residents' tablets she responded to a resident at risk of falls, a resident who was not eating and a resident who was holding faeces, all of which were unpredictable safety hazards. By responding in this way, there was increased likelihood of a medication error due to these distractions. But, if she had not responded to the unpredictably hazards, then this may have also caused harm to these residents.

> "We are meant to sign for the drugs. If it is missing, I think have they been dropped? It's easy to drop them. Have they been thrown at you? Which happens. And it's easy when you're rushing around and distracted to forget to document something."
>
> (Shannon, Nurse, Site 2, Formal Interview)

Another important factor to consider was the responsibility of the staff. In both sites, the person administering medication was also the person in charge. Thus making it more difficult to make medication rounds protected, as they needed to be able to respond to other important tasks, such as a GP call, deteriorating resident, staffing issues etc. From this vignette the theme of responsibility for safety comes through, not only the responsibility for safe medicines management, but also that of general safety in the home which the nurse responded to and demonstrated. This theme of Responsibility was covered in more depth in Chapter 9.

FALLS

I will now elaborate further on unpredictability, focusing more specifically on residents' fluctuating physical ability. As we saw in the case of Margaret, many residents were living in care homes due to a decline in their physical ability. It was well acknowledged in the literature that older adults were at a higher risk of falls (Craig, Murray et al. 2013). Care home residents have been found to be three times more likely to fall than older people in the community due to a variety of risk factors; physical frailty, long term conditions, physical inactivity, cognitive impairment, visual impairment and the unfamiliarity of new surroundings (NICE 2013, Cameron, Bowles et al. 2018). The observational and interview data from this thesis supported that many residents did have many of these factors. Margaret's vignette demonstrates her physical frailty, a long-term condition, physical inactivity and unfamiliarity in her surroundings.

Due to prominent decline in physical ability, it was found that there was often a mismatch between what staff and relatives felt the resident was able to do physically, and the residents' perception of their ability. I will now explore this, taking us back to Margaret's story to exemplify this safety challenge.

> *Margaret had now been living in the care home for well over 2 months. She had been managing quite well around the home with a stick. The staff would ask her to use her buzzer for someone to walk with her, but she often forgot, or didn't want to be a bother to the staff who were so busy all the time. Last week, Margaret had fallen on her way to the dining room. She wasn't sure why or how, she just tripped on her own feet somehow. The result was a broken wrist that was now in plaster.*
>
> *When she got back from the hospital the senior carer explained that they were worried about Margaret falling again, especially as she doesn't use her buzzer. Margaret told them she was fine and didn't want to be a bother. After a long conversation, Margaret agreed to have a mat in her room that would go off when she stood up so that staff could come to help her walk. Margaret still didn't think this was necessary, but the senior was in charge and she knew best, so she agreed to have it.*
>
> *The mat was a nightmare. Margaret couldn't even go to the toilet in peace without it buzzing, and she was managing fine around her room with her new frame. After 5 days Margaret had cracked it. After the carer helped Margaret to get to bed, she leant out and shuffled the mat under the bed. When she went to the bathroom in the night, she was absolutely fine, she didn't understand what the carers were so worried about. This worked just fine and the staff didn't even notice.*
>
> *The next week Margaret wasn't feeling herself. She felt tired and run down and kept needing a wee urgently. The carer said she thought Margaret might have a Urinary Tract Infection (UTI), but nothing was confirmed. She felt totally exhausted today, so she tucked her falls mat under the bed and went to sleep. In the night she went to get up, desperately needing a wee again, this was the third time this evening. When she went to stand up, her legs felt like jelly and she fell onto the floor. Margaret felt pain all down her wrist and shoulder, and her head hurt too. Panicked she called for help and one of the carers came in and saw her on the floor. She kept saying over and over "Why did you move your mat? Why didn't you call us?"*
>
> *Margaret replied "I needed a wee, and you wouldn't have come in time. I thought I would be okay."*
>
> (Vignette)

This vignette presents two typical instances of falls from the care home, and puts together observational and interview evidence from the ethnographic study. The vignette captures fluctuation in a resident's physical ability, the impact of this on her safety, but also the resident taking responsibility for her own safety and taking risks. This account reflects some key findings seen elsewhere in the literature around resident falls, supporting that physical decline and the unfamiliarity of the environment can contribute to an increased incidence of falls (NICE 2013, Cameron, Bowles et al. 2018).

What was apparent was the fluctuating nature of physical disability and dependency in residents. This was often not a static state where a resident, for example, always needed to use a walking frame. In the same day, one resident can be able to walk unaided around their bedroom, use a frame to go to the dining room, and then following dinner feel too tired to stand and require support and a wheelchair to return to their room. Physical ability appeared to often be in a state of flux, impacted by a series of factors such as level of activity, tiredness, time of day, illness, all with no particular set pattern. The result of this was what we see as an example in Margaret's story. On the first occasion she falls unexpectedly, resulting in an injury. On the second occasion, Margaret was tired and had signs of a UTI and fell in the night. It was widely acknowledged that there was a link between UTIs and falls, however the reasons for this link remain tenuous (Hunter, Voaklander et al. 2013, Gibson, Hunter et al. 2018). In both instances, Margaret felt herself capable of walking without falling, perhaps not realising her own fluctuating physical ability.

Nonetheless, in both instances Margaret was asserting her own independence and choice to walk unaided, thus taking responsibility for her own safety in those risks. The staff in this vignette also show responsibility for Margaret's safety and have implemented measures and followed a risk assessment and interventions to support Margaret (i.e. for her to not walk without a member of staff, and then a alarmed mat to alert staff to her standing). But again, Margaret took responsibility for her own safety and made the choice to not seek support to walk, and to put her mat under the bed. This could be perceived as a black and white decision and considered as non-compliance, but what influenced Margaret in this was several sociocultural factors. For example, seeing other people she considered more in need of the carers help and her own social identity within the care home; seeing how busy the carers were every day; having occasions when it took a long time for someone to answer the buzzer, which resulted in her not getting to the toilet in time; feeling she was able to do this on her own and that she was capable. Studies looking at autonomy of care home residents have highlighted the importance of maintaining independence and choice and that this was optimal for the residents' physical and mental wellbeing (Sherwin and Winsby 2011, Hedman, Häggström et al. 2017, Boumans, van Boekel et al. 2018). The themes of identity and responsibility have been explored in more detail in the later analysis chapters.

The vignette presents some broader findings on the influence of unpredictability and uncertainty upon falls within care homes. It was evident that resident physical ability can be unpredictable; as such a care plan or risk assessment put in place may not be appropriate in line with this fluctuating ability. The prevention measures that were put in place may therefore not always be appropriate at different points in time. Moreover, residents may not engage with the preventative steps put into place that again cannot be predicted. Falls prevention in the care home setting was far from simple, in fact, the uncertainty within care homes appears to actually make this inherently complex.

DETERIORATION

A further source of unpredictability was residents' physical and/or cognitive deterioration. As the vignettes have highlighted deterioration already, this will be covered only briefly to highlight how this specifically contributed to unpredictability and safety. The care homes provide care for a complex group of older adults with complex comorbidities, often in their last years of life (Gordon, Franklin et al. 2013). It was therefore understandable that residents in care homes regularly deteriorate both physically and cognitively (Little, Rodgers et al. 2019). Through data collection it was apparent that this deterioration was unpredictable and also impacted upon resident safety. In the fall example above, the deterioration of Margaret was unpredictable and underpinned by a UTI. However, many areas of deterioration were seen over the course of the observation at both sites, this included respiratory infections, diarrhoea and vomiting, a resident having a stroke, and residents deteriorating at the end of their life. All of which were often unpredictable and thus influenced on other areas of resident safety.

CONFUSION AND AGITATION

I will finally highlight confusion and agitation as further unpredictable factors that impact upon safety. This will be covered briefly as this theme has been previously illustrated in the vignettes throughout this chapter. Agitation and at times violence was often an unacknowledged risk within health and social care. Wharton and Ford (2014) highlighted that violence from residents can be a prominent risk towards care home staff and other residents. It has been found that resident agitation presents a challenge in how staff respond and being subject to such violence can result in an emotional response (Rapaport, Livingston et al. 2018), making this a challenge physically and emotionally for those involved.

In this chapter we saw the impact of confusion and agitation in the vignettes about John. These vignettes illustrated that resident behaviour can be highly unpredictable, as we saw in John's behaviour of picking up chairs and trying to fix them, without regard for the safety of himself and others. We also saw how his confusion could cause him to become agitated. Moreover, in the vignette about mealtimes we saw that potential agitation may not happen in isolation, but by having residents all living together there was potential conflict between residents. This was evident throughout data collection that an added variable in resident safety was how residents interacted with staff and with other residents. Like Chaudhury, Cooke et al. (2018), the vignettes suggest that unpredictability of residents' behaviour did not solely depend upon cognitive ability, which may fluctuate throughout the day, but was also influenced by environmental factors. This was also evident in the data, by the suggested change in dynamics when a new resident moved to the care home. As such, confusion and agitation contribute to both uncertainty and safety. Confusion and agitation can be safety issues within themselves, but also may impact on other areas of safety such as accidents and falls. If a resident was confused and tries to walk without their frame, this may cause a fall. Or if a resident became agitated, they may throw a cup at another residents. Both of these scenarios were witnessed within the observational data and reflect just two of many occurrences where confusion and agitation impacted upon safety within the care homes.

CONCLUSION

In this chapter the vignettes have been used to demonstrate how care homes operate with high levels of uncertainty and unpredictability, both in circumstances of fluctuating physical and cognitive ability of the residents. Through exploring the journey into a care home for the resident and relatives I have highlighted the uncertainty of the social setting, the rules and how this operates. Also, from the staff perspective, the unknown of working with a new resident they do not know. The chapter has also considered some example safety scenarios which have been used to contextualise uncertainty within care home safety, to elaborate on the impact of fluctuating physical and cognitive ability of the residents. What has been presented demonstrates the level of uncertainty and unpredictability for all actors within the care home. In exploring this, three key themes were apparent: Individual’s changing social identity, who has responsibility and how this was negotiated, as well as the place of building relationships as a tool to deal with the level of uncertainty in this setting.

CHAPTER 8- Identity and Roles

INTRODUCTION

This chapter highlights a conflict in the narrative of care homes. It outlines a clear tension between safety and delivery of individualised person-centred care. In relation to the overall thesis the chapter contributes evidence that staff, residents and relatives valued identity and individualised care above all else, and that it was important for safety to embrace a personalised approach, rather than safety taking an approach that de-personalises care. The chapter builds an argument for a personalised approach to safety in care homes by exploring the cultural norms of staff, relatives and residents in the two case study care homes. The findings of this chapter feed into later chapters on Responsibility and Relationships. In particular this chapter was the foundation for Chapter 10, which provides insight into the importance of interpersonal relationships between staff and residents to be able to uphold elements of resident identity and safety through personalised approaches.

FORMAL ROLE AND IDENTITY

The first half of this chapter considered identity and role as seen in the formalised approaches within the care homes. This highlighted how the formal culture focused on the safety of residents in terms of meeting their physical needs above all else. Staff roles appeared to be perceived through a task-focused lens, whereby the core elements of their job role were to meet the physical safety needs of residents. The core reason for residents moving to a care home was highlighted as this need for safety, which was also reinforced through surface level artifacts, such as care plans and risk assessments that also focus on physical needs. The impact that physical and cognitive dependency had on the level of support required, and the formal place of relatives as visitors within the care home was also discussed. Together, this section painted a picture of the formal safety culture and highlight that maintaining physical safety of residents was a paramount feature of reinforced across the care homes in this study.

STAFF PRE-DEFINED ROLES

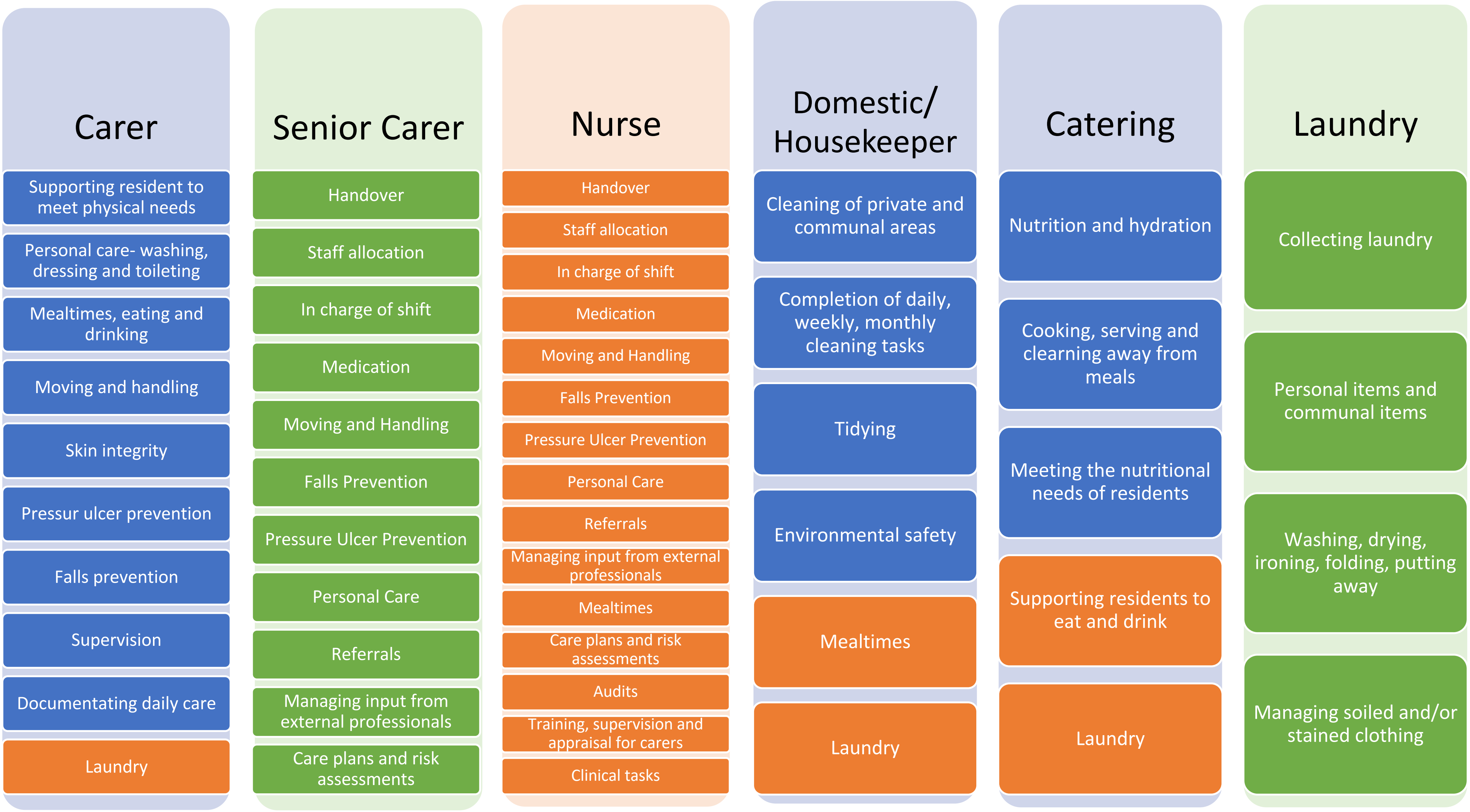
The care homes comprised of a number of different staff, each with pre-defined roles, responsibilities and tasks. The staff distinguished these job roles based on the tasks and routines followed by the staff in each role, with a consensus across both sites in terms of the core tasks associated with each staff group. There were some variations across the two sites in terms of the exact job roles available in each care home. The core staff groups across the homes can be seen in Figure 6. The care homes were comprised of carers, activities coordinator, catering staff, domestic staff (or housekeepers), maintenance staff, managers, volunteers and hairdressers. Site 2 (the residential home) had additional staff groups; senior carers, laundry staff, receptionist and chaplain, whereas site 1 (the nursing home) had nurses.

Figure 6: Staff Groups

When considering the core tasks associated with each of the roles, this changed depending on the site. This was due to the nature of the resident population and also the way the care home was organised. An example of this was that the carers at Site 1 were more involved in feeding residents due to the nature of the resident population who required more assistance with eating and drinking. Another example was that at Site 1 there were no laundry staff, as such the responsibility for laundry was therefore integrated into everyone's role within the care home. A similar pattern was also seen with activities coordinators. At Site 1 the activities coordinator had a vital role in group activities and also 1:1 therapeutic support. However, at Site 2 the activities coordinator focused solely on group activities, with the chaplain instead focusing on 1:1 support. Overall, there were large commonalities between job roles, and themes related to core tasks were compiled based on the observational and interview data from this study (Figure 7).

Figure 7: Job roles

🟦 Both sites
🟧 Site 1
🟩 Site 2



Carer

- 🟦 Supporting resident to meet physical needs
- 🟦 Personal care- washing, dressing and toileting
- 🟦 Mealtimes, eating and drinking
- 🟦 Moving and handling
- 🟦 Skin integrity
- 🟦 Pressur ulcer prevention
- 🟦 Falls prevention
- 🟦 Supervision
- 🟦 Documentating daily care
- 🟧 Laundry

Senior Carer

- 🟩 Handover
- 🟩 Staff allocation
- 🟩 In charge of shift
- 🟩 Medication
- 🟩 Moving and Handling
- 🟩 Falls Prevention
- 🟩 Pressure Ulcer Prevention
- 🟩 Personal Care
- 🟩 Referrals
- 🟩 Managing input from external professionals
- 🟩 Care plans and risk assessments

Nurse

- 🟧 Handover
- 🟧 Staff allocation
- 🟧 In charge of shift
- 🟧 Medication
- 🟧 Moving and Handling
- 🟧 Falls Prevention
- 🟧 Pressure Ulcer Prevention
- 🟧 Personal Care
- 🟧 Referrals
- 🟧 Managing input from external professionals
- 🟧 Mealtimes
- 🟧 Care plans and risk assessments
- 🟧 Audits
- 🟧 Training, supervision and appraisal for carers
- 🟧 Clinical tasks

Domestic/ Housekeeper

- 🟦 Cleaning of private and communal areas
- 🟦 Completion of daily, weekly, monthly cleaning tasks
- 🟦 Tidying
- 🟦 Environmental safety
- 🟧 Mealtimes
- 🟧 Laundry

Catering

- 🟦 Nutrition and hydration
- 🟦 Cooking, serving and clearning away from meals
- 🟦 Meeting the nutritional needs of residents
- 🟧 Supporting residents to eat and drink
- 🟧 Laundry

Laundry

- 🟩 Collecting laundry
- 🟩 Personal items and communal items
- 🟩 Washing, drying, ironing, folding, putting away
- 🟩 Managing soiled and/or stained clothing

Managers

- Leadership
- Policies
- New initiatives
- Care Plans
- Resident and relative engagement
- Audit
- Assurance
- Care Quality Commission
- Local Authority
- Resident forum
- Rota and staffing
- Staff training and development
- Budgets

Maintenance

- Maintaining the care home
- Fire safety
- Health and safety
- Audit
- Equiptment maintenance
- Decorating
- Refurbishment
- Group resident events and activities
- Collecting medications
- Resident interaction

Receptionist

- General enquiries
- Rota and staffing
- Managerial support
- Administrative activity
- Reporting

Activities Coordinator

- Therapeutic and supportive activities
- Group activities
- Celebrations and events
- Extenal visits and activities
- Emotional wellbeing
- Keeping residents safe
- Falls prevention
- Moving and handling
- 1:1 support and activities
- Mealtimes
- Laundry

Chaplain

- Weekly service
- 1:1 spiritual and emotional support
- Individualised support and activities

Volunteer

- Group activities
- 1:1 engagement with residents

Hairdresser

- Hair cutting and styling for resdients
- Personalising hairstyle

This breakdown of tasks may appear over-simplistic given the complexity of these roles. However, these lists comprise the themes from staff interviews and observation related to what their job role consisted of. What can be seen as an overarching theme here was that job roles were defined by physical tasks, and it was through these tasks that staff members made sense of their role and contribution to the care home.

Taking the carer role as an example of the task-driven understanding of work, the core tasks above were identified across both observational and interview data. Throughout observation it quickly became apparent that meeting the daily physical care needs of the residents (personal care and hygiene, mobility and nutritional needs) dominated the carer role. It was common that carers would talk about their job as if it were defined by the tasks they completed.

> *"I help people with their everyday needs, getting them up, feeding them, putting them to bed, make sure that they're safe"*
>
> (Andy, Carer, Site 1, Formal Interview).
>
> *"It's helping them, a lot of it is personal care in the morning, helping them get up, get washed, dressed and ready and taking them for a drink and making sure they've had their breakfast… It is just helping them with their everyday living."*
>
> (Claire, Carer, Site 1, Formal Interview)

Overall, there was an overarching consensus that carers were there to help residents meet their everyday physical needs and keep them safe. The use of the word help was of significance here, as this did not directly relate to care but suggested the staff may viewed their role as helping with both care and safety. The demands of working at the care homes were variable and appeared to be influenced by the dependency of residents, resident cognitive ability, the complexity of medical conditions and co-morbidities and also the capacity of the care home.

> *"Well my responsibility is to look after the residents... So I see that as important, but a lot of the time we have been so busy. We don't often get time to meet their wellbeing side of things, as opposed to just doing the functional care."*
>
> (Thomas, Carer, Site 2, Formal Interview).

This quote further supported the finding that carers perceived their role in the organisation was to meet the physical needs of residents and keep them safe. However, I will go on later in this chapter to explore how there was a disconnect between the formal perceptions of roles in the care home and the informal aspects of culture seen in observation and interview data. This was something seen in the quote above, as the carer draws out that they were often too busy to do anything other than meet the physical needs of residents, but acknowledging their wish to also meet the wellbeing needs of the residents.

ROUTINES

As was noted in Chapter 7, the study revealed that 'routines' in the care homes structured tasks and the working day. Interviews identified that many staff defined their work and role through the daily routine they followed and the tasks they completed at each point in the day. Observational data corroborated that the same daily routine took place each day, with very little variation between the different staff members.

At 730am the shift started with handover, the carers then broke off into their allocated pairs and began to get residents washed and dressed in turn and helped them to the dining room.

Breakfast was served individually to each resident as they got into the dining room. The carers continued getting people up and then began to assist the residents from the dining room to the activities area, lounge or their rooms. They helped people with personal care if they need it. A carer then started to go around with the tea trolley at 10am. The other carers answered buzzers and continued to support residents to mobilise or with their personal care.

At 1200 the residents were supported to the dining room. The carers helped to take orders, serve food and assisted the few residents who needed help with their eating and drinking. The carers cleared away after lunch and then assisted residents again back to their room, to the activities area or the lounge. They then answered buzzers, mainly assisting people with personal hygiene.

Some of the carers took themselves into the dining room and sat completing the paperwork. At 3pm a carer again went around with the tea trolley and then shortly after at 4pm the carers helped the residents again to the dining room for dinner. They assisted again with dinnertime and following this supported residents to mobilise to where they wanted to go and assisted with personal care. They helped some residents change for bed and again did a final round of drinks. It is then time for handover.

Today the routine was the same seen each day. The activities for residents each day, visitors and input from external professionals changes day to day, however the timing and routine appears to structure the day exactly. The only time this routine has really changed was when there was staff sickness resulting in no cleaner or not enough kitchen staff. This resulted in other staff helping with these tasks and disrupting the normal timings and routine of mealtimes and activities.

(Observational Notes, Site 2)

In the narratives around the daily routine what was noteworthy was that for most of these staff groups this routine again focused on physical tasks or the physical care of residents.

> *"In the rooms I tend to start by emptying the bins and then I check the dust and make the bed... Then I do the bathroom. Then it is onto the next room, next, next *laughs*. Normally in the mornings I will do*

> *the dining room as well after the breakfast, I wipe the chairs and I mop the floor and then usual in the afternoon I will do the hovering of the corridors and the rooms."*
>
> (Jane, Domestic, Site 2, Formal Interview)

> *"I just come in in the morning I go and collect all the fresh days laundry and then just work my way through it, you never know what's going to come in, you never know what's going to happen."*
>
> *(Maria, Laundry, Site 2, Formal Interview)*

This further reinforced that staff perceptions of job role were focused on physical tasks. The manner by which staff discussed their role appeared to break down their tasks in a sequential way, as if completing a list of tasks that needed to be done. In this way it can be seen that their core routine was seen to be sequential and repetitive. However, at times this routine would become more dynamic, such as when staff members were off sick, if a resident became unwell, or if a safety incident occurred within the care home. In this instance the normal routine was disrupted, and staff instead had to respond in a more dynamic way.

The routine within the care homes was also something to consider from the resident perspective. Although this may govern the staffs' working day, for residents this routine structured every day of their lives as this was their home. If we look back to Margaret's vignette used in Chapter 7, the routine was something that needed adjusting to, with many people before coming to live in the care home not having any set mealtimes or having to wait their turn to be supported to get up in the morning. The organisation's routine also brought with it rules and restrictions in the lives of the residents. Some routines and restrictions seen during observation were the timing and food available at mealtimes; the time residents were able to get up or when they were able to go to the bathroom as they need to wait for someone to be available to assist them; visiting times; medication times; the timing of and nature of activities available and indeed not being able to move around or go outside of the care home independently. During an observation period, a resident reflected on having to wait for assistance.

At mealtimes I often assisted to take residents in wheelchairs away from the dining area when they were finished. One of the residents said to me "Thank you so much! You don't realise how long we have to wait. Sometimes it is over half an hour, even an hour. Some days I sit waiting for someone to be free to take me back to my room, they have to take all of us you see, and there are only so many people. Because I am with it and not confused, I normally wait 'til last. The others try and take themselves otherwise and it's a recipe for disaster. Oh thank you so much". This was something I had noticed at mealtimes, as people finished eating the residents were taken away from the dining area, nearly everyone needed someone to walk with them, push their wheelchair, or two people to help hoist them. With only 4 staff around some days to help do this for 38 residents, it took a long time. It must take a lot of patience when sharing your home with so many other people.

(Observational Notes, Site 2)

The formal routine within the care home reinforced a very structured approach to the social organisation of the care home. In this way the roles of staff were focused on tasks and routines that were centred around meeting the physical care and safety needs of the resident. What was of note here was that the formal processes the priority appeared to be ensuring the physical wellbeing of residents, specifically meeting their fundamental care needs and protecting them from harm. In these tasks and routine there did not appear to be any space for important interpersonal relationships, and no emphasis given to the psychological needs of the residents. Although the routine of the care homes did involve social activities, such as mealtimes and activities, from the staff perspective, the goal to be achieved was physical safety through these formalised work tasks and routine. Due to the formal staff role and routine focusing heavily upon tasks to ensure the residents' physical care needs and safety, it was argued later in this chapter that individualised care was a supplement to the core role of staff and by taking this approach they were in fact working against many of the policies and processes put in place.

BECOMING A CARE HOME RESIDENT

The narrative of a resident's journeys to becoming a care home resident revealed many significant themes. The most significant to this thesis was that individuals came to be in a care home when they or their relatives felt their safety was compromised due to either physical and/or cognitive decline.

