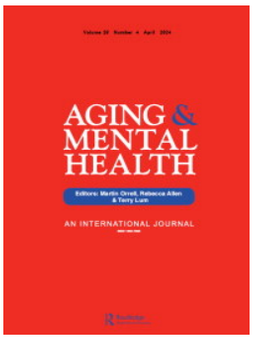

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Exploring the impact of care home environments and culture on supporting residents to 'wander' safely

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ABSTRACT

Objectives: Up to 60% of people with dementia living in care homes will 'wander' at some point, which has typically been seen by staff as a problematic behaviour. A range of non-pharmacological interventions have been tested to either support or prevent wandering. However, even recent innovative practice continues to maintain a focus on reducing or preventing wandering. This study aimed to identify, for the first time, care home staff perspectives on home level factors that facilitate or hinder them supporting residents to wander safely.

Method: Semi-structured qualitative interviews were conducted with 19 care home staff, working in the North of England. Framework analysis was used to analyse the data.

Results: A range of environmental considerations were identified by staff. Care home design influenced how residents were able to move safely around, and inclusion of points of interest encouraged walking to different locations, such as a garden. Staff worried about managing access to other residents' rooms by people who wander. Within the care home culture, prioritising safe staffing levels, training and awareness, involving external healthcare professionals where required and mentorship from experienced staff members, all contributed towards safe wandering. Staff support for positive risk-taking within the care home was key to promote person-centred care, alongside careful oversight and management of relationships between residents.

Conclusion: We identified a range of cultural and environmental factors that contribute towards safe wandering. A positive approach to risk-taking by staff is required to support residents to engage in wandering as an enjoyable activity, whilst acknowledging that there are inherent risks associated with this.

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Wandering; positive risk-taking; dementia; social care

Up to 60% of people with dementia living in care homes will 'wander' at some point (Jayasekara, 2009). While language use around this is complex and often contested, for the purpose of this paper, wandering refers to frequent and persistent walking amongst people with cognitive impairment (i.e. dementia), that care staff or relatives may find difficult to support (Graham, 2017). Wandering may occur because of cognitive changes, issues with orientation to space or time, or wayfinding issues (Algase, 2006). Labelling persistent walking as 'wandering' may also represent an attempt to medicalise lifelong habits of the individual, when seen in a care home setting (Adekoya & Guse, 2019; Algase, 2006).

Nonpharmacological interventions are recognised as the optimal approach for person-centred care when supporting residents who engage in behaviours that staff may find challenging to support in care homes (Meyer & O'Keefe, 2020; NICE, 2018; Scales et al., 2018). Wandering is sometimes labelled as one of these behaviours, and to date, research has broadly focused on preventing wandering. There are multiple risks associated with wandering, which include increased risk of falls, health impacts such as dehydration and negative interactions with other residents (Barrett et al., 2020). Interventions to prevent wandering have included pharmacological and physical restraints (Dewing, 2011; Robinson et al., 2007). Whilst some interventions have successfully reduced the amount of time spent wandering, this does not align with current ethical perspectives around preventing use of physical and pharmacological restraints in social care settings, due to concerns around their safety and impact on residents' health and quality of life (Neubauer et al., 2018). However, evidence has considered whether creating a supportive care environment can reduce the risks associated with wandering, without preventing wandering (Gu, 2015). This includes ensuring adequate staffing levels, to enable person-centred care delivery (van Buuren & Mohammadi, 2022). Alongside this, environmental factors need to be considered, such as having a clear path through the care home without too many decision-making points for choice of direction, and clear signposting around the care home (van Buuren & Mohammadi, 2022).

A range of non-pharmacological interventions have been tested to either support or prevent wandering. However, even recent innovative practice to support wandering continues to maintain a focus on reducing 'persistent walking' and 'spatial disorientation' (Varshawsky & Traynor, 2021), positioning wandering as a problem for care home staff to address and aim to prevent. There are limited evidence-based approaches to guide care home staff that could optimise staff time and input, minimise wandering-related distress, and reduce risks, which can pose ethical, legal, and moral challenges for care home staff (Griffiths et al., 2022; Liddell et al., 2021). There is broad

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agreement that a person-centred approach, involving healthcare providers, families, and residents should be taken, to allow a tailored approach that supports each person's individual needs (Robinson et al., 2007). However, there remains very little evidence of how to do this in practice.

