

**A critical evaluation of the implementation
process of a person-centred model of care in a
new dementia specific care home.**

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For the degree of Doctor of Philosophy

May 2018

Dedications

For Mariela.

Abstract

A critical evaluation of the implementation process of a person-centred model of care in a new dementia specific care home.

This thesis addresses the challenges associated with the implementation of models of person-centred care in newly operational care homes in an English context. This study critically evaluates a model of care produced in house, with academic support named in this thesis as *EMBRACELIFE*. The implementation of person-centred care in newly opened care settings is yet to be explored.

Data collection took place between September and November 2015. An ethnographic approach was taken to fieldwork. Semi-structured interviews and/or unstructured observations were conducted with 20 care workers and 10 people with dementia. Document analysis was also undertaken on 6 personal care plans. A letter from the care provider completed the data set. A thematic approach to data collection was undertaken, informed by principles of discourse analysis.

The finding revealed a culture of care organised around task. Overarching themes indicative of task-based practice were the care planning, activity, outdoor space, care worker perceptions, the mealtime experience, leadership and a lack of choice. The model of care was therefore not fully implemented. The research indicated the implementation process was hindered by organisational issues. These were inadequate staff training, unmet staff expectations, low staff satisfaction, a lack of a team ethos, a high agency staff presence, a lack of flexible care delivery. The newly operational status of the home had a uniquely mediating influence on these findings due to the challenge of assembling a new staff team, having a domino effect on the organisational issues described.

This thesis concludes by suggesting care providers are in need of more support if they are to overcome organisational barriers, accentuated by the challenges of opening a new care home, to achieve person-centred cultures of care in such settings.

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Acknowledgements

Thanks to everyone who has given me words of encouragement throughout my studies and supported me during this time. I'd like to thank my girlfriend Paula in particular, who has always been there for me during this process.

Thank you to the funders of this study, the participants of the research, and everyone at 'Somerset House', who welcomed me into their home, or place of work with such warmth.

Thank you to my supervisors Anthea Innes, Alison Bowes and Samuel Nyman, who have never wavered in their commitment, and whose advice has been invaluable.

Chapter 1: Introduction to thesis

This thesis documents the findings from a multi method ethnographic qualitative research study exploring the implementation process of a model of dementia care, coined *EMBRACELIFE*, based on person-centred care principles.

EMBRACELIFE was developed by the care provider who part-funded this PhD study, with the support from academics working at a university in the south of England. To protect the true identity of this provider they will be referred to as 'Hollyfield'. *EMBRACELIFE* is also a pseudonym for the name of the model produced. The rationale for the development of *EMBRACELIFE* was to promote and foster a person-centred organisational culture, that it was proposed, would underpin the care provided across Hollyfield's services.

This aim of this thesis is to evaluate the implementation of *EMBRACELIFE* within Hollyfield's new build dementia specific care home. For the purposes of this thesis the care home will be referred to as 'Somerset House'. The findings within this thesis aim to address two key gaps in the dementia care research literature. First, the process of implementing person-centred models of care and second, the documentation of the challenges posed when opening and operating a brand new dementia specific care home. The findings of this thesis will, to the best of my knowledge, serve as the first practice example of the process of opening and operating a new dementia specific care home, in England, with the strategic intention to implement a person-centred culture of care simultaneously.

There is a clear need, both within a UK dementia care context, and globally for an evaluation of the process of implementing person-centred care principles in practice, to improve dementia care in care homes. It is estimated 850,000 people are living with dementia in the UK (Alzheimer's Society, 2015). This figure is expected to rise to over one million by 2021 in line with the 'baby boomers' of the mid-20th century reaching old age (Department of Health, 2009). Despite this demographic trend, care standards within many long term care facilities are not meeting the care needs of residents, particularly those with mental health conditions (Kuhn et al., 2002; Hancock et al., 2006; Moyle et

al., 2011; Cadieux et al., 2013; CQC, 2013; CQC, 2017). Latest figures suggest 3% of nursing homes in England are rated as inadequate, 29% as requiring improvement, with 1% rated as outstanding (CQC, 2017). Further, resident abuse has been anonymously reported by care staff to be observed, 'at least sometimes' in 91 of 92 care homes, in a recent UK survey (Cooper et al, 2018).

Dementia care has been described as being in need of practice development if more person-centred cultures of care are to flourish (Spilsbury et al., 2015). In order for this to happen organisational issues such as poor training and/or supervision access for care workers, understaffing, and staff 'churn' or turnover need to be addressed (RCN, 2012). The UK context of these issues is therefore introduced briefly below in terms of regulation, best practice guidance and the evidence base.

The National Institute of Clinical Excellence Care (NICE) published new guidance for the care and support of people living with dementia in June 2018 (NICE, 2018). Within this they recommend all those in care worker roles be given access to person-centred and outcome focused care training that includes:

- *Understanding the signs and symptoms of dementia, and the changes to expect as the condition progresses*
- *Understanding the person as an individual, and their life story*
- *Respecting the person's individual identity, sexuality and culture*
- *Understanding the needs of the person and their family members or carers*
- *The principles of the Mental Capacity Act 2005 and the Care Act 2014.- (NICE, 2018)*

Training inspired by principles such as these are not universally accessible, or delivered, to those in care roles within UK dementia specialist care settings (RCN, 2012; Alzheimer's Society, 2013). Care workers are aware of their own training needs, and have reported a desire for high quality dementia specific training that meets their practical needs, in the context of their working environment (Smythe et al, 2016).

Effective supervision for staff in care settings is a regulatory (CQC, 2015) and legislative requirement (Care Act, 2014) and features prominently within best practice guidance (NICE, 2018). It has been positively correlated with lower staff turnover and higher job satisfaction (Bishop et al, 2008; Choi and Johantgen, 2012; Bethell et al, 2018), as well as improved resident outcomes (McGilton et al, 2016).

Care workers have reported working in understaffed homes (Unison, 2015). Understaffing is perceived by care staff to be a key pressure within workplaces (RCN, 2012). Despite this, the Care Quality Commission (CQC) regulations do not specify a specific ratio for the number of care workers needed per x number of residents. They instead suggest providers deploy sufficient numbers to meet care and treatment needs (CQC, 2015). NICE guidance similarly suggests there is no single recommendable staff to resident ratio (NICE, 2014). Whilst this may seem somewhat ambiguous, there is growing recognition of the need to devise staffing levels in a flexible manner, with the core aim of meeting the fluid, evolving needs of residents (Cohen-Mansfield and Bester, 2006). Indeed, flexible staffing has been identified as a key mechanism in reducing care worker turnover, improving the continuity of care for residents, and improving the chance of a consistent standard of care to emerge in individual settings (Weale et al., 2017).

Figures from Griffiths et al (2018) estimate staff turnover in the UK for those working in adult social care is 30.7%, with 67% of that figure being 'churned' into alternative employment within the sector. Turnover however, is on the increase in the UK, up 7.6% over the 5 year period between 2013 and 2018. Care worker turnover is linked to job strain (Gilster et al., 2018) and a lack of relevant social care qualifications (Griffiths et al., 2018). This in turn is linked to poor care cultures and practice (Edvardsson et al., 2009); thus reinforcing the need to better understand the process of person-centred care implementation in care settings.

A key theme of high performing adult social care services is the prevalence of a culture informed by person-centred care (CQC, 2017). An imperative therefore

exists, to evaluate the implementation of person-centred models of care, and identify the issues, challenges and facilitators that influence this process.

Over the course of study, the literature reviewed enhanced my understanding of the importance of the separation between the process of implementing a model of care and resident specific outcomes. It is difficult to attribute the wellbeing or quality of life of an individual to a specific model of care if you are unaware of how effectively that model has been implemented to begin with. It is therefore necessary to know whether the principles within the model are underpinning the culture of care within a care setting, before identifying how the predominant culture of care is constructed. The need to understand the process of implementation and identify the key principles that underpin the culture of care, led the research away from an analysis of resident outcomes, and towards a research design that centralised the staff experience. The methodology is discussed in full in chapter 3 of this thesis.

The research documented in this thesis is guided by three research questions, these are as follows:

- 1) What is the dominant culture of care at the care home?
- 2) To what extent was the *EMBRACELIFE* strategy implemented within the care home and why was this the case?
- 3) How did the care home's newly operational status interact with the implementation process?

The rest of this thesis is dedicated to answering these questions and in doing so, making a unique and timely contribution to the dementia care field of research. In chapter 2 of this thesis I first describe how my methodological approach is informed by social constructionist theory. After outlining my theoretical position, competing constructions of dementia are critiqued, with the implications for dementia care in care homes central to discussion. Following on, investigation turns to definitions of care, the organisational culture of long term care settings, and the impact of the built environment of care homes upon care practice. I conclude by discussing the influence of an 'empowering' organisational culture, on the quality of life of people with dementia, from a social constructionist standpoint.

In the third chapter of this thesis I set out and justify the research design and methods produced and used. As mentioned above, a design informed by the principles of ethnographic research is favoured, along with a multi method approach, incorporating semi-structured interviews, participant and non-participant observation and documentary analysis. Such an approach strengthens the validity of the research findings through the triangulation of the data. By utilising interviews, observations and document analysis of materials, such as care plans and strategic care implementation guidance, it was possible to analyse my interpretation of the reality of the culture of care 'on the ground', the care planning tools produced to guide the implementation of person-centred care and the care staff perception of the care they were delivering. This enabled a rich data set to emerge from a multitude of sources that describes both the process of the implementation of *EMBRACELIFE* and the perceived reality of the culture of care in practice. In the third chapter of this thesis I also discuss the specific style of ethnographic research I adopt, as well as how it is informed by a social constructionist epistemology. Finally, I outline the initial research work plan for data collection and analysis before reflecting upon how this plan evolved in practice and detailing the adjustments that were made during this applied research study. I go on to discuss any perceived limitations.

The findings chapters of this thesis are presented in three distinct parts. The first findings chapter describes and critically discusses the implementation strategy used by Hollyfield. The significance of the CQC to this strategy as the key English care sector regulatory body is explained. Next, the physical environment of Somerset House is outlined. This findings chapter plays a key role in introducing the research setting and the implementation strategy prior to the presentation of the findings related to the culture of care and effectiveness of the implementation process of the *EMBRACELIFE* model. Documentary analysis of the strategic implementation documents in the context of latest academic literature and policy context plays a significant role in this chapter, as does observations of the built environment of Somerset House.

The second findings chapter presents a detailed account that identifies the predominant culture of care at Somerset House. In doing so the effectiveness of the implementation strategy, in being the catalyst to foster a person-centred

culture of care, is established. Here the data gained from semi-structured interviews with members of the care staff team, my own observations of daily life at the home, and the analysis of resident care plans, are triangulated to form a critical assessment of the dominant constructions of dementia care, underpinning the culture of care at Somerset House.

In the third and final findings chapter the implementation strategy of *EMBRACELIFE* is reflected upon to identify what the challenges to implementation were and how they may have contributed to the predominant culture of care at Somerset House. To achieve this the key implementation strategies were critically analysed in the context of relevant findings. Again staff interviews were of central importance to the findings of this chapter, as well as care documentation analysis and my own unstructured observations.

The seventh and final chapter of this thesis reflectively situates it within the body of academic literature, to ascertain the unique contribution of my research. The findings are discussed in relation to the guiding research questions developed at the outset of the study. The research is then reviewed, to define the limitations of the study, as well as how the findings could be built upon by future research. To conclude, the implications of the research for policy and practice are discussed.

1.2: The approach taken to the literature review

In this thesis the process of implementing a holistic model of person-centred care is explored, with the influence this has on the culture of care being critical. The literature review therefore is broad in scope, covering multiple topic areas including the theory underpinning the research, critical perspectives of theory, staff outcomes, training, competing cultures of care, resident, family and staff perceptions of best practice, the built environment, and models of care.

It was key that I was able to update my literature review over the course of the PhD, as new literature was published. I therefore adopted a narrative style to the literature review (Ferrari, 2015), around the themes I interpreted as relevant

to this thesis. This enables the collation of evidence across multiple topic areas, whilst provides the flexibility to search for new literature through the PhD process. All searches were conducted using the databases Medline and Web of Science. Initial searches of the literature review were conducted between October 2013 and May 2014. Additional searches were conducted within January and May 2018 to update the literature review chapter, and to provide evidence for the discussion chapter. Grey literature was also sought out online such as department of health policy documents, NICE guidelines and CQC reports. An 8 step by step guide to how I searched the literature is provided below:

- 1.) Identify area of interest for example, factors influencing care worker retention in dementia specific care homes. This was typically done in conversation with supervisors.
- 2.) Create inclusion criteria for articles, to ensure the removal of articles is justified and systematic. E.g. only include articles with evidence specific to care homes. Thus, removing all articles focusing on community care, for example.
- 3.) Identify key concepts, relevant to the topic area of interest
- 4.) Operationalise concepts into keywords that best represent the topic areas, and reduce them into manageable terms and use these terms to search the databases using the 'keyword' restriction option. For example the subject area care homes was searched for as follows: "care home" OR "nursing home" OR "residential care" OR "residential home" OR "long-term care".
- 5.) Define search criteria within databases (Any literature published within the last 10-20 years, depending on number of results; English language).
- 6.) Make a judgement on the size of results list. If too large, refine search terms. Typically, this was achieved by revisiting the inclusion criteria, and expanding or refining it.
- 7.) Review abstracts of articles present in results list to remove articles defined as not relevant.
- 8.) Comprehensively read articles that match the inclusion criteria

Chapter 2: Theoretically positioning the research

Below I introduce my theoretical position and explain the context of dementia care through an analysis of models of dementia. The basic premise of social constructionism is introduced and then applied to dementia care in care homes, the focus of this doctoral study. I go on to discuss the traditionally dominant medical construction of dementia. After considering the strengths of this model I explain that the tradition of bio-medical enquiry creates isolation from an analysis of psycho-social phenomena. I discuss how this isolation produces a care environment whereby inhumane care practices have the potential to be normalised. The main contention of this critique is the normalisation of these practices is rooted in, justified and proliferated by the biomedical model of dementia.

Such a discussion is highly relevant to the aims of this PhD study, i.e., to contribute to academic knowledge surrounding the improvement of care practice, through challenging traditionally constructed care cultures and environments. Discussion moves on to Kitwood and his psycho-social theory of dementia care. I explain 'the dialectics of dementia', 'personhood' and 'malignant social psychology'. I explain what person-centred care is through the analysis of these three concepts.

2.1 Social Constructionism and the institutionalisation of knowledge

Social construction is concerned with locating and explaining the socio-cultural processes through which human beings understand the world, self-identity is formed in the individual, and order is formed in societies (Berger and Luckmann, 1966). The basic epistemological premise of social construction, as proposed by Berger and Luckmann (1966) in their thesis: *The Social Construction of Reality: A treatise in the Sociology of Knowledge*, is the apparently constant and objective nature of social reality (the manner in which human agents interpret the social world) is an illusion based on the 'institutionalisation of knowledge' within specific social contexts.

Social constructionism builds upon the Symbolic Interactionist standpoint that human socialisation comes from the ability to share ideas, thoughts, emotions and motives through the medium of language (Harding and Palfrey, 1997). Social construction differs from symbolic interactionism in that the unit of analysis is shifted from how individual people exert influence onto others, to the relationship between social institutions and social groups, within a specific social time and space (Gergen, 1985). For example, the unit of analysis could be the impact of religion, political movements, or western medicine on a specific element of the human condition, such as the family unit, civil liberties or wellbeing.

Over a period of time knowledge produced and passed on to further generations of a given civilization, becomes alienated from the subjective mechanisms of its production: social interaction, facilitated by language. This is due to its widespread usage over many years. Knowledge therefore, appears to the human agent as an ontological or naturally occurring truism or as part of social reality. Knowledge with a history of social dominance and therefore utilised in the production of social order, is particularly prone to this process of institutionalisation (Berger & Luckmann, 1966).

Social order is produced through institutionalising a stereotype of what it is to be human i.e. the social construction of human behaviour and thought (Shotter, 1997). Pressure is exerted on people to conform to this stereotype, ensuring a pattern of human behaviour and activity is followed by members of any given society. The process of institutionalisation is initiated from birth through primary socialisation. Parents pass on their perception of social reality; 'ways of knowing' assumed to be objective, to their children. If the children do not conform to the ideals laid out to them they are punished. Such a means of ensuring conformity is paralleled in adult socialisation, by sanctions given out to adults by dominant social structures, should they threaten what is deemed to be the 'natural' order. These sanctions take the form of the 'deviant' label.

Deviant labels hold large negative connotations and influence the perception of 'normal' people towards those labelled (Goffman, 1963). People labelled as deviant have throughout history, been persecuted, stigmatised and ostracised

from 'mainstream society' (Becker, 1963). In this way human agents are subjected to social control (Berger and Luckmann, 1966; Shotter, 1997). The poor laws, introduced in Great Britain during the Middle Ages, are a good example of this process. Laws enacted in 1608 enforced the widespread rounding up of homeless people from the streets of Britain, who were taken to labour and live in workhouses, segregated from society, and forced apart from their families. Those that refused were imprisoned. Poverty therefore became 'known' as a social ill, legitimated by political and legal processes (Phelan et al., 1997).

Each human agent has a value, status or label, dynamic in nature and specific to other individuals we interact with (Goffman, 1963). For example, an interaction between an employee of a particular business and the owner of that business is mediated by the socially derived meaning behind the labels of 'owner' and 'employee'. The owner purchases the labour power of the employee (Marx, 2001). In a capitalist society the selling of one's labour is an essential part of social acceptance and therefore important, if one is not to be deemed deviant and stigmatised through dependence on the welfare state (Fraser and Gordon, 1994). Hence, a hierarchical relationship exists in which the owner of the business is dominant and exerts power, control and influence over *his* employee. Thus, the labels of owner and employee, in this context, give the interaction between these two people a distinctive and predictable character and tone (Shotter, 1997). The roles or labels cultures and societies ascribe to people therefore influence people's perceptions of one another (Goffman, 1963). Such perception is discernible through everyday communication and interactions. It is possible therefore to discover how cultures, organisations and societies subjectively place people in hierarchical order based purely on the nature of interactions between people, ascribed different social roles, although belonging to the same specific social environment (Berger and Luckmann, 1966). In this manner language not only produces knowledge, through the sharing of ideas, it reinforces it and exemplifies it through the actualisation of dominant forms of knowledge in practice (Berger and Luckmann, 1966).

It is not only interaction, language and communication that is informed by the labels ascribed to us but expectations of behaviour too (Shotter, 1997). It is expected a shop assistant will scan through the consumables brought to the till just as it is expected the consumer will queue in line and pay for the items once scanned.

It may be possible then to use qualitative observational technique to gain a critical understanding of the interactions between care staff members and people with dementia, as well as the expectations placed on care staff members and people with dementia. Whether or not the interactions and expectations have foundation, within the model of care being implemented, will give an indication as to the effectiveness of the implementation plan.

The expectations, communications and interactions people have with others perform a vital function in creating order within any given culture or society. Social constructionists do not take issue with this as an inherent concept. It is only when the character of communication is to the detriment of the human condition of specific social grouping (often those labelled deviant) or the people of a society more holistically, that social constructionist critique is levied (Nicolson and McLaughlin, 1987). In such cases social constructionists attempt to theorise the logic of how this 'detrimental' knowledge is produced through questioning the authority of various dominant social structures. Social constructionists challenge these dominant social bodies through critically analysing the notions of social reality proliferated by these bodies (Harding & Palfrey, 1997). Dementia is one form of the human condition whose traditional biomedical construction and resulting perception has been challenged. This critique will be explored fully. First a consideration of the critiques of social constructionism will be discussed.

2.1.1 Critiques of social constructionism

There are several critiques levelled at the theoretical standpoint held by myself. Through an awareness of the traps associated with social constructionism, and the counter arguments proposed by proponents of this epistemological position, I hope to better justify the theory underpinning this thesis.

Social constructionism stands accused by being relativist, not attending to the realist realities surrounding subject matter, and lacking reflexivity (Bury, 1986). I will discuss my standpoint as a researcher in relation to the concerns of relativism and realism to aid transparency and as a frame of reference. This discussion will allay the fears associated with a lack of reflexive thinking.

First to the claim of relativism, that any universal or widely held generalisation or 'truth' resulting from social constructionist social science methodologies is unsustainable, due to the social constructionist belief that all knowledge is socially and culturally specific (Bury, 1986). As a social constructionist I do not claim to be uncovering any absolute truism in the empirical investigation I have undertaken. It is not claimed that the perspective I take is of more value in terms of its validity, to that of a competing standpoint. I do however hope to gain an understanding of the issues encountered when attempting to change the culture of a specific care setting. I also hope to document the impact implementation has had on care practice, the wellbeing of staff members and people with dementia. This thesis will therefore serve as a practice example that care providers, both in a national and international context, can take lessons from. It is influence over practice and the improvement in the human condition which is the goal of social constructionists not the search for any absolute truths; hence, the motive of good social construction protects it from any claims of being akin to relativism (Nicolson and McLaughlin, 1987).

Realists are critical of social construction due to a perception that social construction does not take seriously external physical realities, influencing the lives and realities of people as they perceive them (Bury, 1986). The realist critique is one that may conceivably be levied against social constructionists interested in dementia, due to the pathological nature of the neurological deterioration, related to dementia by biomedical science. A realist thinker could argue that pain encountered by people with dementia is caused by biological processes, and this stark reality is ignored, or deemed irrelevant by social constructionists. Despite being a social constructionist, I acknowledge the neurological changes that occur in the brains of people living with dementia, and the huge part it plays in the lives of those living with the condition. Rather than displace the notion of disease, I seek to challenge the prominence of the

disease label in the social lives and care of people with dementia (Harding and Palfrey, 1997). Following Kitwood (1997), I am therefore highly critical of the widespread use of the terminology such as 'demented', 'victim' and 'sufferer' and social care practices that prioritise the concept of disease over the person. These labels take an emotional and social toll on people with dementia. They impact upon societal expectations of what dementia is and what people with dementia are perceived to be like (Milne, 2010). In turn this negatively influences the interactions between individuals with dementia and others who they encounter on a day-to-day basis, including those that help with care needs.

2.1.2 A critique of Dementia as a biomedical construct

It was not until the 1980's that Alzheimer's Disease began to be constructed as a distinct medical condition or disease that affected people over the age of 65 (Bond, 1992). Up until that point, Alzheimer's was a disease that was thought to affect people under the age of 65, something now defined as early-onset dementia. Historically, constructions of dementia have been informed by medical institutions (Lyman, 1989). Such constructions were based upon the disease process attributed to dementia, and the effect they are perceived to have on the mental capacity of people living with the condition. Little thought was given to the impact of psycho-social or environmental factors, on people's behaviour. From a clinical perspective the medical model of dementia has led to progress. Issues that can contribute to dementia are now better understood, such as obesity, and treatments have been found that can delay the progression of Alzheimer's disease in some (Knopman et al., 2001; Ritchie & Lovestone, 2002; Anstey et al., 2007).

Whilst the medical construction of dementia has resulted in the stigmatisation and objectification of people with dementia (Benbow and Jolley, 2012), it is helpful in certain contexts. Medical construction gives the possibility of diagnosis; important for three reasons. First, the medical paradigm is based around curative processes. If dementia is a disease it is plausible to suggest that it can be cured, and that people with dementia can find some solace in the search for this. A caveat must be added here however, that the funding of biomedical research, aimed at finding a cure and psycho-social research,

aimed at improving the lived experience of dementia, is grossly imbalanced (Caspi, 2017). The biomedical model of dementia has been shown to maintain its position as the dominant theory or approach underpinning methods of managing and supporting people with the condition in UK (Innes and Manthorpe, 2013; Lock, 2013) and Ireland (Hennelly and O’Shea, 2017). This dominance is maintained by the government response to dementia, focused on research exploring prevention, cure and cause (Swallow, 2017). Indeed, the focus on cure has become so pervasive, there have been calls to reverse funding priorities in favour of care over cure (Whitehouse, 2014). This funding landscape dominance maintains the hegemony of the biomedical model in the UK and beyond. Therefore, people’s perceptions and experience of dementia is often mediated through a biomedical lens or gaze (Swallow, 2017). Consequences of this are discussed later in this section.

Second, diagnosis facilitates the possibility of control and empowerment over the condition and the possibility of peer support; something research has suggested leads to increases in wellbeing and quality of life for people living with dementia, and their carers (Greenwood et al., 2013; Toms et al., 2015). Third, people living with dementia, as a result of diagnosis, are able to plan for the future, through processes such as advanced directives (Berghmans, 1998; Cook, 2008).

UK policy has been to increasingly support early diagnosis (Department of Health, 2009; 2012) and diagnosis rates have improved from 51% to ‘around two-thirds nationally’ (Department of Health, 2016: 6). Concerns therefore exist over the care available for people post-diagnosis, and the central position of the biomedical model in care and treatment pathways. How this impacts upon the wellbeing and self-identity of people with dementia and the services they encounter is central to these concerns (Innes and Manthorpe, 2013; Swallow, 2017).

2.1.3 The ‘Stage’ theory of dementia

The assumption dementia is progressive is built on the premise capacity will decline in a linear fashion resulting in ‘stages’ of dementia. There are 3 main stages of dementia ‘mild’ ‘moderate’ and ‘severe’ yet little evidence to support

their application to people (Lyman, 1989). The subjectivity of human experience and the complexity of the human condition with or without a diagnosis of dementia, renders such simplistic categorisation over-reductionist (Downs, 2006). Indeed, studies have found evidence contradicting the notion of stages of dementia that progress with time. Such studies have shown large variation in behavioural traits and skill performance in isolation of stage labels (Brody, 1982; Ferrini-Strambi et al., 1990; Kurz et al., 1992). Furthermore, Killick and Allan (2001) have documented people in stages of dementia constructed as 'advanced' or 'end stage' telling stories, communicating need and enjoying social interactions.

Once a stage is deemed to fit a person with dementia, care guidelines for each stage are laid out, generically dictating what to expect from the person with dementia, and how to 'deal' with behaviour. Physical and chemical restraints are justified (NICE, 2006) and moves into care settings are recommended on the basis of 'severe' or 'moderate' labels (Lyman, 1989). Such acts of social control serve to objectify people with dementia and systematically displace their autonomy and human rights, whilst subjugating their personal identity; what Tom Kitwood termed 'personhood' (Kitwood, 1997).

Methods of care informed by the biomedical construction of dementia and its stage categorisation, are likely to result in a corresponding decline in opportunity for people to engage in activities of daily living (ADL), to form relationships, and gain mental and physical stimulation (Koehn et al., 2011). Indeed, people living in care settings have been reported to be subject to low levels of social interaction (Schroll et al., 1997; Ballard et al., 2001). Various studies have shown opportunity for social interaction and activity is of upmost importance to the wellbeing and quality of life of people with dementia (McCormack & Whitehead, 1981; Kitwood & Bredin, 1992; Han et al., 2010). The apparent inevitable decline in capacity (characterising a move to a more advanced stage), coupled with the objectification of people with dementia as disease entities, legitimates task-centred care practice in care homes (Crawshaw 1996; Ballard et al., 2001). Studies have shown people with dementia, less active in their care delivery, treated as objects of care and lacking physical and mental stimulation, are more likely to experience a lower

quality of life characterised by depression and 'problematic' behaviours. These include aggression and disturbed sleep patterns (Anderson et al., 2003; Vogel et al., 2006).

The occurrence of 'challenging' behaviours are explained away by the biomedical model as symptomatic of dementia, in isolation of environmental factors, as the person is taken over by the disease. Therefore, care practices can go unchallenged that do not use the individuality of the person as a lens for interaction. The disease construction of people with dementia encourages the perspective among care staff that challenging behaviours are inevitable and therefore, a barrier exists to understanding the need to practice person-centred care (Davis, 2004).

The inability to acknowledge the negative effect living with dementia can have, on various aspects of mental health i.e. depression and anxiety, renders the biomedical model of dementia problematic to a further degree (Bond, 1992). It is unlikely these emotional issues could be directly caused by neurological deterioration. Causation is far more complex and related to negative environmental influences, prompting a psychological reaction, where the person with dementia has their notion of 'self' dismantled (Sabat, 2001). This suggests environmental factors have a significant role to play in behaviour that biomedicine singularly attributes to neurological deterioration (Milne, 2010). This exposes the medical construction of dementia as inaccurate in its representation of the reality of living with dementia, to the detriment of people living with the condition, and their loved ones (Lyman, 1989; Bond, 1992; Harding & Palfrey, 1997).