This first quote highlighted many important themes, and principally highlighted that the decision to come into the care home was considered a last resort:

> *"I'll give you the end of the story and then go back to the beginning more briefly. I'm here because I have Parkinson's, I've had it for ten years now. I was living with my husband, very happily… he looked after me in so far as I needed looking after in those early stages and we did things together and he was thinking ahead about what implications were going to be and so I became less able and then he died suddenly… So I was suddenly in a four bedroom house, on my own, which I could cope with… I realised as my strength began to wane, I was finding it increasingly difficult to do things, the things I enjoyed. Even things as simple as keeping my medication, became very complicated and going down to the post box, began to be dangerous because it involved crossing the road, that sort of thing, and then I realized what I'd have to do, go into residential care. I knew that was coming, because there wasn't anywhere else for me to go."*
>
> (Betty, Resident, Site 2, Formal Interview)

An important theme to consider here was that of loss and the impact of physical decline on safety, as key themes for understanding the decision and impact on becoming a care home resident. What was evident from this quote, and many other similar narratives, was the sense of overwhelming loss. In this short quote alone there were many aspects of loss: loss of work, loss of physical ability, loss of her significant other, loss of support networks and finally the loss of her home and possessions. This was something that we will explore in more depth later on in this chapter. The other important theme to consider was that her reason for coming into the care home centred on her physical decline, which had eventually influenced her sense of safety at home, leaving her with what she perceived as no other choice. This was seen throughout informal and formal discussions with relatives and residents, that physical and or cognitive decline had influenced the safety of the resident and a resounding sense that a care home was the 'last resort'. The following quote further demonstrated the safety concerns of another resident, which led to the decision to move to a care home:

> *"Harry: She came in to have a look at it when we went on holiday. When we came back, then she said "I am going to stay here."*
>
> *Louise: She had had quite a few falls before that.*
>
> *Harry: And she burnt herself cooking.*
>
> *Louise: She shouldn't have been cooking, but she carried on doing those things that she wanted to. At the time, we would just go out for a walk and she would have had falls and that. So, she wasn't safe at all.*
>
> *Harry: She didn't protest at all, she was quite willing to go along with it. In her mind she is okay mentally, even though she is 96. She takes her time to get things out sometimes. With coming to the care home, we didn't pressure her at all, not one little bit. We said "it is up to you."… She did say to us "This is for you." Because she is ok mentally, she knows what she is doing."*

(Harry and Louise, Relative and Relative, Site 2, Formal Interview)

This quote captures the theme of loss and contextualises the extent and influence of physical decline on safety, which led to the individual becoming a care home resident. This quote also presents the nature of decision making with relatives, whereby the decision was made related to safety concerns, but also to relieve the burden on family members who had taken on a carer role of the resident to support their physical needs and safety.

For those residents who had dementia, the loss of cognitive ability seemed to result in the decision to come into the care home sitting wholly with the relatives, but again was considered a last resort and related closely to cognitive decline that affected the residents' safety at home.

> *"Richard: Well, I mentioned earlier that Dad died in 2014… and it became clear that Dad had been protecting mum because the one thing she kept saying to me was who are you? She didn't know who I was. She didn't recognise anybody. She was living in their home at the time but it was clear that she couldn't really look after herself. There was one very concerning episode whereby a double glazing salesman had knocked on the door and mum being lovely as she is, she invited him in and…*
>
> *Dorothy: Not me.*
>
> *Richard: … yeah, you and he was getting all the papers signed for all double glazing and what have you, when thankfully the next-door neighbour noticed a strange car had been parked on the drive for a while and stuck his head in and sent him on his way, thankfully. Basically he thought easy pickings.*
>
> *It became clear that she wasn't eating properly and it became clear that she wasn't coping. We tried her moving in with my brother for a bit, but he was working and he wasn't there all the time and of course Mum got very lonely and nobody was there and she hated it, and so it then became clear that the best place for her was somewhere where there were other people around her all the time."*

(Richard and Dorothy, Relative and Resident, Site 1, Formal Interview)

This quote further supports the overall narrative around becoming a care home resident. Safety was given as the principal reason for becoming a care home resident, whether this was due to physical and/or cognitive decline. In all cases and discussions during data collection, safety was the primary reason for coming into a care home, whether this was the decision of the resident, or that of a relative. Secondary reasons can also be seen within the data presented as that of wellbeing of the individual and to relieve the burden on family members.

With safety acting as the central reason for people becoming a care home resident, it can be deduced that residents had specific care needs that needed to be met to ensure their safety, which they (or their relatives) could no longer meet at home. The expectations of residents and relatives was that staff in the care home will provide a service that meets the physical needs of these residents and keeps them physically safe, therefore reinforcing the theme I have described so far that focuses on physical tasks and physical care of residents. It appears that key physical features of care and safety represent an important understanding that underpins the formal culture of the care home, from the perspective of staff, residents and relatives.

RESIDENT CARE PLANS AND RISK ASSESSMENTS

In terms of understanding residents' physical and safety needs there were certain factors that must be assessed and planned. In both of the care homes the approach to this was thorough and heavily documented, with many different risk assessments and care plans focused on the individual; physical ability, cognitive ability, likes, dislikes and care needs.

During observation one example of this was enactment of the falls policy and risk assessments. At Site 2 there was a resident who had fallen on a number of occasions without injury. She was unstable on her feet and required a frame and staff support to mobilise from her bed to a chair. When my observations began in the care home, the resident initially had only a call buzzer to call for assistance. As she was found not to use this and continued to attempt to mobilise without support, the risk assessment was updated and she was then given an alarmed mat, so that when she stood onto the mat this went off. The resident was then found to push the mat to the side to avoid stepping on this and had another fall while trying to stand and avoid the alarmed mat. At this point she was then given an alarm on the chair, so that it sounded when she stood from the chair. She was also given a crash mat to land on if she fell. In this example over many weeks the resident's fall risk assessment was regularly updated and the appropriate interventions amended to promote the safety of the resident. Through following these policies, risk assessments and care plans the level of intervention did not prevent the resident from falling but did prevent harm with this resident continuing to have falls during the course of data collection, but sustained no notable injuries.

Staff commented that paperwork was a time-consuming part of their work, but also there was a consensus amongst the staff that paperwork took them away from caring for residents and that this was often a tick box exercise to prevent scrutiny, rather than feeling this enhanced the patients' care.

> *"Paperwork's definitely time consuming. It's …I'd say seventy percent of your job really, but it needs to be done. If it's not written down, it's not done is it?"*

(Anne, Nurse, Site 1, Formal Interview)

The care plans and risk assessments used placed emphasis on residents' physical care needs. This could be seen to refelct a medicalised model, with assessments focusing on physical needs and ability of the residents. These care plans and risk assessments formally outlined the ability and interventions to be used with these residents. Some examples were moving and handling, nutrition, pressure area care and falls prevention. However, it was found that although these documents defined clear boundaries and interventions with the residents, these were rigid and could not account for the amount of variability and uncertainty in care homes that I discussed in the previous chapter. One example was a resident who was struggling to mobilise with a frame. Carers and relatives discussed that this resident could stand sometimes to transfer into his chair, but other times he would not do this. Both staff and relatives felt that they had wanted to keep him mobile and were disappointed that this resident was now chair-bound and only moved using a hoist. However, the carers explained that this was due to his risk assessments. As his mobilising had been inconsistent, they could not continue to mobilise him with a frame. This example demonstrates that although this kept the resident safe from a potential fall, it did not account for variation and uncertainty, which staff and relatives otherwise may have assessed daily.

Moreover, the focus on residents' physical abilities could be seen to reinforce the task-focused perspective that continues to run through this chapter. Although this can be considered good practice, as awareness of risks and care needs ultimately keeps residents physically safe, what may become lost in this formal approach was individualised care. On paper, residents can be considered defined by features of their physical care needs, particularly looking at the task-based way people viewed their job roles. At times this was seen in observations in the discussions between staff, referring to residents in such a way defined by the needs and the task at hand.

> *"They're all supposed to be doubles, nobody does it on singles."*
>
> (Gail, Carer, Site 1, Formal Interview)

In this example the carer refers to residents as "doubles" or "singles", referring to these residents as defined by the number of staff who were needed to meet the person's personal care or mobilising needs. This language was commonly seen in observations of the care staff. This appears to further reinforce the task-focused frame on how residents were viewed. It became apparent that staff would group together or identify the residents by their needs and the tasks that need to be undertaken. This therefore showed another way that residents were defined by their physical care needs.

Overall, it appeared that the formal documentation in the care home did reinforce the perceived formal safety culture within the care home. This continued to place emphasis upon the need to meet the physical care and safety needs of residents above all else.

PHYSICAL AND COGNITIVE DEPENDENCY

Physical dependency

As the last section highlighted, the needs of residents were captured in formal assessments. The area these focused on most prominently was physical care and safety needs of the residents. Secondary to this was people's cognitive dependency and capacity. In this next section I consider how the physical and cognitive dependency of residents impacted on their care and safety needs. This section highlights a core finding that residents who were more cognitively able were proactive in their understanding of safety and were able to support their own safety and that of others. Physical ability also did have an impact upon their safety needs, but this was not as significant as cognitive ability. This was because residents who were physically able but not cognitively able were not able to perceive risks effectively and therefore could not promote their own safety.

If a resident was more physically able, this often implied that this resident could mobilise independently. They therefore would require less support with personal care, be able to eat and drink independently, were at a lower risk of falls and did not have issues of pressure area care as they were more physically able. This was a very different picture to a resident who had a high level of physical dependency. Those with more physical dependence needed two members of staff to support hoisting into the bed, chair, wheelchair or commode and required support with personal care needs. Some also required support with eating and needed someone to help feed them and support them with drinks. They may be at high risk of falls if they try to stand and also require regular pressure area care and special equipment due to their lack of movement. There was contrast between the level of support required from the staff in supporting these individuals to meet their everyday needs and to maintain their safety. Through a task-focussed lens it could be argued that a staff member would view their work related to these two residents very differently, one requiring minimal staff support and intervention, whereas the other requiring much more. Within a care home of over 30 residents, each individual will fall somewhere between these two extremes of need, with many fluctuating in their needs and presentation. Residents with physical disability experienced a significant change in their ability from what this was at home, and this may continue to decline or fluctuate during their years spent in a care home. The following extract outlines some of my observations within Site 2 in relation to residents' physical abilities.

This morning, Marjorie, a resident who needed support with transferring to her wheelchair was wheeling herself through the corridor. The activities coordinator appeared distressed and asked Marjorie how she got into her wheelchair. "Why didn't you use your buzzer? You shouldn't be getting into your wheelchair by yourself. What would happen if you fall?" Marjorie replied, "Oh, you always say that, but look at me, I am just fine. I know I have a buzzer, but I don't want to have to wait". The resident had limited physical ability, but continued to assert her independence and autonomy in taking this risk. The activities coordinator had previously told me that this lady falls regularly from not calling for assistance to get to and from her wheelchair. She explained that they were using a sensor mat to alert when she stood up, but the resident kept pushing it under the bed.

Just 10 minutes later, another resident, Victoria, was walking down to lunch. She has a broken wrist in a cast and was walking with her walker. The senior carer asked her, "Why are you walking on your own?" She laughed and responded, "I am perfectly capable." The staff member laughed and told her "I know but we don't want you to fall, do we?" Victoria laughed and said, "Oh shush!" And carried on walking unsupported. Although the two both acknowledges the risk, they appeared to talk of this light heartedly, laughing and the staff member accepted the resident walking on their own.

(Observational Notes, Site 2)

What was evident from this observation, but also from many other situations and resident interviews, was an apparent mismatch in the care home between a resident's expectation and the perception of their own ability on the one hand, and what had been determined in their risk assessments or perceived by staff and relatives, on the other hand. Residents often felt they were more able and saw less apparent risk than that of relatives and staff members. Those who were more physically able were more independent and able to walk without supervision or stand to get into their chair without a staff member and their mobility aid. But this was often distressing to the staff who saw this as not adhering to the risk assessments and care plans in place, often with the view of, "What if they fall?"

I will next consider the level of physical ability and explore the impact of this upon perceptions of the residents.

> *"I don't really go out in the garden, no. I know there are some who go out, but it's if you can do it under your own steam, like one of those, the frame, they'll let you go. Because that way you're fairly safe, you know? But I can't walk without that. So it'll depend on if someone can come out with me, and they are so busy, I don't want to ask them to do that."*

(Dee, Resident, Site 2, Formal Interview)

This quote highlights an important theme, which I will explore later in this chapter, loss of hobbies. But what can be seen here was the impact of physical disability. What was clear within both sites was that the more physically able residents were, the more they were able to be independent and achieve a level of autonomy and engagement in activities that they enjoyed without the assistance of others. This then influenced risk taking, as demonstrated by the last example where residents were mobilising unaided, but this also filtered into their daily lives. Maintenance of the aspects of identity highlighted as important to residents, such as hobbies appear to be out of the control of the less physically able residents, who expressed that they were unable to do things because of being dependent on other people. The significance of this to the thesis was that the less physically able someone was, the bigger the impact this will have on core aspects of their life, and therefore their identity. Those who were more physically disabled will have less autonomy, which will have a direct impact on their wellbeing and perception of identity. This finding will be discussed in more detail in the second half of this chapter.

Cognitive dependency

What I will now go onto consider was the impact of cognitive impairment, which was significant as these residents were unable to draw on past experiences or situate themselves in the present. This had a direct influence on their ability to make sense of their current environment in terms of their own ability and environmental risks. At Site 1 in particular, a nursing home specialising in dementia care, nearly all of the residents were unable to draw on their current or past situation to make sense of their environment. For example, in one instance a resident, Leroy, was wandering around and asking what street he was on and the way home. He kept circling the room and asking different people and appeared to believe completely he was walking a street on the way home and was lost. This inability to situate himself in his own reality, impacted directly on his own capacity to detect and react to environmental risks. In order to prevent him from falling staff would move obstacles from his path, interact with him and use distraction techniques to break his cycle of searching for his way home. This was just one example from the data that demonstrates how those with more significant cognitive impairment and memory loss were less able to take on an active role in their own safety, and instead rely on those around them to establish safety.

Residents who were more cognitively able demonstrated that they were able to make sense of the care home environment and therefore take risks and actions to maintain safety, not only in their own safety, but that of others. The following data extract was from an observation of residents during a board game where the residents were also having a cup of tea.

Tom was a resident who had full capacity mentally, but had high levels of physical dependency. He could only get around in wheelchair and could not walk. He had very poor coordination and control of his arms, often dropping things. We were sat playing a board game with a group of other residents and they were all sat having a cup of tea. He was drinking his tea and has spilt some down himself while drinking. Tom noticsed that Sylvia, another resident, was holding her full cup of tea on her lap and was falling asleep. He started to say her name over and over to wake her up and told her to put her tea on the table. He then turned to me, "I didn't want her to burn herself and spill it. She would have dropped her whole cup down herself." Even though Tom had very limited physical ability, he was able to respond to this risk to the other resident. I asked him, "Why did you help Sylvia?" He said, "That happens a lot, people struggle and I want to help them. I know I can't do much, but I try at least."

(Observational Notes, Site 2)

What was importantly demonstrated by this observation was that residents who were more cognitively able were proactive in their understanding of safety and in helping others who they perceived to need help or to be in danger. There was a distinct differentiation in these groups, those who were more cognitively able, and those who were less cognitively able. Cognitive ability was the most influential factor in relation to safety, and drastically influenced the role the individuals took in their own safety and in that of others. Residents with dementia did not show awareness of safety in regard to their own safety or that of others. The following quote was from a resident discussing how he helped other residents:

> *"In a home, you get people with different needs and I want to help. I'll talk to anybody. I'm not being big-headed, but I'll talk to people. I tell them not to be worried, or to be careful, but sometimes you can't help. Other times you can help a little, just by giving them a spoon. I try and avoid that because they're quite capable doing it themselves. It can be a bit patronising when people help you, but you want to help keep them out of danger… You can sit there and you look in their eyes and you think, "Well, you used to be quite independent when you were younger." That's the thing, old people might be old in age, but they're young at heart."*
>
> (Stephen, Resident, Site 2, Formal Interview)

This quote reinforces that residents with cognitive ability would support and promote safety of their fellow residents. Moreover, it also reflected that this resident saw himself as distinct from those he was helping, recognising that he was distinctly different because he was cognitively aware. When discussing other residents, more cognitively able residents commonly referred to ‘them’ when talking about other residents who were less cognitively able. This was also demonstrated in the below quote:

> *“Jean: Knitting is a good forum to chat away, but you have to keep some of them in order don’t you?...*
>
> *Tina: Sometimes you have to split a couple of people up like get them away from each other because they egg each other on so we have to separate them just move them away from each other.*
>
> *Jean: Yes, yes we do yes…”*
>
> (Jean and Tina, Resident and Carer, Site 2, Formal Interview).

There appears to be a perceived differentiation between residents in that the residents often spoke of ‘we’ and ‘us’ to mean them and staff. The residents and staff presented a combined or shared responsibility for safety, with cognitively able residents and staff working together in supporting residents who were less cognitively able.

These findings further reinforce the emphasis placed on physical care and safety- with physical and cognitive ability appearing to be factors seen to greatly influence safety. The formal aspects of culture reinforce the physical safety of residents. For residents, they were in many ways viewed in light of their physical and cognitive ability, with this influencing the level of care and support required, their autonomy and their ability to have responsibility for their own safety and that of others.

VISITORS

Another important consideration was how relatives were formally viewed and integrated as part of the social organisation of the care home. This next section highlights that the formal role of a relative was as an outsider and visitor within the care home, and how this impacted on their role in promoting resident safety.

The narrative around relatives in the care home setting was very different to what it had been before their family member came to live in the care home. The stories shared in informal discussion and interviews with relatives and residents revealed that before the care home, relatives often acted as carers for their family member and that they felt responsible for their safety. This fits with the narratives discussed earlier in this chapter around coming to live in a care home, and the role of families within that and feeling that a care home was the “safest” option.

In this study, relatives were no longer the sole carer, and this at times appeared to cause conflict and tension between staff, residents and relatives. A distinct point of difference was the amount of time relatives spent at the care home. Many relatives visited regularly for a few hours, but this was in the capacity of a "visitor" turning to staff members to meet the care needs of their relative during this visit. The amount of time and number of visits vastly changed, with some relatives in the home visiting daily for a few hours, to others visiting weekly, monthly etc. This was seen to be distinctly different, and from a staff perspective it was felt that the staff often had a better relationship and felt they understood the resident better than the family member- as the carers spend every day with the resident, in comparison to the relative. This narrative was quite distinct and appeared to influence staff perceptions of relatives and at times the value placed on their opinions.

> "*For the people that don't get the care you've got to fill that emotional gap. You do get attached to people, and you have got to be – you haven't got to be, but you do – become their family, their extended family.* "
>
> (Sarah, Carer, Site 1, Formal Interview)

This caused conflict as the staff saw relatives as visitors in the home, and although they were communicated with and would turn to relatives for advice around the resident, particularly when they were new to the care home, they were not felt to be in control.

> "*You can have some relatives that are there and it's ... you're here to look after my relative and that's it. You get some that are like that and some of them they just sort of get to your patience and you're thinking well take them home then if you don't think we're doing enough care for them. And you sort of think ... when they start interfering with the peace, you think well they wouldn't be able to cope with them at home."*
>
> (Billy, Carer, Site 1, Formal Interview)

Many staff voiced similar concerns and frustrations to this, stating that some relatives have an interest in only their own resident, and do not see the bigger picture e.g. demanding to take their resident to the toilet when a staff member was busy with another resident. Relatives who attempted to have an active role in influencing the care and safety of the resident were often considered to be "difficult" or "interfering". During Site 1 observations it was more apparent that relatives would try to get involved in the care of the residents. This appeared to be due to the high prevalence of dementia, so many times relatives would speak in terms of "what their mother would want" or "what their father was normally like", as if having a voice to promote what they viewed to be best for the residents. The reception of this by staff was that it was listened to and actioned on, such as bespoke care plans following opinions of relatives. Nevertheless, when staff were talking about relatives between themselves, and to me in informal discussions they would describe them as "interfering", demonstrating a quite stark tension in the role of the relative within the care home.

INDIVIDUAL SOCIAL IDENTITY

In this second half of the chapter, I will move on from the narrative of the formal organisational culture to discuss a conflicting finding within the safety narrative. During both interviews and observations at both sites it became apparent that there was a distinct focus on individuals and wellbeing that was not integrated within the formal physical care and safety narrative, but presented a contrast to the formal aspects of culture. This chapter explores the informal aspects of culture and highlights the emphasis that staff, residents and relatives placed on individuals and their perceptions of social identity. This section discusses how individualised approaches influenced ways of working to promote quality of life and safety when working with residents. The place of relatives in supporting elements of identity and personalised approaches to safety were discussed. The chapter gives examples of the changing identity of residents. The chapter closes by discussing the impact of identity and identity crisis upon safety perceptions and actions.

WAYS OF WORKING AND WHAT WAS IMPORTANT

In the previous half of this chapter, I discussed the formal social organisation of the care home. In terms of the ways of working, this section considers the more informal social organisation of care homes and the perceptions and actions that guided staff in their work.

Aside from the narratives about job roles, interviews and observations revealed a distinctly different perception of the care home and the staff members place within this. This perception of the care home appeared to stem from a shared understanding and appreciation of the environment as a 'home', whereby the staff were not only part of a team but were also part of a socially accepted 'family' with shared goals and interests. This notion of 'family' was commonly brought up in informal discussion between staff and also came up in multiple interviews.

> *"They work like we are one big family, we just work together. Which I think is the most important thing"*
>
> (Andy, Carer, Site 1, Formal Interview)

> *"It is like a big family, with the people and the staff and residents as well… It is just like a feeling. *laughs*... When you know everybody and you see the same faces all day every day, and probably because they treat you as a member of a family. They are talking about their lives to you."*
>
> (Jane, Domestic, Site 2, Formal Interview)

> *"The aim is to try and make a family home, a family living in a home, not a group of old people that live in a care home. It's supposed to be like a family that live in a home. That's what we're trying to build, that's the idea."*
>
> (Christine, Chaplain, Site 2, Formal Interview)

Across all of the varied roles in the care home, an emphasis was placed on the importance of relationships and more informal, social elements that influenced their practice in undertaking their formal job tasks. While undertaking the tasks and routine outlined in the first half of this chapter, the staff highlighted that the most important part was maintaining the notion of home. The care and safety they were promoting was within the residents' home and that this should influence the practice of the care home, as this was distinctly different to other institutional care settings. For example, domestic staff talked about getting to know the residents and their interests, helping them with small tasks in their room and finding out how they liked things to be done to tailor cleaning their room or making their bed to the individual. This was considered by the staff to be working outside of their formal role, which they did because they considered this to be important.

The same theme came through with carers who felt that relationships with the residents underpinned all that they did, although they did not always consider this to be part of their formal role. They had a part to play in therapeutic relationships, and ultimately making sure people lived happy lives in whatever way they could support this. In many ways it appeared that a move to a care home saw a transition from strong relationships between relatives and the resident, to this instead being with the staff that worked most closely with the residents. For carers, many staff expressed that they wished they had more time to spend time with residents socially, talking to them, involvement in activities and aspects related to their wellbeing. However, many felt that although this was very important, physical care, safety and paperwork must come first, leaving them with little time to engage with residents in this way.

A further example was provided by the maintenance staff, who emphasised his part in knowing the residents. This was outside of what he considered to be the job he applied for- and related to this overarching understanding that people here were part of a community and that these meaningful interactions mattered.

> *"I never came here expecting to do what I do. I literally thought I was going to be fixing things and painting things with the odd trip in the van… I don't want to disturb them. I'm quite conscious of I work in their home, they don't live where I work. It's like somebody coming into my living room when I'm watching Top Gear and taking out a socket and stuff. You'd be like what's going on, so I'm quite conscious of that. I think if you treat them with a level of respect it's always reciprocated because they're too advanced in their various ailments or they're just having a bad day and they're grumpy old buggers but then the next day."*
>
> (Will, Maintenance, Site 1, Formal Interview)

This culture of relationships, home, family was shared across staff, and there appeared to be a shared understanding of unity and that everyone was playing a part in this whole experience. The result of which was many staff working outside of what may be their formal job role- e.g. when cleaners were off sick, carers, managers and receptionists cleaned the care home. All of the staff found ways to interact with residents in the activities they were undertaking- when formally this was not part of their defined role.

Interpersonal relationships and treating people as individuals can therefore be seen as important aspects that were embedded within the culture of the care homes. This appeared to be in contrast to the staff's perspective on their job role as focused on tasks and physical care. When this group was asked about what they felt was most important to residents, or what was important in their work as a carer, there was a consensus and themes that came through around promoting individuality, choice, happiness and dignity.

"Sarah: To look after the residents, I always say how I would want my mum or my nan to be looked after. Treat them with respect, enable them as much as possible to keep their independence, their own identity, their dignity, their privacy. All those things that are important to me are important to them as well. To realise that it is an illness that they have, and the way they are with you are at times is not what they would want to be like if they could step back. So just treat them with the respect that they deserve, and try to get to know them as much as possible… The more we know about them, the more we can actually tap into them, and make their lives as happy as possible."

(Sarah, Carer, Site 1, Formal Interview)

The overarching theme was the staff perspective on individuality and this as something embedded within and owned by the staff in the care home. This was not how staff perceived their job role, which was task-focused, but formed an informal consensus or understanding amongst staff.

RELATIVES

This notion of family was also portrayed by relatives in interview data. This was expressed as if the care home was being a part of a community. The relatives' formal role was explored earlier in the chapter and was about being a visitor and this narrative around relatives presented some tensions. However, observations of relatives in the care home provided some distinct findings in relation to family and community.

Relatives appeared to view themselves as a member of the wider community- for those who attended regularly. In the formal social organisation of the care home, their place in the safety of the care home was peripheral and as an outsider who at times fed into the staff, but had no core role in safety. However, during observation it was seen that many relatives knew the other residents and staff by first names, not only making conversation about their lives, but also assisting other residents with eating and drinking, helping them when they saw them wandering around, or becoming unsettled or if they thought they might trip on something. Relatives reacted to situations in a way that was as if they were not an outsider but an important part of this community or family, not only involved with their parent or loved one who they came to visit. The informal social organisation of the care home appeared to be much more flexible. Whereby, anyone present in the care home, for whatever reason played an important part in the overall environment, atmosphere and safety of the home

In relation to their own loved one, the identity of a relative presents some interesting tensions with the change of relationship. What was noted was that many relatives had previously been a carer for their loved one, and perhaps felt responsible for their care and wellbeing. For example, in informal discussions a relative explained that they had been their mother's sole carer. They helped them wash and dress, cook, took them shopping and spent every day with their mother as a carer prior to her coming to live in the care home. This was at times a cause of tension, as I mentioned earlier in this chapter, in terms of their involvement in care and expectations and interactions with the care home team. Partially this appeared to be down to prioritisation, where the relative was prioritising their loved one, but the nurses or carers had to manage their workload and the rules they work to. Therefore staff could not give a medication without this being prescribed, or could not get a doctor to visit instantly, or could not drop what they were doing to assist the individual. During observation there were many times that relatives were seen to approach the staff during important tasks, like assisting another resident to eat, walk, or administering medications. Often this was to ask a question about their care, or ask for someone to assist the resident urgently, with an abrupt response when they were told that they would have to wait.