One recent study conducted walking interviews with people with dementia living in care homes, and identified six main reasons why individuals walked. These were walking: (a) as enjoyable, (b) for health benefits, (c) as purposeful, (d) as a lifelong habit, (e) as socialisation, and (f) to be with animals (Adekoya & Guse, 2019). This echoes earlier findings that despite being perceived as problematic by care home staff, people with dementia find wandering an enjoyable activity (Robinson et al., 2007). Together, this research suggests that the views of those who are deemed to wander contrast with more widely held views of wandering as problematic and challenging in care homes by staff and families. The research also raises concerns around the definition of wandering as aimless, or purposeless, as this does not seem to reflect the experiences of those who engage in wandering (Adekoya & Guse, 2019). There is a clear need to develop an evidence base to support staff to better support residents to wander safely, rather than preventing this (Backhouse et al., 2018).

This study aimed to explore the perspectives of frontline staff working in care homes, on how to *support* care home residents who wander to do this safely. Specifically, within this paper, we aimed to explore care home staff perspectives on care-home level factors that facilitate or hinder them supporting residents to wander safely.

Method

Design

A qualitative, exploratory study was conducted, consisting of individual semi-structured interviews analysed using framework analysis (Ritchie & Spencer, 2002).

Participants and sampling

Participants were recruited from care homes from a range of care provider organisations across North England *via* professional networks (e.g. local Clinical Research Network, regional Care Homes Support Network), social media, and snowballing techniques. Posters were shared, and participants were invited to contact the research team if they were interested in participating. Purposive sampling (Palinkas et al., 2015) was used to recruit participants working in a range of roles, with varied demographics. A sampling matrix was created to reflect on the sample recruited and to prioritise obtaining a range of perspectives; focusing on ethnicity, gender and job role.

Procedure

Semi-structured interviews were conducted with 19 care home staff, either in person within the care home or *via* video conferencing, dependent on participant preference. A topic guide informed by existing literature was developed by the research team, to explore staff experinces of people wandering in care homes, and barriers and facilitators to supporting wandering. Interviews were conducted between September 2022 and March 2023. Interviews lasted up to one hour and were transcribed verbatim and anonymised. Audio recordings and transcripts were regularly reviewed by YM-O'C to make sense of the data and refine the topic guide. Participants received a £20 voucher to acknowledge their time and contribution.

Data analysis

Framework analysis (Ritchie & Spencer, 2002) was used. This is a form of thematic analysis, which involves identifying, analysing, and reporting patterns in qualitative data (Braun & Clarke, 2006). This method was selected as it allows both a-priori issues and emergent data driven themes to guide development of the analytic framework. The five steps of framework analysis were followed (Ritchie & Spencer, 2002). Firstly, researchers familiarised themselves with the dataset. Four researchers (AWG, MGC, IC, YM-O'C) then conducted line by line coding of two transcripts, after which the research team discussed and developed the initial themes and categories to develop the framework. The same researchers independently coded each remaining transcript and systematically applied the data to the framework, before charting the data. Finally, key characteristics of the data were pulled together to map and interpret the data set as a whole, through discussion. Development and refinement of the coding framework continued throughout data analysis, to develop the narrative and select indicative quotes (Braun & Clarke, 2006). Consensus between researchers was achieved through discussion when placing quotes within the framework.

Reflexivity

The influence of the researchers was explored *via* regular discussions, considering the positionality of each team member. This included acknowledging our practice and research backgrounds in dementia care, which align with a person-centred approach where wandering should be supported as a form of positive risk taking, and a belief that wandering should not be prevented. Several members of the research team also have, or had, a relative living in a care home. Conscious attempts were made to recognise biases throughout data collection and analysis, including reflections on how to include perspectives that conflicted with the research team's positionality.

Ethical issues

Ethical approval was obtained from University of Liverpool (reference 11504) prior to data collection. Participants provided written informed consent and were offered the opportunity to review their transcript before analysis. Participants were made aware of the potential for distress when discussing issues around supporting safe wandering, and were able to pause or end the interview if at any point they found participation upsetting.

Results

A total of 19 participants were recruited (see Table 1 for an overview of participant demographics). Overall, four themes were identified, each with sub-themes. This paper presents data for two themes that encapsulate issues related the importance of care home environment and culture (see Table 2). For discussion of individual and relational factors, please see (Griffiths et al., unpublished).

Table 1. Participant demographics.

Characteristics	n
Age	
20–34	5
35–49	9
50–64	5
Gender	
Female	16
Male	3
Job Role	
Manager/Deputy Manager	10
Care Staff	5
Activities Coordinator	1
Registered Nurse	3
Geographical Location	
Leeds	11
Manchester	1
Liverpool	4
Norwich	1
York	2

Table 2. Summary of main and sub-themes.