The subjectivity of the medical construction of dementia is not what renders it problematic; it is the contention of social constructionism that all knowledge is produced in relation to socio-cultural forces (Berger & Luckmann, 1966). Rather, the issue lies in the utilisation of this construct to legitimate medical authority, and the control of people with dementia. Foucault (1989) describes how the 'medical gaze' problematizes behavioural symptoms, biomedicine associates with a particular condition. This 'medical gaze' objectified the person as the incarnation of disease. This process of objectification allows for the

social control of older people living with dementia, via the dismissing of their behaviour as deviant (Foucault, 1973). This dismissal provides a societal function through legitimising discrimination against individuality, in conflict with the normative behavioural patterns of mainstream society (Berger & Luckmann, 1966). Thus, providing a form of justification for the marginalisation of people with dementia (Herskovits, 1995).

The stigmatising effects of the biomedical model of dementia, when applied to individuals, can lead to the undermining of aspects of 'self'; having a negative impact on the positive forms of identity that make us who we are (Garand et al., 2009). Our sense of self is fluid across our lifetimes and its strength is dependent upon our autonomy, social relationships and our ability to navigate and ascribe meaning from them (Mead, 1934). Living with dementia is therefore a clear challenge to one's self of sense due to neurological damage, the social construction of the condition, and the associated issues this causes for the emotional wellbeing of people with dementia. Given the subjugation of autonomy and the limited social interaction people with dementia can be exposed to, the self can become threatened. Once the self is compromised, it becomes difficult to connect and position oneself to an immediate psycho-social environment (Harding & Palfrey, 1997). Despite this, the notion that self is displaced entirely has been challenged, specifically in relation to dementia (Sabat, 2001) and aspects of self are retained by people living with dementia, even towards end of life (Caddell and Clare, 2010). It is imperative therefore that care workers focus on maintaining a sense of self within residents. Practice methods include actively building positive 2-way, meaningful relationships with residents, facilitating the creation of new forms of positive identity and life story work (Surr, 2006). Literature related to 'best' practice is discussed in section 2.3.

2.1.4 Reflections

In this section I have presented the main assumptions of social constructionism and applied a social constructionist critique to the biomedical definition of dementia. It is evident that the continued dominance of the biomedical construction of dementia is resulting in negative outcomes for people with the

condition, as a result of becoming marginalised, stigmatised and subjected to inadequate care environments. In the following section I introduce Kitwood's theory of person-centred care, something devised over 20 years ago a solution to many of these issues. In doing so I introduce the key theory increasingly underpinning understanding of dementia (Sandberg, 2018) and the model of care, the implementation of which, this thesis critically evaluates.

2.2 Introducing Person-centred Care

Person-centred care is discussed throughout this thesis; in this section the concept is introduced. Tom Kitwood did much to promote the person over the medical construct of dementia. Kitwood is credited with playing an instrumental role in applying psycho-social critique to the biomedical construction of dementia through the concept of 'person-centeredness'.

The notion of person-centredness was first proposed in the 1960s (Mitchell and Agnelli, 2015). Key to Kitwood's model of person-centred care was a contention that a dialectical relationship (Kitwood, 1990) exists between neurological function and social interactions with others. To impact on the personhood of an individual these interactions would need to fall into two broad categories. First, interactions that detract from personhood were coined 'malignant social psychology' (MSP). Interactions that enhance it were framed as 'positive person work' (Kitwood, 1997).

MSP is a phrase used to describe negative social interactions, experienced by people with dementia that impacted upon the psychological wellbeing of a person, thereby damaging their personhood. Kitwood labelled such phenomena 'personal detractions' suggesting each time a person with dementia is subjected to a form of malignancy; their personhood became damaged (Innes, 2009). A full list of Kitwood's 17 types of MSP, with explanations for each point are presented in Appendix 1 of this thesis. In chapter 5 of this thesis, I categorise some observations using this framework. MSP interactions take place between people with dementia and care workers. Kitwood (1997) suggested MSP is legitimated due to the personhood of residents being deemphasised or unappreciated in favour of the disease. The relationship

between these 17 elements and neurological damage is dialectical, as one's personhood is dependent upon the presence of both, if it is to become damaged (Kitwood, 1990). Psychological reactions are produced as a result of being subjected to a form of malignant social psychology; thus deepening cognitive dysfunction, by disrupting the equilibrium of the self and demeaning personhood (Kitwood, 1997). Kitwood therefore did not debate the status of dementia as a disease, but endorsed an expansion of the concept.

Kitwood (1997) introduced 12 points of positive person work. These included: Recognition, Validation and Facilitation. Kitwood suggested the needs represented by positive person work are deep seated and necessary for the psychological wellbeing of every individual, particularly however, people living with dementia. Kitwood felt this was due to their vulnerability, and reliance on others, to seek out opportunities for positive person work on their behalf (Mitchell and Agnelli, 2015).

2.2.1 Personhood

Kitwood attributed much importance to maintaining the personhood of people living with dementia. This can only be maintained through communicating with people with dementia as unique individuals, recognizing their experiences as valid, and supporting their autonomy, capability, agency and identity (Kitwood and Bredin, 1992; Kitwood, 1997; Brooker, 2007).

Individualised care planning is a key element of person-centred care. Kitwood recognised that life experiences form a key part of personal identity and are as unique as the personality and self-identity, such experiences create. Care workers therefore should be aware of the personal backgrounds of residents, to develop person-centred guidance and practice, that recognises and respects the personhood of people with dementia (Allan & Killick, 2001). Kitwood (1997) stated elements important to personhood include: temperament, innate ability, interests, tastes, beliefs, values, commitments, lifestyle, biography, gender, class and culture.

Kitwood suggested that to fully interpret the actions or agency of someone with dementia, a detailed knowledge of personal background is required. An

awareness of how personal backgrounds shape interaction shifts the lens of interpretation from disease to the person. In doing so care practice that proactively aims to improve the quality of life and wellbeing of people living with dementia becomes possible (Kitwood, 1997). For example; does the person prefer to be called by their first or second name? How appropriate is it to hold a reminiscence session around a particular topic? The answer to questions such as these should dictate the way care workers interact with residents (Kitwood, 1997). Kitwood recommended several different ways of obtaining knowledge, of the experience of dementia, key to person-centred dementia care. These are paraphrased below:

- Texts written by people with dementia.
- Listening to people with dementia.
- Attending carefully to the everyday interactions and communications of people with dementia
- Through discussions with people more likely to be able to empathise with people living with dementia i.e. Family carers or people with a condition that has the potential to lower cognitive function such as mild cognitive impairment.
- The poetic imagination of care workers
- Role play

These ways of obtaining knowledge are all designed to achieve greater empathy between (when applied to this PhD thesis) care workers and people living with dementia in care settings. As with personal background work these steps, in theory, have the potential to shift the lens of care from disease to the person (Kitwood, 1997).

This PhD study aims to evaluate the impact of implementation procedures, with a focus on the development of person-centred care practice. To gain a more full insight into person-centred care, and how effective it is when applied in practice, critiques of Kitwood's theory will be engaged with in section 2.2.2, before a discussion of how more contemporary models of dementia have built upon Kitwood's work.

2.2.2. Lost in translation: A critical discussion of person-centred care and its practical application

In this section critiques of person-centred care are addressed. Discussion will turn to the implications of the person with dementia having their personhood 'bestowed' upon them by others. First however, I postulate that English policy situates a type of person-centred care focused more on the individual, than the fostering of meaningful relationships, to the detriment of practice. The mediating role of the biomedical model of care is raised. It is argued the rise of relationship centred care (Nolan et al., 2004), despite Kitwood holding relationships as a cornerstone of his theory, is demonstrative of this. The principles of embodiment (Martin et al., 2013), are discussed, and it is suggested they broaden understandings of the agency of people with dementia, facilitating innovative strategies for maintaining personhood. More contemporary debates around Citizenship and Human Rights are then explored. Such debates raise the level of critique from the psycho-social to the socio-political, with implications for policy and practice (Cahill, 2018).

Despite the dominance of person-centred care principles within UK policy, regulation and guidance; a concomitant person-centred turn in the organisational culture of UK care settings has been far from universal. Possible reasons for this have already been alluded to in terms of the widespread staffing concerns prevalent in the care sector (RCN, 2012; Unison, 2015; Griffiths et al., 2018). Issues with the translative quality of Kitwood's theory however, should not be overlooked. As Brooker (2007) points out, the specific meaning of person-centred care is far from straightforward, and its principles have been applied in disparate ways (McCormack et al., 2012). Brooker argues the polarised nature of two key concepts of personhood i.e. the centrality of the individual and the necessity of trusting, meaningful relationships, significantly contribute to the existence of this disparity. Attempts to embed person-centred care into policy, have largely centred upon individualised care practice, failing to recognise the fundamental need for valued carer-resident relationships (Nolan et al., 2004). Indeed, individualised care is often seen as synonymous with person-centred care (Brooker, 2007). Policies focusing only upon the

individualising aspects of person-centred care, find common ground with the biomedical narrative, underpinning wider policy responses to supporting and managing people with dementia (Innes and Manthorpe, 2013). It is plausible therefore, that the biomedical model has not been challenged by the emergence of person-centred care within policy and practice, as the site of the 'problem' i.e. the person, has not been displaced. Such a construction does not challenge the objectification of people with dementia as disease. The role of environmental factors and relational factors, in the maintenance of personhood, is therefore beyond purely individualised care planning. The tension that exists between care focused on the individual, and the need for strong relationships to maintain personhood, may be reconcilable. However, it has demonstrably problematised the implementation of person-centred care, leading to the rise of the relationship centred model of care (Nolan et al., 2004). The impact of the relationship centred model on practice is discussed in section 2.3.6. It is not discussed further here as a critique, beyond the question of implementation, as relationships were a cornerstone of Kitwood's vision of person-centred care (Kitwood, 1997).

A more legitimate prominent critique of Kitwood's theory of person-centred care is that by claiming personhood is 'bestowed' upon people with dementia by others, they are framed as inferior or secondary to those without dementia (Dewing, 2008). Thus, as the agency of people with dementia decreases, they become more passive in the maintenance of their personhood. The role played by the person with dementia in the creation of a trusting, two-way relationship, between for example, themselves and a carer, is therefore unrecognised. This is deeply problematic as if efforts from care workers to maintain personhood are absent, it implies the personhood of the individual is severely impaired, or worst still, non-existent. Thus the person, having lost their personhood becomes objectified, or is at risk of 'social death' (Davis, 2004). Embodiment has been proposed as a method for recognising the agency of people who are perceived to have less cognitive ability (Kontos, 2004).

Embodiment is important for three key reasons in the context of the discussion in this section. First, a focus on embodiment reconciles individualised care with the notion that the care environment also plays a role in the maintenance of

personhood. A focus on embodiment allows narratives around dress and hair to emerge, giving clues to how person-centred the culture of care settings are (Martin et al., 2013). As the site of embodiment is still initially at the individual, person level, embodiment is able to reconcile the relationship between the care setting and the individual, despite the problematic way person-centred care has been conceptualised, within policy and practice. Second, personhood is embodied. Thus, embodiment can support care workers in their efforts to maintain agency and personhood; for example, by providing a care mandate for resident choice on physical and material appearance. Person-centred care is therefore operationalised and expanded upon, as the *uniqueness of individuals* is given a practically achievable form of expression, even for those people interpreted as severely cognitively impaired (Kontos, 2004). Third, embodiment theory rejects Kitwood's notion that personhood is *bestowed*. From a social constructionist standpoint, perceptions of reality are produced within the context of social relationships. However, as Kontos (2004) points out, the body as a biological entity, is not merely social; and an awareness of one's body is observable in even those perceived to be in severe cognitive decline. Personhood therefore is not merely *bestowed*, and embodied actions demonstrate extensive agency, creativity and self-expression in those deemed to have little, in Kitwood's theory. Interpretations of embodied actions can therefore be used to nourish relationships between care workers and residents.

A further, more contemporary model that both builds upon and critiques Kitwood's work is the human rights and citizenship approach (Bartlett and O'Connor, 2007; Cahill, 2018). Dementia is a threat to one's ability to defend their own human and civil rights (Kelly and Innes, 2012). A need therefore exists, to produce dementia specific policy documentation that protects the rights of people with dementia at all points in their journey. Rights related to privacy, dignity, autonomy and services, for example (Cahill, 2018). Such rights have been widely absent from dementia focused policy globally, but particularly within an English context that as demonstrated, is dominated by the biomedical model (Innes and Manthorpe, 2013).

Rights based theorists accuse Kitwood of failing to raise his level of critique from the micro to the macro, or from the immediate psycho-social environment, to the broader socio-political construction of dementia and dementia care (Bartlett and O'Connor, 2007). This failing may explain the flawed translation of person-centred care from theory to policy, and ultimately practice. By framing the fundamental needs of people with dementia within legislative discourse, proponents of the rights based approach construct a better defined and more operational notion of best practice. More crucially, from a social constructionist standpoint, rights based theory is legitimated by a key dominant social institution. This legitimatisation facilitates cultural change, through having the necessary influence to shift biomedical discourse, in favour of legal consciousness; impacting how people with dementia are perceived within reality. Thus, person-centred care for people living with dementia is more likely to be achieved, as the status of people with dementia as citizens is guiding the construction of people with dementia and care practice. An awareness of this however, is needed within policy and regulatory guidance if this vision is to flourish in reality (Cahill, 2019).

In this section Kitwood's theory of person-centred care has been critically discussed. Personhood, it is argued is not merely 'bestowed', and such thinking only serves to undermine the agency of people with dementia (Dewing, 2008). Embodiment theorists (Kontos, 2004; Martin et al., 2013) have developed a method of care practice that recognises the agency of all people with dementia, giving opportunities for the maintenance of personhood, lacking in Kitwood's original work.

The main thread of critique proposed however, has centred on a lack of 'translative quality' to person-centred care, resulting in a failure to dislodge the biomedical model of care, from its dominance over UK policy and practice. It is argued the individualistic way person-centred care has been defined has undermined its implementation. It is suggested human rights based theory elevates Kitwood's level of critique, from the personal to the political, and in doing so provides a method of translation for the principles of person-centred

care. In the next section attention will turn to how care is organised, and how this impacts upon the implementation of person-centred care, in care settings.

2.3 Perceptions of best practice and the organisational culture of care within care homes

2.3.1 Introduction

In this section I will examine what constitutes best practice in care from the point of view of people with dementia, their relatives and formal care staff. I then present 4 approaches to the organisation of care and explore how the principles inherent to them, either facilitate or obstruct person-centred care. It is important to note that in reality, those modes of care do not exist in isolation of each other. Competing constructions of care are likely to exist to some extent in any care setting. The polarised presentation of person-centred and task-centred care, as well as 'Hierarchical' and 'Empowering' are used to demonstrate the different ways they inform and characterise the organisation of care. The implications for outcomes relating to wellbeing for staff and residents are also discussed; the relationship between types of care practice, and the organisational structure of care homes are considered.

This chapter is explicitly relevant to this PhD study as the unit of analysis 'Hollyfield' is a care home specialising in dementia care. Therefore, to gain a better understanding of the context of this study, various modes of dementia care need to be defined and their relationship to outcomes for people with dementia made apparent.

In this study a critical comparison between the discourses of care that underpin the implementation strategy, and those interpreted as present in practice, will take place. The similarity an implementation strategy has, with the principles underpinning the organisation culture of care must be identified, and the implications for care practice made clear. To exemplify, flexible working practices may be a core principle of the implementation strategy however, observed practice may be incongruent with this if it is not interpreted to exist in reality, post data analysis. Therefore, the implementation strategy may not have

been supported fully, and the specific types of practice recommended within the care strategy may not be present.

2.3.2 The social construction of dementia care

Dementia care, like dementia, is a socially constructed concept. The dominant perception of care as task orientated is mediated by a medical gaze (Foucault, 1973) in which physical health and safety is the priority, dominant over psychological wellbeing (Kuhn et al., 2002; Hancock et al., 2006; Moyle et al., 2011; Cadieux et al., 2013). Hancock et al (2006) found residents with dementia were having their basic physical needs met however, their social needs were reported as being neglected. Such a method of care is symbolic of what Kitwood labelled the 'standard paradigm' of traditional dementia care, organised around task (Kitwood, 1997). The influence of physical health and safety, within the concept of dementia care, is retained by a culture of care driven by top down targets, minimum standards and a shortage of staff time, capacity and resources (Cohen-Mansfield and Mintzer, 2005; Colón-Emeric et al., 2006; Moyle et al., 2011; Stockwell-Smith et al., 2011).

2.3.3 Care worker perceptions of 'good' dementia care

A 'task orientated' culture of care has been shown to be reflected by care worker responses, surrounding what they believe constitutes best care practice (Spector and Orrell, 2006; Stockwell-Smith et al., 2011; Popham et al., 2012). For example, Popham et al (2012) found care workers believed people with dementia valued health and safety higher than any other aspect of care home life. Ethical decisions surrounding reducing the control and autonomy of people with dementia were therefore believed to be justified, on the grounds that the residents were perceived to value safety above freedom. This finding was reinforced by an environment audit, in the same study, finding health and safety to score highly and therefore of priority.

2.3.4 The perspectives of people with dementia and family members

The notion of care as meeting physical need has not been found to be perceived as acceptable to people with dementia, living in care homes, and their family members. People with dementia and relatives consistently cite care, aimed at improving social and psychological aspects of health and wellbeing,

as the priority over care tasks (Train et al., 2005; Dröes et al., 2006; Spector and Orrell, 2006; Orrell et al., 2008; Moyle et al., 2011; Popham et al., 2012; Duxbury et al., 2013; Heggstad et al., 2013; Bangerter et al., 2016). For example, Heggstad et al (2013) found that family members believed care, based around confirming the person with dementia as a 'relational human being', is the key to dignified care. This requires care workers take the time to communicate with residents, both whilst providing personal care, and more informally, during the day. Notions of care that do not consider the relation aspects of the carer-resident dynamic are at risk of objectifying the person with dementia (Nolan et al., 2004).

Orrell et al (2008) consulted residents with dementia, relatives and care workers regarding the care needs of people with dementia in care homes. People with dementia indicated a higher need for company, activity and higher unmet needs for psychological distress than staff and relatives. This indicates a disparity between how care need is defined by people with dementia and those caring for them. Such a disparity suggests inadequate care provision exists, that does not meet the needs of people with dementia in care homes, as they perceive them.

Spector and Orrell (2006) measured the differences between understandings of quality of life for people with dementia, living in care homes. They found that while there was some congruence between the perspectives of staff and residents, surrounding the importance of family, friends and physical health; people with dementia described a much more holistic notion of quality of life. The ability to complete household chores, the value of relationships and reminiscence were prominent in the responses of people with dementia, yet absent in those of staff. The inference is these aspects of quality of life, important to people with dementia, are not always practically incorporated into models of care for people with dementia, leading to substandard care in some care homes.

In sum, if the perspectives of people with dementia and their family members are taken seriously, good dementia care constitutes much more than meeting basic need or usual care. It requires the meeting of emotional and social need,

coupled with a healthy respect for the identity and capability of residents as human beings. Perspectives of best practice therefore find common ground with person-centred care theory. The discussion will now move on to an analysis of two modes of care organisation: Task and resident. The association between how care is organised and the outlined definitions of dementia care are discussed. The implications for staff wellbeing and the quality of life of people with dementia are analysed. As mentioned previously, the separation of these modes does not represent the reality of care cultures, likely to be underpinned by both modes to a greater or lesser extent. The inconsistent way care has the potential to be practised, within the same setting has been demonstrated, in research (Pink et al., 2014; Chaudhury et al., 2017; Buse and Twigg, 2018). For example, Buse and Twigg (2018) found tensions between task and person-centred care were symbolised through the differing importance individual care workers placed on helping residents dress in a way that reflected their personhood.

2.3.5 Traditional or task centred care

Care organised around task is characterised by daily standardised routines in which care workers practice, framed as for example 'feeding' (Schnelle et al., 2009) or 'dressing' (Twigg and Buse, 2018). The emotional needs and capacity of residents are not considered. The emphasis is on the carer to perform the task for the person with dementia. Residents are therefore in danger of becoming deskilled and reduced to passive objects of care (Askham et al., 2007; Stockwell-Smith et al., 2011). Time efficiently is prioritised and reinforced by peer pressure. Indeed, care workers report judging the quality of their practice, based on the timeliness of task completion (Stockwell-Smith et al., 2011). A lack of time is often cited as a key reason psychosocial interventions, informed by person-centred care principles, are difficult to implement in practice (Rapaport et al., 2017). Care is delivered impersonally, with little to no verbal communication between the person being cared for and the carer. It is common for the resident to be ignored in care settings (Innes and Surr, 2001). Communal provision is underdeveloped and care workers are not encouraged to facilitate resident to resident interactions, or develop activity plans (Kuhn et al., 2002). Indeed, the occurrence of people with dementia engaging in

everyday activities is low (Edvardsson et al., 2014; Smit, 2017). As a consequence, relationships between people with dementia, and carers who work within task-centred cultures, are underdeveloped and lacking in meaning.

Task-centred care has its roots, and finds justification, in the biomedical model of dementia discussed in section 2.1 of this literature review. In short, the labelling of people with dementia as diseased and 'without mind', subjugates their status as relational human beings, objectifying them in the process (Lyman, 1989; Bond 1992). This legitimates undignified care practice, such as the use of physical and medical restraints (Feng et al., 2009), where the efficiency of task completion takes precedent over the emotional needs of people with dementia (Stockwell-Smith et al., 2011; Jones and Moyle, 2016; Ducak et al., 2018). These needs, as exemplified in this section, have been clearly articulated by people with dementia. Therefore, it is not surprising, people living in care homes where care is primarily organised around task efficiency, are more likely to experience a lower quality of life and wellbeing (Cohen-Mansfield and Mintzer, 2005; Vogel et al., 2006; Kunik et al., 2010). For example, Kunik et al (2010) found the occurrence of aggression was predicated on depression, pain and poor relationships between people with dementia and carers.

Symptoms of negative resident wellbeing are positively correlated to stress in staff and lower job satisfaction (Cherry et al., 2007). This was a key reason for staff reporting dementia care as more personally challenging than frail elderly care (Morgan et al., 2002; Brodaty et al., 2003). The prevalence of stress, coupled with poor job satisfaction, has been shown to lead to staff burnout and low staff retention rates (Vernooij et al., 2009; Tourangeau et al., 2010; Heinen et al., 2013). Research suggests the effect of this was to increase and intensify poor care practice, leading to negative outcomes for both staff and resident (Todd and Watts, 2005; Zimmerman et al., 2005; Hunter et al., 2016).

Conversely, high staff retention rates have been associated with better quality of life outcomes for people with dementia (Castle and Engberg, 2007; Collier, 2008). Moreover, person-centred staff attitudes (Moyle et al., 2011) and person-centred care practice (Jeon et al., 2012; Westermann et al., 2014; Barbosa et al., 2017) have been linked to higher job satisfaction and lower levels of

burnout. The low quality of life, symptomatic of task organised care practice, is therefore exacerbated by the negative impact it has on the wellbeing of people with dementia, and the effect this has on staff satisfaction with work.

In summary, person-centred care, due to incorporating social and psychological elements of wellbeing, finds justification in the poor outcomes for both residents and staff, when care is organised around the unit of task (Anderson et al., 2003; Cohen-Mansfield and Mintzer, 2005; Vogel et al., 2006; Kunik et al., 2010; Cadieux et al., 2013). The discussion will now move on to a description of care organised around the person, to uncover whether this improves outcomes for staff and people with dementia, living in care homes.

2.3.6 Resident or Person-centred care

The theory behind the logic of person-centred care is outlined in the first section of this literature review. In short, Kitwood attributes much importance in maintaining 'personhood'. Kitwood (1997: 8) defines personhood as:

'A standing or status that is bestowed upon one human being, by others, in the context of relationship and social being. It implies recognition respect and trust.'

Personhood, as seen in this context, is maintained through communicating with people with dementia as unique individuals, through recognizing their experiences as valid and supporting autonomy, capability, agency and identity (Kitwood and Bredin, 1992; Kitwood, 1997; Brooker, 2007; Edvardsson et al., 2008). Person-centred care can therefore be defined as a resident focused approach, with the core objective of maintaining the personhood of people with dementia. In this context what constitutes 'good' care, as perceived by people with dementia, is in line with a person-centred approach to practice, due a focus on social and psychological and emotional need (Train et al., 2005; Dröes et al., 2006; Moyle et al., 2011; Popham et al., 2012; Duxbury et al., 2013).

Strategies for developing and implementing person-centred care, in practice, have been pursued internationally (McCormack and McCance, 2006; Nolan et al., 2008; Rosvik et al., 2013; Doll et al., 2017; Ducak et al., 2018). The exact nature of the strategy was dependent upon on the core element of person-centred care being endorsed (McCormack et al., 2012). For example, Nolan et

al (2008) developed the senses framework wherein meaningful relationships were put forward as the key criterion for best care practice and 'enriched care environments'. This strategy has been used to develop biographical approaches to dementia care (Brown Wilson et al., 2013).

Biographical approaches have enabled staff to use knowledge about the personal history of people with dementia, fostering meaningful communication and relationships through a greater understanding of the personhood or sense of self of people with dementia (Surr, 2006; Edvardsson et al., 2008; Thompson, 2011; Ward et al., 2014). Utilising biographical information in care delivery has been shown to improve the quality of life of residents and job satisfaction for staff (Clarke et al., 2003; Brown-Wilson et al., 2013). People living with dementia in care settings have described feeling distant from care workers with organisational barriers impacting their right to choice (Donnelly et al., 2016). Evidence suggests the focus on improving relationships between care workers and people with dementia is therefore imperative for the implementation of person-centred care.

Person-centred strategies have helped to yield positive results related to improving health and wellbeing outcomes for residents (Chenoweth et al., 2009; Barbosa et al., 2014; Fossey et al., 2014; Ballard et al., 2018) and care workers (Edvardsson et al., 2011). For example, Fossey et al (2014) reviewed person-centred training interventions, designed for care staff, finding resident agitation and anti-psychotic use to be lower post intervention.

Organisation culture and workforce improvement have been found to be critical to the implementation of person-centred care (Callaghan and Ritchie, 2017), and an absence of macro level organisation change is frequently attributed to environments, where positive outcomes of person-centred care are not always observed (Coyle and Williams, 2001; Koren, 2010 Siegel et al., 2012). The barriers and facilitators that impact the implementation of person-centred cultural change processes have been explored (Beeber et al., 2010; Barbosa et al., 2017; Engle et al., 2017) Person-centred care development can be obstructed due to a lack of recognition from leaders, time constraints, too heavy a workload and understaffing. Conversely, it has been facilitated by supporting

care workers emotionally, and training that involves a practical element within the care setting (Brooker et al., 2016; Barbosa et al., 2017). Sjogren et al (2017) explored factors present within highly person-centred care settings finding a shared understanding of care, leadership, teamwork, as well as care workers having time to spend with residents to be vital. It is important to consider facilitators such as these, prior to attempting to implement person-centred care (Engle et al., 2017).

The efficacy of person-centred interventions can be largely dependent upon organisational factors external to the intervention itself such as leadership, managerial practice, staff empowerment and resident engagement (Hebblethwaite, 2013; Rapaport et al., 2017). This is partly due to the impact these organisational factors have on the implementation process of person-centred care, such as dementia care mapping, when used as a tool to facilitate practice development (Quasdorf et al., 2017; Surr et al., 2018). The literature base around the style and impact of macro organisational factors will therefore now be reviewed. Emphasis will be directed toward how the structure of care organisation at the macro level, influences care delivered at the micro level, between care staff members and people with dementia. It is hoped that this will illuminate organisational cultures within care homes that facilitate person-centred care delivery.

2.3.7 Hierarchical culture

Hierarchical approaches to care are characterised by top-down communication flow where care delivery is instructed upon by senior management to care assistants (Siegel et al., 2012). This leaves little room for staff agency and autonomy on the ground, causing care assistants to lack control and the means for creativity during an average working day (Colón-Emeric et al., 2006). Therefore, an environment is created where the expertise and skill sets of care staff members are underappreciated and underdeveloped. A lack of recognition from senior management concerning the value of their staff and a lack of control over the working environment is likely to lead to a poor job satisfaction, low staff retention rates, incidence of stress and poor health outcomes for care staff (Brodaty et al., 2003; Testad et al., 2009). Conflicts between care workers are also likely to be prevalent (Jones and Moyle, 2016).

The linear flow of communication, described above, creates a clear distinction between those who give orders and those that take them. There is a danger this distinction can be replicated between the residents at the care home and care workers, generating distance between them (Hebblethwaite, 2013). In cases such as this a hierarchy is created not only between levels of staff seniority, but between staff and residents. This discourages the development of meaningful and trusting relationships; important for person-centred care practice (Nolan et al, 2008; Brown-Wilson et al., 2013). Moreover, the lack of communication between the care worker and resident does nothing to empower residents to play an active role in their care delivery. As a result, they are disengaged and passive in the care process (Coyle and Williams, 2001).