Another side to this conflict appeared to be due to their perceptions of the resident. Some of this conflict came from the carers or nurses responding to the resident's current ability and wellbeing, whereas the relatives of residents with dementia instead focused on "what mum would have wanted." One example of this from observation was that relatives would say, "Why is she doing arts and crafts, she never would have done that, she hated arts and crafts," but the resident was currently appearing calm, content and was smiling doing arts and crafts. Another observation was around hairdressing. The relative showed a photo and said, "This was how mum would always look. This was how she likes her hair, she has it done weekly." It was apparent that the resident did not like having her hair done and became very distressed, screaming out and trying to hit the hairdresser. The relative viewpoint on this situation was that the resident would have be upset to see herself without her hair done, making this an issue of dignity based on their mother's wishes prior to her advanced dementia. From the staff viewpoint, this was seen as an issue of wellbeing and safety as the resident was becoming distressed by having her hair done and did not appear to care how her hair looked. The conflict here appears to be distinct differences in perception between the relatives and the staff. For someone with a cognitive impairment, should the emphasis be on their wishes when they did have capacity or on their wishes now in light of the cognitive impairment? Looking at this situation, the resident had capacity enough to make staff aware she did not like having her hair done. However, it was unclear if she had an understanding of the significance of what this activity means. From a safety standpoint, and the perceptions of staff the priority was to treat the resident in a way that keeps them calm and content, thus reducing risk of harm. For many relatives there appeared to be a disregard for what the resident wanted now, and a prevalent hold on to the person that they were before, and their wishes from the past.

> *"You think sometimes it's not worth it, it is a hairdo. They don't need it as a life or death thing. It is a hairdo and if they are happy to have it done, we will do it, and if they don't want it doing it doesn't matter. It really doesn't matter… Some of the other dementia care patients aren't really massively aware and it is then more for the families. To keep them looking like the people that they know. I get a lot of families that when I do see them they say, "Oh, mums hair was great. Thanks." And it is lovely, it is really lovely actually. Sometimes you do think, "Why is this person having it done?" Because they are not bothered. But, then you see the families and you realise that is why they are having it done, because it is about the whole person."*
>
> (Louise, Hairdresser, Site 1, Formal Interview)

Relatives have a vital role as an advocate for the resident as they have known them their whole life and know their history, which was useful for patient care. They also had an interest in their wellbeing, holding the care home to account for the care provided. With this came conflict and some tension, and also the perception of the relative appeared to be situated in the past. This further appeared to influence the relatives' perceptions and attitudes towards safety, for example prioritising dignity over the physical safety of a resident. For example, the quote below displays how a relative focused very heavily on what her mum would have wanted, even though from the carers' perspective, this was not what the resident wanted and was causing distress.

> *"With Josie's family, you're always walking on eggshells. You never feel like you're doing anything good enough and I think she wants her mum to be number one, we're going to get more. Well no, because everybody gets the same. We don't favourite one, and give more attention than the others. That's not fair… It should be what Josie wants. She'll say, "Can I go back to my room?" We have to say, "No, because your daughter doesn't want you in your room." That's what her daughter wants, not what she wants. If I was Josie, I'd be the same, because I like my own space. I like to chill out on my own and some days you don't want people around you. You want to be on your own, but her daughter wants her out socialising, so we have to do it. If not, she just goes mad."*
>
> (Billy, Carer, Site 1, Formal Interview)

This quote above was an important example of how perceptions and priorities in terms of care and safety were distinctly different between relatives and staff. During my observation at Site 1, I observed on almost a daily basis the events as described in the quote above. The resident wanted to be in her room and she would make this known, at times becoming upset and unsettled due to being told she could not. She would also attempt to drag herself to her room in her wheelchair by holding onto walls and chairs in a way that made her at risk of harm. From a safety and wellbeing viewpoint, it appeared that letting the resident spend time in her room helped her to not be agitated, she was calm, and she would not be attempting to mobilise unaided. Nevertheless, the daughter would disregard this and be insistent that her mother should not be allowed to stay in her room and that socialising was best for her. The tension here was between what was best for the resident now (the staff perception of wellbeing and safety), or what she would have wanted in the past (the relatives' perception of wellbeing and safety from a past life proxy).

RESIDENTS' IDENTITY, LIVES AND EXPERIENCES

By exploring the informal social organisation of care homes it has become apparent that the identity of residents was considered important for care and safety. In this section I will attempt to provide depth to the lived experiences of residents to see how residents perceive their own identity and existence within the care home. These findings present what part of residents' identity was considered important including work, hobbies and significant others. This section was important to the wider thesis as these important areas of identity highlight the need for maintaining identity and autonomy in care homes, and by doing this well this was used as a tool to promote the safety of residents, rather than being a conflicting factor for safety.

Care homes are social care settings that are home to a large number of older people, all individuals in their own ways with varying backgrounds, personalities, interests and vast differences in physical and cognitive needs. This was particularly important when we look to explore how people understand quality and safety within care home settings. The way in which residents' identities were co-constructed within this setting revealed important influences upon how residents themselves understood the care home, and had an influence on the perceptions of relatives and staff. Therefore, I first explore the co-constructed narratives of residents using excerpts from field notes and formal interview data. This section highlights three core attributes to resident identity and presents the finding that resident identity was constructed around aspects of their past lives.

This extract was from my first hour of data collection, being shown around Site 1, a nursing home that specialises in caring for people with advanced dementia. This captures some of the interactions between staff, residents and myself and the first suggestion of how resident identity was co-constructed within this context:

(Observation Notes, Site 1)

This first observation extract sets the scene for two important themes, that of work and hobbies, which were echoed throughout my observations and interviews within both care home sites. It was evident from these field notes that previous work life and hobbies of the residents were considered a distinguishing factor in their perceived identity, highlighted by the focus on this within introductions. Moreover, that staff felt this element of identity vital to the quality of their work within this setting, and therefore understanding these elements of identity were core to the work within care homes.

It is day 1 of data collection and Sally, a manager in the care home, showed me around the building. We first went into the main lounge area where Sally introduces me to each of the residents. Partly in conversation with the residents, she tells me their names, and brief information about what they like to do, what they did for work or what visitors they have who live nearby or who come to see them regularly.

We passed Alison, the activities coordinator. I was introduced and they spoke together about the role, explaining that it involves a lot of 1:1 support and does not follow a set plan. "This is because every resident is different and has different likes and dislikes, so each day is different depending on what they want to do." They both gave me a long list explaining to me what different residents enjoyed doing and how in one day they might do flower arranging with a group of the residents, then take a resident out for a walk in the countryside, another resident loves animals so he helps to feed the chickens every day. The amount of information they know about each resident is too much to remember and write down.

In the next lounge, the wall was decorated with the residents' names and a new years resolution for each person. Sally and Alison explained that rather than choose something that they needed to change, they used this to focus on what the residents enjoyed and tried to make these resolutions as a focus for activities. For example, a resident wanted to feed the chickens more, another wanted to spend more time being social in the main lounge area, another resolution was to do more gardening. Alison explained that the most important part of her job was making the residents happy, and anything she could do to make them feel happiness then she would do it. "That is why we are all here, the best part of the job is to see a smile on their faces and know that we have helped them live one more happy day."

(Observational notes, Site 1)

The narratives presented by residents and relatives within the interview data also reflected work life as important, many interviews and informal discussions involved discussion of work lives, roles and responsibilities from the residents' past careers. The following quote captures just one example of a relative and resident with advanced dementia discussing her career.

> *"Richard: Mum and Dad, Dorothy and Victor, met on the buses. Victor was a bus driver and Dorothy was a clippy, weren't you? It was lovely because she got to meet lots and lots of people obviously being a clippy, but you were very sought after, weren't you? All the bus drivers wanted you as their clippy.*
>
> *Dorothy: Oh did they?*
>
> *Richard: Yeah, well that's what you told me, yeah.*

Dorothy: Perhaps I was showing off.

Richard: Well there was one in particular who applied to the management to have you transferred to his bus to be his clippy but you wouldn't have any of it, because you wanted to be Victor's clippy."

(Richard and Dorothy, Relative and Resident, Site 1, Formal Interview)

What was notable from the data was that work was a highly important aspect, both related to the residents' own career or that of a significant other. Throughout the data, residents and their relatives focused heavily on their work life and achievements, with this related closely to significant life events or relationships, such as where they met their husband or wife. The theme of work lives manifested within all resident interviews and appeared to be an aspect focused on by relatives and staff in discussing residents. This was important, as the residents' past work lives were strongly presented as an important aspect of who the individual was and therefore was considered a core and distinguishing aspect of resident identity.

As was highlighted in the first observation extract, the theme of hobbies was also echoed within resident interviews. The hobbies shared were often past hobbies, and included gardening, traveling, poetry, painting, and social groups, among many others.

"Jean: My husband and I we were very involved., We both liked painting and I was a secretary at the local art club for twenty years. Twenty years, I don't know how I did it. It was about fifty people there and I was the secretary and he was the chairman, so between the two of us we did a lot. You know that was our big hobby painting, that's how we met.

Interviewer: Oh really, so how did you meet.

Jean: Well we both went separately on a painting holiday and you sort of go with a group of people and you spend a week living in a hotel or something like that and then you all go out every day and do painting and sketching and all that sort of thing and it's very enjoyable for those that go. This was one of mine and this is one of mine.

Interviewer: They're beautiful.

Jean: The one with the village scene that's my husband's. So they're hanging side by side… So that was our big hobby and we made lots of other friends as well, so there we go."

(Jean, Resident, Site 2, Formal Interview)

The theme of hobbies was therefore linked again to significant others, who often featured as an intertwined part of the residents' narratives. From the data three important themes influence the construction of resident identity, that of work lives, hobbies and significant others.

It was apparent during data collection that care home residents were fundamentally defined by their past lives and experiences, with the narratives of residents' work lives, hobbies and significant others all situated within their lives prior to becoming a care home resident. This was also evident in narratives co-constructed by relatives and staff and was of particular note for those residents with a significant cognitive impairment, whom were far less able to share aspects of their lives. The following field notes present how staff discussed a new resident to the care home:

There was a new resident in the care home today. In handover the nurse explained that he was a farmer and spent his life working on a farm. He had communication difficulties and significant memory loss. They explained that yesterday the staff decided to take him into the sheep field that is over the road and that he was, "In his element, herding up the sheep, it was like he was back working again, he knew exactly what he was doing." The staff appeared to be excited about this and started to talk about getting wellington boots for staff so that they could take him out more in the countryside. They saw importance in his previous life and that this is a meaningful activity for the resident that they wanted to embrace and encourage.

(Observational notes, Site 1)

What was notable in this observation was how this information of the resident's work life has been shared between relatives and staff, and has then been used to engage in meaningful interaction and to guide activities, contributing to quality of care within the care home. Moreover, these core aspects of identity were also used within the care home setting to respond to safety risks and concerns, such as falls and agitation. Below, a carer describes how her knowledge of the resident guides her work in minimising resident agitation:

> *"It could be the last month, last year, last two years of their life, so why should they just sit here, just feel like just sitting here waiting to die. If you don't do things with them, that will happen. So it's important. Some of them, a lot of them will go out in the garden.. In the summer, you spend most of the time in the garden anyway. It helps to keep them more settled; it takes your mind off it don't it? When it starts to get agitated, that's when it's hard, but you can calm people down and bring that back down.*
>
> *Daisy, she, at the start, I used to be able to turn her around with flower arranging. I'd just go and get a load of old flowers out of the store cupboard at the end. "Daisy, I've just been given this job to do, I hadn't got a clue where to start, if you can help me to arrange some flowers," and that would do it for her.*

> *You get to know what they're like, what they're interested in. You could give flowers to Irene and she'd just throw them across the room. She's not got a clue, but Daisy used to love doing that."*
>
> (Jill, Carer, Site 1, Formal Interview)

From this quote there were many themes; those important to this thesis was that knowing the residents' past lives and hobbies can be used as a therapeutic tool in the delivery of quality care, but also in maintaining safety and responding to risks.

The narratives presented by residents themselves, by their relatives and staff all first focused on core aspects of who that person was, or was, and the things that are, or were, important to them. Understanding that the perceived identity of care home residents was constructed around aspects of their past lives laid the foundation for understanding the potential disconnect between them now, and who they see themselves as being and their perceived identity. In terms of culture these findings were important for defining the perceptual frame that residents, relatives and staff view safety through. For those in care homes, resident safety was first about the person as an individual and how to promote their individual wellbeing, of which safety was an important part. It can therefore be seen that the person was placed first and foremost in understanding and negotiation of resident safety. These findings lay the foundation for Chapter 10 which explores these findings further and suggests that information on residents' identity and past lives was in fact central to staff promoting safety and understanding how to protect the residents from harm.

IDENTITY CRISIS

So far a disconnect between the resident's perceived identity and their current reality has been presented. This was a significant finding for this thesis, especially as the physical and/or cognitive decline bringing residents into the care home not only impacts on safety, but also can result in a loss of independence and autonomy with possibly a detrimental impact on resident identity. I will now go on to explore the disconnect between residents' identity, situated in the past, and their current reality. In this section I will outline the sense of overwhelming loss that was evident from the data and how this implies an identity crisis.

The drastic change in residents lives relates to the three core aspects of identity already highlighted: work lives, hobbies and significant others. However, as can be expected, all of the residents had been retired for many years, and therefore had lost the work aspects of their identity that were focused on heavily within narratives of the residents. For example, one resident had been retired for over 25 years, another 32 years, placing this part of themselves in the distant past. What was also significant was that often residents with advanced dementia were unable to draw on or talk about this past part of their lives, yet this was still central to their identity from the perspective of both relatives and staff.

Residents explained a significant loss of relationships, most notably that of a significant other, with most residents' husbands or wives deceased. This data extract relates to a 91-year-old woman and brings into light the impact and loss of living without her husband.

> "*I was only fifteen, sixteen when I met him. Yeah. I can't remember how I met him, but he's a specialised builder. He used to do all these big buildings, you know? They used to be privately done by builders, and he was a master builder. I was quite proud of what he achieved. But he's been dead for such a long time. You can't believe you've gone on existing, you know? I'm ninety-one, and he was about sixty-something when he died. It's so, so long. You think well, why am I still here? You ask yourself questions, you know? Why the flipping heck am I still here? I'm not doing anything special. But, it's God's way isn't it? Mysterious ways. I sometimes say to him, 'What am I supposed to be doing?' I don't know what I'm supposed to be doing now."*
>
> (Dee, Resident, Site 2, Formal Interview)

This extract demonstrates her love and pride for her husband, but also the sense of loss from losing a significant other, and the impact on her sense of purpose, meaning and identity. This was reflected in many resident interviews and informal discussions, with many references to significant others in their past lives and missing them in their present lives. This was another core aspect of identity where there was significant loss. This sense of loss firmly grounds this core aspect of identity (significant others) again in the past, and in direct contrast to their current reality.

Although the loss of a significant other was the most notable, there was also a sense of a loss of support networks more widely. Residents explained that many of their friends had passed away, had their own health concerns and lived too far away. This quote was just one example of losing support networks

> *"So the other thing is that this wandering life we led with the caravan, meant that we didn't have many friends locally as one would expect to have as people who have lived thirty five years in the same area, which has been hard for me, because the people I knew best, who would have been my best visitors, have all got their own serious age related problems. So I have been rather isolated."*
>
> (Betty, Resident, Site 2, Formal Interview)

The quote demonstrated that support networks were dramatically impacted by age, but also by being a care home resident. The loss of physical ability relies on visitors to come due to challenges with travel, impacting greatly upon the independence, hobbies and social lives of residents. This was further supported by the below quote:

> *"Barry: You used to be a Sunday school teacher, didn't you?*
>
> *Hilda: Yeah. We lived close together and I used to go and take your wife to Sunday school and that's how we became friends.*
>
> *Barry: So we are talking a long time ago, because my wife is 72 and this is when she was a little girl isn't it?*
>
> *Hilda: I am 93 this year.*
>
> *Barry: And Hilda is 93. Hilda and I, and my wife, and her brothers and sisters went to … all went to the same church. It was a little church. How long were you associated with the church Hilda?*
>
> *Hilda: Well since I was 2.*
>
> *Barry: Since she was 2, so over 90 years.*
>
> *Hilda: I cannot go anymore, I would like to go to a coffee morning, but it's getting me there. You know I might have got a wheelchair and have to go there. Or we have to have a taxi, I broke this leg when we had a chairlift at home, and I was sitting at the top and went to press it, and it didn't move and I went flying down. So this is why I have got this boot on my foot, I can't … you know I have to have help to walk out. So I don't really go out anymore."*
>
> (Hilda and Barry, Resident and Relative, Site 2, Formal Interview)

This data extract gives just one example of how one resident had not been able to continue going to the church she had attended her entire life. The impact of physical limitations on going outside of the care home was echoed across both sites. It was clear that physical limitations restricted residents from engaging in social events as they had previously. The result was an impact on engagement in hobbies and a loss of socialisation and support. The significance of this to this thesis was yet another area of residents' past lives impacted by a physical decline in health, creating another area of disconnect between the resident identity presented and their current reality.

Building this picture further, the sense of loss also included isolation from a loss of communication, from the residents themselves and other residents being less able to communicate. This was related to both physical decline, such as hearing and eyesight, as well as cognitive decline in being able to communicate and maintain relationships. These physical impacts also influenced the ability of residents to get out, and to maintain hobbies such as painting and singing in a choir.

> *"I have been rather isolated and of course the other thing which has been terribly isolating for me, is that nearly everybody is deaf, and mostly they can't hear what I'm saying, and rather unkindly I might add, even if they can hear, they can't understand what I'm saying, because my mind wanders. I was really starved for conversation, anyway, the other thing that, I'm ashamed of I suppose, it really hurt me giving up my house and having to give away all my things, that we'd accumulated over the years. Particularly my books, I had a wonderful library, and well you can't, you see this room, a large four bedroom house, lovely large double garage and nice garden, planted with bushes and shrubs that all flower."*
>
> (Betty, Resident, Site 2, Formal Interview)

The above quote importantly highlights a picture of isolation from a loss of communication, and that the move to a care home also entailed the physical loss of someone's home and possessions and hobbies. What I have painted here is a picture of loss and disconnect, the areas that construct resident identity have been stripped away in an overwhelming sense of loss and physical disability that has brought people to being a care home resident.

Another area to consider was the impact of cognitive decline and how this relates to loss. Residents who have a cognitive impairment were also affected by all of the elements of loss I have already discussed. In the section on becoming a care home resident you will recall a son explaining that he only noticed his mother's decline when his dad died as he had been caring for her. In many cases residents with dementia have experienced loss of their work lives, hobbies and significant others as well as many other parts of their lives such as social networks and their home and possessions.

The second point of significance to this PhD was that of memory loss. The identity of care home residents has been situated in the narrative of their lives and experiences, then what did this mean for those residents with significant short or long-term memory loss who cannot recall or share these narratives? During Site 1 interviews it was apparent that many residents with dementia did not understand their present situation. This was important to consider and relate back to loss and identity, as these individuals experiencing memory loss will not only have lost core aspects of their identity such as work lives, hobbies and significant others, but also may not be able to recall or communicate these memories.

Many areas that were considered important to resident identity entail significant change and an overwhelming sense of loss related to people, relationships, work, interests, home, possessions and memories. All of these factors impact on the residents' current identity construction which has been situated in their past lives and experiences before coming into the care home. The following data extract demonstrates this as a clear point of crisis in relation to her transition to a care home.

> *"That's when my life here began. So it's a separate story from the rest of my life, because I have this feeling that this is a part of my life that I never foresaw. I was able to look along the lines of my future… with objectives of various kinds, but then suddenly I hadn't really thought about what it would be like to be living somewhere where I didn't know anybody else. I have no goals and no purpose. So that's the end of the road. "*
>
> (Betty, Resident, Site 2, Formal Interview)

This quote shows that the resident's current reality was a time when all of the aspects from the past no longer matter, and thus her constructed identity. What this implies was that this identity crisis may make residents unable to use past experiences to guide and make sense of their current reality. A significant finding for this thesis was the extent of this disconnect and that this overwhelming sense of loss can also be seen to relate to a loss of purpose and meaning, and the impact on this on their understanding of their current environment.

CONCLUSION

This chapter presented a distinct disconnect between the task-focused perceptions of physical care and safety in a care home and more informal aspects of individuality, personhood and identity. The resident, relative and staff perceptions on the importance of individuality and personalised care and relationships was in distinct contrast to the focus on physical safety that was presented in the first half of this chapter. This suggested that the current approach taken to the organisation of care and safety in care homes aligns to an orthodox and medicalised approach, perhaps as a product of these systems and processes originating within acute hospital settings and then being applied to care homes. As such, the formal safety culture did not tailor itself to what is considered important and vital to the wellbeing of residents, and in fact may detract from personalised aspects of care. However, it is the ability of staff, residents and relatives to break the rules which has created an informal culture that values individuality and relationships within the care home.

The contribution of this chapter to the wider thesis was to highlight a prominent disconnect between the formal and informal organisational culture in relation to safety. Moreover, the chapter highlights the importance of identity and individualised approaches within care homes.

CHAPTER 9- Responsibility

INTRODUCTION

This chapter considers how staff, residents and relatives demonstrate and perceive their responsibility for safety in the care home. Building on the findings so far, this section highlights how perceptions of safety and identity influenced individual responsibility for safety.

The chapter starts by giving specific safety examples to demonstrate the complexity of negotiating responsibility for safety between these actors. The chapter explores how responsibility was negotiated by considering the processes, safety rules and bureaucracy within the care homes, and identifies aspects of this that reinforced the assumption that the organisation and staff have responsibility for resident safety. In this chapter, when talking of the organisation, I refer to those in power and leadership positions within the care homes, such as care home managers and senior leadership. The chapter highlights the overarching idea that residents and relatives handed over their responsibility for safety when the resident came to live in the care home. Residents' responsibility for safety will be considered in terms of the amount of responsibility that residents assumed, how residents demonstrated their own responsibility for their safety and that of others, and the distinguishing features of residents perceived as more or less responsible. Relatives were discussed in terms of responsibility in relation to their relative and the rest of the care home community.

NEGOTIATING SAFETY RESPONSIBILITY

To set the scene for this chapter I have used examples from observation and interview data. These have been used to show the practical negotiation of resident safety within the care home and involve the interaction of staff, residents and relatives within the care homes. This has been used to illustrate how responsibility was distributed and co-constructed between key actors. The safety themes of falls, medicines management and agitation will be covered in turn.

Falls

The first area to be considered was falls. Two examples have been used here to demonstrate the negotiation of safety in different fall scenarios during observations.

I was based in the main lounge area. The staff were helping residents to mobilise to the dining area for lunch. During this, I noticed one of the residents, Steve, was wandering around the room and appeared unsteady on his feet. He was grabbing furniture to hold onto and telling the other residents he was lost. As he went around the room, he got a resident's handbag caught on his foot and stumbled. A relative who was sat at a table with their mother quickly stood up and held Steve's hand. They talked to him calmly and a carer came to assist and helped him untangle his foot from the handbag. The relative pulled up a chair and asked him to sit down, talking to him while the carer went and continued helping other people to the dining room tables. I spoke to the carer later who explained that Steve was at risk of falls, but he enjoys walking around the care home and gets very distressed when he is asked to sit still. They explained that he has had some falls in the care home, but they felt this risk was worth taking as they cannot restrain him and it would be detrimental to his quality of life to make him be seated or to have him always under supervision. "If we don't let him walk around, he might lose that independence all together, and that isn't what we want for him."

(Observation notes, Site 1)

The resident in this observation has advanced dementia and was not aware of his own ability or indeed safety risks, evident by him almost tripping on a handbag and also being unaware of his surroundings and stating he was lost. The relative in this situation was the closest to the resident when he began to trip and demonstrated responsibility for safety by assisting the resident and preventing him from falling. The carers in this situation also held responsibility for safety, coming to assist the resident. The staff in this situation also had responsibility in terms of the plan of care for this patient, they demonstrated that although they were responsible for safety, they also felt they were responsible for the resident's quality of life, and that they needed to also promote his independence, allowing him to mobilise and be at risk in this scenario.

I observed the response to an unwitnessed fall of a resident in their room. The resident was found on the floor near her bathroom and appeared to be unharmed. The care staff helped the resident back into her bed and assessed her for any injury. They asked the resident, "Why did you move your mat under the bed?" The resident had a crashmat and a sensor that would alert staff when they stood on this. The mat appeared to be half under the bed, and from the position of the resident it appeared they had tried to then walk around this. The resident stated, "I needed the bathroom. I shouldn't have to wait for you to go to the bathroom., I can walk there myself." The senior stated, "What if you got hurt? It would be my neck." The resident said, "You always say that, and I haven't been hurt yet."

(Observation, Site 2)

This demonstrates some of the challenges in the varied constructions of risk and safety. From the discussion it appears the staff and resident have different perceptions of risk and safety here. The resident did not consider this to be a substantial risk, whereas the staff believe that the resident could come to harm. It was clear from this observation that the care home staff felt they were responsible and accountable for the resident's safety and had in place appropriate interventions. However, the resident who had fluctuating capacity indicates that they did not feel they needed or wanted the staff's help, showing their own autonomy and responsibility for their own safety.

When exploring these two examples, it can be seen that falls prevention was complex and multifaceted, especially in terms of negotiating responsibility between the different actors. Across these examples there were varying degrees and demonstrations of responsibility for safety, but that this can also cause tension and apparent risk. The quote below from a care home manager indicates that what staff do is what is "reasonably practical" to prevent a fall from occurring:

> *"I know if someone has fallen whether that was something that could be prevented, you know that you are doing everything that is reasonably practical, but you still have to go back, you still have to do that paperwork, still got to do that audit."*

(Rosie, Care Home Manager, Formal Interview, Site 1)

Medicines management

To explore medicines management I will take you through one observation of a medication round at lunch time. During this time there were relatives within the care home visiting the residents.

At site 2 it was towards the end of lunchtime and residents were being assisted down from the dining room. The senior (Sylvie) that I was observing has her medication trolley in the dining area and was in turn administering resident medication. She had told me that medication rounds are supposed to be protected. As she was getting out a resident's medication, she noticed a resident stand from the dining table. "Gary! Sit down, you need to wait for a carer. They won't be long." He sat down and she continued to get out the medication. Gary then spilt a cup of juice over the table. Sylvie left the medication trolley, grabbed napkins and started to clean this up. She asked the carer to take over and then went back to the medication trolley. Robert (a relative) came up to Sarah and asked to talk. She said, "I am doing the medication." He responded that, "I am leaving now and it is important." He explained that he was worried that his mum's dose of antidepressant was too high and that she was drowsy and asked why the doctor had not reviewed her antidepressants. Sylvie responded that she did not know and said she will put this on the list for the doctor to review.

(Observation notes, Site 2)

This observation reflects similar findings to Chapter 7, that medication rounds presented many distractions due to other responsibility and safety risks and potential tensions in the distribution and negotiation of safety. In terms of Robert, he may be promoting medication safety by highlighting that his mother's dose of antidepressant may be too high, but at the same time was also causing a risk by disrupting the nurse during a medication round. As such, this observation shows the impact of unpredictability upon medicines management, as well as conflicts in safety priorities between actors.