Main theme	Sub-themes
The importance of environmental considerations in care homes	Influence of care home design on how residents were able to move safely around Inclusion of points of interest to encourage walking to different locations The impact of having access to a garden or other locations Staff worried about managing access to other residents' rooms
How care home culture can influence safe wandering	Ensure safe staffing levels so residents are supportedProvide appropriate training and ensuring staff have awareness of how to support residents Provide mentorship from experienced staff Support positive risk taking within the care home Manage relationships between residents to ensure everyone feels safeInvolvement of external healthcare professionals where relevant

1. Environmental considerations in care homes

Many aspects of care home environments influence care home staff's likelihood of, and perceived safety of, supporting wandering. These include modifiable elements, such as decor or presence of points of interest, and non-modifiable elements, such as corridor layout.

Influence of care home design

Participants highlighted ways that care home and corridor design can support wandering. Access to multiple lounges, connected by well-lit wide corridors, was seen as the optimal layout.

'We don't really restrict it. That's why in our home, the corridors are big, because we know that people may wander. At least they have that freedom to do so.' (ID16)

Discrepancies were noted between new, purpose designed care homes and older buildings. The former was seen as *'an ideal world'* as at the point of design, prioritising safe wandering. For those working in care homes where corridors did not support wandering, this was a logistical challenge that could not be easily overcome.

'A nursing home is built and structured in a certain way. You can't knock three or four walls through to allow one person to wander.' (ID18)

Participants reflected on ways they had increased the contrast in colours in corridors (e.g. differentiating walls and hand rails), and ensured they were well-lit. The homeliness of the corridors was considered to be important, with corridors seen as *'warm and welcoming'* perceived to better support wandering.

'[It's easier to support wandering] with the decoration and dementia-friendly décor definitely, when I came [the corridor] was quite a bit darker, we introduced pastel colours everywhere and contrasts.' (ID02)

However, for residents who wish to leave the care home, the environment could be used to prevent someone leaving. This included examples of doors and lifts being disguised, either by using the same colour paint as the walls, or by using decals (large wall coverings) such as bookcases, to make exits less obvious. Concerns were also raised about residents wandering into *'areas where they're not looked after or protected'* such as the laundry or kitchen. Participants prioritised safety of residents when discussing where they could potentially wander.

'It's very open plan but again, one of the things we've got to make sure of is, if they wander, places like the kitchen, that's obviously somewhere we'd always divert them away from. Because even though nothing's left out that could harm them, it could still be potentially dangerous if they went in to drawers' (ID06)

However, in some care homes, restricting access to certain areas meant that residents were able to have more freedom in other areas. This was perceived as encouraging residents to have autonomy over their location and activities.

'On the dementia floor we don't have a microwave. A pin number on the boiler so you can't get hot water, you know, all things like that. So, they go in the fridge don't they? Help themselves to biscuits, they go in the cupboards. They're in the sink washing up…' (ID10)

Participants reflected on the need to regularly check the environment for safety. Important aspects to check included light bulbs, identifying any shadows from large furniture that could *'deter movement'* if someone thought the shadows were a hole, and the presence of hazards in corridors.

'Checking to make sure the carpet is okay, you know, trip hazards and things like that. Good lighting, good rails.' (ID11)

However, staff acknowledged ways in which the environment contributed to concerns about safety. They reflected on the impact of these safety concerns for residents, which affected decision-making around the safety of wandering.

'The new extension was built with concrete flooring and then laminate on the top. So, when people fall on there, if they fall and bash their heads then they usually end up with a fairly significant bruise, bump, black eye, whatever.' (ID03)

Despite these concerns, the delicate balance between safety and happiness was considered, with reflections on this being a continuum, requiring attention from staff and confidence in their decision-making.

'I believe that it is a safe place for people to wander. I don't believe necessarily it is pleasant. It's not totally free to wander.' (ID18)

Signage was used to help support way finding and reduce confusion. This promoted movement around the home by encouraging residents to help with daily routines.

"We use appropriate signage. 'Dining room this way.' We're looking at putting little stop signs, so, 'Please help us by watering this plant.'" (ID01)

Inclusion of points of interest

Participants ensured that points of interest were included in areas where residents commonly wandered. These were seen

as a way of drawing people in to certain areas and included artwork, reminiscence boards, and post boxes.

'If you're walking, there are reminiscence boards that would attract attention. There is a board about the NHS. There is a board about the Royal Family, about coal mining, things that would catch their interest. It's having them so that it's purposeful and not just walking up and down.' (ID12)

Such points provided purpose or stimulated someone's mind, which was perceived as important. Participants saw points of interest as trigger material for starting conversations. One participant had shared information about the care home on social media and asked people who lived locally to send postcards, which were displayed in the corridor.