An organisational culture where staff are perceived as unapproachable, are lacking in control, and therefore exercise power over residents, is at odds with the narrative of person-centred care (Kitwood, 1997). This has been reflected in research. For example, one study demonstrated the continuation of rigid power dynamics between care staff and people living in care homes. This discouraged the agency of people with dementia, despite an attempt to develop person-centred care (Coyle and Williams, 2001). Another study exemplified a disparity between person-centred 'rhetoric' and the reality of care practice through an analysis of policy documents. These documents reflected a biomedical definition of dementia thus, deprioritising the individual in care delivery in favour of the disease (Venturato et al., 2013). If attempts to develop care practice are not accompanied by adaptations to guidance, management and leadership practices, the application of person-centred care principles will be inhibited (Kirkley et al., 2011; Hebblethwaite, 2013; Engle et al., 2017; Surr et al., 2018).

In summary a hierarchical organisational culture is incompatible with a person-centred approach to dementia care. It does not facilitate the skill set of care workers, incentivises staff conflict and engenders organisational practices that fail to facilitate the development of person-centred care. In reflecting on social constructionist theory, hierarchical cultures where care workers perceive themselves as different to residents will have a predictable and negative impact on perceptions and interactions within care settings. A theoretical alternative to this is therefore necessary and discussed below. It should be noted there is a

lack of evidence for the development of an organisational culture that works cohesively with person-centred interventions, to contribute positively to care worker and resident outcomes (Shier et al., 2014; Zimmerman et al., 2014).

2.3.8 Empowering culture

Research has shown that the empowerment of care staff over their work practice increases job satisfaction and enables the delivery of person-centred care (Andre et al., 2013; Figueiredo et al., 2013; Rokstad et al., 2013). More needs to be done however, to increase the presence of empowerment models. The low status of care work, low pay and lack of involvement in decision making deemphasises the empowerment of care workers (Scales et al., 2017a).

The empowerment of care workers requires communication to flow from care assistant to the management team and for the messages delivered through such bottom-up communication to influence care delivery. The facilitation of two-way communication within care settings ensures the experience and expertise of all staff members is recognised and respected, fostering teamwork and partnership (McCormack and McCance, 2010). This process of staff empowerment has been described as treating care workers in a person-centred manner (Brooker, 2007; Cooke, 2018). Indeed, Kitwood (1997) suggested person-centred care is not possible unless the personhood of care staff is itself respected.

Leaders are expected to engage in care delivery, having an active 'hands on' presence in the care home (Rokstad et al., 2013). The division of labour between care assistants and staff with leadership duties is therefore deemphasised and trusting relationships can develop between staff at all levels of management and indeed, people living in the care home. Engle et al (2017) point out participatory leadership is key if care workers are to feel empowered and cultural change is to take place. Meanwhile, Scales et al (2017a) demonstrate how a lack of leader involvement in care delivery can cause resentment, particularly when coupled with a refusal to acknowledge the experiences of care workers, who have more contact with residents.

The distinction between staff leader and care assistant is characterised by the clear understanding management have, concerning the principles of care they wish to endorse, and the accessible way these principles are communicated (Lynch et al., 2011). Moreover, the responsibility leaders have for the personal and professional development of their staff is prioritised (McCormack and McCance, 2010; Rokstad et al., 2013).

An empowering staff culture is likely to lead to higher staff retention rates and lower staff stress levels due to the control and autonomy care staff have during their working day and the career progression staff experience (Testad et al., 2009; Cummings et al., 2010; Jeon et al., 2010). The implementation of care interventions is also more likely to succeed due to the active engagement of all staff in the design of care models, and the ownership this entails over the model being introduced (Jeon et al., 2010).

The relationships between residents and care staff members are likely to be more fully developed than in hierarchical culture, as the distinction between carer and staff that can inhibit two-way communication is not prevalent. Thus, the voices of people with dementia are heard and their perspectives are able to influence the decision-making process, related to the manner of care delivery at care homes (McCormack and McCance, 2010; Dupuis et al., 2012). Moreover, staff are instilled with agency over their flexible working routine. It is through this flexibility that person-centred care can be applied in practice, due to the individual and unique nature of the various events that a carer responds to, and the individual needs of each person being cared for (Cohen- Mansfield et al., 2006).

The empowerment of care assistants provides a lens to change the organisational culture of care homes on a macro scale, laying a foundational for the development of person-centred care. It is achieved through giving care staff autonomy over their care practice, flexibility over its delivery and valuing the skill and experience of care workers. It is through the establishment of an empowering organisational culture that the full implementation of a person-centred model of dementia care is possible. If no attempts are made to initiate a change in organisational culture, at a macro level, the reality is likely to be the

reproduction of task orientated care, and a failure to practically apply person-centred care. Discussion will now move on to the research that captures an understanding of the high levels of staff turnover in the care home sector. High staff turnover renders problematic any attempt to develop practice and improve standards of care. It is necessary therefore to explore staff outcome factors and their impact on care delivery.

2.3.9 What factors do staff report as key reasons for high staff turnover?

Job satisfaction has been reported as the most prominent cause of care worker resignations (Gilster et al., 2018). Staff consistently state a lack of social support from employers, colleagues, friends and family members as a key reason for leaving their job in a care home setting (Karantzas et al., 2012; Suzumura et al., 2013). Such support is seen as essential to job satisfaction due to the high amount of stressors staff feel they are exposed to during an average shift (Karantzas et al., 2012). One study for example, found 20% of care workers were exposed to some form of psychological distress (Margallo-Lana et al., 2001), whilst another found 68.6% of staff they surveyed were emotionally exhausted (Duffy et al., 2009).

In summary turnover rates primarily suggest better staff support structures will result in lower staff turnover. The provision and availability of such structures then would appear to be advantageous in an implementation strategy for a new model of dementia care. A lack of opportunities for skill and career development also contribute to high turnover rates. Effective leadership therefore should include understanding employee's long term ambitions and attempting to help them realise career aims, through allowing staff to work in areas that could lead to specialisation. Pathways to managerial roles could also be implemented (Tummers et al., 2013). Staff do not seem to attribute leaving their role due to stress caused by people with dementia directly; dissatisfaction with the level of support gained from the organisation they work for is the key factor.

2.3.10 What issues contribute to burnout in care workers?

Burnout is an emotional state of mind and body caused as a result of occupational stressors. It is a type of stress distinguished by three specific conditions: Exhaustion, depersonalisation and reduced personal

accomplishment (Maslach, 1986). Exhaustion is characterised by feeling emotionally unable to contact with others at work meaning a care worker, for example, would not feel able to provide a high level of support for a resident. Depersonalisation refers to a lack of care for the emotional needs and feelings of others one comes into contact with at work. Finally reduced personal accomplishment refers to a feeling of deterioration in the level of skill one has in the job role they are fulfilling (Maslach, 1986).

Despite higher levels of burnout being prevalent in dementia care workers (Todd and Watts, 2005), staff do not equate the stressors that can lead to burnout with caring for people with dementia directly, more failings in the organisation they work for (Testad et al., 2009). Moreover, the psychological disposition of care staff has been related to protect against burnout. For example, 'self-efficacy' or a person's belief in their own ability to care for people with dementia has been shown to be related to levels of burnout. Those with a high level of efficacy were shown to be protected against burnout; those with a low level of efficacy were most susceptible (Duffy et al., 2009; Kokkonen et al., 2014). It is important therefore to gain an understanding of how staff feel about their own ability to adjust to the new model of care. Training and support should be available to smooth the transition period.

A further cause of burnout is staff being dissatisfied with the quality of care being delivered to people with dementia in care settings (Schmidt et al., 2014). This reinforces the findings of Zimmerman et al (2005) who report staff who work within person-centred models of care have higher levels of wellbeing than those who work within task-based models. This suggests staff should enjoy the care they provide more, and have lower prevalence of burnout, when working in cultures of care predominantly informed by a person-centred approach.

2.3.11 What is known about the process and outcomes of care in newly opened care homes?

To the best of my knowledge the body of literature relating to the challenges experienced when opening new care homes is severely limited; as is evidence describing person-centred implementation processes within these settings. One

study by Häggström et al (2004), exploring nurse satisfaction in Sweden does so in the context of a newly opened care home, finding most nurses felt let down by the promises made to them, before the home opened. These promises were interpreted as broken, leading to deep dissatisfaction in the work place. Cuts to the care homes budgets were a large factor in the nurses feeling let down. Despite this, there was a belief things would improve, and nurses described being highly satisfied when engaging residents in individualised care.

2.3.12 Reflections

The way people with dementia, living in care homes, define their care needs is consistent with the principles underpinning person-centred care. This, coupled with the positive outcomes linked to person-centred care practice, justifies the pursuit of its implementation in care home settings. Research has shown person-centred care implementation is obstructed by the macro level organisational culture prevalent within dementia specific care homes (Cummings et al., 2010; Jeon et al., 2010; Kirkley et al., 2011; Hebblethwaite, 2013). However, despite highlighting the impact of organisational culture, the empirical evidence base does not provide a framework demonstrating how to prevent organisational challenges detracting from an effective implementation process. Nor does it provide evidence surrounding the challenges of implementation person-centred care in new dementia care homes, such as Somerset House. The evidence base related to implementation processes of person-centred care is therefore underdeveloped (Shier et al., 2014; Zimmerman et al., 2014). This thesis will attempt to address this gap in the evidence base.

Attention will now turn to the built environment and how it relates to the wellbeing of people with dementia and the ability of staff to implement person-centred care.

2.4 What are ‘dementia-friendly’ care home design principles? How can the design of the built environment of a care home help facilitate the implementation of a person-centred model of care delivery?

2.4.1 Introduction

In this section I will review what is perceived to be ‘dementia friendly’ care home design by people with dementia, their family members and dementia care staff. I will analyse any difference between the perspectives of these groups of people and consider the implications for dementia care provision.

In the discussion that follows I will address what ‘dementia friendly design’ should strive to achieve and give examples of recommendations for specific environments within care settings. The implications for how dementia friendly design can facilitate successful implementation of a person-centred model of care are exemplified.

Ensuring the built environment is adapted in a manner that respects the personhood of people with dementia is an essential element of person-centred care practice (Davis et al., 2009; Campo and Chaudhury, 2012). For example, communication and interaction between care staff members and residents is key to person-centred care. However, if the care home is too spread out or fragmented due to long corridors or a ‘closed door’ culture, then the levels of interaction between staff and resident are likely to be too low for meaningful and trusting relationships to be formed. The strategic implementation of a person-centred care should therefore consider how the built environment and the spaces within care homes are negotiated and used. In doing so care providers can gain insight into how the relationship between the design of the care setting and care practice interact (Brush et al., 2011). The aim of this section of literature is to gain an understanding of dementia-specific environmental recommendations in care settings. These will be reflected back upon in the findings of this thesis, to analyse how appropriate the Ferndown Suite, where observations occurred, was for the delivery of person-centred care.

2.4.2 What is 'dementia friendly' care home design?

The subjective nature of social reality entails that the perception of the residents with dementia, is a key criterion in any discussion about what exactly best practice is in any field; with direct consequences for the wellbeing and quality of life of this demographic. The built environment of care settings is no exception. Despite this, academic literature investigating the perspectives of people with dementia on this topic has rarely been conducted. People with dementia and their family members consistently placed a low level of importance on the physical structure of care settings themselves. In contrast they express a preference for structures that foster privacy, homeliness, autonomy, choice, good care, accessibility, engagement, and meaning (Innes et al., 2011; Barnes et al., 2012; Popham and Orrell, 2012; Liou and Jarrett, 2013; Digby and Bloomer, 2014; O'Malley et al., 2017). The perspectives of people with dementia and their family members reflect the principles inherent to person-centred care, discussed in the first section of this literature review. For example, Innes et al (2011) found residents with dementia believed physical environments were generic, and it is how the space within the building is used by staff and residents that was of value. Choice of environment is seen as particularly important as it enabled people to engage in social interaction with staff and residents, have privacy, or access to outdoor space, depending on how they were feeling at the time (Innes et al, 2011; Barnes et al., 2012; Liou and Jarrett, 2013). O'Malley et al (2017) suggest landmarks and wayfinding aids that hold meaning for people with dementia i.e. unique and distinguishable pictures, are more memorable than written signage alone.

2.4.3 Care workers and family members

Care workers and family members of people with dementia also report environmental flexibility, characterised by choice, to be essential to the wellbeing of people with dementia living in care (Garcia et al., 2012). Staff agreed that homeliness, quiet spaces and privacy are desirable feature of care settings and enhance the wellbeing of residents (Morgan and Stewart, 1999; Innes et al., 2011; Garcia et al., 2012; Popham and Orrell, 2012; Liou and Jarrett, 2013).

The perspectives of care staff differ from those with dementia in considering how the built environment impacts upon care delivery, in a practical manner. For example, Liou and Jarrett (2012) found staff appreciated the open nature of communal environments, as this allowed staff to respond quickly to resident need, while maximising the ability of staff to observe residents to ensure safety. Safety of the built environment is one area prioritised by staff and deemphasised in the responses of people with dementia (Innes et al., 2011; Popham and Orrell, 2012; Liou and Jarrett, 2013). Studies have suggested environments that score highly for safety also score low for control and autonomy (Torrington, 2006; Popham and Orrell, 2012). This exemplifies how the perceptions and experiences of people with dementia can have a direct impact upon quality of life for residents.

People with dementia have clearly articulated their preference for homely environments that are accessible and facilitate privacy or company based on their preference in the moment (Innes et al., 2011; Popham and Orrell, 2012; Liou and Jarrett, 2013; Digby and Bloomer, 2014). Architectural design where the experience of living in care settings is not accounted for, can lead to inadequacies within built environments. For example, the variety of social and private spaces required for environment choice and flexibility could be lacking. Additionally, not sourcing the opinion of people with dementia could lead to an overemphasis on the physical safety of residents. This could impede access to some spaces and settings, particularly if these are outdoors.

A discussion into various design features will now take place. The impact on the wellbeing of residents, and how the built environment can aid staff to implement person-centred care will be considered.

2.4.4 What are dementia friendly design features of built environments?

The perspectives of people with dementia and their family members are reflected in the evidence base i.e. that the physical environment should foster autonomy, give residents choice and control, be homely and facilitate private spaces (Torrington, 2006; Davis et al., 2009; Fleming and Purandare, 2010; Kelly et al., 2011; Zeisel, 2013; O'Malley et al., 2017). A plethora of research has been conducted on how physical spaces should be designed within care

homes. In this section I will only focus on aspects of the communal spaces in care homes, as no observations took place in private areas of Somerset House. A summary of recommendations found within the literature is provided below.

Table 1: Research recommendations for physical spaces in care homes

Area	Recommendations
Corridor Design	<p>Corridor length should be minimised to aid wayfinding and increase orientation (Barnes et al., 2012)</p> <p>Corridors should be divided by communal areas to reduce anxiety, provide opportunities for rest and therefore, help enable residents to use communal facilities (Barnes et al., 2012)</p> <p>Corridors should be wide enough to comfortably fit two bariatric wheelchairs side by side to enable less ambulant residents to interaction and walk with each other (Barnes, et al., 2012)</p> <p>Corridors should be distinctive in different parts of the building to promote visual cues and familiarity for residents (O'Neill 1991; Torrington 2006; Scialfa et al., 2004).</p> <p>Residents should be encouraged to personalise areas of corridors outside their apartments to aid orientation (O'Neill 1991; Torrington 2006; Scialfa et al., 2004).</p>
Way finding	<p>Floor plans and building circulation need to be as simple as possible, with a minimal amount of intersections and 'choice points' (Weisman et al., 1991; Marquardt, 2011; O'Malley et al., 2017).</p> <p>Any walls along walkways should be not cluttered with notifications, such as activity and event information. (Passini, et al., 2000; Pollock and Fuggle, 2013).</p>

Area	Recommendations
	<p>Landmarks should be placed as key points in walkways (Namazi and Johnson, 1991; O'Malley et al., 2017).</p> <p>Signage should be at eye level and take account of walking frame or wheel chair users (Namazi and Johnson, 1991).</p>
Colour contrasts	<p>Colour contrasts should promote cueing, and flooring, skirting boards, and walls should contrast (Marquardt, 2011; Pollock and Fuggle, 2013).</p> <p>Solid colour contrasts should be used rather than complex pattern designs to avoid disorientation, confusion and anxiety (Passini et al., 2000).</p>

2.4.5 Implications for care delivery

The above recommendations typically have the principles of the disability model of dementia underpinning them, and are designed to facilitate the delivery of person-centred care. For example, providing meaningful wayfinding aids helps to support the independence of residents with dementia (O'Malley et al., 2017). Supporting autonomy is one method of maintaining the personhood of those with dementia (Kitwood, 1997; Brooker, 2007; Edvardsson et al., 2008). In this context it is possible to demonstrate how adaptations to the built environment can provide meaningful activity to people with dementia, whilst aiding staff in the pursuit of person-centred care provision.

Dementia friendly physical environment design has been shown to reduce confusion, anxiety, aggression, increase positive social interaction, activity, aid fall prevention, improve orientation and enhance the experience of care (Calkins, 2009; Davis et al., 2009; Burton and Sheehan, 2010; Campo and Chaudhury, 2012; Chaudhury, 2013; Morgan-Brown et al., 2013; Eshkoo et al., 2013). This body of evidence suggests the quality of the physical environment has a direct relationship on the wellbeing of those living within the setting. For example, Morgan-Brown et al (2013) found 'open plan' communal design

increased social interaction between residents and resident activity resulting in increased levels of wellbeing. Moreover, the level of ambience light in care settings has been shown to impact on resident wellbeing. High intensity light exposure resulted in increased wellbeing for people with dementia, characterised by decreased restlessness and regular sleep patterns (van Hoof et al., 2009).

The adaptation of built environments to incorporate dementia friendly principles has also had a positive impact on staff outcomes (te Boekhorst et al., 2008; Verbeek et al., 2010; Willemse et al., 2014). Dementia care staff working in small 'home-like' environments exhibit higher levels of motivation and job satisfaction and lower burnout (Boekhorst et al., 2008; Verbeek et al., 2010). This is reportedly due to better staff support structure in place at smaller-scale care home settings, and care workers having a higher level of control over the care they deliver (Boekhorst et al., 2008). However, staff outcomes may also be related to improved resident outcomes, as a result of the implementation of dementia friendly design features. As discussed in section 2.3, a relationship exists between good quality of life outcomes for people with dementia and staff outcomes such as job satisfaction, retention and burnout. Further research is needed to explore the specific causal direction of these findings.

2.4.6 Reflections

The manner in which people with dementia and their family members, have described the importance of the built environment, is in line with the principles recommended by proponents of person-centred care. It is plausible then that the implementation of person-centred care could be aided or abated by the built environment. The quality of the built environment at Somerset House is not the main focus of the PhD study. No structured or systematic audit of the care home therefore, took place. Observations of the Ferndown Suite, (the main site of data collection within Somerset House) however, were critically compared to the recommendations supplied in this section to assess whether the physical environment contributed to the delivery of person-centred care.

2.4.7 Overall reflections

The positive staff and resident outcomes linked to person-centred care practice, such as increased wellbeing and lower burnout gives justification to the pursuit of implementing person-centred care in care home settings. Further, person-centred care has been shown to be preferred by people living with dementia in care homes, providing a further moral justification to the implementation of person-centred care. A link between the built environment design features and the delivery of person-centred care has been demonstrated.

The evidence for specific organisational cultures that actively enhance person-centred care practice is underdeveloped (Shier et al., 2014). However, a synthesis of the body of evidence reviewed does suggest the development of a culture that empowers people with dementia aids the implementation of person-centred care, improving outcomes for care workers and residents. In the third chapter of this thesis, the research design, methodology and data collection strategy are outlined and justified.

Chapter 3: Research Design: A critical evaluation of the strategic implementation of a new model of dementia care

3.1 The focus of inquiry

For the implementation strategy to be critically evaluated it is vital to explore the culture of care prevalent or dominant at Somerset House. Through utilising constructionist theory as a lens to analyse social interactions, communications and relationships, a picture can be gained of the wider organisational culture of care, and how this manifests itself in daily life within the care home. This picture can then be used to evaluate, the extent that the implementation strategy used to introduce the model of care, has been effective.

3.2 Research questions

My theoretical perspective, coupled with the findings of the literature review has influenced the development of the following research questions that guide this PhD study:

- 1) What is the dominant culture of care at the care home?
- 2) To what extent was the *EMBRACELIFE* strategy implemented within the care home and why was this the case?
- 3) How did the care home's newly operational status interact with the implementation process?

3.3 Research Design

3.3.1 Deciding upon a research design

Prior to my appointment as the PhD researcher on this grant it was proposed the research would be longitudinal, with 3 data collection visits to Somerset House, whereby I would 'track' a number of residents living at the home,

documenting their wellbeing and their care worker interactions at month 1, 6, 12 and 18 from when the care home opened its doors. However, due to practical and research design considerations, and an acknowledgement of the central importance of the implementation process, a multi-method ethnography approach was adopted.

Delays to the opening of the home meant it was unfeasible to conduct research, across an 18-month period, in the context of a PhD, traditionally spanning a 3-year period. Further, it was requested by senior management at Hollyfield that the beginning of data collection was delayed. Key documentation that informed the care of residents at the home was not completed, and it was requested I delayed commencing research as a result of this.

From a research design perspective, it was concluded that an ethnographically informed approach to data collection would enable me to capture, understand and interpret the culture of care more effectively than splitting my data collection into 3 longitudinal phases. It was also concluded that staying at the care home regularly for a consistent period of time over 3 months would enable me to build stronger relationships between myself the research participants, facilitating the development of trust, that would be key if a valid insight into the culture of care at Holyfield was to be captured. These, and further methodological considerations are discussed in this chapter, to give a full account of my rationale for the research design and methods used in this PhD study.

3.3.2 The purpose of research

The aim of this PhD study was to evaluate the implementation process of a model of dementia care. This is not to be confused with an outcomes based evaluation of the model and the principles inherent to the model. The focus here was on the process of applying the model of care in practice, and the cultural and organisational outcomes of that process. Therefore, an understanding of how the model of care was or was not embraced within the care environment was needed. This is quite different to assessing whether the principles behind the model improved the wellbeing and quality of life of people with dementia.

Dismissing health and wellbeing outcomes as irrelevant to the aims of research may appear unethical, given the vulnerable status of people with dementia that participated in this thesis. Such a focus however, finds justification in the necessary and logical separation of process and outcome (Becker, 1970). The findings from an outcome based investigation, into the effectiveness of a model of care would be flawed, without a sound understanding of the extent to which the model has been applied in the first instance (Robson, 2011). Petriwskyj et al (2017) for example reported that issues with the implementation of models of person-centred care may inhibit outcomes. Therefore implementation processes warrant attention.

The effectiveness of model implementation featured heavily in determining the presence or influence of the model in and over care practice. If the implementation strategy was left unevaluated, the extent to which the model of care had penetrated the pre-existing organisational culture of care would be unknown. Therefore, it is not possible to attribute any outcomes based findings, beyond the outcomes of the implementation process, to a specific model of care, without a prior understanding of the process of model implementation.

3.3.3 Influence of my theoretical position

It is the contention of social constructionism that perceptions of reality are mediated by dominant forms of knowledge, perpetuated by those with power or authority (Berger and Luckmann, 1966). Such a reality is discernible in the manner people communicate and act in their everyday encounters with others (Berger and Luckmann, 1966). Moreover, how people position themselves in relation to others, can reveal characteristics about the social processes that underpin any given community (Goffman, 1963). It is therefore possible to experience and explore these processes, through the study of social interactions, relationships, events, actions and/or language; thereby capturing how the dominant culture within a community is constructed.

3.3.4 Influence of research questions

My theoretical position and literature review presented in Chapter 2 has led me to develop the research questions described above. The focus is firmly on how the people who live and work in the care home construct perceptions of

themselves and each other. What these 'on the ground' findings captured, about the organisation culture of care at the care home, were analysed to reveal how fully the implementation strategy influenced practice.

To answer the research questions, a research design was needed that provided a framework for a detailed investigation of the culture of care at the care home. It is through the detailed documentation of the everyday interactions, communications, and perceptions that take place and exist within the home, in the context they are derived from, that an understanding of the cultural organisation of care was gained.

3.3.5 Research design criteria

After considering the purpose of this study, my theoretical position, and the process based focus of inquiry, it was apparent I needed to choose a design that fulfilled the following criteria:

The research design must allow for:

- 1) An evaluation of process to take place.
- 2) A detailed analysis of social interaction, perception, and care documentation
- 3) The detailed study of particular social phenomena, so that generalisations can be made, about the whole community within which that social phenomenon exists or occurs.

These criteria led to me choose a design informed by ethnography for this PhD project. Discussion will turn now to a description of ethnographic research. The relevance and justification for undertaking an ethnographic approach to the research will be explicitly stated.

3.4 Ethnography

Ethnography is a methodological approach, seeking to provide a descriptive interpretation of the construction, characteristic or nature of a community or culture (Hammersley and Atkinson, 2007). Such description occurs through a

process of data collection, explicitly linked to consistent contact with human agents within the context of their daily lives (O' Reilly, 2011).

Ethnography is distinguished from other methodological approaches in that the researcher becomes engaged in the events that occur in the community under study as a member of that community. This kind of data collection allows data to be derived within the social context under investigation, rather than artificially in a formal interview or experimental setting, for example (Hammersley and Atkinson, 2007). Therefore, the observed event or behaviour is tied to the surrounding social context (Marcen et al., 2013).

3.4.1 To what extent is this study ethnography?

I applied the principles of the ethnographic method to this PhD study. While recognising that I was not a 'complete participant', fully immersed into the lives of those living and working in the care home environment for constant period of time, I did spend frequent 'chunks' of time living at the care home, with 1 week separating each visit. During these chunks of time I invested my energies into forming relationships with the participants in the study, helping staff with non-invasive care delivery, eating in communal areas with staff and residents and being generally as visible as possible in the environment. Such activity is in line with ethnographic research principles (Brewer, 2000). These activities can be defined as participant observation, the primary method of ethnography (Hammersley and Atkinson, 2007; O' Reilly, 2011). Such practice was supplemented, by non-participant observation, interviews and the analysis of documentation conducted throughout my time at the care home. (Observational methods are discussed in more detail in section 3.5). Ethnographic research was chosen as the primary research design for this study for the following reasons:

- 1) I wished to capture, understand and interpret the meanings behind the construction of interaction and perception between people living and working in the care home
- 2) I hold a belief that the interactions and perceptions of people that live and work in the care environment can be observed, and are reflective of the wider organisational culture of the care home

- 3) I wished to do everything I could to ensure the interactions and perceptions I observed were not influenced by my presence.

3.4.2 A Social Constructionist approach to ethnography

One principle of an ethnographic approach is that it is possible to observe the culture of a group of people in the everyday interactions and events that occur in a community or society (Geertz, 1973). A realist theoretical perspective would suggest that what is being observed is representative of an objective cultural reality produced naturally through human interaction (Denzin, 1997). A critical realist perspective would agree that the social phenomenon under study exists is an objective reality but would go on to challenge the social processes and mechanisms that they see as producing this reality (Alvesson and Skoldberg, 2009). As a constructionist I would argue it is possible to observe the culture of a community, but this culture is not natural or objective, rather it is mediated or constructed by dominant forms of knowledge implicit in wider social structures and institutionalised through policy and legislative process (Berger and Luckmann, 1966). This knowledge is produced and maintained through language, it does not constitute an objective reality, therefore it is possible to capture an understanding of culture (and as a result, people's perspective), through identifying dominant forms of knowledge and its institutionalisation (Alvesson and Skoldberg, 2009).

It is out of this knowledge that a culture is formed and maintained that guides interaction, perception and communication between people within a given setting. Indications of this culture can therefore be found within texts through the analysis of discourse. For example, when observing a care assistant's interactions with a person with dementia, their action is influenced by the construction of their perception of dementia and dementia care. Such a construction will be produced and maintained by discourses of dementia and dementia care within care delivery documentation, communications between staff, the built environment and interactions between other staff members and residents. Moreover, interaction is contextualised by issues such as work load, stress, health and possibly the presence of a researcher. A constructionist approach demands that I as an analyst engage in reflexive thinking through

problematizing the concept of a realist perspective of interaction and communication (Brewer, 2000).

Geertz (1973) in his thesis *The Interpretations of Cultures* discusses how ethnographers should use 'thick' description to gain access to the perceptions of participants and the meaning that guides interaction. The defining factors of thick description to take into account when making field notes are as follows:

- 1) The social context of the particular event or interaction that is being observed
- 2) The meaning behind action or language
- 3) The sequence of events
- 4) The perspective of the participants being observed

Ethnography as a method informed by constructionist theory, fits with the aims of this thesis and my personal epistemological position. I followed the principles of thick description (Geertz 1973) when taking ethnographic field notes. This helped to guide what were largely unstructured observations, and ensured that I considered the perceptions of my participants when I took field notes. It was possible therefore to reflect on what the dominant discourse i.e. the perspectives constructed through language, captured about the culture of care within the care home, and the implications of this for the implementation strategy of the model of care.