Agitation

The following observation shows a typical example of a resident who became agitated in the care home:

> *There were 9 residents sat in the activities room playing a word game together. During the game, one of the residents (Mary) had mild dementia and appeared to be getting agitated by another resident. During the game Mary began to shout, "You are ridiculous. I should be gone with you completely. I don't want to see her again." The activities coordinator tried to intervene and asked Mary if she would like to go to her room. "So you are in on it too are you? You are all against me!" The resident sat to the left of Mary asked her if she knew any good poems, she turned to me and told me that, "Mary tells the best poems." Mary replied, "Let me think. Have you heard the one about the cats?" Mary appeared to have been distracted by the question and almost instantly appeared calm again and started to tell a poem.*

(Observation notes, Site 2)

From this observation Mary can be seen to become distressed during the word game activity. The resident had mild dementia and often had episodes of agitation during activities. The activities coordinator in this scenario had a responsibility for resident safety, and she attempted to intervene and offered to move the resident in an attempt to calm the situation down. However, this did not work. Another resident in the room, who had capacity, knew Mary well as they had lived together in the home for over 3 years. The resident demonstrated a responsibility for safety and managed to intervene and distract the resident, calming down the situation. In this situation it can be seen that the responsibility for resident safety was context dependent. Had the activities coordinator managed to calm the situation down, the resident may not have intervened. However, they appeared to share this responsibility, in order to achieve safety and calming down the agitated resident. As such, this was an example of a resident with capacity appearing to take responsibility for a resident with dementia.

Expected and unexpected safety responsibility

The presence of uncertainty and unpredictability appears to be a part of all of these safety situations, which were enacted and co-constructed between multiple actors. A notable point was that each of these situations reveal examples of expected, or planned safety responsibility, such as that of staff having responsibility for falls prevention, medication safety and managing agitation. Another example of expected responsibility was that of relatives holding staff to account for the medication review of the resident. However, there were also examples here of unexpected and unplanned safety intervention, such as that of a relative responding to a resident at risk of falling, and a resident helping to deescalate another resident who was agitated.

As the chapter continues, I explore each of these actors in terms of their responsibility for safety. I will start with the broader care home and organisation. I will then discuss staff, residents and finally the place of relatives. The responsibility for safety will be explored to encompass and reflect the key themes and tensions captured in the data above, whilst using further data to provide more depth into my interpretations of responsibility for safety in care homes.

SAFETY RESPONSIBILITY, RULES AND BUREAUCRACY

I will first explore responsibility in terms of the expectations of the care home organisations and how staff responsibility for safety appeared to be reinforced though the processes, rules and bureaucracy of the care homes. To do this I will highlight areas of admission, documentation and external regulation that reinforced the assumption that the care home and its staff held responsibility for resident safety.

The assumption that staff and the care home were responsible for resident safety was reinforced right from the outset of resident care and began even before the residents came to live in the care home through the admission processes at both sites. The formalised admission processes centred on safety and involved a detailed assessment of residents' risks and care needs. At site 1 I observed an initial assessment by one of the managers. They acknowledged that, "The CQC state that all residents should be seen and assessed before you admit, so we try and do that as much as we can." The assessment involved a visit to the resident's current care home and gaining information from the resident, their relative, and the current care home in order to complete the assessment/admission documentation. The assessment focused heavily on aspects of safety, with the discussion of a long list of risks and safety factors such as; requirement of supervision, mental capacity, behaviour, medication needs, fall risk and mobility needs, compliance/adherence, nutrition and risk of choking, and other safety related areas. These were areas where staff were assumed to have responsibility, and where they needed to act to support resident safety upon admission to the care home. The assessment also covered independence and choice, however in the observed assessment this was only covered briefly. This suggested that there was also a responsibility for staff to promote autonomy in the residents. However, as this section was only approximately 5 minutes of an almost 1-hour assessment, it implied that the safety needs of the resident were of more importance. Safety was therefore the focal area of assessment during the admissions process, with the choice of whether to accept or not accept the resident into the care home centred on their safety and physical needs. The admitting care home held responsibility for the assessment of safety and ensuring that the care home could meet the resident's needs.

This observation of an initial assessment reinforced staff responsibility for safety, as the manager undertaking this assessment was responsible for this safety decision and deciding whether to admit the resident concerned. The responsibility for admissions was at a senior level within the care home, and undertaken by the owners/ care home managers, or delegated to the nursing manager- who I was observing in this observation. At the end of the assessment, the nursing manager I observed stated that, "*Their behaviour would have to be pretty bad for us to not accept them."* This appears to be in contrast to what I observed in terms of the various areas of physical safety assessed, with the manager suggesting that it was "behaviour" that was the deciding factor, rather than the list of other safety needs considered. However, what was clear was that the assessment process implied both organisational and staff responsibility for safety, both in the decision to admit and in gathering the essential information and risk assessments required for care planning and ensuring safety on admission to the care home.

These formal processes and documentation continued to focus on the safety and care needs of the individual, which implied further that the care home was taking responsibility for the safety of the residents. Care plans and risk assessments underpinned the care for each resident at both sites. The overarching assumption in the development of these care plans was that these were then to be followed by staff, and therefore promote and ensure the safety of the residents. However, it was noted across multiple observations that this was not always the case. For example, during observation with a carer at site 2 they disclosed that, "*We never have time to read the care plans, but we don't need to because we work with the resident every day and we know how they mobilise and if they aren't acting like themselves."*

Care plans and risk assessments were used as organisational tools to promote and ensure resident safety. I will now use the example of Margaret from our vignette in Chapter 7 to explore this further. During Margaret's assessment and admission, she was deemed to be at risk of falls due to her having multiple falls at home in the past year. Her falls risk assessment and care plan therefore indicated that she was to use her walking frame and to call for assistance for supervision while mobilising. By putting in place this risk assessment and care plan, the care home was taking responsibility for Margaret's safety by defining a plan of care that minimises the risk of a fall. Margaret decided to not call for help and mobilise unaided. What was witnessed here was the staff reminding Margaret to call for help and therefore promoting adherence to her care plan. However, as Margaret continued to not call for help and walked unaided with no apparent problem, staff eventually stopped reminding Margaret that she needed supervision while walking, thus not following the care plan. One day Margaret was feeling unwell with a UTI and attempted to mobilise, as she had been for weeks. Due to being ill, she felt weak and unsteady walking with her stick and this resulted in her falling. At this stage the organisational process would have been to update her care plans accordingly with her changing needs and ability. However, as identified in

Chapter 7, in the care home a resident's physical ability can change rapidly resulting in it not being possible for care plans to reflect the constantly fluctuating ability and needs of the resident. This therefore presents a challenge in the model that formal documentation and care plans can be adhered to completely in order to maintain safety. Engrained in all of these formal processes, care planning and risk assessments was the notion of adherence and an expectation that staff and residents will work to what was set out within the documentation. It therefore presents a very positivistic view of safety that did not account for the nature of sociocultural factors and unpredictability that was prevalent within the care home environment. These formal processes therefore conform to prevalent orthodox approaches within the wider patient safety literature (Waring, Allen et al. 2016). In this example Margaret, having full capacity, decides to not follow the care plan set out. However, when she fell, it was often viewed to be due to a fault of the staff who should have prevented this fall. In light of this, falls incident reporting, investigation and further risk assessments and care planning would be carried out by the nurses, senior carers or managers, often looking for other interventions or steps to ensure a fall did not happen again. This example reinforces the perception that from an organisational perspective staff were considered responsible for resident safety.

The perception that the care homes were responsible for safety was reinforced by the expectations of external organisations involved in the regulation and monitoring of these care homes. Key external organisations in England care homes include the Care Quality Commission, the Local Authority and Clinical Commissioning Groups. Each of these setting standards for care homes to work to in relation to safety and quality of care. As care homes were regulated externally, they have to report on safety areas, such as reporting falls that occur within the care home. The organisational responsibility for safety can therefore be seen as significant as they were held accountable by external regulators and funding bodies. External regulation and litigation was seen as the key reason for completing the formal processes and documentation. "*If it isn't written down it hasn't been done, and w*e must *write detailed care plans which we need to show the CQC."* At site 2, this was also the case for area managers who visited the care home and covered multiple care home sites. It was notable that adherence to formal organisational rules was more important on days when they were being visited by the area manager, in comparison to other days where staff applied these rules, care plans and risk assessments more loosely. The influence of external regulators and senior management may be because of perceptions of authority. The influence of authority was that staff would adhere to policies and rules in their presence, and take measures to "tick-boxes" without actually seeing value in these activities.

Although external organisations emphasised the care homes' responsibility for resident safety, many viewed this as an unhelpful approach in improving safety and quality. This was because it was felt that these external organisations focused too heavily on the bureaucratic aspects of the care home, such as the care plans and risk assessments, as evidence of safety and quality of care.

> *"I just find it amazing how people like CQC… seem to spend too much time concentrating on paperwork. Paperwork is important, but it's not more important than people."*
>
> (Maria, Laundry, Site 2, Formal Interview)

The care home manager below explores how external organisations can often look at safety in a way that was felt to be inappropriate for the care home setting that was extremely unpredictable:

> *"One of the agendas that the CQC inspect is about how you manage your team, and of course that is a big part of what I do here... The paperwork trails are things that you have to do to satisfy the regulators. It is a shame that their starting point isn't to actually come and see what we are doing well and to listen to us."*
>
> (Rosie, Care Home Manager, Formal Interview, Site 1)

This quote presents that external regulators look to ensure safety, and therefore reinforce the notion of organisational responsibility for safety. However, the perceived usefulness of this focussing on documentation was questionable. Overall, what was found across both sites was that formal processes, both internally and externally appear to be based on the assumption that the care home organisation and its staff were responsible and therefore accountable for the safety of residents.

HANDING OVER SAFETY RESPONSIBILITY AT THE DOOR

Similar to the organisational perspective outlined already in this chapter, staff, resident and relative views appeared to also reinforce the perception that the organisation and staff held the responsibility for the residents' safety. I will briefly consider each of these groups in turn to present some of the data that has supported this finding.

Across the observational data and interviews staff felt they were responsible for resident safety. In the last chapter when job role was considered, it was apparent that many areas of people's perceived job roles related to safety. This was seen in observations where all groups of staff took steps to prevent harm and respond in safety situations. Moreover, staff interviews also reflected that staff felt responsible for safety:

> *"In my role I need to keep them safe by assessing their mobility and their mental capacity as well. Because if the person can't take onboard advice that the physio's and myself are giving, then they could fall."*

(Leema, Carer, Site 2, Formal Interview)

Moreover, this was seen to happen right from the outset of care, with staff acknowledging that residents came to live in the care home because of their physical limitations:

> *"I doubt anyone chooses to come and live here and they're all here because they've got to be here. So they're like 'well I would rather be at my house but I can't because I can't walk about and I need help' and so everybody here to be honest is like a reluctant resident."*

(Christine, Chaplain, Site 2, Formal Interview)

In Chapters 7 and 8 I highlighted that safety was the central reason that residents came to live in the care home. This was an important finding and with this comes the notion of responsibility. Many residents and/or their relatives acknowledged that the resident and/or relatives were no longer able to maintain the resident's safety in their home. Before coming to live in a care home, it was implied that the resident or their relative felt responsible for safety, which they no longer felt was being achieved. With moving to the care home residents and relatives also viewed that the "care home" and "staff" would keep the resident safe, and in fact was maintaining their safety. As such, it can be seen that responsibility for resident safety was being handed over at the door to the care home staff, with the expectation that living in a care home will ensure someone was safe.

> *"Maybe I take it for granted, but I'm safer here than I would have been staying in my own house. It's quite complex isn't it. The drugs for example, it was quite ridiculous the way I was. I spent so much time thinking about whether I've got the right order with Boots correct and I had a couple of falls in my house too."*

(Betty, Resident, Site 2, Formal Interview)

On reflection, both residents and relatives felt that the care home was the safest option. Linking back to responsibility for safety, the perceptions of residents and relatives further reinforced the notion that the organisation and staff were responsible for resident safety. Moreover, the way that this was discussed implied that this was something often taken for granted with the assumption that "living in a care home will ensure safety." However, the idea of being "unsafe" in a care home only appeared to be something discussed or considered for those who had a negative care experience in a previous care home. In this instance it was felt that the care home and staff were still responsible for safety and that it was therefore the "care home" and "staff" that were held accountable for the harm or poor care that the resident had experienced.

In terms of responsibility for safety, the themes role and identity (discussed in Chapter 8) influenced the way that staff embodied and enacted their responsibility for safety. The enactment of safety in care homes was not just to follow procedures, but to work above and beyond the policies and processes. Moreover, what staff did to promote safety was largely conditioned by the organisation. There were also additional things they did to take responsibility. For example, staff would double check and follow-up, demonstrating that they were taking additional responsibility for safety on their own merit. This appeared to be due to personal values and perhaps workplace norms, rather than being dictated by the organisation.

RESIDENT RESPONSIBILITY

In this section I highlight the ways in which residents were seen to maintain responsibility for their own safety. This chapter builds on the findings from Chapters 7 and 8 which highlighted the impact of physical and cognitive ability upon resident safety.

What was seen through observation and both informal and formal interviews within the two care home sites was that residents did maintain some responsibility for their own safety. As such, although the overarching assumption appeared to be that the organisation and staff were responsible for resident safety, residents remained active partners within their safety experiences. This was both in relation to following care plans and in taking risks by going against a care plan. However, how this looked at each care home site was distinctly different due to the different levels of cognitive ability amongst the resident populations. Resident cognitive ability was seen to be the most significant defining feature of resident responsibility for safety.

Residents who had full mental capacity were largely viewed to have responsibility for their own safety. The common view of staff was captured within this following quote:

> *" She knows what she is doing, she has capacity, so I cannot force her to do anything. If she doesn't call for assistance and falls, that is up to her. We cannot force people to have help."*
>
> (Leema, Carer, Site 2, Formal Interview)

This view was typical amongst staff, residents and relatives at Site 2 where the resident population had a large proportion of people without any cognitive impairment. This was also commonly witnessed in observations, with residents taking responsibility for their own safety in terms of proactively ensuring safety. Examples of this included: using call bells, asking for assistance, alerting members of staff to changes in their ability and highlighting to staff potential trip hazards such as cups left on the floor, or something someone had dropped. Moreover, it was seen that these residents were also able to take responsibility for making their own judgments when taking risks. The following quote highlights that those with capacity were felt to be accountable for their own decisions:

> *"Certain people are responsible for their own safety. Like James who's broken his arm, he's got the capacity… They know we're busy and sometimes for them it's like 'I don't want to hinder the girls they've got enough on'… We can't be with them twenty-four seven, we can't. If we could, it'd be a lot better world wouldn't it? The residents are still independent people. It's like me. I'm independent. If someone said to me you can't do that you've got to wait, I would say 'Why not, why can't I?"*
>
> (Gareth, Senior, Site 2, Formal Interview)

This quote shows the perception that residents have responsibility for their own safety and were able to make decisions around risk. This was viewed in a very personal way, and appears to position autonomy as the key reason why residents should maintain their own responsibility for safety.

What was also notable was that these cognitively able residents were not only demonstrating responsibility for their own safety, but also that of others. This was an important finding as it demonstrated that safety and responsibility was co-constructed between the actors within the care home, residents within the home, relatives, staff and the wider organisation. For example, this resident below shares the story of her alerting staff to another resident who they thought may be hurt:

> *"I was lying in bed trying to get to sleep and somebody kept calling out, 'Help, help, help me!'… I went to the door and I could hear it... At the same time the door opposite opened and John was there and he said, 'I think it's him calling out for help.' So I said, 'That's alright I'll do my buzzer.' John went and listened, it was Derek. He went there and he said, 'It's alright mate, help's coming,'… and they soon came along. Tom said 'I'm feeling a bit shaky are you?' I said, 'Well yes I am a bit.' He said, 'Let's hold hands.' And there we were standing there holding hands. [laughter] I thought if anybody comes along here now they'll say 'whatever's going on here. [laughter] She's only been here two minutes and she's holding hands with somebody' but we were both nervous you know…*
>
> *We've had to call for help for Margaret once or twice too. She'd banged on the wall. I thought I'd better go and see and she said 'I'm in distress.' So I said, 'What can I do?' And she said 'I need help.' So I thought I'll buzz the thing and get somebody to come."*
>
> (Jean, Resident, Site 2, Formal Interview)

Residents can be seen to play an active role in promoting the safety of others. Overall, residents who were cognitively able demonstrated responsibility for their own safety and that of others.

A further area was that in being responsible for safety themselves, residents with capacity also directed and held staff accountable. For example, during observations a resident was seen to point out to a volunteer that the hoist was placed in the way of the door and could be a trip hazard. Moreover, during medication rounds some residents were also seen to ask the senior carer what medication they were being given and also asking about when their visit from the doctor was scheduled. All of which shows not only they responsibility for their own safety, but them holding staff as accountable and double checking the safety behaviours of staff.

In contrast, for residents who had advanced dementia and did not have capacity it was seen that they were not responsible for their own safety. Residents with dementia were acknowledged to be unaware of risks and were not considered responsible for their own safety, however they still had a part to play in safety. In relation to residents with dementia it appeared to be acknowledged that in order to promote independence and quality of life, residents would be at risk of harm's such as falls:

> *"I don't think you can keep them a hundred per cent safe, unless you're with them all the time, like one to one. There's going to be accidents and because you can't be watching them twenty four seven, and it wouldn't be right to either really."*
>
> (Jill, Carer, Site 1, Formal Interview)

Residents with a cognitive impairment were largely not considered to be responsible for their own safety, however it was also commonly believed that independence needed to also be promoted and that these residents should be allowed to take risks.

> *"It can be difficult to keep people safe, but there again they're independent, you can't stop them from walking about. You can help them. You can try and prevent them from moving furniture about, but if they're safe and they're happy to do that then why not? If you can see there's a danger coming there and somebody's going to trip over it, then yes you intervene."*
>
> (Anne, Nurse, Site 1, Formal Interview)

Staff were instead responsible for safety, however they still treated these residents as individuals and attempted to promote independence and allowed risks to be taken in regards to safety:

> *"I think it was our (carers) responsibility to keep them safe to an extent. But then I think some little risks are okay, like Julie likes to get up and walk around but she don't like to use a frame. I think if she's with someone who was willing to hold her frame for a few seconds I think she's alright to be by herself. But we've got a few that I'd think, 'Sit down, sit down, now, I'm not having you breaking your hip on my shift!' ... But I think it's them and the risk that they want to take. I mean they don't get many*

> *choices to have a risk, not while they're here so I don't see why I should more or less glue them to the seat almost…*
>
> *We have the odd few round here that like to wander but we wouldn't really say they're in charge of their own safety because there has to be someone around to make sure they've still got the safety levels there."*
>
> (Billy, Carer, Site 1, Formal Interview)

Overall, resident responsibility for safety can be seen as clearly dependent on the resident's cognition. This can be seen as a spectrum, with those at the higher end having more capacity and therefore more responsibility for safety. However, this was not a clear boundary where residents did or did not have the capacity to make safety decisions. Instead this was a continuum where each resident had a varied level of responsibility. Moreover, due to the fluctuating and unpredictable nature of resident's conditions, as outlined in Chapter 7, where the resident fell on this spectrum could change daily or even hourly depending on their condition.

RELATIVE RESPONSIBILITY

I covered earlier the notion of handing over safety responsibly at the door. For relatives who were previously a carer for the resident, this was an important dynamic to consider. For these groups part of the admission process was relaying important safety information to the staff in the care home. Looking back to the example of the assessment for admission, this was observed for a resident with dementia. In this assessment, the relative was answering the questions as part of this assessment and therefore this can be seen as an important transition or handover from the relative to the care home staff. What was notable here was the impact of patient cognitive ability. For those residents with less cognitive ability, the responsibility that the family had for handing over safety information was significant, as the resident could not hand over this information themselves. This was in direct contrast to a resident with capacity, who during an interview talked me through her initial admission questionnaire that she completed herself with the staff.

The responsibility that relatives had for handing over information spanned past pre-admission and appeared to be an ongoing responsibility for the relative. At Site 1, many observations captured relatives sharing information with care staff regarding the past life, likes, dislikes and ability of the resident. This was more prevalent at Site 1 than Site 2, where almost all of the residents had dementia of some degree. This quote below indicates the role of a relative in her mother's bowel problems. The daughter's role was to relay information on food intolerances and possible causes of this concern:

> *"We've got one lady that's got an ongoing bowel problem and she's had it forever and obviously the daughter's managed it so she can tell us about it… So working alongside the family we have come up with a management plan as well, but you have to rule out things as well don't you and eliminate them. Her medication has recently changed, yes she is having more bouts but is it deteriorating because of an age thing or is it. So yeah, you do work with relatives."*
>
> (Shannon, Nurse, Site 1, Formal Interview)

Moreover, this handover of safety information was also seen to work both ways, with relatives contacted when the resident had come to harm or an incident had occurred.

> *"Yeah he phoned me this morning and I just said, "Oh she had a bit of a stumble." If it was any worry, I'd be phoning the relatives straightaway and if they'd hit their head, I'd have had to phone him last night. So that's just for our protection."*
>
> (Anne, Nurse, Site 1, Formal Interview)

What was interesting in the quote above was that the nurse discusses how the relatives were contacted following a fall. It was implied that the reason they call the relatives was in fact seen to be for the protection of staff to prevent litigation.

Another area of responsibility for relatives appeared to be holding staff as accountable. As was highlighted earlier in this chapter, relatives viewed the care home staff as responsible for their resident's safety and as such relatives appeared to hold them as accountable for aspects of patient care. For example, at Site 1 many relatives were seen to ask nurses about aspects of care, such as medication reviews, GP visits, updates on medical conditions and information on incidents (for example if the resident had fallen or come to any harm). What was noticeable was that at Site 2 there were far less observations of relatives asking for information regarding their relative, especially for those with capacity. Again, it appears that relatives only felt they had this responsibility if the resident did not have the capacity to tell them this information themselves. What should also be noted was that holding staff to account for the care provision and safety of the resident was not always considered a positive thing. There were many instances observed where this appeared to be an area of tension between the care home staff and the relative involved. Many informal discussions and observations captured that staff felt relatives were "interfering" when they asked questions and checked areas of care had been completed for the resident.

During an observation the daughter of Sally (a resident) felt strongly that she should not be allowed to stay in her room unsupervised. However, Sally wanted to be in her room reading and would repeatedly wheel herself to her bedroom door asking to be allowed back in. The quote below captures the apparent tension between relative views and that of the residents:

> *"It is difficult sometimes, because you fight with the daughter and fight, and then Sally will say I've been in my room all day and the daughter will get really upset and it's like, but it was her choice. If you've not upset the daughter then you've upset the resident because that's what she wanted to do."*
>
> (Anne, Nurse, Site 1, Formal Interview)

Finally, relatives demonstrated responsibility for physical safety within the care homes. During observations at both sites, relatives were viewed to actively promote safety. This was not only for the resident they were visiting, but also for other residents. Relatives were seen assisting residents during mealtimes at Site 1. Moreover, at both site relatives supported residents who appeared to be agitated and engaged them in conversation to calm them down. They also were witnessed to help residents who were attempting to stand unaided and helped to pass them walking aids, or to ask the resident to wait for the staff to help them. As such, it can be seen that within the care home relatives also felt responsible for the general safety of residents in the care home and would actively intervene to promote resident safety. Overall, relative responsibility for safety falls into three distinct areas, sharing safety information, holding staff accountable and promoting general safety.

CONCLUSION

The chapter has discussed how organisational and staff responsibility for resident safety was assumed and ingrained within formal processes and external regulation. Despite this, it appeared that staff, residents and relatives all had varying degrees of responsibility for resident safety. Negotiating safety responsibility in care homes was complex and multifaceted and that the theme of uncertainty and unpredictability was prevalent in all safety areas. A key defining feature of the level of responsibility that residents and relatives had was the mental capacity of the resident concerned. Overall, it was apparent that responsibility for safety in care homes was not clear cut. This was due to the level of unpredictability within the care home, which required responses from multiple actors in order to prevent harm and maintain safety. The response of individuals in preventing agitation or falls, in many ways appeared to be opportunistic and circumstantial. The person most appropriate to respond depended on who was present and how the individual resident responded.

This chapter further reinforces that safety requires an understanding of the resident as an individual. A clear example of this was in the observation on agitation, where a resident was able to de-escalate the situation using the relationship they had with the other resident. Moreover, knowing the resident also appeared to be important in promoting and facilitating their own autonomy and responsibility for their own safety. As such, this chapter has continued to support the need for individualised safety approaches in care homes, which will be explicitly addressed in the next chapter on relationships.

CHAPTER 10- Relationships

INTRODUCTION

The thesis has argued that there was a need for personalised and individualised approaches to safety in care homes, which responds to people as individuals. Having already highlighted the importance of individualised approaches, this chapter will contribute to this thesis a focused look at relationships in the care home to illuminate the importance of relationship-centred approaches to safety in care homes, how these work and how relationships can support personalised approaches to safety.

I will provide a detailed picture of how resident and staff relationships were important to establishing safety within the care homes. The chapter will first outline the nature of these relationships and give examples of how this relational approach promoted safety and enabled personalised risks to be taken. I will then move into deeper analysis and explore the importance of getting to know the individual residents for safety in care homes. I will finally conclude by suggesting that relationships were vital to the delivery of a personalised approach to safety and risk within care homes.

THE NATURE OF THE RELATIONSHIP

The relationships between staff and residents appeared to be built on a number of key areas including information about the resident's life, preferences, behaviours and ability, as well as having an emotional connection with the resident.

As I have already discussed in this thesis, "getting to know" the resident was considered important to resident safety and this transition was a vital part of establishing relationships between staff and residents. When staff talked about "getting to know" the resident, this statement was often not specific and during interviews there appeared to be an assumption that you knew people or you did not, with staff commonly not defining what it meant to know someone and what this looked like. However, during observation and informal discussions the nature of the relationships between staff and residents became apparent and therefore I will use these themes to define key areas of these relationships and knowing the residents.

PAST LIVES AND IDENTITY

The first theme was one already discussed in Chapter 8. The residents' past identity was a vital source of information for staff and this was often used by staff to demonstrate that they knew the resident.

In Chapter 8, field notes showed the example of a resident who had only been in the care home for a few days when the staff found out that he used to be a farmer. The resident was disorientated, thinking he was on his farm, and was becoming agitated and restless. As the care home was in a rural area, one day when he was unsettled and agitated, they decided to take him into an adjoining sheep field. The staff reported that when he was there, he appeared oriented to where he was and was herding sheep with ease, and for the rest of the day the resident was settled. This example illustrated how knowing a resident's past career can help to support their safety through de-escalating situations and providing a personalised approach to the resident. Similar examples were seen daily where staff used information about residents' past lives to prevent harm through talking with them about their past lives and engaging them in activities they knew were related to their careers or hobbies.

Knowing the residents' past lives was also used to subtly guide staff in their interaction with the residents. The way staff interacted with each resident appeared to change depending on their background and their relationship. During observation it was noticed that when interacting with a resident who used to be a teacher staff would talk to her about her career and fun facts that she knew. Whereas another resident who was a stay-at-home mum, staff would interact with her by discussing her family and looking through photos and by doing gardening, which was one of her hobbies. Another resident had lived alone most of her life and had spent a lot of time travelling. She liked to spend time in her room alone, so staff would always interact with her on an individual basis as they knew she had never liked group activities. These were just some of many examples that illustrated the individualised interactions that stemmed from understanding the residents' past lives. In relation to safety, applying a personal approach to this interaction was felt to be how a calm atmosphere was maintained and how harm was prevented, predominantly falls and agitation.