'So, now we have a massive map with lots of postcards with little messages. So that's working, a one to one conversation [with a resident] without feeling you need to have a subject to talk about.' (ID07)

The importance of sensory points of interest was acknowledged. This included fake grass, interactive displays, and items that could be picked up and moved around the care home. However, challenges with this approach were also acknowledged. Where it was unclear that a mural was not real, this could lead to increased confusion for residents.

'The bakery mural that we've got on the wall, I really think we need to get something there that [residents] grab, like put a little shelf with some buns or something. I mean, they might be plastic buns, just because I have witnessed a couple of residents look like they're standing, just waiting for bread.' (ID08)

Strategies were put in place that utilised existing space differently, either adding or removing furniture from specific areas. Participants reflected on increased tiredness and decreased muscle strength amongst residents, and how these interact with the environment.

'We've got pretty long corridors in some areas. We're investing in some chairs and a little seating area because as you get older, your limbs aren't as strong, and you get a wee bit tired. So, we're hoping to implement some little rest stops.' (ID01)

A person-centred approach when changing the environment, to increase engagement, was prioritised. Personalised items could help people identify their own room and see that as a destination for their walk.

'We have memory boxes outside people's doors. So, we've been working to make them more person centred to the person whose door it is.' (ID10)

Providing access to a garden or other locations

The importance of ensuring access to a garden was clear. Enjoying time in the garden, often with a staff member, was seen to reduce distress for residents.

'One of the residents likes to go for a walk in the gardens, and so it's a nice way that they're not just wandering around the household … if it's a nice day, you can take them round the gardens. And it's very stimulating for them.' (ID06)

In some settings, a small garden space was a barrier, as residents were unable to move freely. Participants suggested that seating could encourage people to spend time in the garden in small groups.

'We're quite lucky that we've got a lovely secure garden. But it's not very big. So, once they've walked up and down, it's the same thing over and over again.' (ID03)

Managing access to other residents' rooms

Concerns were raised about residents wandering into other residents' rooms, particularly when either or both individuals had dementia. Implementing strategies such as personalised items around people's doors, or having different coloured doors, helped to reduce confusion.

'I have one [resident] that always gets lost, that's why they wander. He thinks that all the bedrooms are his room because the layout of the building, corridor wise, the door colour, layout, and shape is the same. He just sees the same door, It's my room.' (ID16)

Residents wandering into other resident's rooms could be distressing to the person whose room it was, which was seen by staff as an understandable reaction to an '*invasion of privacy*'. Participants discouraged residents from going into rooms if they were walking together, by raising awareness of the room belonging to someone else or stating that it is *'a bit boring in there'*, as a distraction technique.

'I know a few of the residents have got quite visibly upset by it or quite anxious by someone being in their room, which anyone would.' (ID05)

The issue of someone wandering into someone else's room at night was highlighted, with consideration of how this could be frightening. This was particularly concerning for residents who may struggle to get out of bed, who had additional vulnerability in this situation. Participants felt responsibility for ensuring the safety of all residents.

'One issue I came across when I did nights, is that residents who wander up and down corridors can go in people's rooms when they're asleep which can be frightening.' (ID18)

In one care home, gates were placed across doorways into resident rooms to restrict access, to encourage those who wished to wander, without impacting on privacy and safety of those who preferred to stay in their room.

'We introduced the gates and said, 'Would you like a gate? We'll just put it across your door. You can come and go as you like, but it will stop this gentleman that's a bit more advanced with his dementia coming into your room.' (ID15)

Whereas in another care home, no strategy was in place to restrict access, which meant that all rooms were accessible to residents.

'There's no strategy. It's just let them be free. If they go into somebody else's room and they take something, 'Can I just have a look at that, please? Can I just pop it back in there? Do you want to come and see what's in your room?' 'Oh, this is not my room?' 'No, it's not your room. Let's go down here.' (ID09)

In summary, this theme highlighted the importance of care home design from initial building design to smaller ongoing decorative changes that were responsive to individual resident needs and personalised, to help encourage familiarity. Where possible, access to a garden was offered, to provide a change of scenery for residents. Concerns were raised about safety, especially where a clear path to wander was not available, and how to maintain privacy and safety when residents wandered into other residents' bedrooms.