3.4.3 How does ethnography deal with the issue of researcher bias?

The question of researcher bias is an issue that impacts upon research no matter the methodology or method. However, ethnographers are particularly prone to the critique that their presence invalidates the research, as a core claim of ethnography is that by being 'close to the action' and analysing data derived from naturalistic settings, a narrative can be produced that represents a given reality (Becker, 1997; Brewer 2000). Critics of ethnography question how authentic and 'natural' the settings (and the behaviour that occurs within settings) can be in the presence of a researcher. Becker (1998) refutes these critics by dismissing the ability of participants as members of a given setting to sustain unnatural behaviour or pretence when observed and engaged with over long periods of time. Becker speculates, on the contrary, that ethnography can

stake a claim to being less affected by research bias than any other method as a result of the length and frequency of points in time data are collected during ethnographic research (Becker, 1998). Other writings have expressed the need to be reflexive when undertaking ethnographic research, taking into account the researcher's presence in any analysis so that this limitation is not ignored (Hammersley and Atkinson, 2007). Reflexivity is discussed in greater detail in the next section.

3.4.4 Reflexivity

As a social constructionist, it is important to recognise the role my own perceptions and interpretations play, in the construction of the realities I observe and write about (O'Reilly, 2009). The knowledge or schools of knowledge that guide my perception hold sway upon how I observe and understand social worlds and cultures. The findings within this ethnographic study therefore are an interpretation of the culture, represented through the lens of my perception of reality. My reality is informed by theoretical and substantive beliefs such as my social constructionist epistemic position, and the challenges associated with maintaining personhood in care settings. This is a key reason I positioned the research in the first 2 chapters of the thesis.

I was keen to examine the language used by care staff, particularly when engaging with or describing residents, believing this to be deeply revealing about wider care culture. My interpretation of culture was also influenced by what I chose to observe and when; as well as practice realities, such as what I could observe. Decisions were guided by my interests and what I believed would give a firm understanding of culture. Often, this could be when a hive of interactions were taking place. For example, during mealtimes and structured activity sessions. The thinking was that during these times, staff and residents would be more communicative about both themselves and each other, and would be readily observable. It should be noted therefore, my perception of when and where rich data would be observed, may have led to an overrepresentation of specific events within the data.

I could not ethically justify observing care practice in private areas, such as bedrooms and bathrooms. Moreover, I could not record observations on floors

where people without the capacity to give informed consent resided. Therefore, the culture of care I constructed was constrained to observations of life on the public areas within the 'residential suite'. The data are therefore moulded by academic standards and ethical practices that dictate what experiences are justifiable to observe.

One of the more important decisions I made, that shaped the data set, was guided by my own ethical principles. I decided to cease interviewing people living with dementia in the care setting. I did not feel doing so was ethically justifiable, despite having ethical approval to do so. Factors that influenced this conclusion were the process focus of thesis, and my interpretation that speaking with residents was of limited utility in answering such questions. This decision was influenced by my reading of the data, and my feeling that to engage a resident with dementia in a formal interview, I had to have sound reasons for doing so. In the context of the research aims, and based on the quality and relevance of collected data from the first interview to these aims, I consciously decided to cease interviewing residents. Observations of malignant social psychology within the setting, coupled with the need to interview residents in common areas of the care home also contributed to this decision. I could not risk negatively influencing relationships between staff and residents, or guarantee confidentiality.

Throughout my time at Somerset House I was acutely aware and reflexive when straddling the border between participant and non-participant observer. Two main factors were reflected upon when weighing up the role I was about to play. First, was a careful consideration of my relationship with the participants involved, and the direction of communication between us at the time. I would only participate only when invited to directly by a participant in the setting, be that a resident or care worker. This was a mechanism I used to try and prevent my presence making the participants feel awkward, and to minimise the influence of my presence on what I was observing. The extent that I was a participant observer, or otherwise in this study, was also determined by the level of trust the participants had in me as researcher, and the consequent level of access granted to partake in events and activities. Upon reflecting upon my time collecting data within the care home, there were key moments where

participants interacted with me in a way that suggested I could justify becoming a participant observer. An example I remember particularly fondly is reflected in the field note presented below. I had spent around an hour sitting next to and speaking with Colin when the following incident occurred:

The music session is about to begin upstairs, [care worker] approaches Colin and asks if he would like to take part. Colin looks at me briefly, then turns to [care worker] before pointing at me and although he struggles to verbally articulate, it's clear he is asking the care worker if I am allowed to join him in the session. I almost felt like Colin was trying to do me a favour by 'getting me in' to the session. I certainly felt Colin had enjoyed my company and we had made a social connection. (Extract from Fieldnotes).

I had already been invited to the music session by a care worker, earlier that morning, however, for Colin to invite me made me feel more comfortable taking part. It also meant I felt comfortable interacting with him in a meaningful way. I would sit with him at mealtimes, go for walks in the garden with him and help him walk from one part of the suite to another.

I would also consider what I was being asked to do, before deciding whether to cross the line between purely observing and participating. For example, during times when no staff member was present in common areas residents would request things from me. Most of the time it would be simple information, such as questioning when lunch was; occasionally however, I would be asked to assist residents. For example, to get their pills, or help them to the toilet. This created ethical dilemmas for me in the field. These are reflected upon in greater detail in section 7.7. In the context of reflexivity however, I want to focus on how I interpreted my role as participant, or the request of me to become a participant, in relation to my interpretation of the data. The perception of me as staff member I did find reflective of a lack of care workers in common areas; not due to a lack of numbers, but due to staff being needed elsewhere in the suite. Often this was in private areas where one to one, or in some cases two to one care was being delivered. My presence in the field therefore did impact on the

data, through my reflections on what my participation meant for the culture and organisation of care at Somerset House.

In summary, my perceptions influenced a myriad of factors that when combined, produced data centred a dynamic relationship between myself, the setting and those living and working within it. This included where and when I decided to conduct my observations, who I spoke with during observations, at what point I engaged beyond being a non-participant observer, how I interpreted actions, interactions and language, the documents I chose for analysis and who I decided to interview. I was to be aware of the possibility of my presence impacting on the everyday events that took place at the care home. I noted any instances when the context of events seemed to be undermined by my presence, and engaged reflexively with the data to capture what the impact of my presence was, on the interactions within the care home. As data collection progressed I noted several instances of Malignant Social Psychology (MSP) (Kitwood, 1997) that although challenging to witness, seemed to suggest the care workers, who participated in the research, were behaving with little regard for my presence.

3.4.5 Sampling strategy

The number of participants recruited in an ethnographic study is usually small. The focus is not on achieving a large sample size, from which externally valid generalisations can be made, but on gaining an in-depth rich data set on the community engaged (Robson, 2011). This study therefore made use of a small sample, drawn from the care workers and people with dementia living at the home. As a result, recruitment was limited to the care home in question. Sample size was limited to the number of staff and residents working and living at the home who would give informed consent to participate.

Staff participants were selected purposively. I was keen to ensure the voice of all types of staff members were visible in the data. This included care assistants, care supervisors, registered nurses (RN) (both general and mental health) and managerial level staff. I also identified staff members from all groupings who worked day, night, weekday and weekend shifts, to gain a

holistic picture of the staff experience and culture of care, across shift patterns. Below I outline the approach used to recruit staff participants in this study. This approach was adaptive and changed dependant on who I was hoping to recruit, where they worked, and at what time.

To increase my chances of recruitment I attempted to build trust with staff members prior to the beginning of data collection. I visited Somerset House during the 2 weekly induction training course, introducing myself and bringing in doughnuts for everyone as an icebreaker. The staff members I engaged with reacted positively to this, showing a keen interest in study participation. I sent out information sheets to the site administrator who promised to leave copies in the staffing rooms. I hoped this would familiarise staff with the study, prior to me entering the home to collect data. I began staff recruitment on my first visit to the home post opening. First, I spoke with the administrator and my assigned gatekeeper for the study (dementia lead nurse), to get an indication of who showed an interest in the study. I also had my own ideas, based on who had shown an interest during my induction day visit. I was taken into the Ferndown suite and introduced to the people living and working there at the time. I stayed visible in the suite for the rest of the morning, speaking with staff and residents, and telling them about why I was here and taking them through the information sheet. I started with those I felt, based on knowledge gained previously, would want to be involved. Most of these initial discussions were with staff members who were very happy to be involved, commenting that they had 'wondered when this was all happening', that they'd heard about the study previously, or words to that effect. Most I spoke to in this context signed up on the spot. However, recruitment was not always so straight forward. Some staff who initially said they would like to participate, hesitated to fill in a consent form, or sit down with me to go through the information sheet. I remember one RN in particular, on the surface sounding very happy to participate, but in the end could not find the time go through the process necessary to do so. Reasons included being too busy with practice based responsibilities, such as giving out medications, annual leave, and sickness.

Throughout my time in the research setting I met with my assigned gatekeeper to discuss possible participants. This was key to the recruitment of care workers

on the other suites, who I typically would not bump into within the home. In some cases I would ask a staff member I knew to introduce me to this individual. Other times I would go to the suite and directly approach the identified individual. This provided a challenge as I was not conducting observational research on those suites. As a result, I was largely unfamiliar to these staff members, and had not established a trusting relationship. Despite this, I was able to recruit a number of staff members from these floors, and interview them.

Once the staff participant had agreed to take part in the research, I arranged an interview with them at a time they felt was convenient. I was keen to stress that the most important thing was their responsibility to the residents, and I would not want to take up time during particularly busy periods; I was flexible with when we could meet. On 3 occasions these interviews did not occur. The most common reason cited by participants was being too busy, for example because of colleague absence. On 1 occasion the participant was on sick leave. One staff member was happy to participate in observational research, but refused to be interviewed.

Table 1 below details the number of participants and ID code for each participant. In total 10 people living with dementia consented to participate and 20 care workers participated. Those interviews have been identified in the table with an 'i' in brackets. Care workers is a generic term used in this thesis to describe any member of the care team from managers to care assistants. Where necessary to distinguish between roles I have done so, referring to Care Assistants, Care Supervisors, RNs and Managerial level staff and the Dementia Lead Nurse.

Table 2: Participant Groups, Numbers and ID codes

Participant Groups	Number of Participants	Participant ID codes
People with dementia	10	425,426,427 (i),428,429, 430,432, 434,435,436
Care Assistants	6	525 (i), 528 (i), 526 (i), 533 (i), 536, 544
Care Supervisors	9	527 (i), 529 (i), 531 (i), 532 (i), 535 (i), 539 (i), 542 (i), 543, 545,
Registered Nurses	3	537 (i) , 540 (i), 541 (i)
Managerial level staff/Dementia Lead Nurse	2	538 (i), 534 (i)

The care home had 5 distinct suites, each with 12 one bed rooms. However, during data collection one suite was non-operational due to safety concerns. Moreover, a second suite was occupied by residential needs people, who did not have dementia. The care provider had made the strategic decision to temporarily rehome residents from a sister care home whilst a refurbishment took place. The residents in 2 of the suites were assessed by myself, with the use of a gatekeeper, as not having the capacity to give consent, following Dewing's (2007) method of process consent (Discussed in more detail in section 3.7). This effectively meant I was able to recruit people living with dementia from one suite in the care home. The care provider labelled this suite as for people with dementia, with more 'residential needs'. Whilst I was unable to recruit people with dementia from the other 2 operational dementia specific suites, I was able to interview care workers from these suites to capture a picture of what it was like to deliver care in these environments.

3.4.6 Participant pseudonyms and job roles

- People with dementia: Josephine (425), Geraldine (426), Patricia (427), Eve (428), Adeline (429) Colin (430), Emma (432), Cynthia (434), Deirdre (435), Donald (436).
- Care Assistants: Helen (525), Danielle (528), Jennifer (526), Henrietta (533), Rachel (536), Denise (544).
- Care Supervisors: Daisy (527), Alexa (529), Matilda (531), Joanne (532), (Charlie) 535, (Zara) 539, (Gemma) 542, Amy (543), Jack (545).
- Registered Nurses: Nathan (537), Wendy (540), Caroline (541).
- Managerial Level: Edith (538), Vera (534).

3.4.7 Introducing the residents

Josephine: Josephine is a keen musician and an extremely intelligent person. She is very well spoken however, does struggle to hear people when they try to speak with her. She often needs people to stand in front of her when in conversation. She walks with a stick most of the time, although the staff have begun to introduce a frame. She tends to become anxious if left unstimulated for a prolonged length of time.

Geraldine: Geraldine is bilingual and loves to speak in both her native language of English, as well as French. She is always telling jokes to the staff and making them laugh. She has difficulties walking and gets around in a wheelchair, with the help of staff members. She is regularly visited by her children, whom she is very proud of.

Patricia: Patricia is another intelligent person. She does not seem content living at Somerset House and can often seem quite down. She is an independent person who is able to walk and eat without assistance. Her high level of

capacity means she is often found taking part in activities within the Ferndown suite, such as quizzes and board games. She is often visited by her grandchildren.

Eve: Eve loves animals and is often found cuddling her 'soft cat' companion. She takes it everywhere she goes and is sure to ask the care workers for a saucer of milk for her cat at mealtimes. She also likes to read magazines. Eve is always asked to sit in a chair with modifications attached to it due to health issues with her feet. She is asked to walk with a frame for her safety.

Adeline: Adeline is an enthusiastic person who is always smiling and seems content and happy to be living at Somerset House. She walks with a frame and seems to enjoy 1-1 time with care workers, getting her nails polished and filed and reading.

Colin: Colin is an amiable person who can often be seen dancing in the communal lounge within Ferndown. He is a very strong walker, and loves the outdoors. He is a keen artist and enjoys visits from his wife. He does have some communication difficulties that he can find frustrating at times. He can become anxious, when bored of his surroundings. Colin enjoys half a bitter with his meal.

Emma: Emma has a high level of capacity and reads her favourite newspaper when delivered each day. She is visited by her Husband very frequently. She does get anxious about why she is at a care home, and cannot understand why she is not living at home with her Husband. Emma is able to walk with a frame. She is very aware of the medication she is on and can become anxious about whether she needs to take it.

Cynthia: Like Eve, Cynthia is a big animal lover, and is often found interacting with the soft animals in the Ferndown suite. She feels very at home at Somerset House and takes great pride in the appearance of the suite. She is able to keep herself well entertained cleaning and dusting the trinkets placed in the main hallway of the suite. She likes to help the care workers where she can. She is a bit of a night owl and is often the last person off to bed at night.

Deirdre: Deirdre is a very caring person who is always asking others how they are, and seems genuinely interested in the people around her. She is quite frail and is always seen in her wheelchair. She is a humorous person and a good communicator with a high level of capacity. She has a strong regional accent, something I can certainly relate to.

Donald: Donald is another of the residents who is a keen animal lover. He is good friends with Cynthia and they often bond over the soft pets in their care. He is an independent walker and is always dressed smartly in trousers and a buttoned long-sleeved shirt.

3.5 Methods of data collection

The methods of data collection used, were defined by the kind of the evidence required to answer the research questions proposed, and the aims of the research. With this in mind the following criteria was developed:

3.5.1 Criteria

One or more methods of data collection were required that capture:

- 1) The construction of the perceptions participants have about themselves and others in the care home setting
- 2) The construction of the relationships between participants
- 3) The construction of interactions between participants

The development of these criteria led to the selection of unstructured and semi-structured observational and interview methods as the main instruments of data collection for this ethnography, supplemented by document analysis of care plans. In this section the selection of these methods are justified.

3.5.2 Observations

Observation as a data collection method is defined differently depending on two distinguishable factors. The first factor is the level of participation a researcher has in the everyday routine of a particular community or social group (Robson,

2011). Participation observation involves the total immersion of the researcher into the environment under study. The researcher becomes an active member of the community or social group, taking part in events, having a role in those events and sharing the experience of being in the group with participants (May, 1997). This active membership allows a detailed picture of the customs, culture and practices of the social group to be obtained through the researcher's interpretation of the events he or she has witnessed (Robson, 2011).

Participation observation is heavily associated and the key data collection method used within ethnographic research (Becker, 1970; Hammersley and Atkinson, 2007; O'Reilly, 2009).

At the other end of the spectrum is non-participant observation. Here the researcher's role is purely observational. He or she does not intervene in the goings on of a community, or social group, above and beyond the inherent interference of being there in the first place (Robson, 2011). The majority of observational research fits between these two extremes (Hammersley and Atkinson, 2007; O'Reilly, 2009).

The second factor to consider was whether the observations would be guided by a specific tool, and therefore be structured, or whether they would be unstructured. Structured approaches are used more often in outcome based evaluations, due to the quantifiable nature of the data they produce, and the use of the data in defining the success of a programme or model. In contrast, unstructured observations have an exploratory function (Robson, 2011). The inherently open nature of unstructured observation means this method is appropriate when the context of a case, and its relationship with whatever is being evaluated, is not known prior to the investigation (Becker, 1970; May, 1997). To exemplify, my epistemological position leads me to believe that the organisational culture of care within a care home, has a role in the construction of interactions between care staff members and people with dementia. I did not however know anything, about how the implementation strategy impacted upon organisational culture, and therefore the values of that culture. This was revealed during and not prior to data collection taking place through analysing the discourse of verbal and written communication and interaction within the care home, and gaining an understanding of how that discourse contributes

towards the interactional process. I could not therefore create a predefined observational tool, identifying what the culture of care at the care home is, as I have no idea of how it will manifest itself in reality. Such a tool would have been based on how I imagined the organisational culture of care was constructed (Becker, 1998). Instead I induced this information from my observations and the analysis of discourse, allowing a picture of the care home culture to be developed, as evidence accumulated (May, 1997). A largely unstructured or 'informal' observational approach therefore fitted with the criteria produced for the methods of data collection I used.

3.5.3 What are interviews and what kind of interviews will I conduct?

The interview method is a second core method of ethnography. The basic tenant of an interview of any type is the use of verbal communication to prompt responses from a participant (Brewer, 2000). Interviews were used in this ethnographic study to capture how participants construct their perceptions of care staff members and people with dementia in the care home and the meaning behind this construction (Bryman, 2008; Silverman, 2009). Their responses were not necessarily taken at face value; rather the discursive meaning of the language chosen, was identified and triangulated in a reflexive manner, with data gathered from observation and document analysis. Responses were then applied to the question of what the meaning of perception constructed by participants reveals about the wider culture of care at the care home and the implementation process. What participant responses uncovered about the philosophy of dementia care was the main objective and reason for utilising the interview method (Brewer, 2000).

Interviews are routinely used in dementia care research to gain a picture of the culture of care in care settings (Chalfont and Hafford- Letchfield, 2010; Kirkley et al., 2011; Hebblethwaite, 2013; Renee et al., 2014). For example, Kirkley et al (2011) used a range of interviews to explore the impact of organisational culture on the delivery of person-centred care in respite care, finding the knowledge, attitudes and 'personal qualities of staff' as barriers to the provision of person-centred care (Kirkley et al., 2011).

It was of importance that I created a rapport with participants prior to data collection, particularly with reference to the interview process. I was aware that my relatively young age, lack of vocational experience in care home settings and status as a researcher, (and therefore 'outsider'), could all reduce the co-operation and trust my participants have in me and subsequently, the quality of the data (Brewer, 2000; Bryman, 2008). It was necessary therefore, prior to commencing data collection, to visit the care home purely to initiate familiarly and relationships with participants, whilst giving initial briefings to participants in relation to the research process.

Semi-structured interviews were arranged with participants each time I visited the care home. The method however, was only useful to use with care worker participants. I therefore engaged in unstructured conversations with participants living with dementia when conducting participant and non-participant observation on an ad-hoc basis. This aided me in following up on the motives behind the interactions and communications I observed, in an informal manner, whilst minimising disruption to the care home environment.

Unstructured and semi-structured interview methods facilitate the collection of open ended data. In doing so data are more likely to adequately reflect constructions of perception, grounded in the responses of participants, rather than any pre-conceived ideas of the researcher. Moreover, responses are likely to be more detailed, descriptive accounts (Bryman, 2008, Silverman, 2009; Robson, 2011).

3.5.4 The importance of documentary analysis in ethnographic research and this PhD study

Social agents do not only disclose information about their perceptions, and therefore the underpinning culture of social groups or organisations, in observable social interactions and interviews (Hodder, 1994; Atkinson and Coffey 2004; Miller and Alvarado, 2005). Evidence of this can also be found in written documentation, particularly in care home settings where evidence of the culture and priorities within care practice, and social interactions between staff members and people living with dementia, are routinely recorded and represented in various mediums (Hung and Chaudhury, 2011). The focus of

this PhD is on the care planning documentation and the strategic implementation document. Such documents were routinely used to guide or inform care practice, thereby providing insights into the cultural organisation of the care home (Miller and Alvarado, 2005). This ethnographic study would have been incomplete therefore, if it lacked a critical analysis of the aforementioned documentation (Owen, 2014). This analysis captured whether the principles of the model of care are implemented in the documentation that in theory, were enshrined into care plans. To achieve this, I analysed the discourses of dementia and care within the text in the documents, taking into account its purpose and aim.

By applying knowledge surrounding competing models or perspectives of dementia care to these texts, and understanding how the texts reflected the implementation strategy of the model of care being introduced, evidence was captured reflecting the organisational culture of care at the care home. This evidence contributed towards a critical comparison between the organisation of care at the care home in reality and the model of care being implemented. Implementation was then evaluated, based on implications drawn from a critical comparison of the discourses within the model of care in theory, and the cultural organisation of care in practice. The analytic approach undertaken, informed by principles of discourse analysis, is discussed later in this thesis section.

In this section I have introduced the various methods of data collection used in this PhD study. I have justified the utilisation of an ethnographic multi-method research design. It is through the synthesis of data gleaned from a range of qualitative methods consisting of observational, interview and documentary analysis, that a holistic evaluation of the implementation process of the model of care was achieved (Flick, 1992).

3.6 Analytic frameworks: Theoretically derived thematic analysis

One of the advantages to taking a thematic approach to analysis is the flexibility of the method and its ability to be compatible with various epistemic positions

(Braun and Clarke, 2006). Analysis was by and large theoretically driven by the template of the model of care itself, *EMBRACELIFE*, and its implementation strategy. The data therefore is largely coded to answer two key research questions:

- 1) What is the dominant culture of care at the care home?
- 2) To what extent was the *EMBRACELIFE* strategy implemented within the care home and why was this the case?

Themes and codes were also derived from the data, but the starting point for analysis was a more pragmatic analytical interest that sought to understand the process of the implementation of *EMBRACELIFE*. This required a more structured approach, critically comparing *EMBRACELIFE* and its implementation strategy, with the evidence in the dataset in a direct and purposeful manner. The specific aim of this was to locate both the culture of care, and the organisational mechanisms underpinning the implementation process. The majority of codes were therefore predefined, having been derived from the model of care and its implementation strategy.

Throughout the analysis my social constructionist position informed data interpretation. It did so through elevating the observed reality to the prevailing socio-cultural context. Therefore despite having predefined codes, analysis went beyond the surface, to attempt to understand how perceptions and communications reflected the construction of care, at Somerset House. This latent approach, attempted to understanding the meaning behind the communications observed in the data, and can therefore be described as having overlap with some of the principles of discourse analysis (Braun and Clarke, 2006); discussed in section 3.7.

To summarise, themes in the first chapter were derived from the *EMBRACELIFE* model and to a lesser extent, the data. Themes related to chapter 6 were driven solely by the implementation strategy for *EMBRACELIFE*. Both the *EMBRACELIFE* model and the implementation strategy are presented in chapter 4.

3.7 How interpretation and analysis of data was informed by principles of discourse analysis

The social constructionist contention that language is the medium through which knowledge, and therefore social phenomena, is constructed is central to the justification of my analytical interpretative framework. (Berger and Luckmann, 1966; Geertz, 1973; Porter, 1996; Galasinski, 2011). Knowledge is embedded within cultures through discourse (Bazerman, 1990; Potter, 1996). Discourse can be understood in this context as the underpinning meaning of language. A psycho-social model of dementia care for example, may be underpinned by person-centred, social citizenship or disability model discourse (Innes, 2009). By analysing texts, and understanding the underpinning discourse of dementia imbued within the text, it is possible to capture a picture of how and where the principles of a model of care are implemented and where they are not. Texts within discourse analysis are defined as verbally spoken words as well as written documents, signs, and symbols (Phillips and Hardy, 2002). Texts are therefore central to the construction of care practice and the tools, such as care plans, used to inform it (Potter, 1996).

The focus of analysis was centred upon the meaning of language in relation to discourses of dementia. Such an analysis served as a means to examine data 'beyond the surface' to explore the underlying trends in the discourse. Discourse analysis principles are therefore compatible within research, underpinned by a social constructionist epistemology (Potter, 1996). The search for meaning within the discourse of text implies the rejection of a naturally observable reality, in favour of a reality produced through the use of specific forms of language, imbued with ideological assumptions, in various textual mediums (Fairclough, 1993; Phillips and Hardy, 2002; Galasinski, 2011).

By exploring the discourses that underpin communications, interactions and care guidance, it was possible to gain a picture of the cultural processes that contextualise the reality observed. Data gained from this analytic approach was analysed holistically, to contextualise it and to draw implications about the culture of care practice (Wooffitt, 2005). It was through pin-pointing variations within the discourses of care practice that this approach to analysis, became a

useful strategy for understanding the impact of the implementation process on the culture of care. For example, at times the evidence suggested the culture of care was person-centred, whilst at other times a more disease or biomedical focused model of dementia care was indicated (See chapter 2 this thesis for a discussion of constructions of dementia care). Areas where implementation failed to permeate practice were therefore possible to identify. The question then turns to why this is through an analytical focus on the strategy used to implement *EMBRACELIFE*. By doing so, this thesis contributes to filling a key gap in the knowledge base, around how to effectively implement person-centred models of care. Analysis was therefore explicitly focused on the epistemological belief that the language and terminology used within care settings, is representative of how care practice is organised on a macro level, rather than an analysis of the syntax of individual texts, hence this approach is not a classic discourse analysis, but rather a thematic approach informed by the principles of discourse analysis.

3.7.1 The process of thematic analysis

Braun and Clarke (2006) describe thematic analysis as a 6 step process. These steps are: To familiarise oneself with the data, generate initial codes, search for themes, review themes, define and name themes and produce a report. I describe how I adopted these steps below.

1. Familiarise myself with the data: The data set was read through three times prior to formal initial coding. Memos were made in Nvivo 11 for the interview data and written notes were produced for the observational and care plan data around the language used within the data and the perceptions of dementia and care they may represent. Further, notes were produced around types of data that appeared relevant to each other. For example, observational data of activity, the guidance around this in care planning and the perspectives care workers and the person with dementia interviewed on activity and the construction of activity within Somerset House.

2. Generate codes: Model or implementation strategy driven codes: Data was coded where appropriate as relevant to the detail of the care model *EMBRACELIFE* and the detail of the workforce implementation strategy. These

were as follows: Care Model: Activity, care planning, mealtime experience, outdoor space, choice, leadership and communication. Workforce implementation strategy: recruitment, leadership, staff development, training, retention and staff turnover.

Data driven codes: Data that did not fit into the coding frame outlined above, but was still interpreted as revealing of the culture of care at Somerset House, and therefore the implementation of *EMBRACELIFE* was coded into 'meaningful groups' (Braun and Clarke. 2006: 18), across the data set.

3. Searching for themes: Braun and Clarke (2006) state this step is the point at which themes begin to emerge. The starting point was to group codes into themes that relate to the specific implementation points of the *EMBRACELIFE* strategy, and the workforce implementation strategy. For example training, related to the implementation point or theme of 'Workforce', as did staff retention codes. This way a direct comparison could be made between the strategy in theory and the interpreted reality. This however, was not always possible. Not all implementation points were observable in the data set, such as the macro-organisational criteria related to leadership in the care sector (See chapter 4). Further, not all data relevant to the questions posed within this PhD thesis were subsumable under aspects of the implementation strategy.

Additional data driven themes were therefore created, based on the general care worker perceptions of their work, their roles as carers and the people with dementia they cared for, to gain an understanding of the discourse within these perceptions. Once the data related to the *EMBRACELIFE* model of care had been themed the data codes within each theme representing distinct discourses of dementia and care were identified as subthemes. A critical analysis of the dominant and subdominant discourses of dementia and care were therefore identified for data relating to care practice. The findings related to this data set are presented in chapter 5.

4. Review themes: Data grouped into themes based on predefined coding frames were reviewed, refining themes. This involves the collapsing data from large overarching themes into better defined, multiple smaller themes that reveal aspects of each implementation point, relevant to the data. 'Care

planning' was broken down into 'A lack of staff consensus' and 'Care planning as reflective of task centred care'. 'Activity' was broken down into 'recreational activity' and 'stimulation beyond recreational activity'. Outdoor Space was broken down into 'A lack of opportunity and equality' and 'outdoor access as deprioritised'. Food and the mealtime experiences was sub themed into 'Inadequate food and choice' and 'Inconsistent mealtime experiences'. 'Leadership' was refined around 3 new themes: 'Leaders with heavy clinical and task-based workloads', 'Communication between leaders and care workers and 'Leaders with institutional backgrounds'

5. Redefining themes: At this point I considered how I would present the themes within my thesis to form a coherent answer to the research questions posed (Braun and Clarke, 2006). In chapter 5 themes were reviewed and refined to reflect the dominant construction of care at Somerset House and how the *EMBRACELIFE* model of care influenced this. 'Choice' was redefined as 'Choice as informing practice?' and the overarching theme of leadership was renamed 'Leadership as reflective of tasked-centred culture'.