Understanding the residents' identity was an essential part of the cultural landscape of safety. Specifically, knowing the resident as an individual enabled staff to be guided to shape and change their safety practices and response to risk. For example, the manner in which they would communicate with that individual was greatly influenced by the relationship they had. Staff explained that their approach was guided by relationships and knowing how the resident responded. For example, for some residents, distraction and a calm nature worked best, whereas others responded to jokes and banter, and others responding to firm and clear instructions. The approach used during safety interactions with residents, such as during moving and handling was therefore clearly influenced by how well the staff knew the residents' and the relationship they had.

PREFERENCES AND ROUTINE

Another key area of knowing a resident was their normal routine and preferences. This information related to all areas of the individuals life regarding their individual preferences in areas such as, their morning routine, activities, food and drink. Individual preferences and routine were important points to know about a resident, as this information ensured that staff could structure the day in a way that prevented or responded to risk.

> *"Knowing them helps with what you can talk about to them. If you know that they always like to wear make-up, or certain jewellery and perfume, and what time they want to get up. If you know they are a want to stay in bed person, who has never got up before nine o'clock, what their interests are... So the more we know about them the more we can actually tap into them… If they are unsettled, you do something and that's why it helps knowing them... Sylvia loves cuddling the dog, if Julia was upset and frustrated we know that she's got dolls in the room, and she likes to push the buggies with them in. It's distracting them in a positive way, not just saying no to them."*
>
> (Sarah, Carer, Site 1, Formal Interview)

As was demonstrated in the above quote there were many examples of preferences in terms of daily routine. This was also the case for activities that residents preferred and engaged in as part of their normal routine, such as people who had a newspaper daily or undertook hobbies such as gardening. Moreover, preferences were apparent in terms of food and drink. This was vital to promoting autonomy for residents and maintaining choice in all areas possible.

> *"The most important thing to the residents, is to understand them better, and give them choice. It's the choice which is the most important thing to them, giving them choice and dignity."*
>
> (Andy, Carer, Site 1, Formal Interview)

Aspects of the residents' routine were important for safety and maintaining a calm environment. Staff indicated that routine provided structure for residents that helped to maintain safety. This was the case with residents who had a cognitive impairment, as well as residents with no cognitive impairment. I will use two examples constructed from my observational data to highlight this point.

For Geraldine, a woman with advanced dementia, she had always followed a set morning routine. She would wake up at a certain time, get washed and dressed and have her breakfast at 6am. When moving to the care home she was found to be unsettled at 6am and trying to stand unaided from her bed and had previously fallen due to this. After speaking to her daughter, the staff decided to try a new morning routine that mirrored that from at home. As soon as Geraldine woke up at 6am she was supported to get washed, dressed and taken to the dining room to have breakfast. By doing this, the resident remained settled, had appropriate support, and was no longer trying to stand unaided. In this example, knowing the resident's normal routine supported safety and minimised risk for this resident in terms of falls.

The next example was from Site 2. Martin did not have a cognitive impairment and was able to walk with a stick. In the mornings he often felt unsteady on his feet. Martin normally woke by 6.30am and when he pressed his call bell the staff would come to support him to get to the bathroom and for a wash. That morning, Martin woke at 6.30am and pressed his call bell. When he pressed it, he could already hear the call bell sounding. Five minutes passed and a member of staff came to say they would be with him next. He waited another 10 minutes, and they did not return. Martin decided he would just sort himself out, as the staff appeared to be too busy this morning and he wanted to go for breakfast. As Martin got into the bathroom, he felt unsteady, got his foot caught on the commode and he fell.

In these two examples, preferences and routine could promote safety, but also deviation from this can cause risk. During observation many examples were observed where deviation from preferences or routine resulted in unsettled behaviour or in risk taking by residents. It was also suggested by staff that having a routine and knowing the residents' preferences were all parts of ensuing a calm environment and atmosphere for the residents. Knowing the residents' individual preferences therefore enabled staff to achieve this routine.

THE NORMAL

In discussion with staff at both sites they mentioned the relationships they had with residents and that this meant they knew and understood what the resident was like, often referring to this as their 'normal'. The relationship staff had with residents allowed them to know the person's normal, and therefore enabled them to respond when people deviated from this. As was touched on earlier, this aspect of the relationships was found to be harder to define and staff commonly could not articulate what they meant by this. From observation it was apparent that what made up this 'normal' was the usual and typical behaviours, appearance and attitude of the resident, how they would normally act and respond on a given day. Although this had fluctuations throughout the day and in changes of circumstances, over a long period of time the staff naturally knew what the 'normal' presentation of a resident was like in a diverse number of circumstances. As staff could not always articulate this, it appeared to be that staff could respond to quite subtle cues and changes in behaviour, attitudes or appearance of a resident, that to them flagged as a deviation from the resident's 'normal'. To reflect on this, I will go back to the suggestion that this close relationship remains something tacit and difficult to define.

The concept of the residents' 'normal' appeared to be an amalgamation of subtle information on the residents' physical and mental state. Some examples were if they were not eating, or appeared drowsier, or if they were less communicative than normal, or if they were more agitated or restless than normal. An example of this would be the staff noticing the resident responding differently at mealtimes, or during a certain activity. During observation, Ralph was a resident who was always restless in the evenings and would pace up and down the corridors. One day Ralph appeared settled and was asleep in a chair at 5pm. For the staff, this was a deviation from his normal and a cue to get him reviewed by the nurse, as this was very different to his normal behaviour. It can be seen here that knowledge of the normal routine for this resident provided a basis of assessing abnormal or worrying behaviours. Subsequently, the normal acted as a trigger mechanism for staff to notice and act on what they considered a deviation from these patterns of behaviour. However, to someone who did not know Ralph, this likely would not have triggered any investigation.

> *"By knowing the residents.. it makes the job easier, because if you know the resident, then you know how to deal with that person. If today, if I come here and then I notice Miss D's not well because I think "yesterday she was not like that". So, if there's anything going around I know because I have that bond with them… I can notice that quick, so it's very important to know your residents."*
>
> (Billy, Carer, Site 1, Formal Interview)

The above quote demonstrates how this carer feels that knowing the residents helps them to detect deterioration if the resident was unwell, as they were able to compare this to the residents 'normal' and how they were on previous days.

There were two important influences that knowing the residents and having a relationship had. The first was that what may appear to an external observer as unpredictability in someone's unsettled behaviour, to staff may be predictable as they know that a resident for example, normally becomes unsettled at bedtime, or during mealtimes. The second was that what an external observer may assume was normal behaviour, such as a resident asleep in a chair at 5pm, to staff may be a deviation from the normal and a cause for concern.

Overall, knowing the resident's normal was useful as this helped staff to predict what to others could be unpredictable behaviour. By doing this staff could promote safety and prevent risk, such as falls prevention. Moreover, this enabled them to detect differences and this was often a prompt for staff to contact external support. For example, noticing that a resident's mobility had become slightly more unsteady prompted review and physiotherapy intervention. Or noticing a resident had become more confused than normal was a prompt for a GP review of the patient. Although these could be seen as clinical indicators, during informal discussions staff would commonly refer to this as 'the normal' or acting different to 'the normal'.

PHYSICAL ABILITY AND RISKS

A further area of the relationship between staff and residents was staff having an understanding of the residents' physical ability and risks. This moves on from the previous theme, as this was often discussed by staff as part of the residents' 'normal'. During both observation and interviews the staff had a detailed knowledge of the residents' physical abilities and also the risks related to them. However, the source of this information was not just from formal documentation, such as care plans and risk assessments. Instead, the relationship and knowing the resident added a level of depth to staff understanding of the resident's physical ability and risk. This depth included knowing how residents typically responded in real time to a diverse range of situations.

> *"We know them really well, so we know that, say if somebody you can walk but maybe he's not that steady on his feet, so we try by assisting them to walk, so that we just minimise the risk of falling anyway, but it's not that hard, if you know them anyway…*
>
> *We know that oh if you go to certain person, he likes to grab things, so if you go over there, he will grab that frame from the other resident, so you can stop things before they happen"*
>
> (Andy, Carer, Site 1, Formal Interview)

This quote demonstrates how a carer perceived them knowing the resident to help them to promote safety. The example they gave of a resident who might try to grab another resident's frame was a useful example, as this was something that could cause a fall and was a potential hazard. In this instance the relationship with the resident influenced the staff member's perception of risk. The resident was viewed as a risk to others mobilising and therefore staff were quicker to notice and intervene if they saw this situation unfolding. It was therefore evident that knowing the resident had a direct impact on staff perception of risk for that individual. However, in terms of this interaction between residents, this would likely not be captured in standard falls risk assessments. In a care home of 30 residents, it would be impractical to risk assess the interactions between each resident and the 29 other residents. This example was therefore useful in showing the extra level of complexity in understanding the residents' physical ability and risks. These could change depending on the environment and the interaction between residents. Through having a relationship with all of the residents in the care home, this provided a level of depth to their understanding and ability to promote safety.

> *"At the moment, it is so frustrating for Julie. I can understand it, she is thinking that she can get up and walk. Sometimes, she uses a stand aid to pull herself up and she is thinking that her legs are better, and she is wanting to go off walking, and you can see her trying to get up out of the wheelchair. She can't walk, she would be in grave danger if she actually did stand up. So it's just trying to get through to her, and trying to distract her, and explain.*
>
> *I know today she is saying she wants to go out in the sunshine, and she has been out. But the other day when she was a bit down, just looking at the chickens, we took a walk down the road, things like that. It is a big juggling act, because when you are telling somebody no, they can't do it, that's a big thing, especially for an adult… these residents don't know their limitations at times."*
>
> (Sarah, Carer, Site 1, Formal Interview)

This typical example showed how the carer had empathy for the resident in terms of their feelings and responded in a way that promoted safety. This quote demonstrates that the staff member had an understanding of the resident's mobility, behaviours and emotions but also an understanding of what activities the resident enjoyed to facilitate distraction and prevent agitation and falls.

Staff having an understanding of residents' physical ability and risks was far broader than just their mobility. Across both sites it was observed that staff proactively responded to residents in terms of absconding, agitation, eating and drinking in terms of allergies, swallowing difficulties and malnutrition, pressure area care and responding if the resident appeared unwell or showed signs of deterioration. Falls prevention was the example most used by staff in interviews. However, observations demonstrated that the use of relationship-based knowledge to guide safety actions was far broader and stemmed into all areas of safety within the care home. Moreover, in informal discussions staff explained that they knew about these areas because they knew the residents, and again linked this to the relationship they had with the resident from working with them every day for many years.

EMOTIONAL CARE AND CONNECTION

The final area of the relationship between carers and residents was an emotional connection as part of this relationship.

> *"Since I've been here we've formed relationships and it's all about building relationships and friendships like a family because you meet the same people in and out."*
>
> (Christine, Chaplain, Site 2, Formal Interview)

Throughout observation at both sites the care home staff demonstrated emotions towards the residents and felt strongly that these people were like friends or family. However, staff were not only observed to say residents were like family, but were consistently seen to demonstrate care, compassion and genuine emotion towards the residents.

> *"I have known them all so long, that's like real friendships, yes that's a big deal isn't it and I'm going to leave soon actually so that is going to be sad, because I will miss them. I know Harvey in and out. I know his wife, they both came to live here for a bit. Harvey came here then he went home then his wife had an operation something done to her leg. I know about his grandchildren, I know he used to be a postman."*
>
> (David, Chaplain, Site 2, Formal Interview)

The above quote demonstrated a typical example of how staff would talk about their relationships with residents on an emotional level. The emotional connection between staff and residents was apparent in some of the interviews. During the interview with a hairdresser at Site 1 who had worked at the care home since it opened, she became very emotional about how much she loved working with the residents and began to cry during this dialogue.

> *"Out of everything I have ever done in my life, and I have had a few jobs, this has been the one that I have always kept on and always been here, I love it. *laughs * Yeah I do love it. I have friends who think it is a really depressing, dismal job, but no it is really not. When you get there and start talking to those residents and laughing with them and they are holding your hand, It is really good. I am getting quite upset actually…I guess it is, I have never realised it, never thought about it ever.. I have been a mobile hairdresser for a long time, and you come and go in people's lives and you don't really ever think about it. "*
>
> (Laura, Hairdresser, Site 1, Formal Interview)

From this quote, it can be suggested that working with people in care homes requires an emotional investment from the staff, which forms as part of this relationship. During the observation period many observations at both sites also captured this emotion, with staff laughing and joking with residents and sharing details about their personal lives with residents. They were also seen to be visibly upset when a resident was unwell, if a relative upset a resident and when residents came to the end of their lives. This emotional connection and investment was seen to influence and drive staff in their motivations for care and promoting the wellbeing of the residents. However, this was also demonstrated to be a source of emotional labour, particularly when staff were dealing with patient deaths and end of life care.

Overall, the relationships between staff and residents has an important caring and emotional connection. This was something distinctly different to just having the knowledge about a person, such as could be gained from care plans. As such, this emotional connection can help to explain why staff felt they knew residents so well. This personal connection with residents can also be seen as important in building trust, as well as facilitating safe and high quality individualised care for residents.

RELATIONSHIPS AND SAFETY

Across both care home sites, getting to know the individual residents was considered a vital part of care, with many stating this was the most important way to promote resident safety.

> *"The key thing about the people living here is that they need people to be looking after them that know them."*
>
> (Rosie, Care Home Manager, Site 1, Formal Interview)

In the previous chapters I have highlighted that care homes were a setting that were prone to uncertainty and that resident behaviours can often be unpredictable. Getting to know the residents as individuals was considered essential for dealing with this unpredictability, with these relationships considered by staff to be one of the only ways to understand and predict resident behaviour. Many instances were observed across both sites where staff prevented harm by picking up on subtle cues from residents and also being able to interact with the residents in a familiar way to deescalate situations and distract residents appropriately. Staff often associated the care observed as underpinned by the relationships they had and knowing the resident they were working with.

> *"You get to know them. Everybody's different… Getting to know that individual person is the most important thing, and then they might not hit you or throw their dinner at you or pull your hair because you know what they don't like and you keep them calm…*
>
> *it's like a family network really, just a small family network because when you're at work, you're at work seven hours and then sometimes you do fourteen-hour shifts, it's a long time, a very long time"*
>
> (Gail, Carer, Site 1, Formal Interview)

These relationships and how they promoted safety were something that staff were less able to define tangibly. This was often seen to be something "they just knew" and not necessarily something they could measure or document, suggesting a subtle link between relationships and knowledge. A number of staff members defined how they detected deterioration in the same way a mother "just knows" something was wrong with their child, or how they would know something was wrong with their own family members. This was described in a way that staff did this without formal risk assessments, but from the relationship with the resident.

> "*It is a bit like having, if a mother has a child and that mother tells you that her baby isn't well, you listen to that mother because they have that instinct, they know that child so well."*
>
> (Rosie, Care Home Manager, Site 1, Formal Interview)

During my observations at both sites, some staff reported that they did not feel they needed to read or engage with care plans due to stating they knew the resident better than what could be documented in care plans and risk assessments. This was potentially problematic, but suggested the significance of how relationships influenced safety perceptions and behaviours. On a staff level, many staff reported that the relationships they had with the resident was more important to safety, than the care plans, risk assessments and processes put in place by the organisation. This appeared to be a form of relational practice, whereby the basis for some aspects of safety culture stemmed from relationships and subsequently influenced their understanding of safety, and safety behaviours. This shows a disconnect between the formalised safety processes put in place by the care home and the reality of how staff reacted and engaged on the frontline. Formal documentation was often viewed to be proof of the care provided, with care and safety behaviours guided not by this documentation, but by the relationships staff had with the residents and their relatives, and knowing the resident as an individual. However, as noted in the below quote some individuals did report that care plans were useful in helping them to get to know new residents before they had time to form close relationships with them.

> *"You get to know them. Everybody's different, they might not want cream on, they might not want shampoo on their head, there's always a way around it to get their hair washed. So that's where you have to read the care plans and find out what this lady or gentleman likes or doesn't like."*
>
> (Gail, Carer, Site 1, Formal Interview)

Staff often suggested that they knew residents better than even their family members. This could suggest a type of proxy role, whereby the closeness of these relationships was important and also influenced staff's personal investment and perception of their responsibilities. As seen in the following quote, many staff reported that these relationships did not just comprise of knowing factual information about the resident, but having an emotional connection and trust as if they were indeed a friend or family member.

> *"We are the ones that are here seven hours a day, and we spend more time with them than probably anybody else, we are their next closest… This is their home, and to them we spend an awful lot of time in their home. You will say our home, this is our home, because to me, when I come here, it is my home as well as their home, because we are part of their lives, such a big part of their lives."*
>
> (Sarah, Carer, Site 1, Formal Interview)

A key finding within this theme was that safety was promoted by frontline staff through getting to know the individual and using this information to influence care and safety.

> *"Not having a high turnover of staff is important, because a lot of the staff have been here, but they know the residents. And therefore they can give them greater care based around what their needs are."*

(Craig, Admin, Site 2, Formal Interview)

The above quote suggested that knowing the residents was considered important, and that this must be built through staff who regularly work with the residents. This therefore may provide an explanation for the "settling in" period during admission, as discussed in Chapter 9, with staff relating unsettled behaviour during this transition to them not knowing the resident, and the resident also not knowing or trusting the staff and environment.

> *"We have a new lady in and we have to figure out her needs and what she is capable of doing and what she needs help doing. It is a process of us getting to know her, and her getting to know us."*

(Kirsty, Carer, Site 1, Formal Interview)

The above quote captured how getting to know the resident was a vital part of the transition to live in a care home. Moreover, it was seen that both relatives and residents had a vital part to play in providing information for staff to get to know them. As I discussed in previous chapters, who this responsibility lay with depended on the cognitive ability of the resident in question.

A final important area of these relationships was that interpersonal relationships were considered to be important by residents and relatives. The relationships they had with staff was a distinguishing feature of the residents' experience. When talking to residents, many residents would talk at length about the relationships they had with staff and how they felt they knew them. The following quote demonstrated how a resident who had day care in the care home decided to live in the care home because of these relationships he already had with the staff.

> *"He thought about it for a day and then came up with, "I 6think it will be a good time to go while I can choose where I'm going", instead of being put in somewhere. Because he knows everybody here and the system and so I think that helped him to move in quickly and quickly settle down. He settled down very quickly, I'm very pleased."*

(Margaret, Relative, Site 2, Formal Interview)

This was also the case from relatives, who commonly stated they could trust the care of their loved one to the staff.

"Kate: The staff know mum so well and they do seem happy in their work I would say… I think it makes all the grandchildren, and like my Dad and Mum, feel like they're in safe hands, you don't feel like there's any kind of risk of them being … not looked after. I think the relatives feel … yeah, kind of the trust …

Diana: Well, we are looked after. Yeah, we trust them."

(Dee and Kate, Resident and Relative, Site 2, Formal Interview)

Overall, the relationships in the care home between the staff, residents and relatives were considered important for safety and quality in the care home. This was seen to support and promote safety in the care home and could explain the "settling in" period discussed by staff when a new resident came to live in the care home. From the staff perspective, knowing the resident and having a relationship with them enabled them to deal with often unpredictable behaviours and to deescalate safety situations and prevent harm. Finally, having these relationships enabled residents and relatives to feel safe, and that this relationship helped to create trust.

CONCLUSION

This chapter has extended the literature around safety by showing examples of how relational practices influence the perception of safety, and enactment of safety in care homes. Good safety practice in care homes was centred around a personal approach, enabled by the close relationships between staff and the residents. This was very different to the typical medical model, which was nonetheless often applied to care homes. The relationships formed between staff and residents informally guided staff in their ability to deliver safe care and deal with high levels of uncertainty and unpredictability. What was shown in the numerous quotes and examples from observations was the vital place of the relationship between staff and residents. This has been shown to support staff to respond and promote safety, whilst also focusing on the best interests of each resident to make judgments based on that individual's personal preferences and needs.

This chapter contributes to the overall thesis by providing an explanation of why relationships were important within care homes, and also how these work to support care and safety in care homes. The central finding was that relational and individualised approaches to safety were essential within care homes to enable staff to respond to uncertainty and keep residents safe. Moreover, this chapter has further highlighted the disconnect between the formal safety approaches applied in care homes, and actually what makes safety works-relationships.

CHAPTER 11- Discussion

INTRODUCTION

The thesis has presented an ethnographic study exploring the organisational culture of care homes as it related to safety. In the preceding chapters, the findings have been presented as four overarching themes; Uncertainty (Chapter 7), Identity and Role (Chapter 8), Responsibility (Chapter 9) and Relationships (Chapter 10). It was important to emphasise that these themes were closely inter-connected and the intention of this chapter was to present the rich and dynamic cultural fabric as manifest in these themes and address the research question. The chapter achieves this by first presenting a conceptual understanding of culture in care homes, showing the relationships between overarching themes of this thesis and how this relates to safety. The contribution of this thesis to the patient safety literature will be highlighted, specifically drawing on its contribution to understanding culture in relation to safety. The findings developed through the thesis will then be applied to key areas of care home policy and practice. Due to the timeliness of this PhD with the COVID-19 pandemic, a section of this chapter will be dedicated to exploring how the insights from this work could have influenced the response to the pandemic. The opportunity to shape future safety work within care homes during the inevitable change that will take place post COVID-19 will also be discussed. Overall, the discussion will highlight the theoretical and practical significance of these findings and summarise how this study has extended existing literature around these topics.

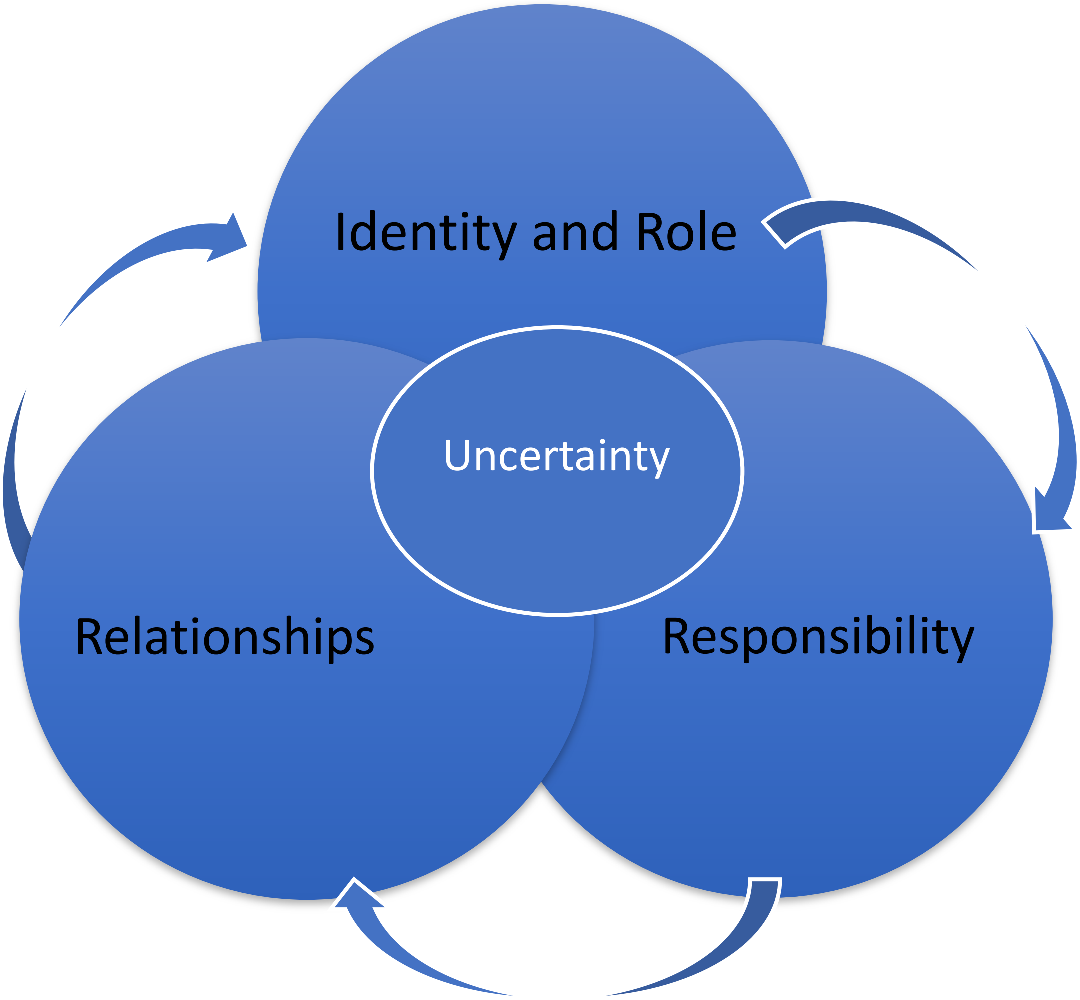
A CONCEPTUAL UNDERSTANDING OF CULTURE IN CARE HOMES

I will first reflect on how the overarching research question has been answered. In doing this, I will draw together the findings to present a conceptual understanding of culture in care homes.

HOW DO CARE HOME EMPLOYEES, RESIDENTS AND RELATIVES GIVE MEANING TO AND VALUE ISSUES OF SAFETY IN CARE HOMES?

The thesis has presented four overarching themes that were shown to underpin the cultural landscape of safety within care homes (see Figure 8).

Figure 8: A Conceptual Understanding of Culture in Care Homes



A foundation of uncertainty

Uncertainty has been widely acknowledged as a major influence upon health and social care and has been acknowledged to challenge prevalent positivistic assumptions (Mackintosh and Armstrong 2020, Fox 1980, Fox 2000). In this thesis uncertainty was argued to be a defining feature of care homes and underpinned how staff, residents and relatives perceived safety. Two prominent examples were that uncertainty was shown to underpin areas of safety practice and the resident experience of coming to live in a care home. Safety was felt by the staff, residents and relatives to be both uncertain and unpredictable.

Care homes commonly operate following a routine of care and tasks. Within this the residents themselves have been considered an unpredictable factor that may not conform to this routinised practice (Brannon and Bodnar 1990). Living with dementia (van Wijngaarden, van der Wedden et al. 2018), resident illness trajectories (Barclay, Froggatt et al. 2014), and also experiences of living in a care home have been specifically associated with uncertainty (Lanoix 2017). Unpredictability was also commonly associated with the behavioural and psychological symptoms of dementia, which can include depression, anxiety, psychosis, agitation, aggression and disinhibition (Hamdy, Lewis et al. 2017, Tible, Riese et al. 2017, van Wijngaarden, van der Wedden et al. 2018). This thesis clarified these findings and showed that residents would often present unpredictable behaviours that were associated with safety risks. My study further suggested that unpredictability filtered into all areas of the culture and impacted upon safety measures and response to risk. A key finding of my research was that the culture within care homes was shaped around response to uncertainty, and that Identity and Role, Responsibility and Relationships were key to being able to manage safety. As resident behaviours were often unpredictable this added a layer of complexity to how staff in this setting gave meaning and value to safety. This finding was of particular significance, as the formal patient safety approaches were largely positivistic and attempted to put in place measures of control (Paddock et al. 2019). My study contributed that the culture of safety in care homes was underpinned by uncertainty and unpredictability, and therefore could not be controlled or predicted by the common dominant, orthodox approaches within patient safety (Waring, Allen et al. 2016). This same criticism was recently acknowledged by Mackintosh and Armstrong (2020) when revisiting the literature on uncertainty in light of the recent COVID-19 pandemic, and acknowledged that uncertainty remains a prominent part of all health and social care.