2. How care home culture can influence safe wandering

Alongside the environment, the care home culture can also influence care staff's likelihood of, and their perceptions of the safety of, supporting wandering. This includes understanding of and willingness to support residents, management of relationships between different residents, and whether positive risk taking is encouraged.

Ensuring safe staffing levels so residents are supported

Participants highlighted the importance of staff presence to support residents. Management understanding this and adapting staff levels was integral to supporting safe wandering.

'It's okay when there isn't so much pressure and you are well staffed. But when a resident begins to walk and you are working under a lot of pressure, you are attending to so many things, it means one person has to stop what they are doing and go with the one who you know is at high risk of falling and just be with them because you can't stop them.' (ID13)

Balancing the needs of individual residents with providing equitable care across all residents was challenging. One care home was described as '*overstaffed*', which allowed them to provide more personalised support. However, in other care homes, staffing levels did not allow wandering to always be supported, and decisions were made on who could be supported.

'If you take one person out… I can't take him out every single day because I don't have the staff to do that. And it would not be fair on the other 59 residents.' (ID03)

Where residents may try to leave the care home, this was seen as frustrating, requiring attention that staff would prefer to focus elsewhere.

'If somebody is continually hanging by the door and you're letting people come in and out, nurses and doctors… it can be very tiring and draining to have somebody you have continually got to keep an eye on.' (ID04)

In one case, encouraging or supporting wandering was perceived as a *'lazy tactic'* as it may be easier to let people wander around the care home without a staff member rather than to implement person-centred strategies to support their well-being.

'It can be a lazy tactic as well on behalf of staff, it's easier to let people wander than be trying different things with them.' (ID18)

Where staffing levels allowed, participants took the opportunity to walk with the residents, which was perceived to increase safety.

'If they're walking about, we will say, 'Why don't we go for a walk outside together?' and then they're wandering but they're safe, they're with someone, and they're not coming into any harm.' (ID05)

For some, those who wander were seen as being unsettled and requiring attention to be supported to sit, rather than continue wandering. Participants reflected on the need to be pragmatic in responding to each individual, and safety was often highlighted as the reason for preventing wandering.

'Sometimes we do find it quite challenging when residents… you'll get them settled and sat down and then two minutes later they'll be back up wandering. Sometimes it can be really challenging to try and get them focused on something else for their safety.' (ID05)

The importance of knowing residents well allowed participants to better support wandering through the delivery of person-centred care. However, they acknowledged frustrations for residents who do not communicate verbally, or where other issues arose within the care home.

'Most people, I'd like to think they're very supportive and their main motivation is to support all the residents and do as much individual care with all of them as they can. I think sometimes just, naturally, it can be a bit frustrating, because, if you're short staffed, it can be difficult. If someone say, there has been the odd occasion that if someone has maybe fallen and then, you've got to have extra support for that person.' (ID06)

Staff are required to bring together multiple perspectives, drawing on their knowledge of the resident, and their interpretation of why someone might be wandering, to formulate a response. The high skill level required to provide person-centred care was acknowledged.

'It's that skill of knowing your resident and the interpretation, knowing the life history, and putting all those things together. It takes very skilful staff members to be able to understand and then implement a response to it, and know when to intervene and when not to intervene.' (ID15)

Providing appropriate training and ensuring staff have awareness of how to support residents

Broadly, a lack of training about supporting safe wandering was identified, with training focused on safeguarding and falls prevention. Participants reflected on the need to educate new staff, as due to poor understanding, they may try to prevent someone from wandering. However, some saw this as *'common sense'*, that should not require training.

'To be quite honest, I've never had any actual training on why people wander. I personally think that if we had more individual training on people's needs, and you found out more about maybe the reasons they wander, that would help a lot.' (ID06)

Training was crucial to developing theoretical knowledge and understanding of why someone would wander, and providing an opportunity to reflect on care home policies and procedures. Participants felt that training should be balanced with on-the-job learning.

'The classroom-based stuff gives you a better understanding of what to look out for. But to me, it's the on-hand experience, actually being in that moment, spending time with all your residents and knowing when something's changed. And that's very hard to teach. I'd say the classroom stuff gives you that opportunity to step back sometimes and not make a judgement and think about and try and interpret and giving you the confidence to get it wrong.' (ID15)

In one care home, training focused on understanding why someone was wandering and what their perception of the situation might be.

'The training was all about their moods, 'Why are they walking with a purpose?' and how we interact. So if somebody says, 'I'm off to the shops,' 'Oh, okay, then. What are you off for?' is the question. If they say to you, 'Do you want anything?' just say, 'Oh, pick us up a loaf of bread. So make it like as if they're achieving something for you as well as them.' (ID08)

Participants also reflected on perceptions of wandering have changed over time. They acknowledged that staff *'want to do the right thing'* but may not know what this is.