6. Write up: The findings have been written up and presented within this report. Braun and Clarke (2006) emphasis the need to present enough data extracts to evidence the themes and the points being made. They recommend producing a narrative that interests the reader.

3.7.2 Why utilise the principles of discourse analysis within this ethnographic study?

Discourse analysis has been described as a complementary component of robust ethnographic study (Galasinski, 2011; Krzyzanowski, 2011). Ethnography, carried out in conjunctive with discourse analysis, gains empirical legitimacy through the systematic analysis of the meaning underpinning language. The texts observable within care home settings have an existence in isolation from the researcher, when the issue of researcher bias is adjusted for. The researcher's interpretation of the meaning of the data are applied purely at the analysis stage of the research, rather than during collection, as with traditional ethnographic research (Galasinski, 2011). This is significant in

studies of dementia care that seek to explore the perspectives of people with dementia, where the analyst does not have dementia themselves, or does not assume the role of a resident with dementia. In the majority of cases, including this PhD study, the researcher assumed a role more akin to a care worker or volunteer when conducting participant observation (Chatterji, 1998; McColgan, 2001; Dobbs et al., 2008; Forbat and Wilkinson, 2008; Sharpp, 2008; Lyons, 2007; Abramson and Corey, 2009; Ericsson et al., 2011; Harnet, 2013; Stephens et al., 2013). The researcher therefore runs a high risk of misrepresenting the views of people with dementia, in ethnographic studies that do not separate data analysis from collection, as the researcher is not 'coming from' the perspective of a person with dementia. An analysis of care worker communication and interaction, and the underpinning discourses of dementia, can however, give an understanding of what the predominant culture of care is within a care home.

The above justification of an approach informed by discourse analysis should not serve to undermine the crucial role of taking an ethnographical approach to data collection in this study. While a critical comparison between the 'macro' model of care and instances of 'micro' care documentation could be achieved through pure discourse analysis, the influence of these documents on practice and perspective would remain unknown (Christmann, 2014). How these texts are interpreted and internalised by social actors within the context of their everyday lives, would need to be observed in situ, for a sound understanding of how policy implementation influences practice (Johnson, 2011). An ethnographic approach to discourse analysis therefore, expands the types of data available to discourse analysts, increasing the possibilities of, and contextualises the findings of traditional discourse analysis through a focus on practice (Poole, 1990). For example, a discourse analysis of naturally occurring verbal exchanges between care workers and people with dementia during care delivery, is made possible through ethnographic study. Ethnography enables the researcher to capture contextual knowledge of social life, through the repeated and immersive observation of multiple social actors, across a sustained length of time, in situ (Geertz, 1973; Brewer, 2000). The role of language, and therefore culture, in the construction of care practice were more

fully understood; thus this enabled me to fully answer the questions posited within this PhD thesis.

3.6.3 Data collection plan

Here I summarise how I collected the data and practically 'did' the research.

Table 3 Phase 1: Contextualising, briefing and preparing the study

Objectives	Timescale	Methods	Data source
Familiarised myself with the care home environment. Identified and gained access to relevant documentation. Briefed and recruited participants, arranged dates and arrangements for data collection. Initiated processes of consent.	2 weeks	Informal conversations with members of the community, observations of the built environment, lay presentation of data collection plan and research objectives	Field notes

Phase 2: Data collection and analysis

Table 4 Document analysis

Research method	Timescale	Participants	Data sources	Criteria	Quantity of data
Document analysis	Carried out for the duration of the study	People with dementia and care workers	Resident care plans, model implementation documentation, letter response from central management	Care plan documentation used in practice	6 care plans were analysed. 3 implementation strategy documents were analysed. Letter response from central management

Table 5 Observational data collection and analysis

Research method	Timescale	Participants	Data sources	Criteria	Quantity of data
Participant and non-participant observation	6 3-4 day periods of data collection. Twice per month over 3 months (Sept-Nov 2015)	People with dementia and care workers	Verbal and non-verbal interactions between members of the community, including myself during Participant Observation.	Non-invasive care delivery such as meal times, observations of care in communal areas and recreational activity. Observations took place on all the various shifts that occur, including night shifts. In total 3 weekends were observed (Friday-Sunday) and 3 weekday shifts were observed (Monday-Thursday)	Observations lasted approximately 90 minutes per session and occurred twice in each 24 hour period. In total 42 observations took place.

Table 6 Interview data collection and analysis

Research method	Timescale	Participants	Data sources	Criteria	Quantity of data
Interviews and conversations	6 3-5 day periods of data collection, twice per month over the course of 3 months	People with dementia and care workers	People with dementia and care workers	Interviews were sought to add depth to data gained from observation and were subject to the consent of the interviewee. Interviews were pre-arranged with participants at least one day in advance.	17 formal semi-structured interviews took place. 16 with care workers and 1 with a person with dementia. Informal conversations occurred with care workers and residents during the time spent in communal areas, supplying these interviews.

3.7 Some ethical considerations of this study

3.7.1 Involving people with dementia in the research process

People with dementia have a right to participate in research which has the potential to enhance dementia care in the future. It was recognised that it was my responsibility to ensure the protection of any participants from harm, and to follow standard ethical procedures while working with people with dementia.

3.7.2 Gaining informed consent

All the participants involved in this ethnographic study were be able to give informed consent. Any potential for harm was highlighted, discussed and understood. Consent was demonstrated through verbal discussions, where participants were briefed with the aims and objectives of the study; the provision of information sheets, clearly explaining the methods of investigation, whilst stating participant rights to issues such as confidentiality and withdrawal. Participants were given the opportunity to ask any questions they had once briefed. Once each participant verbally articulated their consent, and subject to a thorough understanding of the study being displayed, participants were asked to provide written confirmation of their consent by signing a form. In instances where participants lost the ability or did not feel comfortable writing, a proxy was asked to provide written consent on their behalf following a verbal expression of consent from the person themselves.

3.7.3 Consent as an on-going process

Process consent is a method that challenges normative ethics paradigms that tend to be based on clinical frameworks, excluding people with dementia due to utilising a definition of informed consent that favours cognition (Dewing, 2007). The dementia specific guidance developed by Dewing (2007) takes a 5 step approach to ensure people with dementia are engaged with to support the consent process, thereby enabling inclusion. I describe this process below:

Step 1: Background and preparation. A gatekeeper, in the form of the dementia lead at Somerset House, during the time data was collected was engaged with to provide background information about potential participants with dementia. This ensured someone who has an established, trusting relationship with the

residents was involved in the recruitment process. If the gatekeeper did not feel they have a strong enough relationship with the individual person with dementia, an alternative gatekeeper was sought; in the form of family member. The gatekeeper role added a layer of safeguarding to the recruitment process, by ensuring an individual who has an established relationship with potential participants was able to advise and advocate on their behalf if necessary. They also aided me in understanding the personality of the possible participant and how they liked to be engaged with and spoken to. For example, I was informed one participant, Josephine, needed to be communicated with slowly, in a quiet space, a short distance apart and in faced towards me. It is important to note; the gatekeeper role does not involve proxy consent. All participants needed to provide evidence of being able to give informed consent themselves.

Residents were approached initially by myself and the gatekeeper, in the Ferndown suite. First, the gatekeeper explained who I was, where I was from, and why I was here. She then asked if it was OK if I spoke with them for a short while about the research. At this point I began the process of establishing the basis for consent, described below.

Step2: Establishing the basis for consent. Here evidence for the capacity for the person with dementia to give consent was sought (Dewing, 2007). In some instances, the person demonstrated clear capacity to consent in conversation. For example, some residents could clearly grasp that I was from a university, interested in life at the care home, observing this, and perhaps speaking with them about their satisfaction with living in the care home. Where this was not as clear cut a more nuanced method of establishing the basis for consent was necessary. I engaged with the gatekeeper to understand indications of well and ill being for each potential participant. Typical examples include understanding the meaning behind different facial expressions, or finding out how a person usually communicates and interacts in a group setting, and being alert to any unusual deviation from that. For example, one resident, Colin, who had issues with verbal communication, demonstrated both a willingness to engage with the study, and an understanding of it. He responded to my comments positively, through a combination of pointing, nodding and verbal expressions. Capacity to

consent is not a static or linear process. Approaching people with dementia when positive indicators of wellbeing were present was therefore imperative.

Step 3: Initial consent. At this point I had established whether or not the potential participant is likely to be in a position to give consent to take part in the study. If this was the case, the study was introduced in detail, and the giving of informed consent for the specific study in question was assessed. Given that the consent process was centred upon my interaction with people with dementia, coupled with an understanding of the written information on the participant information sheet, it was vital all required information pertaining to the study was laid out and accessibly presented. Normative academic terms were therefore deemphasised in the information sheet text, in favour of promoting a lay understanding of the research, without misguiding prospective participants of what participant entailed. For this reason, separation information sheets were produced for people with dementia and staff members. Please see Appendices 2, 3 and 4 to view the information sheets used.

Step 4: Ongoing consent monitoring. Consent was conceptualised as an ongoing process (Dewing, 2007). As mentioned above, capacity and therefore consent can be dependent upon how someone is feeling at a given moment. This is particularly relevant to people with dementia, whose ability to consent in research has been questioned on the basis of mental capacity. I therefore negotiated consent with participants on an ongoing basis, post the initial expression of consent, formalised by the signing of the consent form. To facilitate this both verbal and non-verbal cues were actively observed during all phases of data collection. If I had any reason to suspect informed consent may have been withdrawn or breached, data collection was to cease immediately and the consent process revisited in full.

Step 5: Feedback and support. After every data collection activity I debriefed the participant(s), to capture a picture of how the participant was feeling, and how they felt about the data being used to inform the findings of the research. They were reminded of how their right to confidentiality and withdrawal. A debrief also took place with the person with dementia's designated gatekeeper, to enhance my understanding of non-verbal cues that may have occurred

during data collection and minimise the chances of missing a cue in future interactions. No information disclosed by the participant during data collection was discussed, the upmost care was taken not to breach the participant's confidentiality.

Understanding the importance of a continuation of consent throughout the research process was emphasised. This was important, given the ethnographic nature of the research design.

3.7.4 Confidentiality and anonymity

The data was anonymised post collection, aiding confidentiality so any data was untraceable to any one participant. The participants were informed of their right to complain and have their complaint discussed and resolved. There were no complains made, however.

3.7.5 Data Storage and recording

During data collection a Dictaphone was used during interviews. This was subject to agreement on a participant by participant basis, although all participants did agree. I carried a Dictaphone around with me at all times in the field. Agreement was sought verbally when briefing participants, prior to formal agreement by the signing of the consent form. All recordings were transcribed verbatim as soon as possible post collection. The audio recording was destroyed in line with confidentiality agreements once transcripts have been produced. All data was stored electronically in a coded file. Furthermore, any paper notes were transcribed electronically and again coded for confidentiality purposes. This was explained in briefing and stated on the consent form. If a participant failed to consent to audio recording, or asked the recording device to be turned off at any point, field notes would have been taken as an alternative. Again, this issue was not raised by participants.

3.7.6 Decisions about data

During my time at Somerset House several decisions were made, both consciously and subconsciously, about what data to collect, where I should collect data, and at what times. Many of these decisions have already been discussed, or will be discussed in this chapter. The decisions made referring to

what observational data I collected, and when, is discussed in section 3.3.4. There I describe how my own interpretation of what rich data are, and where it would be most likely to be collected, influenced my keenness to observe those events. Examples included structured activities and mealtime experiences. The decision to cease interviewing participants with dementia is discussed in section 3.8.2, as is the necessity to conduct data collection in common areas. In this section, my decisions around when I collected data and who with are described.

I collected data at various points in time, to achieve a holistic picture of the culture of care at Somerset House. This included day and night shifts in the morning, afternoon and evening. I also separated visits into weekday and weekend stays. The vast majority of observational data was collected with resident and staff participants in the common areas of the Ferndown suite. This was due to the residents, who gave informed consent, living on the suite. I did not conduct observations of other suites, even when staff participants were working there. This was due to the residents they were interacting with being assessed by my gatekeeper as being unable to give informed consent. I did not personally assess these residents however, I felt the views of funder representatives should be respected. I did not want to challenge my gatekeeper's view, as I was concerned this could damage my relationship with her and impact her motivation to support the study. I was particularly aware of this as someone with no formal care worker experience, and the aims of the research being focused on process, and therefore staff experience. There was one instance where data was collected that involved people who did not give informed consent to participate in the research. This created an ethical dilemma, discussed towards the end of this thesis, in section 7.7.

3.8 Strengths and Limitations of study

3.8.1 Strengths

The principles of ethnography enabled me to gain an insight into the culture of care at Somerset House that would not have been feasible through a cross-sectional study, where the research site was visited for hours, rather than days at a time. Through living at the care home for between 3 and 5 days at a time, over a period of months, I was able to gain the trust of residents and care workers, understand the context of events, interactions and actions necessary to interpret observations accurately. This enabled me to observe, understand and record subtle phenomena within the care home, the significance of which were revealed due to how familiar the methodology allowed me to become with the care setting, and the members of its community.

The multi method approach taken to data collection, whereby documents were analysed, staff were interviewed, the environment was surveyed and observations of care and events were conducted enabled me to produce triangulated findings, using a range of evidence, giving a holistic picture of the implementation process. It was possible therefore to track the implementation process from the initial strategic policy documents (document analysis), through to the initial phase of implementation (mainly through the retrospective accounts of staff initially recruited and present at the two week induction), and the implementation strategies (or lack thereof) once of care home had opened (document analysis, staff interviews, observations). The strengths and weaknesses of the implementation process were therefore revealed and implications for policy and practice produced as a result.

The ethnographic approach to data collection tended to reveal data and challenges that were, unique and specific to the Somerset House context; meaning the lessons learnt from some findings were idiosyncratic and therefore unlikely to be of use for wider practice. Despite this, the multitude of methods used, facilitated an analysis of the implementation process of a person-centred model of care, from the CQC inspired policy documents, to the challenges that

occurred when practical attempts to deliver the model of care that made. Therefore the strong link between the implementation strategy and the CQC regulations, provided a sound justification for the relevance of the study to any English care provider, seeking to improve their dementia care. As a result, the study is deemed to have theoretical generalisability. It represents a key gap in the related body of literature, that other care providers can learn from. The implications of the findings of this study for the relevant legal and regulatory system serve as a further example of this.

3.8.2 Limitations

Hollyfield part-funded this PhD study. The commitments to the funder included conducting the research in their new-build dementia specific care facility. The research site was therefore purposively selected with purposively selected participants. The cohort is also relatively small, involving data from only 30 participants. It should be stated therefore that although the care home is subject to the same policy and regulatory context as every other care home within England, the findings of this thesis are not generalizable. The organisational decisions made by Holyfield, in particular the decision to engage residents with dementia with a residential care team, also seems unlikely to represent common practice, further limiting generalisability

The findings within this thesis are open to the critique that the perspective of people with dementia is underrepresented. At the outset of the study it was envisaged interviews with people living with dementia would form a key part of the research design. In practice however, only one interview with a participant with dementia, Patricia, was conducted. When in the field I was unable to interview anymore people with dementia for four key reasons. These were:

- The lack of informed consent achievable, limiting the number of participants suitable to interview with dementia
- The communal location of the research setting for interviews
- The examples of malignant social psychology observed at the home
- The research being focused on process and not outcomes of model implementation

The first issue was the vast majority of residents at Somerset House were assessed as not being able to give informed consent to take part in the research, using Dewing's (2007) method of process consent, as described previously in this section. Fewer still were assessed to have the capacity to answer questions in a formal interview. Only 10 residents, all of whom lived in the 'residential' Ferndown Suite were assessed as initially having the capacity to understand and give informed responses to questioning in an interview. The first (and only) interviewee I chose was the person I had assessed, through using the dementia lead as a gatekeeper and my own informal interactions, as having the highest level of mental capacity of anyone living at the home who had consented to take part in the research. Despite this, perhaps due to my own inability to ask the right questions or build a good enough rapport with the participant, I struggled to obtain detailed responses. The experience made me reflect upon and begin to question, the suitability of and justification for, using interviews in this study with people with dementia.

All data collection involving people with dementia was required to occur in communal areas of the home, with open care worker access. For example, the one interview I conducted with a resident took place in the lounge area. As part of the ethical approval process, I had committed to only collecting data in communal areas, with respect to participants with dementia. I was concerned this would lead to staff members overhearing comments from residents that may have impacted resident/staff relationships and/or interactions. I could not therefore guarantee the confidentiality of participants with dementia. This was compounded by the numerous instances of malignant social psychology (MSP) observed during care worker conversations and staff/resident interactions. I was therefore not only concerned about breaches of confidentiality as a matter of principle, but also due to the possible impact on relationships and interactions, between the person being interviewed and the care team. The decision to refrain from interviews was made in the knowledge that they were not essential to meet the aims and objectives of the study, with the focus being on the process of implementation and not the outcomes of implementation for residents. Staff perspectives on their role and care delivery can help identify how care is organised (Stockwell-Smith et al., 2011). Whilst discussions with

staff were essential to gain a deep understanding of aspects of the implementation process, such as recruitment, staff development and training, staff retention and leadership; interviews with residents, whilst critical for outcome based data, such as wellbeing, were deemed unlikely to reveal relevant data that could not be obtained via more ethically justifiable methods.

3.9 Summary

In this chapter I have described the purpose of the thesis as focused upon the process of implementing person-centred care in a newly operational dementia specific care home. I have discussed how my theoretical perspective and research questions has led to the use of an ethnography multi method research design and justified the methods utilised. The thematic analytic framework and process has been described as well as the rationale for using principles of discourse analysis an analytic tool. Ethical procedures were presented, including the use of process consent. Finally, reflections were made around the strengths and limitations of my methodological approach. Attention will now turn to setting the context for the presentation of the findings of this thesis.

Chapter 4 - Setting the scene: Introducing the findings chapters, Hollyfield, the implementation strategy and Somerset House.

4.1 Introduction to findings

The overarching aim of this PhD study is to capture an understanding of the implementation of person-centred care strategies. In doing so, a contribution will be made towards filling a gap in the literature surrounding the effective implementation of person-centred care principles and cultural change in care home environments. To achieve this aim, an analytic strategy has been devised, that enables a critically comparison between the principles Hollyfield wish to implement in theory, and the interpreted reality of the culture of care at Somerset House in practice. Culture is defined in this context, as the dominant principles and perceptions within the environment that inform everyday care delivery and the relevant processes. Understanding how care staff members perceive care, the people with dementia they are caring for, and each other, will therefore be explored. Without an indication of the dominant culture, it would not be possible to gain an understanding of the influence of the strategy utilised, as a description of the reality of care is required to ascertain the influence of the principles on that reality. This chapter will therefore describe and critically discuss the implementation strategy, used by Hollyfield in an attempt to embed the principles of dementia care, endorsed by the Care Quality Commission (CQC), consistently in their everyday care delivery. The significance of the CQC for the development of *EMBRACELIFE* is explained. Next, the physical environment of Somerset House is described, serving a dual purpose. Firstly, as an introduction to the research setting, prior to the presentation of the findings. Secondly, to contextualise findings, adding richness and depth, this will be useful when discussing findings, explicitly linked to the physical environment.

Chapter 5 is chiefly concerned with a critical analysis of the overarching culture of care prevalent within Somerset House. The chapter will end by coming to a

conclusion on the construction of the cultural of care enabling an assessment to be made on how fully *EMBRACELIFE* was implemented.

Chapter 6 will focus on exploring the organisational factors that contributed to the implementation (or lack of) of *EMBRACELIFE*. This will lead into the discussion section of the thesis, focusing on identifying the contribution to knowledge of this thesis and detailing the lessons learnt for policy and practice from this PhD study.

4.1 Principles, strategies and the physical environment

4.1.1 The *EMBRACELIFE* Model: What were the desired principles of dementia care and what was the implementation strategy produced to achieve this in practice?

The key aim of this chapter is to discuss the principles of dementia care, central to the *EMBRACELIFE* model. The strategy designed to implement *EMBRACELIFE* will also be introduced. These descriptions will contextualise the findings of this thesis, capturing a picture of the how fully strategic guidance was followed, and the difference or similarity between what Hollyfield wanted their care to resemble in theory, and the interpreted reality in practice. In doing so an indication of the influence of the implementation process will be achieved. First however, Hollyfield as a care provider is briefly introduced, adding context to discussion and illustrating the scale of Hollyfield's operation, and the relevant interactions between the different homes during the time data was collected. Please note to ensure the funder is not identifiable descriptions have been altered.

4.1.2 Hollyfield

Hollyfield is a registered charity, providing a range of care services in southern England. The services they provide include: Dementia specific and residential care home provision and community respite for people living with dementia, among other services (Hollyfield, 2013).

Hollyfield's approach is to help shape and support a local community where people are offered a range of services to support their wellbeing and

independence (Hollyfield, 2013). Their mission statement is not quoted to protect funder identity. The principles include: To be innovative; life-changing; to help people with dementia and older people more generally; enrich people's lives; and create person-centred methods of care that improve the quality of life for their service users.

These statements suggest Hollyfield has a strong community focus, and is willing to engage with the people it supports, to help improve its services. The development of their services and staff team seem highly valued as does the autonomy and dignity of the people cared for. These statements therefore are a solid starting point for the person-centred culture, Hollyfield wish to achieve through the implementation of *EMBRACELIFE*.

Hollyfield make around 20% of care home beds available to residents via social funding, either through council or NHS placement. Hollyfield promise that all the income they generate is used to support their charitable work, achieved for example by, access to state funded beds. The monies received from state funding does not cover the full cost of living at Somerset House. This is typical across the UK care sector (CMA, 2017). Hollyfield therefore classifies accepting these placements as charitable work.

4.1.3 Hollyfield's care homes

Hollyfield currently operate 5 care homes. These are Somerset House, Falcon Lodge, Elizabeth House, Fairview House and The Old School House. Falcon Lodge, Elizabeth House and The Old School House all provide a mix of residential and nursing services and are not dementia specific care homes.

The Old School House was given to Hollyfield by a third party who were no longer able to operate the home in the Autumn of 2015 at around the time I began fieldwork, this resulted in a resources being allocated to the care home during the first year of operation at Somerset House.

Fairview House provides a mix of residential, nursing and dementia care.

Falcon Lodge was being refurbished during the fieldwork and the residents were temporarily relocated to the Silverburn Suite, on the top floor of Somerset House. A number of Falcon Lodge care workers were also working at Somerset

House during this time. They were asked to work with all the residents at Somerset House, not just those who had come from Falcon Lodge. It is important to note that as Falcon Lodge is not a 'dementia specific' care home, the staff transferred to Somerset House did not have any training or experience in dementia care. They were also not considered within the implementation strategy described later in this section.

Having briefly introduced Hollyfield as a care provider discussion will now turn to the *EMBRACELIFE* model, informed by the latest academic literature.

4.1.4 '*EMBRACELIFE*': A discussion of Hollyfield's model of dementia care.

Here each of the 7 points of the model of dementia '*EMBRACELIFE*' are outlined and described. It is important to note the name of the model has been changed to protect the true identity of Hollyfield. The values that underpin the model are discussed, and the relevant body of literature is visited, to capture a picture of the evidence base for each point. Discussion of *EMBRACELIFE* in theory will facilitate a critical comparison between the data collected in practice and the principles of care that inform the model. In doing so an indication of the influence of the *EMBRACELIFE* model on the culture of care at Somerset House will be constructed.

The *EMBRACELIFE* model consisted of the following 7 key implementation areas (Hollyfield, 2013), again the title of most of the implementation area has been changed.

- 1) Activity
- 2) People we support
- 3) Care network integration
- 4) Leadership
- 5) Social Inclusion
- 6) Loved ones
- 7) Workforce

These 7 key implementation areas of *EMBRACELIFE* model will now be discussed in detail below.

Activity

Hollyfield related the criteria below to activity:

- Personalising activities
- Supporting individuals to undertake normal day to day activity, for example making their own cup of tea
- Providing individuals with outdoor space, through accessible gardens, outings and where this is not possible 'bringing the outdoors into indoor space'
- Working to maintain the social world of all people living with a dementia

Various studies have shown opportunities for social interaction and activity in care environments is of upmost importance to mental and physical wellbeing as well as the quality of life of people with dementia (Chung, 2004; Han et al., 2010). For example, Han et al (2010) found a weekly structured music intervention decreased the prevalence of depressive symptoms in people with dementia.

Hollyfield however, defined *occupation* as something beyond the generic, rather it should be tailored to the needs of each individual person living at the care home. Activities tailored towards the personal preference and cognitive abilities of people with dementia have been shown to be associated with a better quality of life and activity engagement (Kolanowski et al., 2011; Port et al., 2011; Mohler et al., 2012; Morley et al., 2014). Kolanowski et al (2011) for example, found levels of alertness and attention in tailored activities to be higher, and levels of agitation to be lower, than in a generic counterpart activity.

Hollyfield identified a need for all people living with dementia at their care homes, to have access to a variety of indoor and outdoor space, on a regular basis. The adequate provision of such a space has been shown to reduce depression, agitation and boredom (Chapman et al., 2005; Jonveaux, et al., 2013; Pollock and Fugle, 2013; Abraha et al., 2016). Finally, Hollyfield recognised the importance of people's social lives for their wellbeing.

People we support

Under the heading 'People we support' Hollyfield stated the following:

- To provide a holistic approach to care planning/needs assessments which consider the physical, psychological, social and spiritual needs of an individual
- Creating time for staff to work with our service users on an individual and meaningful basis
- Enhancing individual eating experiences through day to day access to nutritious food that provides choice, variety and familiarity and access to food when it is wanted
- Preserving personhood through the development of life-story work
- Providing an environment that supports users to maintain their independence
- Support informed decision making and person choice
- Encourage active participation and promote the things the person can do instead of focusing on what they can not

The principle of personhood was highly visible here. The personhood of an individual is the essence of who they are, it's what makes a person unique (Kitwood, 1997). Kitwood devised the concept of personhood to help conceptualise and do justice to a person with dementia's personality. Aspects include their temperament, abilities, interests, tastes, beliefs, values, commitments, lifestyle, biography, gender, class and culture (Kitwood, 1997). Personhood is discussed in more detail in section 2.2 and person-centred care features throughout chapter 2 in relation to care practice.

A holistic approach to dementia care is inherent to the idea of person-centred care and life story work is one way of imprinting personhood into the consciousness of staff (Kitwood, 1997; Surr, 2006; Brown-Wilson et al., 2013). Life Story work is discussed in more detail in section 2.3

Hollyfield placed emphasis on developing strong relationships between their staff and residents. They believed this is an important step in the development

of an individual and meaningful approach to staff to resident interaction. Various studies have linked the wellbeing of people with dementia, to strong resident/staff relationships (Surr, 2006; Custers et al., 2010). Such relationships however, are difficult to achieve. People with dementia living in care homes have reported a lack of social engagement with staff who were 'too busy' with their other responsibilities (Moyle, et al., 2011).

Emphasis was placed on the eating experience via the quality and choice of food provided, as well as when a choice of food is provided. While this is important it would be beneficial to see further emphasis placed on other aspects of mealtime experiences. Staff practice and the environment can have a large impact on the mealtime experience, as well as the quality of the food (Hung and Chaudhury, 2011).

An environmental focus was placed on supporting residents to maintain their independence. Hollyfield's emphasis on choice is reflected by empirical evidence that states the physical environment should foster autonomy, give residents choice and control, be homely, provide privacy and allow company in equal measure (Torrington, 2006; Davis et al., 2009; Fleming and Purandare, 2010;; Kelly et al., 2011; Zeisel, 2013).

Care workers were encouraged to aid residents in making their own decisions and choices. The Mental Capacity Act (2005) states that decision making should only be made on behalf of an individual with dementia, if it has been determined they do not have the capacity to make a decision on the issue at hand (Boyle, 2013). This is important as it explicitly states that lacking capacity in some areas does not mean an individual should be deemed incapable entirely (Donnelly, 2009).

Finally, Hollyfield expressed a desire to encourage 'active participation' and promote the things residents can do, not the things they cannot. Vocational tasks such as simple food preparation, ironing, dusting and polishing are not necessarily beyond people with dementia and can facilitate meaningful social interaction (Brooker & Duce, 2000; Torrington, 2009). The organisation of care

delivery at care homes, societal views and how care staff perceive their role however, can all limit opportunities for people with dementia to be active in their own care delivery (Martin, et al., 2013). For active participation to permeate into practice, care staff will need to be reflective about their role in relation to each resident. Moreover, care staff need to be given the time to consider not only whether a resident could perform an activity more independently, but also whether they would want to. To make these judgements care workers would require detailed knowledge of each resident. The emphasis placed on developing strong relationships between staff members and residents, was therefore well placed.