The thesis suggested that uncertainty underpinned the experiences of both residents and relatives and their perceptions of safety. Uncertainty was associated with the significant life changes taking place for the individual, socially, physically and emotionally (Porter and Clinton 1992). Lanoix (2017) suggests that this disruption to life causes uncertainty, and that the liminality of living in a care home causes constant ambiguity for residents. The findings of my study extended the work of Lanoix (2017), as residents within this thesis explained they had no purpose, and some described this stage as ‘waiting to die’. Paddock, Brown Wilson et al. (2019) further argued that care homes imposed institutional routines and practices that restricted independence and autonomy of residents and also caused the bounded expression of identity and personality. This may be a possible explanation for the liminality felt by residents, as the restrictions upon independence and identity within care homes were unlike any other experiences due to the high levels of dependence of residents (Moilanen, Kangasniemi et al. 2020). Moving beyond these two studies, my findings proposed that residents may indeed view this as a transitionary stage where they see themselves as no longer an active participant in their life and it was evident that aspects of autonomy and identity were restricted within the care homes. Uncertainty and ambiguity were therefore prominent influences on the experiences of living in a care home, which influenced how residents gave meaning to and valued safety.

The notable changes taking place within care homes, such as staff turnover and resident deaths also bring uncertainty with them. Lanoix (2017, pg.40-41) suggests that this makes care homes a “fragile and shifting community where loss lurks but was never acknowledged”. The impact of a deteriorating resident upon families and carers also brings significant uncertainty. These changes within their loved one cause a sense of unfamiliarity in their own role and an inability to make sense of the situation (Braine and Wray 2016). For relatives this has been found to bring uncertainty for the future and change the relationship dynamics within the family (Braine and Wray 2016). This thesis clarified both Lanoix's (2017) and Braine and Wray's (2016) findings and suggested that uncertainty was a prominent part of the resident and relative experience, particularly related to the changing identity and role of both residents and relatives.

Overall, uncertainty was found to be a significant factor that framed the perception of staff, residents and relatives in relation to safety. Although many formal safety measures and processes within the care homes attempted to control and standardise safety practices (e.g. audit, risk assessments, care plans and policies), it was found that this could not always account for or control uncertainty, which led actors attempting to deal with this informally. As this conceptual understanding was explored in more depth it will become apparent that there was often a disconnect between the unpredictable and uncertain nature of care in this setting and the structured routines and processes that were often put into place within care home organisations. Although safety processes aim to produce order and certainty, these routines and processes were trying to fit a system of predictability to a setting of unpredictability.

The defining features of culture in care homes

Social identity has historically referred to how people's self-concepts were based on their membership to social groups (Tajfel and Turner 1979). In line with the broader theoretical positioning of this thesis, I will align with a sociocultural perspective on identity. Identity was not considered a definite or bounded entity, instead narratives of identity were seen to be inseparable from the cultural rules and social practices that constitute them. Identity was seen to be influenced by context; for identities to be viable these narratives must fit within the broader social context (McDonald, Waring and Harrison 2006). This thesis has found that residents experience many changes to their social context and identity, including integration into a new social group- being a resident. Moving to a care home involved many distinct life changes for older people, such as social status, habitual activities and loss of autonomy (Porter and Clinton 1992, Riedl, Mantovan et al. 2013, Paddock, Brown Wilson et al. 2019). This thesis confirmed the findings of Riedl, Mantovan et al. (2013) and Paddock, Brown Wilson et al. (2019) and suggested that these losses endangered the identity of care home residents.

Through my study I argued that people with dementia experienced a loss of identity, which has been frequently recognised in the literature (Radden and Fordyce 2005, Hampson and Morris 2016, Brown 2017, Paddock, Brown Wilson et al. 2019). Brown (2017) notes that dementia was synonymous with loss. Furthermore, it has been suggested that this sense of loss was a part of the resident experience that often goes undiscussed and therefore unaddressed (Lanoix 2017, Paddock, Brown Wilson et al. 2019). This was of significance as loss of identity has been suggested to foster loneliness and depression within care home residents (Riedl, Mantovan et al. 2013, Theurer, Mortenson et al. 2015). My study extended and went beyond this previous research by highlighting this sense of loss, particularly in the resident experience, and situated this within the formal and informal culture of care homes. Loss of identity caused a potential identity crisis for residents, which interfered with residents' comprehension of their present situation and ability, specifically in relation to safety. Furthermore, Paddock, Brown Wilson et al. (2019) have suggested that moving to a care home causes a significant loss of identity for residents due to strict institutional restrictions and routines. This constituted the care home context in which the identity of residents needed to be constructed, and residents therefore had to redefine their own identity and personality in order to fit within the restrictions and routines of the care home.

McDonald, Waring and Harrison (2006) have suggested that how individuals respond to safety processes and rules was dependent on the identities they occupy, and how they negotiate the social rules of that identity. As care homes were a setting that was the residents home, their identity as an autonomous individual was significant, and therefore was found to impact on how residents responded to the safety processes within the care homes. The notion of self-identity has been suggested to be more important in modern society because of our increased autonomy and freedom for self-expression (Kehily, 2009), which raises specific challenges for residents at a time when their autonomy was significantly challenged. Riedl, Mantovan et al. (2013) found that the potential loss of identity made residents want to 'fight for autonomy' and explained that activities such as waiting for help and support was felt to be degrading and powerless. Moilanen, Kangasniemi et al. (2020) suggest that residents having physical dependence on others for their physical needs was the most prominent cause of lack of autonomy for residents, which could cause them to then attempt to not ask for support. The desire to maintain independence was also an important influence on safety perceptions of residents, who may consider taking risks in order to achieve autonomy. Residents taking risks and not seeking support could be seen as the result of them not making allowances to fit with the restrictions and routines of the care homes, which Paddock, Brown Wilson et al. (2019) identified as a threat to residents' identity. However, this could be due to the informal cultural landscape within care homes that placed emphasis on the individual and maintaining their identity and autonomy. The social rules of residents as autonomous people in their own homes therefore had a powerful impact upon their expression of independence and responsibility in making safety decisions, and consequently framed how they gave meaning to and valued safety (McDonald, Waring and Harrison 2006).

In terms of staff perceptions, knowing individuals and maintaining their identity was said to be important to safety and quality of care, which was in direct contrast to conventional orthodox approaches to patient safety. This demonstrated the link between the theme of Identity and Role and that of Relationships. Getting to know the individual and features of their past was a vital part of the informal cultural landscape of the care homes. This was considered important to maintaining autonomy and a sense of self for residents. Interpersonal relationships were important to quality of life for people living with dementia and continuing to give value to the lives of these older people (Brown 2017). This thesis also identified that relatives had an essential role in promoting relationships between staff and the resident through the sharing of life stories and information, particularly for those with dementia. Previous studies have highlighted the importance of staff-resident relationships in the provision of care, in particular for understanding care needs, fostering trust and meeting the emotional needs of residents (Wilson 2008, Wilson and Davies 2009, Gharibian Adra, Aharonian et al. 2019). My study extends these findings by contributing that relationships were not only important for the provision of care, but directly impact upon the ability of staff to keep residents safe. The findings of this thesis supported that knowing the resident provided a vital interpersonal relationship, and important information, that enabled them to facilitate safe care. Such as, the finding that interpersonal relationships between staff and residents enabled effective distraction tactics and helped staff to notice unique changes in behaviour that could lead to a safety incident. Relationships with residents were an essential part of the culture of safety in care homes, this shaped construction of identity in relation to safety, and also enabled effective prevention measures and intervention on an individual level.

The theme of Responsibility was linked to Relationships and knowing the resident, as this fostered trust that enabled negotiation of responsibility for safety to take place. Responsibility for safety often involved a balancing act between the tensions of safety versus autonomy, which has been described as an important factor for maintaining a sense of self, health and quality of care for residents (Riedl, Mantovan et al. 2013, Moilanen, Kangasniemi et al. 2020). The conceptual understanding presented in Figure 8 shows the interlinking nature of these features of safety culture that were all built on the foundations of uncertainty. The perception of resident identity will impact on responsibility for safety, and in turn the relationships between staff and residents. This could result in both negative and positive experiences in terms of safety practice. For example, it was observed in this study that a resident with advanced dementia was admitted to a care home with no relatives available to provide background information. As such, the staff felt uncertain and did not know the resident's normal ability or limitations, or how best to work with the resident. This limited their ability to form relationships with the resident. The result was that the resident was confused and distressed and staff deemed that the resident could not take responsibility for their own safety. The staff felt wholly responsible for the resident's safety with little risk taking. This can result in more restrictive practices in order to maintain safety, and less promotion of autonomy. Paddock, Brown Wilson et al. (2019) acknowledged that restrictive practices within care homes were commonplace and have a drastic impact on resident wellbeing. My study extended this research and argued that the formal approaches to maintaining safety would often be restrictive, such as implementing falls prevention measures. Formal safety processes were found to often promote safety at the expense of autonomy when strictly adhered to.

On the other hand, my study also showed that within care homes the culture could promote interpersonal relationships, personalised risk taking and promote safety without such restrictions. This was an important finding that extended the work of Boumans, van Boekel et al. (2019), who suggested that relationships between residents and caregivers were important for promoting resident autonomy. Margaret's vignette showed a resident admitted to the care home with physical needs. Margaret let the staff know her life history, normal ability, likes and dislikes. Although the resident and staff had uncertainties and had only just met, they built a relationship and the staff got to know her normal limitations and desire to be independent. As the staff had more information and had started to build trust with Margaret, she was encouraged to be involved in safety decisions and to take responsibility for her own safety. At times she would choose to mobilise without assistance to maintain her independence. In this example we can see that the relationship with the resident impacted on how they were involved in choices about their own safety. Overall, the conceptual understanding of culture shows that identity and role, responsibility for safety and forming relationships were important to promoting safety amidst the uncertainty of care home settings. When these elements were present they could facilitate safety and autonomy, but when these were missing the result was a lack of autonomy and reliance on the formal safety processes.

The defining features of culture in care homes can be used as a tool for dealing with the omnipresent uncertainty within care homes. The culture described in my study was one that inherently places value on person-centred and relationship-focused care, in which personal identity and relationships were seen as essential to safe and high-quality care.

The conflicts of formal and informal culture

The conflicts within this conceptual understanding of culture can be explained as the presence of contrasting formal and informal cultures. Looking at the organisational culture literature, it was widely accepted that formal rules, structure and processes can shape organisational culture (Meek 1988, Parker 2000). This dominant structural-functionalist perspective, typically found within the safety management literature, was flawed as it views culture as an abstract entity that not only structures social life but can be manipulated and controlled to enhance performance (Parker 2000). In many ways the formal safety processes seen in this thesis can be interpreted as superficial artifacts at the surface level of the organisational culture, which attempted to influence and control the safety behaviours of actors within the organisation (Schein 1988, Schein 2004, Schein 2010). For examples, staff worked to set job roles and their work was highly routinised and task driven. It was overall found that the formal culture and safety processes within the care homes were highly structured, routinised and task-oriented.

Practice within the care home sector has been acknowledged to be routinised and task-oriented (Brannon and Bodnar 1990, Paddock, Brown Wilson et al. 2019). As the dependency and complexity of residents has increased, care homes have responded by taking a more task-oriented approach to care (Lievesley, Crosby et al. 2011).

Moreover, multiple channels of assurance and regulation taking place in the care home sector have reinforced the need for bureaucracy, with what was fundamentally a model designed for acute hospital settings (Smithson, Richardson et al. 2018, Department for Business Innovation and Skills 2016, Ulsperger and Knottnerus 2007). The task-orientated nature of care work was often prioritised by management (Kadri, Rapaport et al. 2018), and involves strict division of labour, making work boundaried, highly regulated and formalised (Daly and Szebehely 2012, Syed, Daly et al. 2016). A study by Havig, Skogstad et al. (2011) found that a task-oriented leadership style was most beneficial for ensuring quality. However, this can be called into question as the measure of quality in this study was productivity, which may mean that the impact of this leadership style upon other aspects of quality such as person-centred care were not considered. Given the financially-driven nature of the care home market in the UK (Blakeley and Quilter-Pinner 2019), it was plausible that a task-oriented approach has been widely adopted to yield the most productive workforce. Moreover, the drive within the care home sector towards standards and role design reflect much broader trends in safety improvements, particularly evident across wider health and social care services (English and Lindsay 1993, Sharp, McAllister et al. 2018, Kusi-Appiah, Dahlke et al. 2019). My study therefore confirmed that formal safety practices within care homes largely conformed to orthodox approaches to patient safety, and aligned to the perspective that culture was something the organisation 'has' that can be manipulated and controlled (Waterson 2014, Parker 2000).

The routinised and task-oriented nature of care home work reveled in this study could be related to the nature of this workforce as mostly unregistered, and often unskilled workers (Skills for Care, 2019). Benner (1982) highlighted that novice workers often have work set out in key tasks and objectives to compensate for the lack of experience and expertise. By doing so this protects against discretionary judgements in performing key tasks (Benner 1982). Moreover, some of this task-oriented and rountinised work could be described as 'rituals' within the care homes. Rituals have been explored within the nursing literature and offer some insight, these were often considered to be tasks where it was carried out routinely with no thinking or problem solving (Walsh and Ford 1989, Philpin 2002). In relation to this theses findings, many of the formal safety processes could be seen to fall into the space of routines and rituals. However, the task-oriented and routinised approach may did has a role in structuring the work of a low qualified and largely unregistered workforce, particularly as the care home workforce was often transient with high turnover and temporary workers (Centre for Policy and Ageing and Bupa 2012, Skills for Care 2019).

However, my thesis revealed that staff, residents and relatives did work outside of the formal tasks and safety processes in order to achieve safety. The informal cultural landscape of the care homes was centred on getting to know residents and building relationships, and was therefore in conflict with the formal safety approaches. Viewing the culture of safety through an interpretivist lens, it was apparent that the manifestation of informal safety behaviours in care homes was demonstration that the organisational culture 'was' the organisation (Waterson 2014, Parker 2000). The informal culture and practices of staff, residents and relatives were therefore characterised by shared meaning, values and beliefs manifest in the social context of care homes, reconstituted within the day-to-day of organisational life (Schein 2004, Waterson 2014). In this study, distinct differences and conflict in approaches and priorities were associated with the formal processes and informal cultural landscape.

Task-oriented processes and systems have been found to directly contradict the person-centred care rhetoric of care homes. Previous studies have found that the moral and emotional side of care home work was often taken for granted and not prioritised, and that task-oriented approaches can be a barrier to person-centred care delivery (Kadri, Rapaport et al. 2018, Sharp, McAllister et al. 2018). Providing care for residents involves emotional connection and relationships were deemed a vital part of maintaining quality of life and personhood for older people, especially for those living with dementia (Wilson 2008, Wilson and Davies 2009, Fleming and Kydd 2018, Gharibian Adra, Aharonian et al. 2019). The findings from this study add that relationships were vital to ensuring resident safety, as this enabled staff to notice and respond to subtle behavioural cues to prevent harm. For example, in John's vignette, building a relationship and using a tailored approach to his care promoted safety much more than trying to follow the standard care home routine. This suggested that the informal cultural practices of the care home, although different to the formal processes, did still promote safety. Kadri, Rapaport et al. (2018) and Bollig, Schmidt et al. (2015) concluded that care home staff often feel burdened by ethical dilemmas in their work and there was prominent conflict between person-centred care and keeping residents safe. What was evident in this thesis was the inherent conflict between the person-centred care and safety, which appeared to stem from the cultural positioning within the care homes. The orthodox formal safety processes brought with them assumptions around adherence, bureaucracy and standardisation, whereby deviation from these processes was considered poor practice (Waring, Allen et al. 2016). However, the informal culture was found to prioritise individual approaches that were necessary for ensuring safety, often possible through performance adjustments and working outside of care plans and risk assessments in order to respond to uncertainty (Hollnagel and Wears 2015).

This study attempted to not only explore the surface level of safety culture, which encapsulated formal safety processes, but the basic underlying assumptions that were the essence of organisational culture (Schein 1988, Schein 2004, Schein 2010). The themes captured in the conceptual understanding of culture were the presentation of the informal cultural landscape of the organisation, based on the underlying assumptions, taken for granted meanings and ideologies of the actors in this setting (Schein 1988, Meyer and Rowan 1991, Schein 2004, Schein 2010). This informal culture can be explained to have manifested from the interactions between staff, residents and relatives. Informal cultures were typically argued to be difficult to capture in research as they were only visible in the decision-making and reasoning of actors (Wirth, Markard et al. 2013). What was of note in this study was the finding that there was a disconnect between the formal and informal cultures within care homes. This study offers a unique contribution to the patient safety literature, by arguing that the formal safety processes within care homes at times detract from achieving safety, and that residents were instead kept safe due to the informal cultural practices that takes place and act outside of the formal systems and processes. It was therefore evident that within the care home, the systems only work because of the ability of staff to use their own judgment and relationships with the residents to work outside of these processes appropriately. Although there was often rhetoric of person-centred care within the care home sector, my study argues that this did not translate into the formal culture of safety within care homes. However, the informal culture strongly embedded this holistic and person-centred rhetoric with staff, residents and relatives understanding safety through their perceptions of identity, responsibility and relationships.

A possible explanation for the disconnect between the formal and informal culture was that developments in patient safety have focused on the acute hospitals, with care homes often an afterthought in terms of quality and safety developments (Devi, Meyer et al. 2018). This was evident even through the language used. The term ‘patient’ safety in itself was not a term that has meaning within the care home sector, which did not care for ‘patients’ but ‘residents’. Despite this, approaches to safety in care homes were consistently adapted from acute hospital settings (Simmons, Schnelle et al. 2016), and therefore many of the formal safety approaches seen in this thesis closely align with an orthodox understanding of patient safety (Allen 2009). This can be seen in the use of risk assessments and care plans, some of these being the same as what was adopted in acute hospital settings. Moreover, there were national steps to standardise care across the NHS and care home sector, such as the implementation of standardised NEWS 2 clinical observations and a drive to implement ward rounds within care homes (Roche and Wyatt 2017, Royal College of Physicians 2017).

It has been argued that applying NHS approaches to care homes did not work (Simmons, Schnelle et al. 2016, Devi, Meyer et al. 2018). Considerable variation across the sector means that the governance and assurance processes were disparate, with many care homes not having the infrastructure needed to implement or sustain the processes put into place. Moreover, the educational background and training of staff within care homes was vastly different to that of the NHS, which was dominated by a professional and expert workforce (NHS Digital 2020). Unlike the NHS, only 6.4% of the care home sector was registered and qualified professionals and of this remaining 93.6% of the workforce a significant proportion has been found to have no relevant qualifications to social care (43% in residential homes and 57% in nursing homes)(Skills for Care 2019). Clinical training or education did not underpin the majority of the workforce within care homes and therefore these NHS-focused models and orthodox approaches do not fit with the underlying assumptions of the staff, residents and relatives in this setting. Instead, many people working within the care home sector report to have been drawn into this career with little or no clinical knowledge, but a desire to care (Higgs and Gilleard 2016, Kadri, Rapaport et al. 2018).

Values-based recruitment has reinforced the profile of staff working in care homes, as employers have reported that recruiting someone with the right values and attitude was more important than recruiting someone who has the correct qualifications or experience, stating that ‘skills can be taught, but personal attributes (kindness, compassion, reliability, honesty, etc.) cannot’ (Skills for Care 2017). Values-based recruitment was adopted across health and social care and was commonly used in the recruitment of student healthcare professionals (Groothuizen and Gallagher 2017, Ritchie et al 2018). The notable difference here between the majority of care home staff and student healthcare professionals was the academic training provided. For care home staff, the training provided was minimal and all workplace and role dependent, however student healthcare professionals have been subject commonly to a three year undergraduate degree programme. This brings into question how values were shaped during undergraduate programmes, which Groothuizen et al (2019) and Callwood et al (2019) explored with student nurses. It was found that during undergraduate training values were both challenged and retained. However, student nurses reported that their understanding of their role and responsibility as a professional had changed and shaped the way they prioritised their values (Callwood et al 2019). Due to the focus of undergraduate programmes on acute healthcare, it was possible that undergraduate training conditions healthcare professionals to frame their values around the rules, policies, guidelines and ultimately the safety-I approach dominant within acute care settings. Reflecting back on the care home workforce, these staff were not subject to such conditioning, and have also been noted to have often low levels of experience and qualifications upon recruitment (Skills for health 2017), which were both characteristics associated with attrition on nursing courses (Mullholand et al 2008). My study shows that not only were care home staff drawn into this career due to a desire to care for others, but that this also underpinned their work and understanding of safety. The underpinning perceptions of safety were shown to focus on a holistic and personal approach, rather than a medical model or formalised safety processes. A possible explanation for this unique perspective on safety was that these staff have not been trained or conditioned to shape their values in line with the professions and safety-I systems and processes. Overall, my study makes a unique argument that the unregistered care home workforce views care and safety through a holistic lens that supports the need for knowing individuals and building interpersonal relationships.

As has already been discussed, work within care homes was fundamentally uncertain and unpredictable (Robbins, Gordon et al. 2013, Barclay, Froggatt et al. 2014, Lanoix 2017). The orthodox approaches seen within the formal safety processes of care homes often worked on the basis of cause and effect, that safety was something which can be controlled (Allen 2009, Waring, Allen et al. 2016). However, due to high levels of uncertainty, although these approaches were put into place these were often not meaningful and were inappropriate for the frontline work of care homes. Taking the example of a written risk assessment; this can be impractical to implement when the nature of the residents’ mobility, cognition and aggression fluctuates throughout the day. Another example was the nature of incident reporting, as in the care home it was noted that many staff would not acknowledge a fall without harm as an incident, whereas by hospital standards this would be. As such, there were some examples in this thesis of staff considering such assessments as restrictive, as they had to account for the worst-case scenario in terms of the residents' presentation. Uncertainty within care homes therefore challenges orthodox safety approaches (Mackintosh and Armstrong 2020, Fox 1980, Fox 2000), resulting in conflict between formal safety processes and the informal culture within care homes

The informal safety culture could further be explained by the nature of this care setting, which in many respects acts as someone's home as much as a formal care setting. Unlike the healthcare settings where these formal safety approaches have been drawn from, this setting was in fact the residents' home, which will influence how people make sense of and promote safety in this setting. Achieving a sense of 'home' for older people living in care homes was important to quality of care, particularly as many of these residents were in their last years of life (Fleming, Kelly et al. 2015, Fleming and Kydd 2018). As this setting was the residents' home where they live the need for maintaining independence and autonomy was significant (Stabell, Eide et al. 2004). This was of particular importance for maintaining a sense of control and identity for older people in care homes (Riedl, Mantovan et al. 2013, Rijnaard, van Hoof et al. 2016). As mentioned earlier, the conflict between promoting safety and autonomy can often be a challenge within care homes. In particular, the context of care homes was distinct as a care setting as the residents' home, and my study showed this to be a prominent feature, with staff residents and relatives describing the home as a family and community. My study therefore extends this literature be suggesting that this perception of home influences how people perceive and enact safety within care homes, and suggests this setting requires a different approach to safety than the orthodox approaches currently taken.

Overall, there was disconnect between the culture of safety and the formal safety processes seen within this thesis. The formal safety approaches taken in care homes, which were commonly adapted from hospital settings, were found to be largely inappropriate for this setting. Care homes were distinct in terms of variation within the sector, workforce, high levels of uncertainty, fragmented digitalisation and this setting as a person's home. All of which influenced how actors in this setting add meaning to and value safety, specifically in relation to their own identity, responsibility and relationships.

Negotiation of responsibility for safety

The three groups explored within this thesis were staff, residents and relatives, all of which were involved within negotiating responsibility for resident safety. This section will not attempt to repeat content from Chapter 9 but will specifically draw out distinct areas for discussion around negotiating responsibility for safety.

In the conceptual understanding of culture described above, negotiations of responsibility for safety were evident throughout. Firstly, it was important to consider how responsibility for safety was viewed from an organisational perspective by looking at the formal safety processes in place. The thesis argued that formal safety processes reinforced the sense that staff were wholly responsible for resident safety. This was further reinforced by approaches to safety within social care, for example the multifaceted regulatory processes in place within the UK which hold organisations and staff accountable for patient safety (Smithson, Richardson et al. 2018). In terms of responsibility for safety, orthodox approaches suggested staff responsibility for safety, seeing harms as preventable if the correct risk assessments and care plans were followed by staff. As such, many of the formal safety processes in place were shown to hold staff as accountable for their actions, with staff suggesting that the need for documentation was to prove that care was done, and to be able to prove this to external parties such as regulators and commissioners and prevent litigation.

This study explored the deeper levels of safety culture and suggested that involvement of residents was essential to safety. This finding by literature that emphasises the importance of promoting autonomy, independence and choice for residents within care home settings (Porter and Clinton 1992, Riedl, Mantovan et al. 2013, Theurer, Mortenson et al. 2015). Moreover, as this setting was the residents' home, this was even more important to ensuring the notion of 'home' was maintained (Fleming, Kelly et al. 2015, Rijnaard, van Hoof et al. 2016). Maintaining independence and autonomy in older people was vital both to quality of life and to their ongoing rehabilitation (Rijnaard, van Hoof et al. 2016, Hedman, Häggström et al. 2017, Boumans, van Boekel et al. 2018). For example, if someone was unsteady on their feet, they should be encouraged to continue to mobilise to build strength and keep the physical ability and autonomy they have. However, if looked at from a purely safety angle, if this person was encouraged not to walk but to use a wheelchair, this may keep them safer, but this would not be the best intervention for their overall wellbeing due to reduced overall mobility and reducing their independence and autonomy. Simmons, Schnelle et al. (2016) concluded that care homes must "find the balance between preserving person-centeredness and resident autonomy while ensuring safety, quality of care, and quality of life for residents" (Simmons, Schenelle et al 2016 p.1). The conflict between safety and autonomy when decision making has already been noted in this chapter to be a significant challenge (Riedl, Mantovan et al. 2013). Boumans, van Boekel et al. (2018) note that relationships between formal caregivers and residents were essential to the promotion of choice and autonomy in care homes, especially for residents living with dementia. Involving the resident and promoting choice, autonomy and independence was a vital part of negotiating responsibility for safety in care homes. In order to achieve this staff must build relationships with residents and understand the resident on a human level, including aspects of their identity. My study extended this argument by supporting that resident autonomy was important to patient safety and that interpersonal relationships can help ensure that independence and risk taking was done safely through person centred risk assessment and intervention.

The thesis offered distinct findings on resident responsibility for safety, specifically how this differed depending on the resident's physical and cognitive ability. For those who were cognitively able, choice and autonomy was considered essential (Riedl, Mantovan et al. 2013, Simmons, Schnelle et al. 2016). Resident cognitive ability was therefore an important part of negotiating responsibility for safety, with those with more cognitive ability often deemed to take responsibility for their own safety, and at times that of others.