'It was always about making sure someone was safe, or distraction, or stopping someone doing that, which I think it feels like the theory has changed a bit on that.' (ID15)

Participants acknowledged the complex skills required to know residents well and understand and interpret their behaviour. They reflected on how they learn from shared experiences within the staff team.

'It's that skill of knowing your resident and the interpretation, knowing the life history, and putting all those things together. It takes very skilful staff members to be able to understand and then implement a response to it, and know when to intervene and when not to intervene.' (ID15)

The importance of prioritising tasks and making the most of each staff member's unique skills was acknowledged. Delivering person-centred care was summarised as ensuring that each resident is always treated with *'respect and dignity'*.

'In my opinion, if you're dishing out the sandwiches for lunch and someone is there, the sandwiches can wait, that person can't. That is ultimately my job. My job isn't to hand sandwiches out. My job is a carer. That's ultimately to care. I don't get specialist training in handing butties out. I do get specialist training in how to deal with challenging behaviour.' (ID18)

Some participants shared a desire to learn more and sought further training which was not available currently. They shared uncertainties about optimal care practices.

'I want to know how to support the residents who wander. I want to know if distracting them from wandering sometimes, is it beneficial or it will just confuse them more?' (ID16)

Providing mentorship from experienced staff

Experienced staff supported more junior staff to ensure that person-centred care was delivered and to challenge assumptions around the need to prevent wandering. This frequently operated *via* a buddy or mentor system, involving shadowing an experienced staff member.

'If the staff who know the people tell the agency and the new staff, Don't tell them to sit down, it is okay, let her, she won't fall, she walks.' (ID02)

Those in leadership roles saw their role as supporting staff to feel empowered to make decisions about supporting safe wandering.

"I think, for me, it's all about empowerment and giving staff confidence. If you give them confidence, they will then go, 'I would like to do this for this person. Is it okay?' And it's, like, yes, absolutely it is." (ID03)

Allowing staff to have the freedom to identify optimal ways to support wandering was encouraged. This allowed those individuals who knew residents well to advise management, and this learning could be shared across care homes within the organisation '*to improve the practice across all our homes'*.

'We've got 100% faith in the team and we respect their experience. So, as long as they just keep us in the loop because half the time I'm just interested in where they're going next, so we can support them as best we can.' (ID15)

Supporting positive risk taking within the care home

Care home managers had a crucial role in determining the culture and attitudes towards wandering within the care home. Implementation of care home-wide strategies supported staff to feel safe to make decisions about wandering.

'I think there's too much, 'Sit down, sit down. You need to sit down.' And as a home manager, it's something that I'm passionate about, that we don't do that.' (ID01)

Preventing individuals from wandering was seen as restrictive practice, especially where medication such as sedatives may be used.

'We support individuals to get around and to mobilise and to use what they've got. Because ultimately, if you're not doing it and you're not actively engaging, you're taking their independence away and it's not what we advocate.' (ID01)

In some care homes, preventing wandering was not even considered as a possibility.

'It wouldn't even cross my mind to stop anyone from wandering. Only if they looked like they were going to hurt themselves, I'd stop. But no… I suppose it's striking that balance. I'd never want them to stop walking around, in fact, I'd encourage them to walk. I want residents to walk around. I want to see them mobile.' (ID17)

Participants balanced the health and safety of residents with providing a person-centred approach. This included learning from incidents such as falls, but not being too restrictive. They weighed up the benefits and risks of supporting someone to walk. However, the impact of falls was acknowledged (i.e. should someone be unable to walk following a fall).

'In an ideal world they should be able to go where they want to go, it's just we're charged with keeping them safe so you've got to balance the risks of them hurting themselves with their right to do what they want to do.' (ID04)

Staff thought about the benefits of walking for both physical and mental health, considering the impact of wandering on muscle strength and balance and seeing this as *'a good form of exercise'*.

'It's about positive risk-taking as well because he'll often fall. But if we stopped him doing that activity, I think it would be detrimental to his well-being, and his mental health, because he does seem to get a lot out of it.' (ID15)

The onus was placed on staff members to sit with feelings of uncertainty and nervousness about resident falls, rather than preventing this to reduce their own concerns.

'It's about allowing carers to feel nervous about it and know that she's wandering but allow her to do that because actually that makes her feel better. And you can't stop her. What you've got to do is do the best you can to minimise the risks' (ID03)

Managing relationships between residents to ensure everyone feels safe

The importance of managing relationships between different residents was acknowledged.