Care network Integration

- Creating forums with health/social services professionals and interested individuals
- Developing a communication strategy for Hollyfield that informs the commissioners, funders and stakeholders of the benefits of our services
- Encouraging other institutions and professionals to work with Hollyfield to develop research into excellence in dementia care practice
- Developing links with local business and companies to provide both sponsorship and support for excellence in dementia care with the local community
- Creating fundraising themed activities that develop relationships with individuals and the wider community
 - Develop care pathways for dementia services to include input from specialist services
 - Encourage participation in the Dementia Friends campaign

Here Hollyfield focused on relationships between themselves as a charity care provider and the external communities, stakeholders, health/social services and businesses. Effective integration with healthcare providers is an important aspect of running a care home (Tucker et al., 2009). Indeed, the department of

health has stated the need for cooperation and collaboration to improve outcomes for people with dementia (Department of Health, 2016).

Residents are likely to have a variety of complex needs that require external physical healthcare provision at some point during their stay at the care home (Department of Health, 2005). This can come in a variety of forms for examples, hospital visits, dentist checks and chiropodist visits. Good relationships with staff at the local hospital, and the individual practitioners employed by Hollyfield to perform procedures, can only result in a better quality of service and a better experience for the person with dementia.

Hollyfield indicated a commitment to continually strive to learn and improve their services by expressing a desire to seek out relationships with research focused institutions and professionals and 'specialist services'. Hollyfield also expressed their desire for strong links with the wider community. Finally, their participation in the dementia friends campaign indicated a knowledge of relevant government schemes.

Leadership

- Promoting the work of dementia champions throughout all services
- Promoting the dementia care profession to our wider audience to encourage individuals to want to work both for Hollyfield and the wider dementia community
- To work with service commissioners to encourage them to recognise care as a career, not just a job
- Build upon our in-house expertise and knowledge so that we constantly develop and improve upon our model of dementia care, ensuring that it is continuously evaluated and reflects best practice

Hollyfield defined leadership broadly around their position as leaders, in comparison to other care providers, in the dementia care profession.

Leadership in care homes is discussed in section 2.3 of this thesis. Hollyfield implied the role of leadership in the workforce implementation plan. Hollyfield

indicates their desire to value, invest in and promote staff development through their interest in the dementia champions scheme and promoting caring as a career and not simply a job. Having care staff members who value the work they do, beyond it simply being a job, is important for the quality of care delivery and the wellbeing of residents.

Social Inclusion

- Providing opportunities for the people living with a dementia to access services within the community.
- Promoting interaction between individuals with dementia and other users of Hollyfield services
- Ensuring that Hollyfield publicity for dementia services meets the needs of our audience
- Encouraging individuals to integrate with people of all ages through excellent local community interaction
- Giving voice to individuals through meetings, surveys and customer feedback opportunities
- Supporting our community to be dementia friendly
- Supporting the development of dementia friendly communities
- Ensuring that our dementia services are inclusive and can provide the level of service required at all stages of the dementia journey

Hollyfield reiterated their preference for people living with dementia at their care homes, to be engaged with the local community, by having access to local services. Living in a closed community of exclusively older people limits interaction for residents with people from other age groups. People with dementia living in care homes have reported welcoming opportunities to interact with not only children, and therefore people from diverse age groups, but animals as well. Both animals and children were seen as less akin to the context of communal living and therefore of interest (Innes et al., 2011). An emphasis on interaction with other service users may indicate a need to ensure people with dementia are not forgotten about at charity wide events that residents are invited to attend. By taking the views of their residents into consideration Hollyfield were showing the value they place on the voice of

people with dementia at an organisational level, setting a positive example for the staff who delivery care within their homes. Consulting people with dementia is vital to ensuring their perspective has an impact on the care they receive and that this care is tailored to their needs and preferences. Giving voice to people with dementia on any issue they hold a vested interest in should be prioritised (Litherland and Williamson, 2013). The perspective of people with dementia should not be assumed; this can only exacerbate the marginalisation people with dementia face (Swaffer, 2014).

Loved ones

- Increasing the trust that is needed between individuals, relatives and staff to provide excellent care
- Creating innovative ways for families to be involved with the day to day lives and care and support of their relatives
- Raising awareness of dementia amongst relatives and friends
- Encouraging the provision of life history information for care planning purposes
- Ensuring staff are available to families outside of normal office hours
- Welcoming families into our services

Hollyfield demonstrated a recognition here of the value and importance of relative visitations to their care homes for people with dementia, laying out various strategies for improving the experience of visitations. Communication with, and visits from family, have been reported as important in terms of connecting residents to the wider community (Moyle, et al., 2011). Empirical evidence suggests that residents of care homes, whose family members have good relationships with care staff members, experience better care outcomes (Haesler et al., 2010). Moreover, disagreements between family members and care staff disrupt the development of relationships between residents and care staff (Haesler et al., 2007). Hollyfield explicitly stated the importance of life history to care delivery and the key role relatives and friends play in the collection of information for life histories. The research evidence suggests life history work can improve relationships between care staff and family members

as well as connecting staff to people with dementia (Kellett et al., 2010). The relationship between family members and staff is emphasised through points such as ensuring families are welcomed into the services, that staff are available to speak to them and that trust is needed. The development of trust is key to a smooth transaction for a family member who is relinquishing the full time carer role and therefore losing an element of control over the wellbeing of their loved one (Kellett, 2007).

Workforce

- Ensuring the number of staff is appropriate for excellent dementia care
- Ensuring an appropriate skill mix of staff is provided
- Promoting volunteering across all services to assist with increasing the numbers of staff available to provide individual time and support
- ‘Allowing’ staff to spend more time with people using our services, providing quality within day to day interactions rather than simply providing care services
- Valuing and supporting Hollyfield staff
- Actively promoting staff development within the field of dementia
- Making the most of the skills of all staff, recognising that all job roles can benefit from excellent interactions between staff and our service users.

Here Hollyfield recognised how the wellbeing and job satisfaction of their workforce within their care homes can have a tangible impact upon the quality of care provided. Staff outcomes are discussed in relation to the latest academic literature in section 2.3. Hollyfield listed several methods of attempting to ensure their staff feel valued, such as promoting staff development, allowing time for staff to get to know residents during quality interactions, and making the most of the skills their staff have. While these were excellent steps to take, Hollyfield could have gone further by giving care assistants a choice of shifts, a choice of care suites to work in or flexible working hours, for example.

Above, the *EMBRACELIFE* model has been described and the literature has been engaged with, to capture a picture of how the model reflected the latest

academic literature. It is clear that the majority of the model finds support in the reflections from the literature. The above description will be used as a starting point in the analytical process for this study. It will be critically compared to the primary data collected, to gain a picture of the extent *EMBRACELIFE* was implemented in practice. Next, discussion turns to the strategy Hollyfield utilised to turn the principles behind *EMBRACELIFE* into a reality.

4.2 The strategy for implementing *EMBRACELIFE*

The aim was for *EMBRACELIFE* to be implemented and showcased at Hollyfield's new build care home, Somerset House; the site of data collection. Hollyfield therefore took the opportunity to introduce *EMBRACELIFE* prior to the opening of the home in an attempt to implement the principles behind the *EMBRACELIFE* model from the outset. Hollyfield developed four strategies for the implementation of *EMBRACELIFE*. These were: Quality Assurance, Engagement, Workforce, Business and Care (Hollyfield, 2014). The care strategy for implementation is the *EMBRACELIFE* model itself, along with its key criteria for each implementation area of *EMBRACELIFE*. No further discussion of the care strategy will therefore take place at this point. Instead, attention will turn to those strategies most relevant to the implementation of *EMBRACELIFE*, with reference to providing care delivery, informed by the principles of the model within Somerset House; the issue central to the aims of the research and therefore, the data collected. The strategies relevant in this context are: Quality Assurance, Engagement and Workforce. Through discussion of these strategies, key elements of the overall *EMBRACELIFE* implementation strategy will be identified, as well as possible forms of data sources, useful for addressing the aims of this study.

4.2.1 Quality Assurance

Hollyfield (2014) set out the regulatory methods and processes through which they aim to ensure the principles within the *EMBRACELIFE* model are informing practice. As is the case with all care providers in the UK the statutory regulatory body is the Care Quality Commission (CQC). Within their Quality Assurance Framework Hollyfield state how the CQC standards and rating system (safe, responsive, effective, caring and well-led) inform all of the care

they provide. Hollyfield set out their own internal auditing process coined the 'Quality and Monitoring Manual' with the aim of ensuring the care they deliver matches the expectation of the CQC. Hollyfield state they plan to implement several monitoring processes including monthly visits from trustees, incident management, safeguarding and feedback from service users. Hollyfield endorse a flexible approach to their internal monitoring depending on the performance of each service. Those services performing well will be audited annually, whilst those perceived as performing weakly will be managed more frequently. Hollyfield also developed new auditing tools, informed by the CQC rating system. The principles behind the philosophy of care the CQC appear to perceive as fundamental to the delivery of high quality dementia care i.e. Person-centred, dignified and respectful are clearly reflected by the EMBRACELIFE model. Therefore, CQC regulatory guidance could become relevant to discuss in relation to the findings of this study.

4.2.2 Engagement

Hollyfield (2014) outline their 5 year (2014-2018) engagement strategy, setting out how they intend to communicate and engage with their stakeholders and target audiences across this time period. For the purposes of this PhD study, the focus will be on the relevant stakeholders i.e. residents living with dementia, their relations, and care staff.

In terms of staff engagement Hollyfield state how they wish to construct a culture where care staff communication is expected and encouraged, across the care staff team from care assistants to the general manager and vice versa. Staff inductions are noted as key to this. It is suggested strong lines of communication between care staff members will facilitate the delivery of high quality care, already described as in line with CQC guidance and the *EMBRACELIFE* model of care. Thus communication, in the manner described, forms a key element of the implementation strategy *for EMBRACELIFE*.

The voices of people with dementia and their relations or 'customers' are described as important in developing services that matter to them (Hollyfield, 2014). Hollyfield acknowledge a fundamental epistemological cornerstone of social construction i.e. that communication plays a vital role in the construction

of culture within organisations and/or communities. It is therefore important to explore not only the direction and presence of communication, but the language of care staff, to fulfil the aims of this study from both a theoretical and substantive perspective.

Hollyfield (2014) make statements that encapsulate their engagement values: Honesty, dignity, improvement, safety, staff development, politeness and compassion. Again, these statements reinforce the messages within the *EMBRACELIFE* model and provide further evidence that findings related to communication, in all its forms, are relevant to the aims of the study.

4.2.3 Workforce

Staff recruitment is put forward as key for the strategic implementation of *EMBRACELIFE*. Hollyfield (2014) state that 70% of expenditure is related to staff hence, the centrality of these criteria. Hollyfield (2014) aligned their recruitment strategy to various national frameworks to ensure their recruitment practice promotes equal opportunities. Hollyfield take a 'value based approach', focused upon recruiting care workers who understand the principles of person-centred care. Hollyfield (2014) state this policy will facilitate the care sector to expand the recruitment pool, by identifying prospective care staff by potential, not experience. Hollyfield (2014) acknowledge, for such an approach to be successful, a programme will be required to support the development of staff. The induction period is noted here as essential. Induction is defined as a period of time, lasting 20-24 weeks, where care staff attend regular training courses and are in receipt of the support needed to be successful. The staff team that started at Somerset House opening attended a 2-week induction training programme where they attended training course around manual handling, fire training and dementia specific training. As part of my own recruitment process for this PhD study I visited Somerset House during this two week training period and recall a distinct 'buzz' and excitement within the care team about the start of their new careers and the quality, both practical and aesthetic, of the facility they were set to work within.

Staff retention was also identified as key to the implementation strategy. Meaningful career progression is stated as a key tool in achieving the overall

aim of a staff turnover rate of 15%. Hollyfield (2014) also claim to have flexible working practices, used to aid the retention rate and increase staff satisfaction.

A final element of the workforce strategy is the Leadership framework (Hollyfield, 2014). This framework consists of 4 'leadership levels': Frontline worker (no supervisory duties), frontline leadership (no managerial duties), operational leadership (directional or operational leadership) and strategic leadership (directors and heads of services). Different expectations are placed on staff based on their 'leadership level'. Those in higher leadership roles are asked to take on the expectations of those below them, and extra responsibilities, in addition. For example, frontline workers are expected to give and receive constructive feedback to enable team development, whereas frontline leaders are also expected to aid staff reflection upon how they deliver services and their development. Throughout the leadership framework, the development of a positive culture is a central theme, where the voice of all staff members is respected. Although the core group of staff are seen as having a role in the construction of this culture, ultimately the implementation of *EMBRACELIFE* model is stated as the responsibility of 'those in senior leadership roles' (Hollyfield, 2014).

Based upon the workforce implementation strategy for *EMBRACELIFE*, evidence related to the care staff recruitment strategy, retention rate, induction and training programmes, and leadership are of relevance to the aims of the study. Implicit within these criteria is a commitment to staff satisfaction and wellbeing; both therefore are of interest. It is clear from this element of the implementation strategy that staff perceptions should be central to the study.

In this section the implementation strategy for *EMBRACELIFE* has been discussed, and indicators of implementation identified, that will help guide and frame the findings of this study. Justification has been found in centralising staff perception. This discussion will be reflected back on, forming the first step in a critical analysis of the care practice and organisational culture prevalent at Somerset House, and how this compares to the theoretical principles. It will then be possible to ascertain the influence of the implementation strategy, as well as its suitability. Evidence that *EMBRACELIFE* was or was not actively

used as a tool to implement person-centred care once Somerset House became operational will also be critically analysed. The lessons learnt will address a gap in the field of study surrounding the strategic implementation of the theoretical principles of dementia care, perceived by the CQC as best practice, and therefore relevant to everyday dementia care provider in the UK at the time of writing. Next, the physical environment of Somerset House is described, contextualising the findings in the next chapter.

4.3 A description of Somerset House

Somerset House is a 60 bed dementia specific care home opened in 2015, The 60 bedroom are divided between 5 suites. Below, I describe the internal and external environment of Somerset House. These descriptions are based upon fieldnotes taken during unstructured observations in September 2015. It should be noted therefore descriptions are based upon my interpretation of the environment, influenced by my experiences and subjectivities. It therefore may not be reflective of the perspectives of others. Description of these physical spaces has been included to set the scene for the reader in an attempt to facilitate engagement and contextualise the findings. This section may also be reflected back upon to illuminate findings and discussion in further findings chapters.

4.3.1 External Environment

Somerset House is positioned behind a car show room just off a busy dual carriage way. There are two entrances, one for visitors and one for suppliers and staff. There is a lack of any green space with the exception of the garden area, accessible from the ground floor 'Ferndown' suite. There are two car parks, one at the front of the build for visitors and one at the rear for staff. At busy periods, such as weekends the visitor car park can become full and there are limited car parking spaces close to Somerset House outside of these. Otherwise, the amount of car parking space is adequate. Somerset House is surrounded by office blocks, car parks and other urban spaces.

4.3.2 Garden

The main feature of the garden design is a mock pebble path that runs around the garden is a figure of 8 with two islands of grass in the middle of each and a flower bed running alongside the path on the outside of the grass spaces.

There is a large red telephone box and a red post box, both designed in a traditional style and some young trees planted. There is ample seating, both at the beginning of the path, by the door where the garden is accessed and in the far North-West corner of the garden. The garden bends around to the right and left to the side of the building. To the left are further flower beds and to the right a large blue boat. Where the garden bends to the left there is a fence behind which is the staff car park where staff gather to smoke. The sound of cars driving on the dual carriage way is prominent.

4.3.3 Internal Environment

Ground Floor

The visitor entrance at the front of the building has two sets of large glass double doors, these are key fob activated. There is a call system on the outside of the building for visitors however, during the day the doors are unlocked. Directly ahead is the reception desk where visitors sign in. This is staffed until 5pm by a variety of volunteers and employees. The administrators' office is to the right of the reception desk. To the left of the desk is a coffee shop that sells baked goods and sandwiches from the kitchen, as well as chocolate and crisps. The coffee shop is staffed by volunteers. Often family visitors and staff members will accompany their relatives or residents here for a cake and a change of scenery. There are several coffee tables to sit at here. Across the way is a separate seating area with a table. I have seen this used as a waiting space for visitors and a space used to speak with people living with dementia after a tour of the building to discuss personal preferences, religious beliefs, likes and dislikes. The entrance to the rest of the home has a set of double doors. To the left of these is a further set of doors that leads to a staff only area containing the kitchen where food is prepared and cooked for the whole home and the laundry is done. This is also where the staff access the building as the entrance from the staff car park is located here. Finally, access to the 'Watkins Wellbeing Centre' is located in this part of the building. The Watkins Centre is a

resource that provides respite for people in the community. The relatives' forum is held here on a weekly basis. Across from the doors leading to the reception area are two lifts, these are large enough to carry someone in a bariatric wheelchair with an accompanying person, although I was warned about using the lifts as they have habit of breaking down. To the right of the lifts is a key fobbed door leading to a flight of stairs that go up to the 1st and 2nd floors of the building. Opposite the lifts is the facilities office where the facilities manager is based and where staff sign in before starting their shift. To the right of the doors, leading from the reception area is the 1st of the 5 care suites called 'Ferndown'. A full description is provided below. The suites are all similar in design. They all have large dining rooms, with identical facilities. They all have separate nurses' offices, a bathroom, a large communal area, a smaller quiet lounge, a toilet, storage cupboards and 12 ensuite bedrooms. I will only describe the ground floor Ferndown suite in depth, as this is the suite where the majority of the data was collected, due to concerns around the ability of residents living on other dementia specific suites, to give informed consent.

Ferndown suite

At concept phase Ferndown was intended to be used for people with dementia with residential level needs defined as lower level care needs requiring support, observation, monitoring or prompting. Therefore, no RNs are based in Ferndown, although they do visit to deliver medications and administer care when needed. The intention was that when people reach a point in their journey with dementia that they need nursing care they move through to the nursing suites at Somerset House. In reality however, this did not happen. Findings are presented that suggest this in Chapter 5.

The Hallway

Ferndown is situated on the ground floor of Somerset House. As you walk through the double doors from the reception area it is immediately to the right. It has a fob activated set of double doors that stops any resident leaving the suite

unsupervised. The hallway of the suite is designed in a T shape with the entrance of the bottom of the T and bedrooms running on either side of the T, divided by the communal lounge space at the top. The dining room is the first room on the left hand side of the hallway as you walk along it from the entrance, the first room on the right hand side is the smaller communal lounge that is not regularly used for any specific purpose. Next on the left hand side is a bedroom with another directly opposite. Next to these bedrooms is a communal toilet and opposite that is the communal bathroom. Straight opposite, at the top and middle of the T is the communal lounge, used regularly by the residents. There are some comfy chairs in the corner of the hallway opposite the communal lounge. As you walk to the left of the top of the T the first room you come to is the Nurses' office followed by 2 bedrooms with a further 3 opposite them. The bedrooms are mirrored on the right side of the T. The hallway is very wide, with enough space to walk two bariatric wheelchairs down beside each other. There are railings alongside each wall. The décor is neutral cream along the shaft of the T with a seaside theme along the top of the T, the flooring is laminate.

The Dining Room

The dining room entrance is composed of a set of double doors that can open all the way out, the flooring is again laminate. Immediately to the left is a chest of drawers with a radio on top, it contains cutlery and place mats. To the right is a sideboard that runs along the length of the dining room. On top of this side board is a hot water dispenser, a microwave and a toaster. Underneath there is a fridge that often contained butter, jams and condiments as well as some staff foods and some storage cupboards with biscuits and dilatable juices. There are further cupboards over the top of the sideboard that contain plates, bowls, glasses and cups. On the floor lie 4 tables each with 4 chairs, meaning there is plenty of seating for the 12 residents (maximum) on each on the 5 suites and care staff and/or relatives too. At the back of the room is a notice board that would typically display the food being served each day for breakfast, lunch and dinner. To the right of this would often be a trolley with used plates and cutlery that would be sent to the kitchen to be cleaned. It is important to note the

Kitchen, where food is prepped is not within a suite at Somerset House but rather, is situated within a staff only area of the building.

The Nurses' Office

Each office has a computer, a desk, all the residents' personal care plans who live within the suite, a signing in sheet, a storage cupboard, a white board and 3 or 4 chairs. Staff would often leave their bags and coats on these chairs while they were working. The office was used by staff to update care plans and computer records for each resident. There is a sign in the window of the office that is supposed to help orientate residents as to the day and time

The Bathroom

No data was collected in the communal bathroom to preserve residents' privacy. Each bathroom had a specially designed bath with a hoist. There were some tiles on the wall in an effort to make the room resemble a traditional bathroom.

The Communal Lounge

The communal lounge has a set of double doors at the entrance that open all the way out. It had cream carpet throughout. There was an 'activities desk' to the right hand side of the entrance with board games, paints and books on it. On the left hand side of the room is the TV and a CD player/radio. During the majority of my observations reruns of old films such as 'the sound of music' would be played that the staff believed would be suitable for the residents to watch. Some of the residents would sing along to songs when the CD player was played. Again these CD's tended to be traditional songs that the residents were perceived by staff to be most likely to know the words to and enjoy.

When I first visited the home the vast majority of the chairs would surround the TV in a semi-circle. When sat in this formation the close proximity of all the residents to each other and the lack of space and privacy this proximity afforded the staff and residents appeared to reduce one to one interaction between staff and residents. During my third visit the layout had changed and the chairs were spread out evenly across the room in bunches of 4. This

encouraged care workers to spend 15-30 minutes with each resident one on one.

In the far left and right hand corners of the room there are two-seater sofas. Opposite the right hand corner two seater is a single chair where one resident would sit everyday due to a modification on the legs of that specific chair. This was a detachable modification, nevertheless the resident was never given a choice of where to sit. Incidentally, this pattern of care was mirrored in the dining room where this resident would be placed in the same seat for each meal.

The far wall of the communal lounge room has a set of double doors that open out and provide access to the garden. This door was alarmed and could be opened by a staff member with a key a fob to turn off the alarm but was inaccessible for residents without supervision. Despite access being available, and the weather being pleasant on many days when I was collecting data within the suite, instances of residents being asked if they would like some time outside was rare.

Bedrooms

Each bedroom entrance was wide enough to fit a single person bed through. I witnessed this during a weekly singing activity that took place in one of the function rooms outside of the suite, attended by 2 residents in their beds. I did not collect any data from inside the bedrooms.

The quiet lounge

The quiet lounge has a single door entrance. Inside there is a book case with some books and board games in it, some comfy chairs and a table with two chairs. This space was not used very often and did not have a clear purpose or function. I conducted some interviews here as care workers recommended it due to its low levels of usage, minimising disruption and aiding confidentiality.

4.3.4 The 1st floor

The 1st floor entrance from the stairwell is key fob activated. Directly in front of this is the managers' office. In here are 3 desks, one for the general manager,

and another for the deputy and a third for the lead dementia nurse. To the left of the managers' office is a function room called the West Moors Lounge. This is a multi-purpose room used for meetings, to handover notes and to hold large scale activities for residents across Somerset House such as the singing activity mentioned earlier. There is a balcony here too and staff use this to enable residents to gain some fresh air from time to time. To the left of the West Moors Lounge is a suite named the 'Lichfield' suite. This suite is occupied by mostly men with dementia. It has a reputation as being for residents with behavioural difficulties. A minority of care workers refuse to work there after having negative experiences. Others mentioned that it was their favourite suite to work in. The demographic makeup of Lichfield was conceived by accident rather than design. Upon the home opening the suite was meant to be a nursing suite with a preference for 'challenging behaviours', but not specifically men with dementia. Over time the aggressive reactions of certain men to disruptive stimulus within the environment led to staff making a strategic decision to group a selection of male residents together for safety reasons.

Across from Lichfield is the 'Sutton Park' suite. Directly outside a set of double doors leading to Sutton Park is a seating area with a table. Staff sometimes accompany residents here for a cup of tea, or to help calm them if they seem troubled. Sutton Park has many residents living there who are approaching end of life and are therefore being cared for in a palliative manner. In Sutton Park the large communal room does not have a TV in it. Both Sutton Park and Lichfield differ from Ferndown in that they have a supervisor who works full time and is solely based in their respective suite. The supervisor in Sutton Park made the decision to move the TV into the quiet smaller lounge to maximise the space in the larger room for more activities that prioritise resident engagement. Sutton Park is the only suite with a weekly activities schedule, designed by the supervisor. In Ferndown activities are conducted on an ad hoc basis some time in between lunch and dinner. It is plausible then the lead care supervisor within Sutton Park felt able to take control over elements of care practice.

4.3.5 The 2nd Floor

The guest room is directly opposite the stairwell. It consists of a shower wet room, a wardrobe, a single bed and a small table with a kettle. Across from the guest room is a smaller function room, again used for meetings. To the left of this function room is the Silverburn suite. This is where the Falcon Lodge residents are living temporarily. Opposite here is the Middleton suite. The Middleton suite was closed as a precautionary measure to protect the safety of residents due a lack of nursing staff available to recruit. The residents from Middleton were relocated from their rooms to other suites at Somerset House.

By describing, the physical care environment, relevant to the data collected, above the reader has been given a clearer picture of the care setting and research site. This will aid the readings of the findings. This description will be reflected back upon with reference to findings that cite the environment or where reflections may prove useful in illuminating discussion.

4.4 Summary

Hollyfield provide care in five homes in the south of England. Alongside the opening of Somerset House, other major ventures were undertaken such as the acquisition of the Old School House and the refurbishment of Falcon Lodge. Hollyfield is a small local operator with a finite supply of resources to manage its operations. These ventures therefore directly influenced each other, as demonstrated by the relocation of Falcon Lodge residents and staff to the Somerset House, shortly after its opening.

The *EMBRACELIFE* model of care found support for its key implementation criteria in the related body of literature. Its principles were influenced by a person-centred philosophy of care. The findings of this thesis therefore contribute to the field of literature, associated with achieving person-centred care in practice. A number of implementation strategies for *EMBRACELIFE* have been identified, beyond the model itself, including quality assurance, workforce and engagement. An analysis of these strategies have revealed the centrality of the CQC, as the main auditing body in the UK to the principles behind *EMBRACELIFE*. This PhD therefore adds to the literature surrounding

the development of strategies that aim to meet the requirements of bodies such as the CQC. CQC regulations then, are relevant to gaining an understanding of the implementation process of *EMBRACELIFE*, and therefore discussed in the discussion chapter (section 7.3). Furthermore, within these implementation strategies factors such as recruitment, care staff retention, leadership and communication have been identified as key to the aims of the research. In addition, the physical environment has been described and will inform, contextualise and illuminate findings. Attention now turns to these findings.

Chapter 5: How is the cultural organisation of care constructed in reality at the care home?

5.1 Introduction

Previously, the *EMBRACELIFE* implementation strategy was described and critically assessed using latest academic literature, to contextualise the findings. In this chapter, findings will be presented thematically to capture the dominant culture, and constructions of care at Somerset House. Key indicators of culture are explored, in an attempt to reveal the dominant discourses of dementia care prevalent within the home. As described earlier in this thesis, the discourse prevalent within how staff construct care, residents, themselves and each other in their descriptions, will form the central element of this analysis throughout this findings chapter. Through analysis, a picture will emerge of the construction of the cultural organisation of care within Somerset House. Findings have been divided into the following themes, as demonstrated by the Figure below: Figure 1: Overarching themes emerging from the culture of care



Throughout, I will refer to the specific job title of care workers. There are three main job roles for staff observed delivering care on the ground: Care assistants, care supervisors and RNs (either general or mental health). I will discuss data depicting the roles and responsibilities of people working in each of these roles from my observations, and my interpretation of how staff perceive themselves and others in their respective roles.

Once an understanding of the culture of care is captured, an investigation into the extent the *EMBRACELIFE* was implemented can take place. In chapter 6 therefore, analysis of evidence specific to the implementation process of the *EMBRACELIFE* model will be presented. A discussion can then take place with in terms of the relevance of this PhD to the wider body of literature and the implications for policy and practice.

5.2 Care planning

The first area addressed by this findings chapter will be an overarching analysis of the care planning documentation. As discussed in the methodology section of this thesis, care planning documents form a key part of the data set. How people with dementia and their care is constructed within care plans, through discourse, has been theorised to be reflective of the culture of care at Somerset House. Throughout this findings chapter, care plans will be reflected back upon, hence it seems logical to start the chapter with this analysis.