The patient safety literature offers some insight into patients' responsibility for safety. Heavey, Waring et al. (2019) note that patients considered themselves to have responsibility for their own safety as they have a duty of care to themselves and hold personal expertise and knowledge of their own body and limitations. Heavey, Waring et al. (2019) also found that patients viewed staff as responsible for safety due to the context of care and their professional expertise. As these findings were within hospital settings, they may not be wholly translatable to the care home sector. My study extended the work of Heavey, Waring et al. (2019) by offering a perspective on resident responsibility for safety. My study suggested similarities between residents and patients, in that residents with capacity also felt they had personal knowledge and a duty of care to themselves. However, the experience of uncertainty and liminality within the care home had a significant impact upon residents' safety perceptions and enactment of responsibility for safety (Porter and Clinton 1992, Lanoix 2017). For example, they may have moved to the care home after physical deterioration and mobility issues, therefore their understanding of their own body and limitations may no longer be accurate. This was something found within this thesis, with at times residents feeling they were more physically capable than they were. My study also considered the responsibility of people living with dementia, which was not captured in Heavey, Waring et al. (2019) study. My study therefore offered this unique contribution that for residents with advanced dementia, their responsibility for safety depended on their level of capacity, with the most cognitively impaired not being able to take any responsibility for their own safety. Moreover, in terms of staff responsibility, care home staff often do not have professional expertise due to the nature of the workforce (Skills for Care 2019). This could impact on residents' trust, as the care home workforce were often not considered experts. However, this thesis has shown that the choice to live in a care home was often driven by a need for safety, and with this residents appeared to still place their safety in the hands of care home staff, whether they were experts or not. Context appeared to also be a relevant factor for care homes, though as care homes were the residents' home this remains distinctly different to hospital settings. Hospital settings could infer staff responsibility due to complex medical procedures (Heavey, Waring et al. 2019), for care homes the context instead suggested more resident responsibility, as this was their home (Fleming, Kelly et al. 2015). My thesis therefore offers a different perspective on this previous research, staff in care homes were more inclined to view residents as responsible for their safety.

This study argued that staff often felt ultimately responsible for the safety of residents' living with dementia, as they were deemed to not always have the cognition to make their own safety decisions. It was widely acknowledged that a diagnosis of dementia can greatly affect a person's safety (Zingmark, Sandman et al. 2002, Sørensen, Waldorff et al. 2008). In many ways the cognitive symptoms of dementia, that affect both Activities of Daily Living and Instrumental Activities of Daily Living, impact on the individual's ability to maintain their own safety (Farias, Park et al. 2013, Mlinac and Feng 2016). If staff were therefore considered responsible for resident safety, this remains complex as staff were also responsible for promoting person-centred care and autonomy for the resident. Staff therefore were required to make a judgment on what was an acceptable risk and to navigate the tensions between safety, person-centred care and autonomy (Riedl, Mantovan et al. 2013, Robbins, Gordon et al. 2013). Department of Health (2010) guidance highlighted these tensions for people living with dementia, describing this as a balancing act between risks and opportunities (Taylor 2010). It has been suggested that when caring for residents living with dementia it is important to take a broader view on risk that accepts that it is not possible to alleviate all risks and takes a more positive approach to risk taking (Neill, Allen et al. 2009, DH 2010). In this thesis negotiating responsibility for resident safety appeared to involve elements of positive risk-taking in which the staff attempted to involve the residents and consider their wishes and wellbeing alongside safety. Positive risk taking is the process of balancing positive benefits that were likely to follow against the negative effects of alleviating risk completely (DH 2010). The thesis showed that residents had an important role within this process, whereby understanding the resident's identity and what is important to them was vital to positive risk taking and safety decisions.

Relatives were also found to have responsibility for resident safety. For residents living with dementia, informal caregivers often have a vital role in their safety whilst at home (Glasby and Thomas 2018, Häikiö, Sagbakken et al. 2019) and whilst in hospital (Rainey, Ehrich et al. 2015, Merner, Hill et al. 2019). Relatives and carers were widely acknowledged as having an essential role in patient safety as a patient advocate and holding practitioners accountable (Lindhardt, Bolmsjö et al. 2006), handing over information to staff (Hemsley, Georgiou et al. 2015, Rainey, Ehrich et al. 2015), and helping patients communicate with staff (Hemsley, Georgiou et al. 2015). All of these findings relate to hospital settings, and there appears to be limited research looking at the relatives' responsibility within the care home setting. Powell, Blighe et al. (2018) highlight that relatives have an important role in recognising deterioration for residents in care homes (Gaugler 2005). However, the broader literature on relatives focuses on family involvement within care homes, and did not look in depth at responsibility for care or safety. Instead this body of literature instead focuses on tasks, or the benefits for residents in terms of their wellbeing (Gaugler 2005).

Due to the limited research on relative responsibility for safety in care homes, it was important to consider the broader patient safety literature and its potential relevance to the care home sector. It has been shown that the preventative measures adopted by caregivers can make certain risks invisible to professionals (Häikiö, Sagbakken et al. 2019). As such, it can be assumed that on admission to a care home, the full picture of resident safety was not visible without the handover of essential information, both related to safety and in getting to know the resident. Specifically, Puurveen, Baumbusch et al. (2018) explored relatives' involvement within care homes and defined this as four distinct types of role; providing hands on assistance, overseeing and/or managing care, socioemotional support, contributing to the community. These findings relate closely to this thesis which found relatives to have a role in overseeing the safety of residents often checking in with staff about appointments, medication, updates and the wellbeing of the resident and providing socioemotional support when visiting the resident. Relatives also contributed to the safety wider care home community, supporting not only their own family member in this way, but interacting with and supporting other residents in the care home. This thesis has shown that at times relatives did provide hands-on assistance in terms of safety, supporting the residents in the care home with eating, drinking, mobility and environmental safety.

Overall, it was shown in this thesis that residents, relatives and staff all held varying responsibility for safety within the care home. This was fluid and context-dependent, shifting with the changing dynamics of the care home, resident ability and the actors present. The negotiation of this responsibility for safety often appeared to be a balancing act between different priorities, which caused tensions between the groups. For example, a resident who went to the bathroom without assistance because it had been 5 minutes since they pressed the call bell, as the resident assumed staff were too busy. In doing this they were taking responsibility for their own safety, deciding to go against the advice of staff. If this did result then in a fall, it could be questioned who was responsible. The care staff who did not answer the call bell sooner were with another resident who was being assisted. They were protecting safety as they could not leave the resident they were already assisting. However, relatives might think that the resident was in the care home to be kept safe and therefore staff should be held accountable, as they did not prevent the fall. This was typical of the views of relatives, which often focused on the wellbeing of their own resident in the care home. This example demonstrates the typical conflicting perspectives of actors within the care home and shows that responsibility for safety within care homes was fluid and changing due the prevalent uncertainty within care home settings. It can be concluded that responsibility for safety was complex and was shaped by a variety of factors related to residents, relatives, staff and the broader organisation.

SAFETY-I IN CARE HOMES

The thesis presented that at the most superficial level of organisational culture, the formal safety processes and structures conformed to an orthodox perspective on safety and consequently aligned with the safety-I approach. The formal approaches to safety in care homes embedded policies, structures and processes that aimed to assess risk and standardise practices, which could therefore be seen to reinforce a negative perspective on safety (Hollnagel and Wears 2015, Woodward 2019). Such approaches can be seen as bimodal, with deviation from safety processes viewed by the organisation and external bodies as a failure that should have been mitigated (Hollnagel and Wears 2015). Evidence of this was seen throughout the thesis and was reinforced by regulatory bodies and commissioners that measure care homes against set criteria and hold them to account if any components were missing or failing (CQC 2016). The formalised safety processes seen within this thesis were often rigid and viewed safety as something that could be controlled, aligning with the functionalist paradigm

(Parker 2000). As was discussed in Chapter 2, the safety-I approach can be criticised for not accounting for the complex interplay of social, cultural and organisational factors and for focusing on failings rather than how systems were able to adapt and promote safety and resilience (Edmondson 2011, Carson-Stevens 2018). Safety-I approaches can therefore be seen to provide an idealised view on safety that often did not address the core issues. This was evident in how the formal processes were shown to not consider or account for the key themes found to be essential to safety practice in this thesis; uncertainty, identity and role, responsibility and relationships. Moreover, safety-I approaches have been deemed inappropriate for complex systems in today's society, and particularly for healthcare settings that are complex and full of uncertainty (Plsek and Greenhalgh 2001). This thesis has highlighted that uncertainty was prevalent within care homes and therefore the formal safety approaches seen in this thesis can be further criticised as inappropriate for the complexity of safety in this setting.

This thesis largely supported the broad criticisms of the safety-I approach (Hollnagel and Wears 2015), however consideration must also be given to the strengths of this safety approach in the context of care homes. This study captured two high quality care homes, without significant staff turnover, temporary agency use, or concerns around quality and safety, which may explain why the safety-I approach appeared to limit the ability of staff to achieve safety. Safety-I approaches attempt to provide structure and control through standardising practice and setting out clear standards and boundaries for work (Woodward 2019). Whilst this can be argued to limit the autonomy of staff in initiating and responding to complexity (Woodward 2019), this could also provide particular benefit to poor performing and high turnover care homes. Allen and Vadean (2017) and the Royal College of Nursing (2012) have both reported that high turnover in care homes negatively impacts upon quality of care. Safety-I approaches applied in these circumstances could provide many safety benefits, as staff would be unable to be guided by more relational approaches due to the transient nature of a workforce with high turnover and agency use (Allen and Vadean 2017). Furthermore, safety-I approaches can provide structure and consistency and foundations for safety within poorer quality care homes with an unstable workforce, to guide novice workers in routine safety and care tasks (Walsh and Ford 1989, Philpin 2002, Skills for Care 2019, Benner 1982).

THE SAFETY-II APPROACH

It was widely accepted that healthcare settings are complex adaptive systems, which consist of non-linear dynamics and the interplay of many actors and systems (Plsek and Greenhalgh 2001, Woodward 2019). This thesis considers that care homes are part of complex care systems that include heterogeneity of organisations (Lievesley, Crosby et al. 2011), privatisation (Blakeley and Quilter-Pinner 2019), complex funding models (Competition & Markets Authority 2018) and multifaceted regulation (Department for Business Innovation and Skills 2016). Care homes are also complex as this setting was the residents home (Oliver, Foot et al. 2014), function with a largely unregistered workforce (Skills for Care 2019), and lack the infrastructure to deal with this complexity (Coulter, Roberts et al. 2013). To improve and achieve safety within complex adaptive systems it was deemed important to look at patterns of resilience and adaptation across the system (what works), rather than isolated errors or problems within sub-systems or units (what doesn't work) (Plsek and Greenhalgh 2001, Woodward 2019, Ball and Frerk 2015, Chan 2016, Fairbanks et al 2014).

To explore the culture and safety within care homes a safety-II approach was taken to this study. This adopted an appreciative approach that attempted to look at how safety worked within care homes (Plsek and Greenhalgh 2001, Woodward 2019). The study was therefore able to look beyond the surface levels of organisational culture and reveal the complex interplay of cultural factors influencing how staff, residents and relatives attributed meaning and value to safety (Schein 2010). If a safety-I approach had instead been taken to this study, it would not have been possible to explore the interplay of sociological factors upon safety practices, such as the significance of identity and social relationships within the care homes.

Taking a safety-II approach to this study added value and unique contributions to the literature. The essence of organisational culture within care homes was found to be informal cultural practices that did not focus on surface level artifacts, but instead involved deviation from these systems and processes in order to respond to uncertainty. The humanistic approach taken by staff therefore included performance adjustments that responded to the various unpredictable circumstances of the care home (Hollnagel and Wears 2015, Woodward 2019, Woodward 2019a). The informal culture demonstrated an approach that achieved safety through relationships and individualised approaches, rather than widespread standardised care and processes. Through the approach taken it was possible to capture the complexity of influences upon safety, whilst also capturing the formal safety-I approaches used within the care home (Plesk and Greenhalgh 2001). Through doing this it was possible to see the nuanced interplay of actors and see conflicts between the formalised safety processes and the informal culture that guided staff in their work. Specifically showing the value of relational and personalised approaches to safety in care homes.

Overall, the thesis suggests that in care homes safety-I approaches alone appear to limit the ability of staff to achieve safety, and require them to work outside of formal safety processes to achieve safety. However, there still remains an essential place for safety-I approaches in laying the foundations for quality, safe care. The thesis therefore supports arguments that optimal safety practices should incorporate both safety-I and safety-II drawing on strengths of each of these approaches (Woodward 2019, Woodward 2019a). This was an important contribution as approaches to safety must be context specific to ensure success. Although this study found benefits in the safety-II approach for care homes, a limitation of the safety-II approach was that this approach may be inappropriate for services that do not already have establishes safety-I approaches, such as poorer quality care homes that are facing workforce challenges. It was therefore essential that future work considers how safety-II approaches to research and safety innovations in care homes can be developed to learn from the practices of high performing care homes, whilst being made appropriate for implementation in poorer quality services.

APPLICATION OF FINDINGS

Across the care home sector in England approaches to patient safety have been broadly taken from NHS acute hospital settings and applied to care homes (Simmons, Schnelle et al. 2016, Devi, Meyer et al. 2018). Safety approaches within acute hospital settings have been dominated by orthodox approaches, explored in Chapter 2. The approaches to safety adopted for the care home sector have similarly been dominated by safety-I approaches that attempt to standardise safety practice though structured systems and processes. Many authors have previously challenged that taking acute NHS approaches and applying these to care homes was ineffective and did not work (Simmons, Schnelle et al. 2016, Devi, Meyer et al. 2018). My study supported this argument and critiqued the orthodox approaches to safety that have been applied in care homes. My study has shown that safety was not achieved through these formalised surface level artifacts, but instead relied on staff working outside of these systems. Applying these findings to UK care home services, my study suggests that more holistic and context driven approaches are of importance and that for safety to be achieved tailored safety initiatives must be considered to move care homes away from orthodox safety-I approaches. Safety research and improvements in care homes should instead align with a sociological approach that are able to consider broader sociological factors influencing safety within the care home setting, such as uncertainty, identity, responsibility and relationships. It was important that safety processes resonate with staff, resident and relative perspectives and understanding of safety within the care home.

The thesis calls into question wider national initiatives and policies that attempt to standardise and embed safety practices across the sectors. An example of this was the drive to embed NEWS 2 across acute, community and care home sectors (Royal College of Physicians 2017). This initiative was a national attempt to standardise across health and social care services the way that clinical observations are undertaken. This presents distinct challenges for the care home sector, as NEWS 2 was a hospitalised system which uses clinical observations that are rarely used in care homes. As my study has shown, recognising deterioration in fact relied heavily upon knowing the resident and noticing subtle changes in their behaviour and presentation, and consequently asking for them to instead use clinical observations would not resonate with care home staff in a meaningful way. Such approaches, although successful within acute settings, are unlikely to be successfully implemented within the care home sector due to these approaches' safety-I assumptions. My thesis therefore also makes a recommendation that attempts to standardise practice across health and social care are likely inappropriate, and that safety initiatives for care homes should instead be derived specifically for this setting, taking account of the staff group, how people understand safety in this setting, and the nature of this care setting as the residents' home. The findings of this thesis also challenge the regulatory and commissioning models implemented across care homes in England. Chapter 5 highlighted that regulation by the CQC has been questioned as this currently uses a standardised regulatory model across acute, community, mental health and care homes (Smithson, Richardson et al. 2018). This thesis therefore supports arguments for an approach to regulation that was tailored to the needs of the care home sector.

APPLICATION TO COVID-19 PANDEMIC

The timing of data collection was prior to the COVID-19 pandemic in 2020. It would be a missed opportunity to not capture somewhere within this thesis the significant challenge and change this has brought about for the care home sector within the UK, and the potential contribution of the findings of this thesis moving forward. This next section will outline and reflect on the response to the COVID-19 pandemic in England in light of the findings of this thesis.

The COVID-19 pandemic has highlighted prominent disparity between the NHS and care home sector and has shown the urgent need for a reform across UK health and social care (Daly 2020, The National Care Association 2020). The initial response during the COVID-19 pandemic reinforced many of the challenges faced by care homes. At the outset of the pandemic, the government was criticised for being 'too slow' to support care homes, focusing resources on the NHS. The emphasis was on ensuring capacity in the acute sector, with discharge of patients from hospitals a priority. The main acknowledgement of care homes at the outset of the pandemic, was in their role to relieve hospital capacity by taking COVID-19 patients, and initially deemed a low-risk area (Daly 2020). Initial guidance set out that care homes must accept patients from hospitals, but with this no support was offered in terms of how to risk assess and manage these patients with highly infective COVID-19, something which was well outside of standard care home practices. By the 15th April 2020, it was estimated that 25,000 patients had been discharged to care homes in England (Office 2020) and at this time there were no restrictions or even testing in place to monitor the spread of COVID-19 to the care home sector (Daly 2020). It was clear from this initial response that the needs of care home services, and the needs of their vulnerable population were not acknowledged. The response to COVID-19 highlighted a clear disconnect between policymakers and the care home sector. My study argued that safety responses in care homes are often not focused on care homes, but are instead taken and adapted from NHS settings. What can be seen in the COVID-19 response, was not only that the care home sector was not focused on in this safety response, but it appeared to be completed overshadowed by the NHS (Daly 2020). The role of the care home sector was treated as a downstream tool to solve NHS capacity issues (Daly 2020), rather than an essential service in its own right and with its own unique safety interventions needed.

Another criticism of the policy response was that the same resource in terms of funding, staffing, and PPE seen in the acute sector was not afforded to care homes, leaving care homes feeling abandoned and under resourced (Daly 2020, Gilroy 2020, The National Care Association 2020). In particular, it has been challenged that the lack of funding and PPE available to the care home sector left them unable to protect this vulnerable population (Gilroy 2020). The PPE at the outset of the pandemic greatly prioritised NHS services, with no specific acknowledgement of PPE needs of care homes until the 15th May 2020, by which time the resource given was still minimal (Daly 2020). At the outset of the pandemic 3.2 billion pounds was given to local authorities to support the COVID-19 response (Daly 2020). However, the funding models for care homes are complex and was not purely by local authorities. Indeed a growing number of care homes are run as wholly private establishments for self-funded residents (Competition & Markets Authority 2018), which brings to light the question of whether such organisations received any financial support to enable safety measures to be put into place. This funding response can therefore be challenged to again not be tailored to the care home sector, and did not show an acknowledgement of the complex funding arrangements of care home services.

By the 15th April 2020, it was acknowledged that there were significant mortality among care homes, which before has not been captured and was not included in the national statistics on COVID-19. It was therefore noted that these areas were in fact high risk due to the vulnerable populations within care homes, with the majority or residents either vulnerable or extremely vulnerable. COVID-19 outbreaks within the care home sector had a detrimental impact, with over a third of care homes in England having experienced a COVID-19 outbreak (Public Health England 2020). Moreover, the ONS (2020) has shown a 159% increase in deaths within care homes during the pandemic. It has been widely criticised that these high mortality rates are partly due to the delayed response to support care homes, specifically its “relative slowness, lateness and reactiveness in relation to the NHS; the inadequacy of the focus on care homes” (Daly, 2020 p.991).

The COVID-19 outbreak in care homes has put the urgent issue of safety in care homes to the forefront of the national agenda. This has resulted in a responsive effort from the government and NHS in an attempt to control the COVID-19 pandemic. However, this effort can be criticised as not conducive to principles of patient safety for a number of reasons. Firstly, the COVID-19 pandemic has highlighted the lack of command and control over care homes, as was highlighted in Chapter 5, due to the diversity of this sector (Daly 2020). As such, overarching policies and guidance was issued from Public Health England, NHS England, the British Geriatric Society, CQC and more. All of which appeared to adhere to a safety-I approach to achieving safety and asserting external control over safety practices within the care homes. Moreover, this response to the pandemic was in direct contrast to the findings of this thesis, which instead highlighted the importance of autonomy within care homes and the need for tailored approaches that are context specific and promote adaptive safety solutions for care homes.

Secondly, these changes can be criticised due to the nature of these policies and guidelines. A key principle in patient safety was the need for clear communication, getting staff involved and understanding the exact context of the care homes. These policies can therefore be criticised as the government response did not meet the needs of care homes, there was no involvement of care homes in the initial response, and it was clear that there was little acknowledgement of the safety needs of residents. The policies that set out what to do (for example in terms of PPE and isolation) at the outset of the pandemic were NHS focused and gave no clear indications of how to achieve this within care homes (Daly 2020). This further supports that these policies did not account for the challenges faced by the care home sector (Daly 2020). One such challenge was that care homes have not been prepared for the necessary changes and therefore the physical spaces used were not set up to accommodate such changes in terms of infrastructure, organisation and delivery. My study offers a further critique of the COVID-19 response in care homes and perceptions of safety for people within care homes are vastly different to that of the acute sector. As such, care homes do not necessarily understand the NHS-centric language within these policies that again are dominated by an orthodox and safety-I frame of thinking. The result here was that there has been limited work on ensure the COVID-19 response was fit for purpose for the care home sector, which may significantly impact on the implementation of such changes. My study argues that to implement and achieve safety in care homes, responses need to move away from NHS centric, orthodox approaches and that sociocultural approaches that are tailored to care homes settings should be used. For the response to the pandemic to be successfully implemented, an integrated response that works with the care home sector was required to ensure this addresses the complexity of care home services and staff, resident and relative perceptions of safety.

A further key area of response was to include care homes in the system with the NHS as a whole and promote further integration between health and social care services. The role of care homes was viewed as essential to the wider response to the COVID-19 pandemic (Daly, 2020), however the narrative of this setting as the residents' home was lost. Alongside this inclusion within the NHS system, changes to guidance have included enhanced GP involvement and looking at NHS involvement within care homes. This has highlighted challenges, such as the lack of digitalisation within care homes to be able to link and share data, which has led to further reform in terms of upscaling care homes to have digital access (National Care Forum 2020). Many of these changes can be seen as positive advancements in terms of patient safety. However, in light of the findings of this thesis these can also be challenged due to the dominant orthodox approaches. The COVID-19 pandemic appears to be another example of NHS approaches being lifted to fit within the care home sector and therefore will likely mean that such safety-I driven initiatives will be unsuccessful and unsustainable within the care home sector.

Another important consideration was that during the pandemic the functioning of care homes was drastically changed due to governmental restrictions (Daly, 2020). The most important changes to note are that of social distancing and blanket rules around visiting (essentially no visiting) to care homes during the pandemic. This thesis captured the dynamics of care homes under more normal circumstances and it was highlighted that relatives had an important place in the safety culture of these care homes. This was particularly important for residents with cognitive impairments such as dementia. Relatives also had an important role in helping to maintain normality and uphold aspects of identity for these residents. The move to having no visitors within care homes no doubt had a significant impact upon the culture within the care homes both in terms of safety and in terms of quality of life for residents. As relatives in this study were shown to be active participants in maintaining safety for residents, this potentially had an impact on increased responsibility for staff and residents in terms of safety. Furthermore, it was noted earlier in this section that the response to the pandemic resulted in a loss of the narrative of this setting as the patient's home. This study argued that the interpersonal aspects of identity and relationships were vital to culture in care homes, particularly as this was the resident's home. The drastically increased numbers of patient deaths, admissions from hospitals and no visitors could have impacted on this common acceptance of this as the resident's home and also presents this time as having even more uncertainty than ever. The liminality of care homes also had a significant impact on the resident experience within care homes, and their responsibility for safety. It was therefore possible that the pandemic emphasised this liminality significantly, potentially affecting the resident experience.

In light of the findings of this thesis, it was clear that the response to the COVID-19 pandemic has followed similar patterns to what we have seen historically in terms of safety advancements within care homes. It was particularly evident that approaches to enhancing safety within care homes have focused on responsive strategies, policies and guidelines that are adopted from the NHS sector and therefore provide an orthodox and safety-I approach to safety. What appears to have not been addressed here was an attempt to foster a culture of safety within care homes towards positive reform. As the emergency situation of the COVID-19 pandemic resolves my study suggests that it was imperative that future reforms take an inclusive approach that was context driven and acknowledges the important unique qualities of safety cultures within care homes. This was vital to ensuring that safety developments within care homes are appropriately implemented, embedded and sustainable within the sector. There was opportunity for the findings of this thesis to help shape ongoing developments and reforms in safety within care homes, specifically ensuring that approaches taken learn from what we know did not work in care homes, and instead focuses on approaches that capture the impact of uncertainty, identity, responsibility and relationships.

LIMITATIONS AND FUTURE RESEARCH

In Chapter 6, I have already noted some limitations related to the methodology of this study. This section will expand on these to highlight how this may have impacted on the interpretation of the findings and implications for practice.

As an immersive ethnographic study the data captured was qualitative in nature and, in line with the social constructionist ontology of this thesis, was subject to interpretation of the participants and myself as a researcher (Slater 2018, Camargo-Borges and Rasera 2013). The data captured the socially constructed nature of reality, which was shaped by my engagement with participants, therefore if someone else were to conduct this same study, the data they capture and their interpretations may differ from my own (Camargo-Borges and Rasera 2013). As an interpretive researcher, my presence cannot be taken out of the study, and I was not only the researche but also part of the data (Gouldner 1972, Davies 2008). My ability to become immersed in the field shaped the depth of activity I was able to observe in the care homes, and the stories participants shared with me in interviews. As a researcher it was possible that participants behaved differently when I was present and that this caused bias in interviews, where staff told me things they thought looked favourable, or which they felt I wanted to be told (Flores 2016, Blee 2017). The measures taken to address this were the length of time spent in the field to establish rapport with participants and the triangulation of data across observational and interview data.

Furthermore, my own experiences and dual identity as a nurse framed how I was perceived in the field (Tedlock 1991). In Chapter 6 I highlighted that role conflict was a challenge during data collection, with multiple examples of staff asking my advice or for my assistance with clinical tasks more suited to a nurse. Coffey and Atkinson (1996) state that it was impossible to control how the researcher was perceived, and this was an uncontrollable factor during data collection. Moreover, the interpretation of the findings were shaped by my clinical background and experiences working in acute care settings. This study therefore did not suggest its findings as absolute truths, but an interpretation of the socially constructed reality of these two care homes (Camargo-Borges and Rasera 2013). As steps were taken to get feedback from participants on my interpretation of the data, it was believed that the findings do represent these care homes and that there are important transferrable messages and learning that was relevant to the wider care home sector, as was demonstrated by my application of these findings to the recent COVID-19 pandemic.

As was discussed in Chapter 6, the sites chosen were of a high quality rating. This decision was made for two reasons. Firstly, I followed recommendations from EnRICH (2017), which suggested that research conducted in poor quality or struggling care homes can put residents at risk. Secondly, the appreciative safety-II nature of this study intended to capture good practice and therefore high performing care homes were selected to explore how safety was understood and enacted. The conceptual understanding of safety in care homes therefore demonstrates this from the perspective of high performing care homes which already have positive outcomes. It could be argued that the notions of safety seen in this study were made possible by the high performing nature of these care homes, for example having stable management, good leadership, low staff turnover and agency use and other factors associated with high performance in care homes (CQC 2018). As poor performing care homes were not included in this study it was not possible to comment on if similar themes and findings would have been found. As many poor performing care homes have high staff turnover and agency use (Skills for health 2019) it can be assumed that relational approaches to safety, as seen in this thesis, may be limited and safety may present in a different manner. As was noted in the discussion, it was also possible that poor performing care homes may require more focus on use of safety-I and standardised routine safety practices in order to maintain safety amongst novice workers and a transient workforce (Walsh and Ford 1989, Philpin 2002, Skills for Care 2019). The findings from this thesis may not be transferrable to poor performing care homes.