'Some residents like communicating with friends or walk around holding hands, they're quite tactile, and you anticipate that there's not going to be any issues. But equally, you need to afford oversight when residents are mingling and communicating.' (ID01)

However, relationships between residents may change over time and this needed careful and responsive support.

'*We update where we're at with all the different residents, and how they've interacted, and if there has been an issue. Maybe there has been a little bit of conflict, and it's making sure that you know how to deal with that and make sure those residents are then feeling more secure and relaxed than they were.' (ID06)*

Staff felt responsible for knowing the personalities of residents and supporting them to build relationships with others.

'Knowing where there's a clash of personalities, where people don't necessarily get on, you can make informed decisions as a management team to bring people in together that are going to get on well, and you anticipate they're going to have a really good relationship.' (ID01)

Participants felt tension between management, residents and their families, when trying to support wandering without causing upset to anyone else.

'*We had one resident who had this thing about going in rooms and taking objects. It would always be things of sentimental or practical value. Things like people's glasses. He'd build a collection.' (ID18)*

Involvement of external healthcare professionals

In situations where staff did not feel able to support a resident, external support was appreciated. This may include the General Practitioner (GP), who could prescribe medication to support someone to sleep at night, reducing confusion during the day, or a physiotherapist assessment to check someone was mobilising safely.

'We do the best we can. Then when we can't do any more, that's when we bring in other parties and to do further assessments. You do have to get approval and you do have to seek advice because no one knows best in those situations.' (ID18)

Where concerns were raised about the frequency of falls, referrals were made. Families were integral to these conversations, to ensure that appropriate plans were implemented.

'I think if someone is having regular falls, a GP review to make sure that everything physical is okay, get the GP to liaise with the family as well and involve them in all decisions and all conversations that are happening.' (ID15)

The support of external healthcare professionals was seen as beneficial for residents, to support them to continue to wander.

'As long as you access appropriate support, OTs, physiotherapists, GPs… you can do it in a really lovely way that's really beneficial for people. Don't just let people exist. It's so important that they have enrichment in their lives.' (ID01)

In summary, this theme highlighted the importance of culture on staff willingness to support wandering, including staff knowledge and delivery of person-centred care, and attitudes towards positive risk taking. This allowed staff to support resident relationships and friendships, but avoid potential conflicts or clashes around spaces or possessions. Participants sought additional training to support safe wandering, but were confident in seeking support from external healthcare professionals where they experienced uncertainties.

Discussion

This study aimed to explore attitudes towards wandering in care homes. Whilst wandering in care homes is commonplace, there is currently very little evidence for how staff can support residents to wander safely. This paper reports on two overarching themes; the importance of environmental considerations in care homes and how care home culture can influence safe wandering.

Participants reported a range of environmental considerations that could support safe wandering. In line with existing evidence, having a clear path for walking through the care home without too many decision-making points reduced confusion and burden of choice for residents (van Buuren & Mohammadi, 2022). Clear, dementia-friendly signage ensured that destinations were clear to residents, and reduced the likelihood of someone getting lost (van Buuren & Mohammadi, 2022). Low-cost strategies that can be easily implemented are likely to be well received by care home staff and management and provide a quick way to support safe wandering for residents.

The culture of a care home is known to impact the experience of those living and working there and influence the quality of care delivered (Killett et al., 2016). Having a culture with shared beliefs that wandering should be supported, aligned with behaviours that support engagement, within an environemnt designed to benefit residents, is likely to lead to best practice (Killett et al., 2016). However, there is currently limited evidence for what best practice consistitutes, or what this might look like. A culture that embeds a positive approach to risk-taking is necessary to promote wandering as demonstrated in a range of settings, including retirement housing and extra care facilities (Barrett et al., 2020). Therefore, our findings build on evidence to demonstrate that the underlying principles of positive risk-taking can also be applied within care home settings, for the delivery of person-centred care and individualised strategies that support individuals with dementia. Management acknowledging staff anxiety or concern about the risks of wandering, whilst encouraging them to sit with these feelings, could increase acceptance of wandering within care homes. Whilst there are physical elements of the environment that cannot be changed, creating a supportive culture can reduce the risks associated with wandering (Gu, 2015), for example through increased recognition of wandering related benefits and staff confidence. We suggest that strategies and interventions focused on developing positive beliefs and attitudes, and staff confidence in delivering person-centred care to support wandering, should take the current workforce challenges into account, i.e. staff shortages and high levels of staff turnover.