5.2.1 A lack of staff consensus

Typically care staff reports on care planning documentation vary depending upon how accessible and usable the individual staff member felt they were:

The care plans themselves are quite complex and we don't tend to sit and read through them because they're very long and they're very drawn out... The supervisors would update them on a monthly basis, or update them if they needed to be updated, and they contain hobbies, likes and dislikes, their daily routine, things that they like

doing, things that they really don't like... if we've got people that are unwell I'll always write at the top "I'm unwell at the moment, please just be aware that I may need extra fluids" or what have you. If the manual handling's changed I'll just write at the top "please read my manual handling because it's changed" I think sometimes because the nurses write them, there's certain bits that maybe aren't quite as personalised as they could be. (Interview with care supervisor, Alexa)

If the care staff team 'don't really read them' this raises questions about how the care plans were used and for what purpose. Analysis of the documents confirmed they are updated so they likely served some form of function. The comment surrounding nurses was possibly revealing as it indicated tailoring care based on the individual, a key element in person-centred cultures of care, was not being fully achieved by the nursing team, who are expected to be leaders by Hollyfield (see chapter 4). Whilst this evidence alone does not substantiate the claim, further investigation is warranted and will be conducted later in this chapter.

Other care workers reported care plans were accessible to lay people indicating that inexperienced care staff members understood the guidance:

Care plans are really clear here because each and every point we are writing it separately and even the lay person can understand that, what we mean from that. (Interview with registered nurse, Caroline)

Care plans were completed electronically and typically had 16 sections (Personal Care, Medication, Sleeping and Resting, Infection Control, Breathing and Circulation, Physical Care, Foot Care, Mental Cognitive Behaviour, End of Life Care, Social Interests and Hobbies, Nutrition, Sight Hearing Communication, Mobility, Oral Health and Continence Management.) The 6 care plans in the sample ranged between 7 and 12 A4 pages in length. Each page consisted of a table detailing the section of the care plan with a column for

'observations', 'resident goals' and 'interventions', relating to the section. Care plans were reviewed periodically usually every 4 to 8 weeks. Care staff members however, reported and were observed updating care plans on a daily basis. The care plans in principle therefore, seemed to cover the issues necessary to achieve the best possible health and wellbeing outcomes.

5.2.2 Care planning as reflective of task centred culture

Care plans were typically detailed in the observation column in sections relating to clinical and task based care, such as medication, pain management and personal care. A lack of information in the resident goals and intervention column suggested the care team can struggle with entering relevant information in them. As resident goals and person-centred interventions inherently require resident input, it is possible to infer a lack of resident involvement in care decisions. This issue could have been due to a lack of strong relationships between nurses and residents, or organisational obstacles to the development of nurse/resident relationships within the care environment. The specific reasoning for this will be investigated further in this thesis through the presentation of the findings. Often the resident goal and intervention columns were filled with repeated guidance from the observation column or generic statements such as the following taken from 'resident goals':

[Person] would like staff caring for them to have full knowledge of their past medical history (Eve, Emma, Josephine, Patricia, Deirdre).

General statements such as the one above do not resemble resident goals, rather they read more like the staff expectations i.e. that it is expected all staff have full knowledge of the medical history of the persons they are caring for. Here, rather than the care plans having the potential to be used as an active tool in care delivery (as the instructions given in observation related to clinical/task based care), the plans acted more as a reminder of general policy. The column title therefore did not match the information given below within it, and staff seemed to struggle to give a unique insight into the person's goals and aims, interpreting them from their observations, rather than discussing them with individuals.

The majority of the time within the care planning care staff referred to the person in question by their name, adding a personal and humanising touch to the largely task-focused documentation. An attempt was made to incorporate the preferences of people, relating to specific aspects of care such as the gender of the care staff member, the types of food people enjoy eating and personal hygiene preferences; personalising the necessarily task based care plan sections. This suggested again elements of care plans could be used as an active element in care delivery, rather than simply a place to record information for regulatory purposes. There was evidence within care plans that the capability of people to independently carry out their own care tasks had been assessed, demonstrating an effort made to ensure residents use the skills they have and were not made passive in the care process.

Patricia responds well to female care staff approaching her around 8am to assist Patricia with a shower (Extract from Patricia's care plan)

There were however, inconsistencies with the use of person-centred terminology and phraseology, describing the person who the care plan belonged to and the care activity.

Emma would prefer a female to assist them in moving and handling (care plan for Emma)

In the above example the care staff member referred to Emma by their first name, rather than a label such as 'resident' (This label is used in Cynthia's care plan). They also stipulated the preferred carer gender for the individual, and indicated the person was not passive during the interaction, through the term 'assist'. Despite this, the care staff member referred to the care activity as 'moving and handling'. Such terminology conjures up imagery of moving objects, instead of helping people with difficulties walking independently, and is not reflective of discourses around dignity and personhood.

Some of the titles of the sections are indicative of a disease-based discourse of dementia. In particular, 'Mental Cognitive Behaviour' excludes a discourse of environmental stimulus, in favour of a focus on the cause of 'behaviour',

intrinsic to the person, behaving in a way not perceived to be appropriate by care staff. The term is aligned to a disease-focused discourse of dementia, as the issue of 'behaviour' is perceived to be a mental issue, symptomatic of the individual. This was evident in the sparsity of person-specific guidance in the resident goal and intervention columns, already discussed, and notes by care staff within the 'Mental Cognitive Behaviour' section of the care plan:

Cynthia tends to shout very loudly, and showing signs of anger towards residents. Cynthia is the only resident in Ferndown that expresses this behaviour... Cynthia suffers from Alzheimer's disease and Dementia therefore she is disorientated and unable to discuss her care and wishes (care plan for Cynthia)

Jospehine is currently on... behaviour chart due to... increase agitated behaviour towards staff... she will often sit in the lounge and bang her stick on furniture which in turn can irritate some of the other residents in the lounge, she had also been grabbing staff... (care plan for Josephine)

Disorientation, while common in people with dementia, is not a fixed state and can be improved by environmental interventions, such as wayfinding aids (Marquardt and Schmieg, 2009; O'Malley et al., 2017). To dismiss the ability of the person in question to have an input into their care plan, based on this reasoning appears to be a misunderstanding of the concept of disorientation and the subjective experience of dementia. The discourses of dementia within the term 'Mental Cognitive Behaviour' served to reinforce and validate these misunderstandings. It may be that currently the person in question does exhibit high levels of disorientation, however the care plan did not detail any attempts by the care team to remedy this, or characterise it beyond the generic label by giving further information in other columns.

There was further evidence of staff discounting environmental stimulus in Cynthia's care plan. There it was reported how she was taken up to the Silverburn suite for coffee. However, these visits were discontinued due to Cynthia 'shouting out of the blue':

Cynthia was joining residents in Silverburn, having tea, coffee and a chat... sometimes out of the blue Cynthia would start to shout... this was discussed with [Manager at Hollyfield] and the decision was made that Cynthia was unable to come over (Extract from Cynthia's care plan)

The 'Interests and Hobbies' section of care plans generally gave a good depth of information about the person histories of residents. Despite this, the 'resident goal' and 'interventions' columns, as seen in other sections, had a lack of person-specific information inputted.

[Person] would like the opportunity to participate in social, cultural and spiritual activities of her choice... (care plans for Geraldine, Cynthia, Eve, Emma, Josephine, Patricia)

Eve chooses not to participate in activities, care staff to offer 1 to 1 time with Eve (care plan for Eve)

The majority of care plans did not mention a personalised activity in relation to a person living at the care environment in the care plans. The specific type of 1 to 1 care recommended for the person in the above quote was not identified. This gave the impression the guidance used in the care plan may have been difficult to implement in practice. Activity is a key theme within this findings chapter and will be presented later.

In summary, the care plan template, despite featuring specific terminology imbued with a diseased focused discourse of dementia did have some potential to encourage the development of a person-centred culture of care. Care staff typically recognised the importance of the care plan sections focused on improving mental stimulation, social interaction and activity. The data suggested however that care plan guidance, inputted by the care home staff, was inconsistent; with some being individualised, and others filled with a generic comment. This suggests care staff had stronger knowledge of some residents than others, and did not always complete care plans in collaboration with residents.

5.3 Activity

5.3.1 Recreational activity

Care workers suggested people with dementia were likely to enjoy engagement in activities that are meaningful, of their choice, and developed with their personal preferences in mind.

I think sometimes, people are thinking that you've got to have a lot of planned activities, but you don't actually need to do that, because you pick up on something that somebody might be keen to do on that particular day. You've got to know the resident really... You can't really have a regime, of everyone's going to do such and such on a Monday, because it won't work (Interview with Henrietta)

I was with [a resident], we were having a chat ...it was a good day for him... then he said to me, but what am I doing now? I'm just sitting here every day. And I said, well, what would you like to do? And he said, all I really want to do, is go to the beach. At the moment, he can't because we need a special wheelchair for him, so that he can go out on the transport, to go to the beach. But it is being addressed. I've spoken to [persons] family as well and they're already having him assessed for this special wheelchair. So, fingers crossed, he'll be going to the beach. So I'm...it's just a simple thing, isn't it, that he wants to go the beach so he should go to the beach. And then I was thinking, could we bring the beach to him? (Interview with Helen)

These comments were reflective of a perception of people with dementia as individuals. Helen's belief in the desire of residents to be involved in activities and trips were indicative of this. Care workers also displayed initiative in attempting to fulfil the desires of residents to take part in activities, as shown in the beach anecdote, indicating a passion for facilitating the choice of residents. Care workers also expressed how activity did not always need to be structured or planned.

The main suite-based group activity of the day was not personalised for the majority of residents. Examples of the main group activity include quizzes, music listening, television watching, singing and dancing, a balloon passing game, the 'guess the name', cakes and tea and hangman. The following extract from field notes described a typical afternoon suite-based activity:

As I walk into Ferndown there is a quiz going on. The questions are the same as the previous three times I had witnessed quiz activity on this suite. Emma is sitting reading 'the daily sparkle'. Colin is asleep in a chair, Eve is asleep in the same modified chair she is always sat in, to the far side of the room. Donald is asleep. Geraldine is being visited by family. Patricia is taking part in the quiz but no one else appears to be. (Extract from fieldnotes)

Questions asked within quizzes were not always reflective of the experiences, personal histories or eras likely to be relevant to the residents lives, for example during one observation a care assistant asked the residents what the 'e' stands for in email. Eventually, despite observing the same quiz reads out three times, I did observe a new quiz:

Quiz, starts... [Care worker] has printed off new questions 'because she can't find the old ones'... Three care workers are engaged in the quiz despite only two residents looking interested in the activity (Extract from field notes)

Although it was encouraging to see the care worker download and use a new quiz, her comments suggested this was for her benefit, rather than the residents. Further the quiz appeared to be providing more stimulation to the care workers on shift than the residents. This was evidence of a more staff centred approach to care than person-centred care.

Observations of the everyday lives of the people living at Somerset House indicated a great deal of variation in the opportunities for meaningful activity that residents were engaged in. Patricia, Colin and Emma were observed being engaged in activities that may be defined as personalised or developed based

on what was important to people in their past. These included activities, such as art work (Colin), choosing to play board games (see below) (Patricia) and being in receipt of the specific newspapers they like to read (Emma):

Danielle asks Patricia if she wants to play scrabble with her, she also asks Geraldine if she wants to play, no one else is asked, maybe she doesn't think they can play. Danielle asks Patricia loads of questions about what words are: 'Would you say this is a word' 'Not really' Patricia says. (extract from fieldnotes)

These observations mirrored the guidance in care plans for those participants, suggesting a connection between the activities laid out in plans, and the activities delivered in practice:

Patricia enjoys telling stories of the things she has done in her life. Patricia enjoys sewing and knitting, travel programmes and listening to talks and debates. Patricia likes things that engage the mind. Debates, doing card and board games, quizzes (extract from Patricia's care plan)

There were examples in care plans however, of guidance for personalised activity or activity important to people not always being applied in practice. It was noted in Josephine's care plan that she enjoyed playing musical instruments, based on the life history information, also documented in the care plan:

Josephine would like to play the piano or organ... she will need staff to show her where the organ is located so that she can play music whenever she wants (extract from Josephine's care plan)

During observations no staff member attempted to engage Josephine with her instruments or the instruments available to play, owned by the care provider. During fieldwork an inquiry was made with a care staff member, asking if the keyboard could be moved into the suite so that the person could be encouraged to play. The care staff member agreed that this would be a good idea. The next day the keyboard has been moved into the quiet lounge in the suite however, it

remained there unplugged during every subsequent visit and no observations were made of staff engaging or attempting to engage Josephine with the keyboard. There is a gap therefore between the instructions given in the care plans for this person, and the reality of her opportunities to be involved in the activities for this individual.

Observations made during fieldwork suggested the care team at Somerset House did provide activities that seemed to positively stimulate the minds of residents. In particular, the 'the weekly sing along' session and the availability of the café in the reception area, where families can come into the home and have a cake and a hot drink with their relative:

Emma is being visited by her husband, staff tell me he visits almost every day and during the visit they always go to the café area for a 'change of scenery' (Extract from field notes)

Myself and 6 of the residents on the residential care suite are accompanied upstairs by 2 members of the care staff team to the West Moors Lounge for the singing and dancing session. Upon arrival it is clear the activity is well-organised. 7 relatives of residents are present at the activity, along with 20 residents (4 of whom have been helped into the room in their beds) suggesting the care team try to include all the residents who would like to attend... some of the relatives are visibly emotional during the session, holding the hand their family member as they sing along (Extract from field notes)

That seven relatives were present at the singing and dancing activity session suggested the care team at Somerset House were taking steps to involve families and stimulate quality interactions between family members and residents. The presence of relatives also indicated the session has been widely advertised and effectively communicated. Indeed, the reception desk would often have a sign up to let visitors know what was coming up in terms of activities in the West Moors Lounge to encourage attendance. This was indicative of a culture of care that embraced and recognised the importance of family member visits to the lives of residents. The weekly sing along session,

although not typical of day-to-day activity, was enjoyed by all those in attendance, including the staff members leading the activity. It is demonstrative of an attempt by the care staff team to implement a culture of care that prioritised the mental wellbeing of the people living at the care home, and is aligned to the 'Loved ones' implementation criteria within the *EMBRACELIFE* care strategy.

During my visits to Somerset House I did not observe any examples of activities that connect individuals with the wider community, neither, in terms of people from the community coming into the home to put on activities, such as singers or speakers, nor residents going to events in the community. One person with dementia expressed their concern that speakers were not involved with activities in the home:

It would be nice sometimes, if a speaker would come in and talk to you about something" (Interview with Patricia).

At the time data was collected the home did not have a 'minibus' driver, meaning residents could not be taken on trips outside the home. A senior management level staff member expressed their concern about taking an individual out due to this being perceived as favouritism and therefore, unfair on the rest of the residents. They also described issues with insurance, if involved in a motor accident when taking a resident on a trip in their own car.

Observations suggested that a weekly singing activity promoted visits from family members and appeared to stimulate residents in a positive manner. This activity therefore had direct and indirect positive influences on some residents, who enjoyed the activity, whilst benefiting from the company of family members. Despite this day-to-day recreational activity did not engage the majority of residents on Ferndown Suite. Care staff reports on activity suggested a desire to implement meaningful activities however, the degree that such activities were observed 'on the ground' varied depending on the resident, and the data suggested more could have been done to personalise group activity work. A gap appeared to exist between the guidance in care plans based on life histories, surrounding personalised activities for some residents, and the reality

in practice, whilst for others there was a lack of personal information guiding activity provision.

5.3.2 Stimulation beyond recreational activity

The gap between staff perception of activity and the reality of day-to-day activities in practice raised a concern surrounding the levels of positive stimulation residents were exposed to at Somerset House. Members of the care team and residents described their concern with the level of mental stimulation and activity:

They [residents] are just sat in chairs all day and that is where they're left, and it's no good for anybody. Even though they've got dementia, it doesn't mean that their brains still aren't working, and they still need to have some activity to keep whatever brain matter they've still got active (Interview with Danielle).

No [I don't enjoy living here], for me, it's not anyway. I hate it. Spending so much time on your own. Nothing really to do.... I think they could probably do a bit more here, to get people involved in different things.... It just seems like a nothing place. Nothing going on (Interview with Patricia).

According to observational data Patricia was the most engaged in personalised activities. However, she still felt isolated and lonely. Both quotes were indicative of a lack of general day-to-day activity outside of the recreational activities that occurred. The observational data reinforced this perception:

Josephine is given little attention by care staff. After 30 minutes she asks 'where do I live? She seems to become anxious. I believe this anxiety has occurred due to a lack of stimulation. As soon as Josephine asks a member of staff tells her she lives here at Somerset House and her room number is [number]. A carer then comes to show her where her room is. (Extract from fieldnotes)

There were several examples in the data set where residents questioned where they were and what they were doing 'here'. In the above example, the care staff team were reacting to the person's anxiety however, the anxiety was not resolved by engaging the resident in an activity of any sort. Instead, the perceived cause of the anxiety was focused upon. Care organised in this manner is indicative of a clinical culture, prevalent within Somerset House due to the 'curative' discourse invoked; relieving anxiety in the short term, does not aim to prevent anxiety reoccurring but rather to alleviate the symptoms. If care staff engaged the person to begin with they would be less likely to have become anxious in the first instance.

The people living and working at the care environment lacked access to some of the kitchen appliances necessary to support the stimulation of residents, such as a kettle or oven. A description of the kitchen/dining room area of the Ferndown Suite is provided in chapter 4 of this thesis. From this description it is possible to observe that hot water is gained from a 'hot water dispenser' rather than a kettle. When not in use the dispenser would be locked and the key hidden, to prevent residents from using it and potentially burning themselves. This machine would likely be unfamiliar to the people with dementia, making it difficult for them to operate, even when assisted. Residents would be asked several times a day if they would like a round of toast or a cup of tea. I did not observe however, any member of staff helping a person with dementia operate the dispenser to making their own cup of tea during my visit. I also did not observe any member of staff helping a resident make their own toast or operate the microwave, despite these appliances having less of a safety risk and being more familiar to residents. I know from my stay in the guest room that there are kettles within the care environment however, the data suggested they were not used to facilitate 'normal everyday activity' with residents. Staff members therefore did not seem aware that helping residents to undertake normal everyday activity was a priority. This point finds evidence in the lack of day-to-day activity reported in the care plans for residents. Whilst care plans are detailed, there is no section for supporting everyday activity. Activity and mental stimulation was solely defined in terms of communication and recreational activity such as games, and activities like knitting and singing:

Emma enjoys activities there are stimulating to her, she is not a fan of games that she sees as 'childish' such as skittles and prefers activities such as quizzes and singing (extract from Emma's care plan)

When viewed in the context of the issues already presented in this chapter surrounding recreational activity, the narrow definition of activity and mental stimulation within care planning materials is doubly problematic. It leads to a questioning of how much a priority stimulating residents was for the cultural organisation of care within Somerset House. Staff perceptions were reflective of this point:

So it seems to be more like one main activity a week rather than activities every day, and a choice of activities for residents. I think people sometimes forget that even just sitting there looking at a book together or chatting about the newspaper and things is actually an activity. Instead, there seems to be one activity and the only thing they have in their day, really, is being washed, having medication and getting fed (Interview with Registered Nurse, Wendy).

A minority of residents within the Ferndown Suite appeared able to physically and mentally stimulate themselves through interacting with the internal physical environment and various objects of interest within the suite:

[Person] is very active, always walking around asking questions, tidying up by rearranging the sideboards in the hallway and picking up bits of dirt or litter from the floor and engaging with others, both staff members and residents. She seems to take ownership of the home and will often comment that 'this is my home' and takes pride in its appearance (Extract from fieldnotes)

In the example above the role of care staff in engaging the person in tidying up was limited. I interpreted the person to be tidying up autonomously due to a sense of pride in where she lives, rather than due to staff encouragement or facilitation. It is possible however, the design of the environment and the

placement of reminiscence objects throughout the main hallway of Ferndown Suite played a part in creating this sense of pride:

Cynthia clearly sees herself as having a role at the care home. She says she made many of the fixtures and trinkets in the corridor. She is very protective of them, she likes to make sure everything is in its place (Extract from field notes)

There were very few examples of care staff members engaging people with dementia in non-recreational activity such as cleaning, doing laundry, washing up or making tea or toast. This may have contributed to a high level of inactivity for residents outside of more traditional notions of activity such as singing, dancing and quizzes. My observations suggested this was leading to residents becoming anxious after long periods of inactivity. The lack of engagement in every day activity may have come from a lack of access to appliances such as washing machines, ovens and kettles within suites however, the data suggested staff were not conceptualising normal everyday activity as an option when planning how to stimulate and occupy residents, as care plans made no mention of normal everyday activity.

5.4 Outdoor Space

5.4.1 A lack of opportunity and equality

Care staff members felt it was important for the wellbeing of residents at Somerset House to experience outdoor access however, they reported that the outdoor space available was underused. Typical responses, when asked whether residents could go outside included:

Not very often, [given outdoor access] because obviously the suite is full now. You know, we could take the ones that could walk and everything, you know, you could take two or three down with a carer, which was fine. But, now it's, like I say, it's having the staff to be able to take them down to the garden... when we had like, the farm animals come in, a month or so ago, virtually all the residents went down there. So, only a couple of

people stayed up here, so we could leave maybe one or two people up here and that was fine. We left them obviously with the carers and then the rest of us were all in the garden with the residents. They absolutely loved it and anyone that didn't want to stay down we just brought them back up. (Interview with care supervisor, Zara)

Definitely the garden [is underused], and people say, it's too windy, it's too windy. Well, you know, there's coats and scarves and there's enough staff to walk with somebody all around the garden. We could put up windbreaks, there are things we can do, that's not a problem. (Interview with managerial level staff, Edith)

The garden, we have got a beautiful garden out there, and I see it as it is just wasted. They don't, I mean I know winter is coming and stuff, but they don't get to get as much use out of the garden as I think they should have. I mean, some of the chaps up here would love to be out in that garden more often than what they can. But, if you haven't got enough staff in the suite, then you haven't got the staff to be able to take the gentlemen downstairs to go out in the garden, which is a shame (Interview with Helen).

It was suggested the number of residents living at Somerset House was having a detrimental effect on the time residents spent outside, as care workers felt they were too busy, or were lacking the numbers, to facilitate outdoor access into the daily routine of residents. This raised two issues. Firstly, that residents were perceived to require supervision when outside and secondly, that enabling residents to have a mix of indoor and outdoor space was not prioritised. Evidence for these points was found in the observational data set.

Zara hinted that people living at Somerset House who cannot walk were not likely to be given the opportunity to access outdoor space by suggesting only those 'that could walk and everything' were afforded time outside. This view was shared by another care staff member who indicated a link between the physical and clinical needs of residents and a lack of outdoor access:

I think unfortunately the residents in Ferndown, they get to go outside more because it's just down there and things. A lot of the units, for example, [Lichfield suite], where people have a lot of physical nursing needs, they need bed rest and to be turned regularly and stuff, I think things like that get forgotten (Interview with Registered Nurse, Wendy).

The majority of residents were not afforded any access to outdoor space during time spent conducting observations. Only one person, Colin, was heard being offered the opportunity to go outside, according to field notes. Colin, was observed outside with a care staff member or relative on four occasions.

5.4.2 Outdoor access as deprioritised

Access to the garden area was locked and alarmed and the door handles involved several sequences to open. I did not witness a group activity outdoors during any of my stays, although one is described in the first quote above. The following extract is representative of the difficulties staff encountered with providing a safe and accessible outdoor space:

It's a really sunny day outside so I ask [care supervisor], supervisor for the afternoon, if he has to supervise people in the garden. He explains that he does, he suggests the garden is not that dementia friendly i.e. poisonous plantation / things people can trip over. He also talks about the need to apply sun tan lotion. I tell him that I am here until 2pm and I am happy to supervise if people wish to come outside and they have sun tan lotion applied. I ask some residents if they would like to go outside... Geraldine says 'I think I'd quite like to go out there, I'd be an Irish Jewel... If I wasn't here I don't think [care supervisor] would be capable on this suite to allow people outside due to the complex needs of multiple residents here, and the amount of task based care, he and his team needed to prioritise (Extract from fieldnotes).

The care team appeared to have been informed they needed to supervise residents in the garden at all times and ensure residents were protected from the elements by applying sun cream needed and ensuring residents were

wearing suitable clothing. These issues, along with the staff reported lack of time available for accompanying residents outside, the hazardous garden area, and the locked doors to outdoor areas, inhibited residents experiencing an outdoor environment.

Along with the limited examples of individual residents being accompanied on walks in the garden, I did also observe care staff members accompanying people with dementia (Deirdre, 436) to the balcony on the second floor. This seemed to be in response to residents displaying signs of anxiety or to prevent confrontations between residents.

The decoration within the suites at the care environment could be defined as an attempt to 'bring the gardens into their indoor space'. In the Ferndown suite for example, the wallpaper has a seaside theme to it and in [Sutton Park suite] there are flower themed pictures on the wall and the end of the hallway there is a hanging basket, with a bench to sit next to it.

In the review of care plans I was unable to locate any information involving outdoor space as part of care delivery to improve the emotional wellbeing and physical health of residents, suggesting access outdoor space was not explicitly at least a priority for care staff, and the potential benefits of having access to outdoor space may not have been fully understood.

5.4.3 Summary

A minority of residents were observed being accompanied outside into the garden area or to the balcony from time to time. The majority of residents however, spent all of their time indoors, with no choice of spending time outside, unless they needed to leave the suite to travel for a clinical appointment. Staff reported feeling too busy to supervise people with dementia outside as a reason for this, as well as not feeling the garden was safe enough to allow people with dementia to enjoy it without supervision. Observations of the built environment (see chapter 4) suggested Somerset House was designed with thought to bringing the outdoors into the home however, the care plans reviewed did not include guidance on achieving outdoor access for the

residents either inside or outside the home. The cultural organisation of care in reality was therefore detached from the staff perception of the amount of opportunities afforded for residents to access outdoor spaces. This contributes to the evidence gathered previously in this findings chapter that the day-to-day mental and physical stimulation of residents was not embedded within the cultural organisation of care at Somerset House.

5.5 Care worker perceptions of care

Staff perspectives on typical resident interactions were polarised. Some reported comments indicative of a person-centred culture, whilst others were filled with a more clinical and task-based discourse:

Comfort I think, and friendship really I think with a lot of the residents, kindness, caring, and familiar face there for them, to be quite honest, yeah... No, no, none [obstacles to achieving comfort and friendship] whatsoever, no. It's a very peaceful place really, yeah, very peaceful... Yes, I've never had any obstacles that have come up, and I think I'm a good carer, I hope I am to be quite honest (Interview with Helen)

The role is really, you are sitting, chatting to people about memories and things. That's what they actually want (Interview with Jennifer).

Helen used words such as 'friendship' and 'comfort' to describe the care assistants' philosophy. This important of a familiar face is noted. Jennifer indicated reminiscence was central to the role she had and therefore her interactions with residents, suggesting the mental stimulation was a priority for her within practice. The discourse underpinning these terms was consistent with an approach to dementia care that attempts to maintain the personhood of an individual. The care assistants' perspective, coupled with her statement that she had not encountered 'any obstacles' to achieving this, indicated the culture of care at Somerset House could facilitate person-centred care. This point is contradicted however, by the perspective other colleagues:

They're not getting the extra. They're getting the basic. They're getting their teeth done, they're wash, they're changed, and then you have to leave the room because you have another one up wandering (Interview with care supervisor, Daisy).

It can be quite clinical because we have to...we've got a lot of pressure areas and fragile skin and a lot of pain, there's a lot of pain management, a lot, massive amounts of it, and it can get...I know when you're short-staffed, it kind of does become a little bit more task and clinical... you've got to get that done otherwise they're going to be dirty and they're going to be wet and they're going to be unsafe. We try our best to still keep it as person-centred as we possibly can, but also knowing that by the time we go home at eight, all 12 of them have to have had a pad check between six and eight o'clock, so you've got two hours to do 12 residents is quite tight for four of you; or three of you on some afternoons (Interview with care supervisor, Matilda).

Model of care is very kind, benign, physically mostly adequate care, with flashes of person centre, with attempts here and there of individuals to bring person-centred thinking into the mix (Interview with Dementia Lead, Vera)

The reports of care detailed within these quotes indicated an attempt to 'bring person-centred thinking' into the mix however, this is reported as inconsistent in practice. The pressure of clinical and task based workloads were mentioned as reasons that reduced opportunities for person-centred care. Completing tasks, aimed at maintaining the dignity and safety of residents do not inherently contradict person-centred discourses of care. Indeed, tasks, even if clinical, can be completed in a person-centred manner. The second quote recognises this by stating 'we try our best to keep it as person-centred as possible', in the context as what is constructed as severe time pressures. These pressures appear to describe a culture of care constructed around task where 'all 12 of them have to have had a pad check between six and eight'. Further evidence for this was found in the first quote where, the care supervisor appeared to be

making a choice between completing a full debrief with the residents, post personal care, to give 'the extra' and addressing the needs of other residents. The care supervisor constructed clinical and personal tasks as 'the basics', separating whatever is perceived as 'extra' as something not basic and therefore extra or not necessary, but to be delivered if possible i.e. not embedded as a priority within the culture of care. Within each of the 3 quotes there was an implied recognition of person-centred discourse as favourable, indicating a disparity between the care that staff would like to deliver and the care being delivered in reality. Further examples of this disparity were identified within the data set.