Finally, I would like to suggest some future research that would build on the findings of this study, and also address some of the study limitations. Ethnographic research should be carried out within poor and moderate performing care homes to explore organisational culture and safety. This research was vital to ensure that the findings from this thesis are transferrable and able to inform quality improvement across the care home sector. The conceptual understanding of safety in care homes should also be used as the basis for participatory research with staff, residents and relatives within care homes. This work should focus on the development of participant led approaches to safety within care homes. The outputs from this work should be evaluated to give insight into new innovative ways to approach safety research and quality improvement within care homes.

CHAPTER 12- Conclusion

The thesis has brought together my findings and presented a critical reflection on its contributions to the wider literature, policy and practice. To answer the research question the study shows that staff, residents and relatives attributed meaning and value to safety through four themes that were presented as a conceptual understanding of culture. This brings together the themes Uncertainty, Identity and Role, Responsibility and Relationships in order to explain the cultural landscape within the care homes of this study. A principal finding of this thesis was that actors within care homes understood safety in a way that was far different to traditional orthodox understandings of safety. This caused a conflict between the informal and formal cultures and safety practices within these care home organisations, requiring new approaches to be considered.

Uncertainty made care homes an inherently complex care setting and had a significant influence upon safety practices. This finding supported previous findings around uncertainty in care homes, and highlighted the distinct impact uncertainty had on safety and how safety was enacted within the care home sector. Another key contribution of my thesis was the acknowledgement that the formal safety culture comprised of surface level artifacts that aligned with a dominant orthodox and safety-I approach to patient safety, as was seen commonly across acute settings. Due to the prevalent uncertainty within care homes, it has been acknowledged that these formal approaches in care homes are greatly limited and that safety was achieved by staff working outside of these surface level artifacts. My study therefore offered a unique finding that the high levels of uncertainty in care homes presented a challenge for the implementation of orthodox safety approaches within the care home sector. I have suggested that orthodox, safety-I approaches are inappropriate for dealing with the high levels of uncertainty within the care home sector and that other approaches that are more inclusive should therefore be used.

Each of the themes Identity and Role, Responsibility and Relationships explored and reflected important aspects of the informal culture of safety that staff used in order to deal with uncertainty. My study presented a new contribution of an overall conceptual understanding of culture within care homes, whilst also revealing the intricacies of each of these themes in relation to safety and quality of care. Resident identity and humanistic, individualised approaches have been highlighted as vital, not only for care, but for safety. This argument supported previous studies that have highlighted the importance of identity within care homes. I took this argument further by applying this to safety within care homes and suggested that an acknowledgement and understanding of resident identity was an essential part of safety in care homes. My study therefore contributed to previous literature by suggesting that getting to know residents' individual personalities and identity was an important feature of safety, and through doing this effectively staff are able to provide individualised care and tailor their approaches to identify risks and enact safety in a personalised way. Moreover, I further suggest that by knowing the individual residents in this way, staff are able to deal with the high level of uncertainty to promote safety and prevent harm.

My study also presented distinct findings around the responsibility for safety. I suggested that within the care homes there was a particular emphasis on promoting resident autonomy and responsibility for safety. This was argued to be of importance within this setting due to this care setting being not only a care setting, but also the residents' home. Whilst exploring responsibility for safety, it was also suggested that resident responsibility for their own safety was of the most significance for residents with mental capacity. The thesis therefore makes a contribution to literature on patient safety by looking at the responsibility of residents and offers and perspective on how residents enact their own responsibility for safety and how this was altered depending on cognitive and physical ability. Moreover, my thesis made a further contribution by commenting on the negotiation of safety between actors and suggesting that staff and relatives also have responsibility for safety, but that their responsibility must be balanced with that of the resident. My thesis suggested that for residents who had less physical and cognitive ability, and consequently were not responsible for their own safety, both staff and relatives therefore had more responsibility.

Relationships with residents were key to being able to use individualised approaches to safety. Building interpersonal relationships between staff and residents enabled staff to get to know the residents and use this relationship to promote the resident's safety. Relationships between staff and residents facilitated tailored safety approaches that acknowledged the ethical challenges of balancing safety and autonomy for residents, and were seen by all actors to be of vital importance for safety and quality of care. My thesis built upon previous research that suggested relationships between residents and staff are important, and made a new contribution in applying this to safety. These relationships were essential to achieving safety in care homes, and that approaches to safety interventions should embrace and promote interpersonal relationships and individualised safety approaches.

Overall, my study suggested that the culture of safety in care homes promoted a humanistic approach to maintaining safety that helped staff to create adaptive solutions that were bespoke and utilised person-centred safety and risk for residents. My study therefore argued that more holistic and contextual approaches to safety are required in care homes. This approach resonates with staff understandings of safety that take a much more relational standpoint when looking at safety and was also appropriate to this setting as the residents' home. The underpinning perceptions of safety were shown to focus on a holistic and personal approach, rather than a medical model or formalised safety processes. My study therefore makes a unique argument that unregistered care home workforce has a different perceptual frame to those in acute NHS contexts, whereby care and safety are viewed through a holistic lens that supports the need for knowing individuals and building interpersonal relationships. This was an important and significant contribution to policy and practice in care homes, as approaches to safety in care homes do not commonly take a tailored holistic approach. This could therefore offer a potential solution to the difficulty in implementing safety interventions within the care home sector.

Finally, my thesis has criticised areas of practice and policy, particularly in response to the COVID-19 pandemic. The example of the pandemic response for care homes offers a concrete demonstration of how if the wrong safety approach was taken, this can have a devastating affect with implications for the wellbeing and lives of our vulnerable populations. Applying my study’s findings, I have argued that if a sociocultural approach to safety had been taken that was tailored to the unique needs of the care home sector, the pandemic response would have had a more positive outcome. Moreover, such approaches still offer a potential solution for the roll out and implementation of safety policy and practice as we transition out of the current COVID-19 pandemic.

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APPENDIX 1- Integrated Literature Review Data

Reference	Country	Setting	Theoretical Underpinnings	Method	Measurement Tool	Level of Analysis	Micro/Macro	Pts./Service Users	Power Relations
(Abbas, Bassiuni et al. 2008)	Egypt	Hosp	Func/struct	Survey	SCS	1	Micro	N	N
(Aboul-Fotouh, Ismail et al. 2012)	Egypt	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Agnew, Flin et al. 2013)	UK	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Al-Ateeq 2008)	USA	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Alahmadi 2010)	Saudi Arabia	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Allard, Bleakley et al. 2011)	UK	Hosp	Func/struct	Survey	SAQ	1 2	Micro	N	N
(Ammouri, Tailakh et al. 2015)	Oman	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Armellino, Quinn Griffin et al. 2010)	Canada	Hosp-ICU	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Arnetz, Zhdanova et al. 2011)	USA	Nursing Homes	Func/struct	Survey	NHSOPSC	1 2	Micro	N	N
(Ausserhofer, Schubert et al. 2012)	Switzerland	Hosp	Func/struct	Survey	Safety Organizing Scale	1 2	Micro	N	N

(Azmal, Omranikho et al. 2014)	Iran	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Bahrami, Chalak et al. 2014)	Iran	Hosp	Func/struct	Survey	HSOPSC	1 2	Unclear	N	N
(Ballangrud, Hedelin et al. 2012)	Norway	Hosp-ICU	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Barbosa, Floriano et al. 2016)	Brazil	Hosp	Func/struct	Survey	SAQ	1 2	Micro	N	N
(Berland, Holm et al. 2012)	Norway	Home Care	Interpretive	Focus Groups	N/A	1 2	Micro	N	Y
(Bethune, Canter et al. 2012)	UK	Hosp	Func/struct	Survey	SCS	1	Micro	N	N
(Bonner, Castle et al. 2009)	USA	Nursing Homes	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Brborovic, Sklebar et al. 2014)	Croaitia	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Brown and Wolosin 2013)	USA	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Burström, Letterstål et al. 2014)	Sweden	Hosp- ED	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Carney, Mills et al. 2010)	USA	Hosp	Func/struct	Survey	SAQ	1 2	Micro	N	N
(Carvalho, Gottems et al. 2015)	Brazil	Hosp	Func/struct	Survey	SAQ	1 2	Micro	N	N
(Castle and Sonon 2006)	USA	Nursing Homes	Func/struct	Survey	HSOPSC	1 2	Macro	N	N

(Castle, Wagner et al. 2011)	USA	Nursing Homes	Func/struct	Survey	NHSOPSC	1 2	Both	N	N
(Castle, Wagner et al. 2011)	USA	Hosp & Nursing Homes	Func/struct	Survey	HSOPSC and NHSOPSC	1 2	Micro	N	N
(Chen and Li 2010)	China	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Currie and Richens 2009)	UK	Hosp	Interpretive	Focus Groups	N/A	1 2	Micro	N	Y
(da Silva, Barbosa et al. 2016)	Brazil	Hosp	Func/struct	Survey	SAQ	1	Micro	N	N
(Danielsson, Nilsen et al. 2014)	Sweden	Hosp	Interpretive	Interviews and Focus Groups	N/A	2 3	Micro	N	N
(Davoodi, Mohammadzadeh Shabestari et al. 2013)	Iran	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Doherty and Saunders 2013)	UK	Hosp	Interpretive	Interviews	N/A	3	Micro	Y	Y
(El-Jardali, Sheikh et al. 2014)	Saudi Arabia	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(El-Jardali, Dimassi et al. 2011)	Lebanon	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(El-Jardali, Jaafar et al. 2010)	Lebanon	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Erler, Edwards et al. 2013)	USA	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N

(Etchegaray and Thomas 2012)	USA	Hosp	Func/struct	Survey	HSOPSC and SAQ	1 2	Micro	N	N
(Fridell and Ekberg 2016)	Sweden	Hosp	Interpretive	Focus Groups and Interviews	N/A	2 3	Micro	N	N
(Fujita, Seto et al. 2013)	Japan, China, USA	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Ghobashi, El-Ragehy et al. 2014)	Kuwait	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Gimenes, Torrieri et al. 2016)	Brazil	Hosp- ICU	Interpretive	Participatory Action Photographic	N/A	1 2	Micro	N	N
(Ginsburg, Tregunno et al. 2014)	Canada	Home care, medicine, ambulatory, community, LT care	Func/struct	Survey	SCS	1	Unclear	N	N
(Gunes, Gurlek et al. 2016)	Turkey	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Hamdan and Saleem 2013)	Israel	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Handler, Castle et al. 2006)	USA	Nursing Homes	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Hartmann, Rosen et al. 2008)	USA	Hosp	Func/struct	Survey	PSCHO	1	Both	N	N

(Hartmann, Meterko et al. 2009)	USA	Hosp	Func/struct	Survey	PSCHO	1	Micro	N	N
(Hatam, Keshtkar et al. 2012)	Iran	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Haugen, Søfteland et al. 2010)	Norway & The Netherlands	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Hickner, Smith et al. 2016)	USA	Medical Offices	Func/struct	Survey	MOSOPS	1 2	Macro	N	N
(Hoffmann, Miessner et al. 2013)	Germany	Family Practices	Func/struct	Survey	SCS	1	Micro	N	N
(Holden, Watts et al. 2010)	USA	Ambulatory Care	Func/struct	Survey	SAQ	1 2	Micro	N	N
(Hook, Boan et al. 2016)	USA	Hosp	Func/struct	Survey	HSOPSC	1 2	Both	N	N
(Hughes, Chang et al. 2009)	USA	Hosp	Func/struct	Survey	SCS	1 2	Micro	N	N
(Ito, Seto et al. 2011)	Japan	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Kagan and Barnoy 2013)	Israel	Hosp	Func/struct	Survey	SCS	1 2	Micro	N	N
(Khater 2015)	Jordan	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Kristensen, Tugvustein et al. 2016)	Denmark	Hosp	Func/struct	Survey	SAQ	1 2	Both	N	N

(Kristensen, Sabroe et al. 2015)	Denmark	Hosp	Func/struct	Survey	SAQ	1 2	Both	N	N
(Kuosmanen, Tiihonen et al. 2013)	Finland	Hosp	Func/struct	Survey	HSOPSC	1 2	Both	N	N
(Lee, Phan et al. 2016)	USA	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Lee, Wung et al. 2010)	China	Hosp	Func/struct	Survey	SAQ	1 2	Micro	N	N
(Leong, Afrow et al. 2008)	USA	Dental Care	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Liu, Liu et al. 2014)	China	Hosp	Pragmatic	MMR Survey and Interviews	HSOPSC and Interviews	1 2	Micro	Y	N
(Livorsi, Knobloch et al. 2016)	USA	Hosp- ICU	Pragmatic	MMR Survey and Reflective Diary	HSOPSC and Interviews	1 2	Micro	N	N
(Louch, O'Hara et al. 2016)	UK	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Luiz, Simoes et al. 2015)	Brazil	Hosp	Func/struct	Survey	SAQ	1 2	Micro	N	N
(Marsteller, Wen et al. 2015)	USA	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Martowirono, Wagner et al. 2014)	The Netherlands	Hosp	Func/struct	Survey	SCS	1	Micro	N	N
(Minuzzi, Salum et al. 2016)	Brazil	Hosp- ICU	Func/struct	Survey	HSOPSC	1 2	Micro	N	N

(Mitchell 2012)	Canada	Home care, mental health, acute, community, LT care	Func/struct	Survey	Modified Stanford Instrument	1 2	Unclear	N	N
(Molloy 2012)	USA	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Nie, Mao et al. 2013)	China	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Ornelas, Pais et al. 2016)	Portugal	Hosp	Func/struct	Survey	MOSOPS	1 2	Micro	N	N
(Peterson, Rogers et al. 2016)	USA	Hosp	Func/struct	Survey	SCS	1	Both	N	N
(Profit, Lee et al. 2016)	USA	Hosp- ICU	Func/struct	Survey	SAQ and HSOPSC	1 2	Micro	N	N
(Pronovost, Weast et al. 2003)	USA	Hosp	Func/struct	Survey	SCS	1	Micro	N	N
(Quillivan, Burlison et al. 2016)	USA	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Raftopoulos and Pavlakis 2013)	Cyprus	Hosp- ICU	Func/struct	Survey	SAQ	1 2	Micro	N	N
(Raftopoulos, Savva et al. 2011)	Cyprus	Hosp	Func/struct	Survey	SAQ	1 2	Micro	N	N
(Rhodes, McDonald et al. 2016)	USA	Primary Care	Interpretive	Interviews	N/A	3	Micro	Y	Y
(Robida 2013)	Slovenia	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N

(Santiago and Turrini 2015)	Brazil	Hosp- ICU	Func/struct	Survey	HSOPSC and SAQ	1 2	Micro	N	N
(Schwendimann, Zimmermann et al. 2013)	Switzerland	Hosp	Func/struct	Survey	SAQ	1 2	Micro	N	N
(Silva-Batalha and Melleiro 2015)	Brazil	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Singer, Gaba et al. 2003)	USA	Hosp	Func/struct	Survey	Specifically designed	1	Both	N	N
(Singer, Meterko et al. 2007)	USA	Hosp	Func/struct	Survey	PSCHO	1	Both	N	N
(Singer, Lin et al. 2009)	USA	Hosp	Func/struct	Survey	PSCHO	1	Macro	N	N
(Smits, Wagner et al. 2009)	The Netherlands	Hosp	Func/struct	Survey	HSOPSC	1 2	Macro	N	N
(Speroff, Nwosu et al. 2010)	USA	Hosp	Func/struct	Survey	SAQ and SCS	1 2	Micro	N	N
(Tabrizchi and Sedaghat 2012)	Iran	Primary care	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Thomas-Hawkins and Flynn 2015)	USA	Hosp- Outpatients	Func/struct	Survey	SAQ	1 2	Micro	N	N
(Thomas, Hyer et al. 2012)	USA	Nursing Homes	Func/struct	Survey	NHSOPSC	1 2	Macro	N	N
(Tomazoni, Rocha et al. 2015)	Brazil	Hosp- ICU	Func/struct	Survey	HSOPSC	1 2	Micro	N	N

(Top and Tekingunduz 2015)	Turkey	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Turunen, Partanen et al. 2013)	Finland	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Ugurluoglu, Ugurluoglu et al. 2012)	Turkey	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Ulrich and Kear 2014)	USA	Hosp	Func/struct	Survey	HSOPSC and MOSOPS	1 2	Micro	N	N
(Van Noord, De bruijne et al. 2010)	The Netherlands	Hosp- ED	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Verbeek-Van Noord, Wagner et al. 2014)	The Netherlands	Hosp- ED	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Vifladt, Simonsen et al. 2016)	Norway	Hosp	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Vlayen, Hellings et al. 2012)	Belgium	Hosp	Func/struct	Survey	HSOPSC	1 2	Both	N	N
(Vlayen, Schrooten et al. 2015)	Belgium	Hosp	Func/struct	Survey	HSOPSC	1 2	Both	N	N
(Wagner, Capezuti et al. 2009)	USA and Canada	Nursing Homes	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Wagner, McDonald et al. 2012)	USA	Nursing Homes	Func/struct	Survey	NHSOPSC	1 2	Micro	N	N
(Wami, Demssie et al. 2016)	Ethiopia	Hosp	Func/struct	Survey	HSOPSC and Interviews	1 2	Micro	N	N

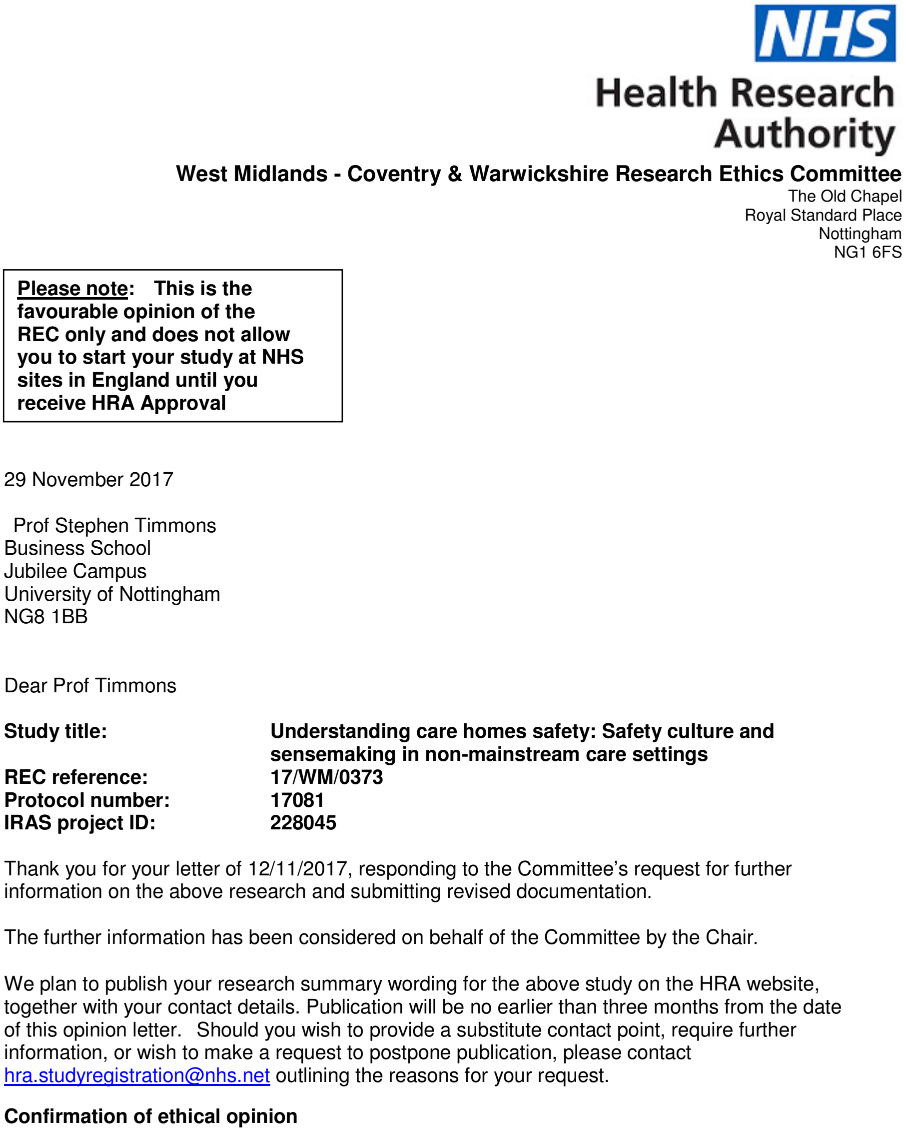
(Wang, Liu et al. 2014)	Brazil	Hosp- Operating Room	Pragmatic	MMR	SAQ	1 2	Micro	N	N
(Waterson, Griffiths et al. 2010)	UK	Hosp	Func/struct	Survey	HSOPSC	1 2	Both	N	N
(Webair, Al-Assani et al. 2015)	Yemen	Primary Care	Func/struct	Survey	MOSPOS	1 2	Both	N	N
(Yilmaz and Goris 2015)	Turkey	Hosp- ICU	Func/struct	Survey	HSOPSC	1 2	Micro	N	N
(Zakari 2011)	Saudi Arabia	Hosp	Func/struct	Survey	SAQ	1 2	Micro	N	N
(Zhou, Bundorf et al. 2015)	China	Hosp	Func/struct	Survey	PSCHO	1 2	Micro	N	N

APPENDIX 2- Update of scoping review

Reference	Country	Setting	Participants	Research Method	Measurement Tool	Level of Analysis	Focus
(Banaszak-Holl, Reichert et al. 2017)	USA	Nursing homes	Frontline staff	Survey	NHSOPSC	1 2	Culture Analysis
(Bondevik, Hofoss et al. 2017)	Norway	Nursing homes	Frontline staff & administration	Survey	SAQ	1 2	Culture analysis
(Desmedt, Petrovic et al. 2018)	Belgium	Nursing homes	Frontline staff & administration	Survey	NHSOPSC	1 2	Culture Analysis
(Herr, Raharimanana et al. 2017)	France	Nursing homes	Frontline staff	Survey	NHSOPSC	1	Psychometrics
(Kusmaul and Sahoo 2019)	USA	Nursing homes	Frontline staff	Survey	NHSOPSC	12	Culture Analysis
(Li, Cen et al. 2019)	USA	Nursing homes	Administration	Survey	NHSOPSC	12	Culture Analysis
(Lin, Tseng et al. 2017)	China	Nursing homes	Frontline staff & administration	Survey	NHSOPSC	1	Psychometrics
(Longo 2018)	USA	Nursing homes	Frontline staff & administration	Survey	NHSOPSC	12	Culture Analysis
(Marshall, Cruickshank et al. 2017)	UK	Nursing and Residential homes	Frontline staff & administration	Mixed methods	MaPSaF	12	Culture analysis and feasibility
(Ree and Wiig 2019)	Norway	Nursing homes	Frontline staff	Survey	NHSOPSC	12	Culture analysis

(Smith, Greene et al. 2018)	USA	Nursing homes	Frontline staff	Survey	NHSOPSC	12	Culture analysis
(Teigné, Mabileau et al. 2019)	France	Nursing homes	Frontline staff	Survey	NHSOPSC	1	Psychometrics
(Temkin-Greener, Cen et al. 2020)	USA	Nursing homes	Administration	Survey	NHSOPSC	12	Culture analysis
(Titlestad, Haugstvedt et al. 2018)	Norway	Nursing homes	Frontline staff	Survey	NHSOPSC	12	Culture analysis
(Vrotsou, Perez-Perez et al. 2020)	Spain	Nursing homes	Frontline staff & administration	Survey	NHSOPSC	1	Psychometrics
(Wagner, Brush et al. 2017)	USA	Nursing homes	Frontline staff	Survey	NHSOPSC	12	Culture analysis

APPENDIX 3- REC Approval letter



NHS
Health Research Authority
West Midlands - Coventry & Warwickshire Research Ethics Committee
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

29 November 2017

Prof Stephen Timmons
Business School
Jubilee Campus
University of Nottingham
NG8 1BB

Dear Prof Timmons

Study title:	**Understanding care homes safety: Safety culture and sensemaking in non-mainstream care settings**
REC reference:	**17/WM/0373**
Protocol number:	**17081**
IRAS project ID:	**228045**

Thank you for your letter of 12/11/2017, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of advertisement materials for research participants	Final V2.0	12 November 2017
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [INSURANCE]		22 September 2017
Interview schedules or topic guides for participants	FINAL 1.0	20 September 2017
IRAS Application Form [IRAS_Form_06102017]		06 October 2017
Letter from funder	FINAL 1.0	20 September 2017
Letter from sponsor [SPONSOR LETTER]		22 September 2017
Letters of invitation to participant	FINAL 1.0	20 September 2017
Other [supervisor cv]	FINAL 1.0	20 September 2017
Other [resident and relative poster]	FINAL 1.0	20 September 2017
Other [staff poster]	Final V2.0	12 November 2017
Other [resident and relative poster]	Final V2.0	12 November 2017
Participant consent form [CONSENT STAFF]	Final V2.0	12 November 2017
Participant consent form [CONSENT RESIDENTS]	Final V2.0	12 November 2017
Participant consent form [CONSENT RELATIVES]	Final V2.0	12 November 2017
Participant information sheet (PIS)	Final V2.0	12 November 2017
Participant information sheet (PIS) [PIS RESIDENTS]	Final V2.0	12 November 2017
Participant information sheet (PIS) [PIS STAFF]	Final V2.0	12 November 2017
Research protocol or project proposal [PROTOCOL]	Final V2.0	12 November 2017
Summary CV for Chief Investigator (CI)	FINAL 1.0	20 September 2017
Summary CV for student	FINAL 1.0	20 September 2017
Summary CV for supervisor (student research)	FINAL 1.0	20 September 2017

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at
http://www.hra.nhs.uk/hra-training/

17/WM/0373 **Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely

pp. T Jones

Dr Helen Brittain
Chair

Email:NRESCommittee.WestMidlands-CoventryandWarwick@nhs.net

Enclosures: "After ethical review – guidance for researchers" *[SL-AR2]*

Copy to: *Ms Angela Shone*

APPENDIX 4- Interview Topic Guide

Interview Topic Guide

(Final version 1.0: 20.09.17)

IRAS Project ID: 228045

Title of Study: Care Homes’ safety Culture

Introduction Questions

Staff:	Role
	Length of time working in care home
	Main responsibilities
Residents:	Length of time in care home
	Any previous experiences of care homes
Relatives/Friends:	Relationship to resident
	Length of time in care home

Overall experience

Staff:	Worked in a care home before?
	What aspects are most important in your role?
Residents:	Tell me of your experience in this care home?
	What part of your care is most important to you?
Relatives/Friends:	Tell me of your experience in this care home?
	What part of your relatives care do you feel is most important?

Safety and Quality

All:	What does good care look like?
	When we talk about safety in care homes, what comes to mind?
	What do you feel are the most important to maintain safety?
Residents and Relatives:	What can staff do to make you, (and your relative) feel safe?

Experiences

Staff:	Can you talk me through a time that you were involved in a safety situation?
Resident/ Relative:	Can you talk me through a time that you were made to feel safe or unsafe? (made to feel your loved one was safe or unsafe?

Safety Topics for Further Discussion

All:	Promoting choice for residents
	Communication
	Falls
	Pressure Ulcers
	Deteriorating residents
	Training and Development
	Responsibility for safety
	Safety Risks
	Vulnerability of residents