This was consistently reflected on by participants in the present study, who differentiated between their ability to better support wandering when they were sufficiently staffed, compared to short staffed. For example, to consider the high levels of turnover, any solutions and strategies developed should be part of staff handovers/inductions. Discussing solutions or strategies within staff handover would help to ensure consistency and continuity in approaches used across day and night shifts, amongst staff members who may have more or less familiarity with residents.

Strengths and limitations

Although our topic guide and aims focused on strategies to support wandering, some participants discussed situations in which they would not support wandering, usually due to safety concerns. This offers an important reflection on current perceptions of wandering within care homes, in terms of helping understand how to support residents, relatives and staff, and therefore was incorporated into our analysis. This represents the dominant narrative within existing literature, where the focus is on implementing strategies to prevent wandering (Neubauer et al., 2018). Within interviews, we did not specifically ask participants to reflect on the impact of dementia on wandering, although this was frequently discussed. Therefore, our results are applicable to health and social care settings that support individuals with cognitive or communication difficulties more broadly, and not only to settings where people with dementia are present.Our study has several limitations. Participants self-selected for interviews, and therefore may have had particularly strong opinions on wandering in care homes, which may not be representative. Over half of our participants were Managers or Deputy Managers, who are less likely to be regularly supporting residents to wander in care homes, and therefore staff working in those care homes may not enact the same person-centred care practices mentioned by participants here. Participants were recruited from care homes who were willing to engage with research, who have time and budget to prioritise research and implementation of findings, which is unlikely to be representative of the broader social care sector. Additionally, our sample only included staff members, and did not include the persectives of resident or relatives, who may converge and diverge with staff, and also may change over time.

Future research should ensure that the perspectives of these populations are incorporated. Additionally, wandering in care homes should be examined using methods such as ethnography, to see how staff, residents and relatives support safe wandering in daily practice together. All participants in the present study work in care homes for older adults in the United Kingdom. Policies and attitudes towards wandering vary in different countries. Future research should consider the impact of geographical location and culture on willingness and ableness to support safe wandering.

Clinical Implications

Within this study, participants highlighted the importance of high quality training, supplemented with mentorship and shadowing of experienced staff members, to effectively support residents. This is in line with evidence that training alone is insufficient for behaviour change amongst care home staff, and should be supplemented by peer support, supervision or mentorship (Fossey et al., 2019). Therefore, organisations should ensure that policies are in place to allow staff to shadow others when supporting residents to wander, to model best practice. This should be placed alongside work with residents and their families to gain an understanding of how walking and wandering has existed within their life history and ensure agreement around positive risk-taking procedures to support safe wandering (Adekoya & Guse, 2019; Barrett et al., 2020). Staff must be equipped with the knowledge, skills and guidance required to balance resident preferences and safety, across care homes (Backhouse et al., 2018). Creating a supportive care environment can reduce the risks associated with wandering, without requiring residents to stop wandering. People with dementia may unintentionally cause challenges to staff, leading to tensions between keeping residents safe from harm and supporting their freedom and autonomy (Backhouse et al., 2018). A proactive approach involving routine implementation of individualised non-pharmacological interventions could help reduce the risks associated with wandering (Backhouse et al., 2018). Ongoing assessment and review may be required to ensure that person-centred strategies are implemented for each resident (Barrett et al., 2020). The design and use of the environment can also empower people with dementia to walk and wander safely (van Buuren & Mohammadi, 2022). Providing visual cues and clear access between rooms where residents enjoy spending their time promotes better wayfinding, supporting individuals to navigate safely to their chosen destination (Marquardt et al., 2014; van Buuren & Mohammadi, 2022).

Wandering is currently conceptualised as a 'problematic behaviour' (Cipriani et al., 2014), which requires reconsideration. When residents themselves are asked about their reasons for wandering, a range of positive reflections were obtained, highlighting the enjoyment and purpose associated with this activity (Adekoya & Guse, 2019). Whilst the risks of wandering, such as falls, injury and altercations between residents, persist, these should not overshadow the benefits. A care home culture that supports positive risk taking with regards to wandering will allow residents the opportunity to wander safely, supported by staff where required.

Conclusion

In conclusion, our study identified a range of strategies that can help care staff to support residents who wander. We identified culture and environmental related factors that contribute towards safe wandering. A positive approach to risk-taking is required to support residents to engage in wandering as part of everyday life, whilst acknowing that there are inherent risks associated with this. Future research should consider the specific conditions required for the strategies to work well, and use ethnographic approaches to explore how safe wandering is supported in daily care home practice.

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