Care staff members tended to discern a difference between what they wanted or perceived their role should be and what is was in reality. This seemed to be a source of frustration among those care staff members who felt this way:

Sometimes I feel I am just here to give them medications and I don't like that... (Interview with Daisy)

I feel like a dog's body, like you're just shoved out and it's just go and get on with it. There's no role here. I wouldn't want to be a supervisor. I don't even know why we have them. I don't know what they're for. And seniors just get treated like dog's bodies anyway (Interview with Danielle)

Yeah, so I think my role here should be that I am able to focus more on the residents who do have the more prominent mental health needs who do display the challenging behaviours and being able to educate the staff about this. I understand through all of my jobs as a nurse it's really important to give medication and respond to people's physical health needs in a timely manner, but sometimes it feels like that is all that I do... (Interview with Registered Nurse, Wendy)

In these examples the staff members were displaying frustration through dissatisfaction with their job role. As with the previous quotes surrounding the separation of tasked based care from person-centred care, task was

prioritised in the role, defined as administering medication. The mental health nurse seemed to suggest that she would have liked a prominent role in changing the culture of care at the care home by 'educating staff' about challenging behaviours. This indicated a proportion of the people living at the care home are demonstrating low levels of mental wellbeing and high levels of anxiety, resulting in 'challenging behaviours'. That the nurse wanted to educate staff suggested that the care team were having problems preventing 'challenging behaviours' occurring and easing the anxiety or aggression of people with dementia once such behaviours arise. Indeed, in interviews with other care staff members this issue was discussed:

Yeah, we have residents that can really kick off, throwing tables, being verbally and physically aggressive towards staff and residents... when it's just two of us I'm constantly worried about what we might face (Interview with care supervisor, Matilda)

As an RN she reported feeling it is her role as a senior figure at the home to intervene with the issue and yet she felt she cannot due to being overburdened with task-based responsibilities. This evidence suggested therefore that the culture of care was constructed around the unit of task, to the extent that the expectation of staff roles did match the reality in some cases and nursing staff did not feel they have enough flexibility in their role to realise their expectations, despite the low wellbeing of some residents, and the educational needs of care staff members under her leadership.

5.6 Constructions of People with dementia

Care staff members seemed to have knowledge of some residents' personal histories including information such as previous occupations, the places they have lived, whether they have children, were/are married and any talents the person may have. As this information was typically given in the care plans analysed, it was likely care staff members did familiarise themselves with the care plans of the residents they were caring for, facilitating meaningful engagement when engaging residents in conversations:

Geraldine is often encouraged by staff members to teach them French. She is more than happy to do so when asked and seems to enjoy it, she gestures with her arms when speaking and draws laughter from the room (Extract from fieldnotes).

Despite several instances of staff using knowledge of residents to elicit meaningful conversations some care staff members, particularly from the RN team felt they did not have time to engage meaningfully with residents. There were also instances of care workers working without dementia specialist training from Falcon Lodge care home who suggested they didn't value communication with people with dementia:

I get bored down here, you can't really have a conversation with them (Conversation with Denise).

Danielle reported negative, stigmatising perspectives of people with dementia were held by a RN at the home, who suggested investing in tools to mentally stimulate people with dementia was a *waste of money*:

I had a donation of about 30 colouring books, and some of them are a bit intricate and the residents weren't really interested in them, and some of them I think were really good... and I was told by one of the nurses before they found out that they were donated that I shouldn't have wasted my money on dementia patients (Interview with Danielle).

During observations there was one incident where a care assistant made a crude joke about a resident, demonstrating a lack of respect for their dignity and privacy. The joke was made during an activity session in the lounge of the Ferndown Suite and witnessed by several residents:

During the quiz the subject of one care staff members pet snake comes up. 'What's it like having a pet snake?' 'I love it, the only problem it stinks when they go to the toilet' 'What does it smell like?' '[a residents name is mentioned]'. There is muted laughter to this joke, Helen looks at me, shocked, seemingly aware that what was said was in very poor taste but

says nothing to Daisy I am genuinely horrified and amazed by the joke, particularly as it was told in my presence (Extract from fieldnotes).

These examples of malignant social psychology (Objectification and Mockery) were interpreted as relevant to how meaningful or individual interactions between care workers and residents can be; as it is questionable whether anyone with these views would be amenable to working with residents on a meaningful basis, even if given the time. This highlighted the difficult but important task of recruiting staff, particularly those staff constructed as leaders, such as nurses, whose values matched the ethos of the care provider. This was despite a proactive and strategic effort to recruit person-centred care workers, including nurses.

Evidence for why the care worker may have felt comfortable telling such a demeaning joke about the resident was found. For example, I observed a sign outside the room of the person in question stating 'All staff must wear gloves before entering'. This sign frames the person as an object of care. Moreover, I had overheard other care workers discuss how 'it stinks' in this resident's room. The evidence suggested therefore, this instance of mockery was not isolated and further, it was underpinned by environmental cues that objectified the resident.

Observations of care delivery in the common areas of the care home revealed a varied amount of time, spent by care staff working with residents on an individual and meaningful basis. This variation appeared dependent on suite leadership, the physical environment and whether a key worker strategy had been employed by the care supervisor:

The chairs are arranged in a semi-circle surrounding the TV. There isn't much space between each chair, the lack of space and privacy this proximity afforded the staff and residents may be inhibiting care staff from spending one to one time with residents... This morning upon entering the lounge area the layout had changed and the chairs are spread out evenly across the room in bunches of 4, rather than being in front of the TV. The 3 care team members on the Ferndown Suite have

been assigned key worker roles for 4 residents, by Charlie. I have noticed a marked increase in staff spending time with residents on a one to one basis. For example, Helen spent 15 minutes with Geraldine and during this time filed her nails (Extract from fieldnotes)

Care staff members perceived a lack of consistency of care at Somerset House, which was perceived to be due to an oversubscription of supervisors, with their own ways of organising care delivery:

It's just that you still need a guideline to give them the proper care rather than walking round going, well, has anyone done [Person's] bed? The trouble is with the day you have seniors that are here but they're not here all the time. They could be on today and then they won't be back until two days so it's all very different (Interview with care supervisor, Charlie).

I think the only problem...I noticed before when they opened this one, the management, they've given this supervisor the power and then suddenly they become, oops, I have this power, I'm the supervisor. I'm the one running the floor. Yes, you are running the floor when it comes to the care side. You educate / allocate the other care staff members what they needed to do. But at the end of the day I'm still the one in charge and what's going on I should know, because what will happen, I'm still the one responsible. I am the one with the pin... (Interview with Registered Nurse, Nathan)

There were many care workers with supervisory roles and this was perceived as creating a lack of consistency in approaches to care and conflicts within the care team. For example, not all supervisors organised care in a way that promotes one to one interaction, such as the key worker approach.

Variation in the perspectives of care workers on whether residents are receiving person-centred care interactions reinforced the point that the amount of individual and meaningful care delivered is inconsistent and varied from shift to shift, depending on who was leading the care on each suite, the care workers

who were working at that time, and the time pressure associated with that shift. There was also evidence the central position of task, as depicted within the cultural organisation of care, was having a mediating influence on the care practice of staff members. Examples of Malignant Social Psychology, were observed or reported that promoted stigmatising perspectives of people with dementia; raising questions about the suitability of individual members of the care staff team to work with people with dementia, their training and the recruitment process.

5.7 Food and the mealtime experience

5.7.1 Inadequate quality and choice

Staff members felt the quality and choice of food on offer at Somerset House was inadequate:

The only thing food they have to change... Because the residents are not able to have it because it is not up to their physical needs... Yes. They can't [ingest food] see, now today's food you have heard already the comments and sometimes just two pieces of sandwich and crisps for the residents, that's not enough... for me as a normal person (Interview with Registered Nurse, Caroline).

Here Caroline was demonstrating concern that no 'soft' option was available to residents at all mealtimes. From my own observations the main meal was served at lunchtime (the mealtime experience and timetable is discussed further below) and had a soft option however, the evening meal did not. This raised questions around the nutritional intake of residents with swallowing difficulties and equally, equality within the care home. Aside from that it was concerning that the RN constructed herself as 'normal' and therefore the residents as abnormal. Framing people with dementia in this manner negates their personhood.

The food... from what the feedback from the residents and some of the care staff members that have eaten the food is, that sometimes it's nice

but that seems to be quite a surprise because most of the time it's not of a good quality. I know a couple of the residents on the Ferndown Suite yesterday were supported to make complaints... to the kitchen (Interview with Registered Nurse, Wendy).

I do think for the amount of money that people pay here, the food is appalling. Really small portions, not enough traditional meals that the generation of the residents would like to have. Not enough fruit, vegetables, good dietary fibre. Yeah, for example, the soup, you never know what it is. It's always a bit like that (Interview with Henrietta).

These quotes were typical of negative staff reports of the food quality. Henrietta also indicated a concern about the nutritional intake of the food served. Further to this, the quote revealed the care staff were not always aware what they are serving, suggesting residents were not made aware of what they were eating, at least some of the time. This may have also caused health issues, prevented residents from eating or led to anxiety; if residents had specific dietary requirements for health, cultural or spiritual reasons.

The quality of food and nutritional value of food served during observations varied, reinforcing the perspectives of care staff members:

The food arrives. It is chicken and mushroom pie. Yesterday the food was pasta bake and appeared to be of very poor quality. Today the food seems better however, I am unsure as to how manageable the individual elements of the dish are. Potatoes are very large on the plate, as is the pie itself and the cauliflower. I wonder if this is impacting on some resident's ability to eat their meal independently (Extract from fieldnotes).

Denise is mashing up a fish cake for Cynthia. While she is doing this she says that 'it smells like cat food'. It is possible residents may have heard this comment, she also says that the food 'looks disgusting (Extract from fieldnotes)

The mealtime experience was thoroughly observed. Breakfast was served flexibly based on when the resident would like to eat, allowing residents to sleep in if they wish. No resident was put under pressure to eat breakfast and some went without a formal breakfast if they did not want any or got up too late:

Colin hasn't got up yet today and hasn't eaten anything (Extract from fieldnotes)

With the exception of breakfast, meal times were highly structured. Lunch was consistently served at 1230 with the evening meal served between 1700-1730. At around 20 minutes before these times staff began helping residents who struggled to walk independently to the dining room. If residents were ill or refused to go to the dining room, it was not uncommon for staff to facilitate the resident's preference to eat either where they were, or in their bedrooms, under supervision. Despite this, residents were not always given choice about where they sit once they arrive in the dining room:

Eve asks a resident 'excuse me could I sit here please'. Before the resident can reply a member of staff intervenes and says 'no you can't sit there, you have to sit over here, that chair over there is especially for you'. (Extract from fieldnotes)

Rachel helps Colin into the dining room, Rachel does not initially offer Colin a choice of where to sit. Colin rejects the seat he is being led to, at this point he is offered a different seat (Extract from fieldnotes)

Residents were rarely given a personal choice or made aware about what they were going to eat. There were 1 or 2 choices on the menu per course and menu options were inadequately communicated by care staff as demonstrated by the following extract from fieldnotes:

I ask Denise about what the residents are having for dinner but she doesn't know. She tries to find a menu but can't (Extract from fieldnotes)

The menu was entirely textual meaning there were no visual cues, such as pictures of food. The menu was located behind a table on the far wall of the

kitchen, rendering it hard to access, find and view, particularly when people were sitting at the table in front of it. No observations of residents engaging with the menu were noted, further reducing the possibility for residents to choose what meal they wanted to eat.

There was access to foods such as cereal, toast or biscuits for residents to eat within each suite as and when they wanted. Outside of lunch and dinner servings, provision of a hot cooked meal was rarely observed, as kitchen staff did not work during the evening. This reinforced Patricia's point, around the larger meals being served in the afternoon, against her preference. Care workers were observed periodically asking residents whether they would like a bite to eat. One care worker reported asking for some food from the kitchen between lunch and dinner for a resident and the kitchen were happy to help:

...sometimes you have a resident not very well, and they suddenly at three o'clock go, "oh I want something to eat", I've asked the kitchen for an omelette before at three, and they quite happily made it for me. I was like, "it might be the only time we get for her to eat", and they were like "oh yeah, no, that's fine" (Interview with Jennifer)

There was snack type food available and accessible to care staff members at all times. Care staff members were regularly observed offering residents food items such as cakes and biscuits.

5.7.2 Inconsistent mealtime experiences

Mealtime experiences on the whole seemed to be inconsistent in terms of the quality of the experience. There was no guidance available to staff on how to create a pleasant dining experience, meaning the experience and organisation of mealtimes typically varied, depending on the members of care staff on duty. The following two extracts below demonstrate this:

Frank Sinatra is playing on the cd player, staff are wearing aprons as a visual cue, Patricia and another resident are enjoying a glass of wine and Colin has half a bitter. Patricia told me the food was 'so so'. Staff are

sitting and eating with residents however they are talking between them rather than interacting with residents. After a couple of minutes, they open up their conversation to include residents. 'Patricia, what's your tippie of choice?' 'Red or white' she replies. Amy goes over to another table to involve the residents on that table in the conversation... Helen notices Geraldine isn't eating their desert and asks if she would like a yogurt instead, the resident smiles and nods her head. (Extract from fieldnotes)

Eve is sat in the same chair as normal, in the same position. Donald is physically moved while sitting in his chair to get Eve in the chair. Geraldine asks Patricia 'do you know what's coming? I don't think we do, do we?' From the quiet room opposite Josephine (who has been segregated due to perceived behavioural issues, despite her protests) starts to shout 'oi' and begins to clap to draw attention. A resident shouts at Josephine 'Oh do shut up!' Matilda walks into the quiet lounge and shouts 'Josephine!' Don't speak to me so rudely please, I don't get paid enough. Matilda walks back into the dining room: '£7.20, it's not enough!' She looks exasperated. Josephine then spit some food in the direct of the care worker 'Josephine, that's vulgar, you don't spit food at me!' Matilda shuts the quiet lounge door on Josephine. Josephine gets up out of the room: 'I'm not going back into that room.' She states. Matilda: You are upsetting everyone in the dining room, turn around.' Josephine shouts: 'Help! Help! Help!' Matilda shuts the door to the quiet lounge again with Josephine inside. Another care worker says I'll just sit with her; it will be easier.... Extract continues below...

Alexa places some food down for Patricia, no communication takes place... Patricia says 'It's ridiculous that's too much [food]... ridiculous' She seems very irritated by the amount of food on her plate. Alexa takes the food away, she offers it to me instead, I politely decline the offer. She then plates up a smaller portion for Patricia but she still seems upset. I can hear Patricia talking about the size of meals: 'They are too big at lunch and small at dinner... I think it is done to suit the staff... Colin is

not eating his food... care worker tells him 'If you eat your sandwich you can have some banana sponge and toffee sauce'. I wonder if Colin was assisted with their food he would be better facilitated to eat it (Extract from fieldnotes)

In the first example the organisation of the mealtime experience observed here was influenced by a person-centred discourse. The staff team created a pleasant atmosphere by playing relaxing, familiar music in the background and wearing aprons to provide a visual cue that suggests food has been prepared for the residents on site and will be served shortly. Staff were sitting with residents at the tables, thereby integrating themselves into the resident group eating their lunch. Staff engaged residents by eating with them and conversing with them. Choices were offered to residents, indicating a respect for their person preferences.

The second example was distressing to observe and the inverse of the practice witnessed within the first example. One resident was perceived by the care supervisor as a threat to the wellbeing of the other residents in the dining room, and was therefore prevented from joining the group to eat. This fits with Kitwood's definition of punitive Banishment, one of the 17 types of Malignant Social Psychology (Kitwood, 1997). The carer on duty at the time suggested her behaviour disturbed the other residents, and could cause confrontation. However, by isolating the person in a room directly opposite the dining room, they directly caused the person a large amount of distress, in turn this created a negative atmosphere as two staff members reacted to the person's behaviour by shouting at her, in a manner similar to what Kitwood termed 'Accusation', whilst berating their working conditions. The resident showed clear signs of negative wellbeing as a result of the care workers interactions with her.

A lack of communication between care workers and residents detracted from the wellbeing of residents. Moreover, when residents were spoken to, to encourage them to eat, there was evidence of infantilisation. One resident in particular was told they could only have dessert if they finished their lunch, a technique parents tend to use on their children, from my experience. Although the care worker in this example was not being malicious with this comment, and

the resident did not seem to mind, I was concerned about how others may react to such an approach to communication. In any case the care worker did not have the right to deny the resident dessert, should they have wanted it. It should be noted that in the second example, the supervisor on shift (who was the care worker responsible for the quite severe personal detractions observed) was a temporary member of shift from the Falcon Lodge residential home being refurbished at this time Somerset House opened. The influence of the strategic decision to place care workers from a residential need home to Somerset House, whilst it was still newly operational is discussed further in section 6.2 of this thesis.

5.7.3 Summary

There was a lack of choice of food each day for lunch and dinner and the menu was not utilised or adequate to help facilitate the limited choices available. I interpreted the food to be inconsistent in terms of quality during my stay at the care home. Staff felt the food quality and choice of food was unacceptable and residents were observed complaining about the quality of food served. The mealtime experience varied and this variation seemed to be based around what staff were on shift and responsible for overseeing the dining room at the time. A lack of available guidance may have contributed to this variation.

5.8 Resident Choice as informing practice?

Person-centred care is heavily informed by the concept of choice for people with dementia (See chapter 2). Some care staff members discussed how they perceived residents to have a lot of choice offered to them on a daily basis:

Because people have got so much more choice here. Like breakfast, you can start from around half past seven, but if people want to eat in their rooms, they can. Or if they don't want to eat it until later, or people can have breakfast in the middle of the night if they want to. Whereas, in a lot of care homes, you don't get that. It's very regimented. Well, that's the meal time. It's sort of...some of them are a bit institutionalised really. And obviously, that's not what it's like here (Interview Helen).

As noted in section 5.7.2, although observational data confirmed the flexible delivery of breakfast, this was not typical of all mealtimes. Lunch was always served at 1230 with, dinner, was always served between 1700 and 1730. The central place of tasks and the generic comments around staff expectations and activity (section 5.1) was also evidence to the contrary of the example given, to justify Helen's position. Data collected from interviews and observations suggested that the daily routine of residents was highly structured and standardised. Care worker reflections on the morning routine was demonstrative of this:

When they come in in the morning it's like well, who have you got up then, and you get that most mornings ...on the upper floors, on the middle floor because they are all wanderers and you do have the doubles ward where obviously they all need to be changed in the morning, they come down here and expect the same type of thing. But down here on the ground floor it's totally different. Down here they're not all incontinent, they don't need to be dragged out of bed in the morning. I would rather get someone up and give them a cup of tea and put their dressing gown on than dress them, but because it's so highly expected of you down here they have to be washed and dressed in the morning, and I don't agree with it (Interview with Danielle).

I'm coming in here and finding the majority of the suite up every night, all 12 of them running around. I came in tonight and one of the residents were soaking wet wondering around. The trouble is if you come in too early on the night shift you get pulled on the floor to work, but the staff don't come on the shift in the morning until bang smack on eight, if not after, so that they don't get asked to help. So you don't get the back up in the morning of the extra staff, but they'll always have the night staff in early enough to help them out. There's no give and take (Interview with Danielle)

Within these accounts further evidence was presented contributing to the finding that the culture of care was organised around task, to the detriment of a

culture informed by a person-centred discourse. Moreover, this was a further example of care staff indicating a disparity between the care they wish to deliver and the reality of their care delivery, thus suggesting the culture of care at Somerset House was having an influence on the care practice evidenced within this study, rather than the care observed being as a result of the practice of individual care staff. Staff were informed during the recruitment process and their induction that choice was to be a key concept of care at Somerset House, and care institutional task based care was to be deprioritised. For some this was an appealing factor and a key reason for accepting the role in the first instance:

I think what it was, when we had the training to begin with and then they said it's not going to be task focused I think people thought, oh, alright then. It was literally like we started, residents slowly came in but we didn't have anything...when the home opened there wasn't anything already in place (Interview with care supervisor, Charlie).

Charlie suggested a lack of support for person-centred care once the care home opened, leaving a void in terms of care strategy and practice guidance for staff to follow.

On my interview they said here we don't get people up unless they need to be changed. So if they're not awake and they're not wet or incontinent then they are to stay in bed. Unfortunately, that has slipped a hell of a lot since I've been here (Interview with care supervisor, Joanne).

Here Joanne reported slippage from the intended forms of care practice imagined, prior to recruitment. The suggestion therefore in both these quotes was that the strategic implementation of the culture of care conceptualised, prior to the opening of Somerset House was not delivered to its fullest. Although much of the findings presented herein corroborate this claim, little evidence has been presented as to why this appears to be the case. This will however be discussed in chapter 6 of the thesis.

Some care workers, while recognising the need for choice, felt the mental capacity of residents and resident safety should play a role in the amount of choice offered and how staff offer choice. This demonstrated a nuanced understanding of choice that considered resident specific factors, such as communication skills, and body language:

You have got to, sort of, make it plain and simple. It's knowing with some residents, it's not like, well, which one of these dresses do you want to put on? It's just pick out two; do you want either of these two? No, okay. Do you want either of these two? Yes, that one. It makes it a lot simpler. So I think if we had more areas I think it would just confuse matters completely... I do think you just need to keep things plain and simple. They still need a choice. They still need their freedom to a point but there's that safety aspect as well because if you have too many areas no-one's going to know where anyone is (Interview with care supervisor, Charlie).

It [choice] should be employed more. I think a lot of the carers are good and they do try their best but there's kind of little things. Like, there's a gentleman upstairs and he doesn't have verbal communication skills anymore but I've been trying to support them to say, sort of, with choosing cereal in the morning, put two choices out to him, because he's very good at making choices with his eyes but I think they kind of think, because that person's not verbal anymore because they've got dementia, they can't really make that choice (Interview with Registered Nurse, Wendy).

Despite high levels of understanding about delivering choice in a person-centred way the RN expressed concerns that some of their colleagues did not grasp the need to communicate choices to residents in a comprehensible manner. This point was mirrored in an interview with another care worker:

I do think things like that, alternative forms of communication, they don't totally get it here. They don't understand why it's so important and

actually what a difference that can make (Interview with care supervisor, Gemma).

There were also attitudes displayed by a minority of staff members actively objectifying people with dementia, suggesting they would not be likely to offer residents' choice:

So these people don't know what they are doing, actually, because they lost all their capacities, yes? It's not a mental thing, but it is the physiological thing where they are losing their memory and the cell degenerating process, that is actually dementia... I will try by probably getting with him and talking with him to settle him. If he is not settling, if I am finding that he is not going to settle, we need something, prescribed medicines, PRN, so that actually he came with PRN medicine from the other home (Interview with Registered Nurse, Caroline).

A Pro re nata (PRN) is a dose of medication used by an RN that is not scheduled. In the case described above the medication was discussed as desirable to impact upon the behaviour of residents. The use of medical restraints can be viewed as a direct threat to the choice of residents, particularly those who struggle to communicate their needs (Banerjee, 2009). Caroline seemed to construct people with dementia therefore as disease, rather than putting the person first and considering their psychosocial or emotional needs.

Observations of care delivery indicated choice was sometimes impeded by the physical and mental disabilities of residents, suggesting those with complex needs were less likely to be given personal choice. For example, one resident in the Ferndown Suite was consistently observed sitting in one chair in the lounge area, due to the need for her to have modified seating.

Despite how busy it is today in the lounge Eve is sitting in the same seat, isolated and away from other people here (Extract from fieldnotes)

On one occasion another person was made to move out of this chair so that the person who was perceived to need a modified chair could sit there:

Eve's modified chair is being occupied by Deirdre. 2 staff members move Deirdre so that Eve can sit there. This is despite the possibility they could obtain the modifying equipment from elsewhere (Extract from fieldnotes).

Residents who struggled with verbally articulating their wants and desires were also less likely to be offered personal choice. Care workers were regularly observed verbally offering residents choices of food or drinks either in the lounge or the dining room during mealtimes. For the majority of residents on Ferndown suite verbal communication was sufficient for the person to make an informed personal choice however, not all residents could communicate their preferences verbally. Evidence from observations suggested more visual cueing and attention to body language could have been employed by staff to aid residents in making choices.

Colin is offered ice cream by Alexa. Colin does not answer, although he does start to display signs of anxiety, fidgeting in his chair, Alexa brings over some ice cream for Colin despite his lack of response. Colin does not eat the ice cream and since it was delivered to him he has become more anxious. I wonder if he is feeling pressured to finish his meal (Extract from fieldnotes)

A staff member is handing out stuffing balls. Patricia and Geraldine are asked whether they would like a stuffing ball. However, Colin is given one and no attempt is made to engage him or inform him of what he has been given (Extract from field notes).

In the examples discussed above the care workers did not offer the people with poorer communication skills choice either at all, or in a medium they could interact with. A pictorial menu here may have given care workers more options in terms of visual cueing.

Staff discussions surrounding the issue of choice were indicative of a task-based culture of care that had a mediating influence on the care they deliver. Despite examples of care workers describing their individual approach to

providing informed choice to residents, there was a concern that this approach was not reflected more generally within the team. This was evidenced by observations suggesting resident choice is unequally delivered, dependent upon the verbal communicative competence of those living within Somerset. The culture of care did not appear to typically resemble the person-centred culture of care imagined by staff prior to their employment or within the *EMBRACELIFE* model.

5.9 Leadership as reflective of task-centred culture

5.9.1 Leaders with heavy clinical and task-based workloads

Reviews of care plan documents suggested a shared responsibility among staff with leadership duties for care planning. Out of the 6 care plans reviewed, 2 (Cynthia and Deirdre) had information entered by RNs, 3 by care supervisors (Emma, Eve, Patricia) and 1 (Josephine) by managerial level staff. RN interview respondents suggested care planning was a core element of their role. This was expected given the role as leaders nurses had at Somerset House, and the task focused way leadership was constructed, as indicated by the evidence presented below:

My role is actually as an RN... that includes all the care, paperwork, so to give necessary instructions and information and if need, training also for them, proper guiding, everything included in it...For their [residents] welfare, health and welfare... For example, they are not capable to take their own personal care, so they need to be attended... we have to feed them and we have to take initiative to get that done for the benefit of them... I enjoy myself here... I am not having any problems with them [the residents] ... I can manager them (Interview with Registered Nurse, Caroline).

My actual role at the moment is very clinical-based. A lot of it is giving out medication, doing notes, responding to emergencies, and to be honest I'm not getting a lot of time to do anything else (Interview with Registered Nurse, Wendy).

A common theme observed in the data set was the RN team seemed to have a heavy clinical and task focused work load. This was made doubly problematic by the role RNs had as leaders within Hollyfield House, as exemplified by the description the nurses gave. Wendy, in particular, suggested being at almost full capacity, with task based duties.

Both examples constructed residents as passive objects of care. The first was more explicit, describing residents as 'not capable' and in need of being 'attended to' and 'fed'. In this example the nurse seemed to internalise her construction uncritically, she did not display dissatisfaction with her perception, in reality she described how she enjoyed her role. A depiction of people with dementia as objectified as units of care work undermines the principles of choice, independence and meaningful activity, so prominent in the promotion of personhood. It seemed unlikely that staff with this perception of people with dementia, and their role, could develop meaningful relationships with the people they care for when the personhood of the individual is not recognised.

5.9.2 Communication between leaders and care workers

Care workers made comments during interviews suggesting they were not listened to by staff members with leadership roles, such as RNs, resulting in tension between staff groups. This was demonstrated by the following interaction between a care supervisor and a RN about the clinical symptoms of a resident, described by the care supervisor in question:

That lady came in with it [scabies]. They thought she had just a hive rash in the beginning. When one of the other ladies got it I was on shift with one of the seniors and I said to the senior I've seen it before that is scabies. I said it's either scabies or it's some type of shingle rash, I was like it's one or the other, but it's definitely not hives. When the nurse came down and I said to the nurse about it the nurse fobbed me off and told me it was hives, and that patient went untreated for another six weeks nearly, and it just got to the stage where she was literally absolutely riddled with it before they even treated her... They are the

qualified ones. They're the ones that have been nurses for god knows how many years. What they say goes. What they say is gospel (Interview with care supervisor, Joanne).

Joanne reported feeling undervalued and disempowered by how she was dismissed by the nurse in question, she claimed this had a direct impact on the physical wellbeing of the residents, due to the contagious, spreading nature of scabies and the length of time the virus was prevalent within Somerset House. The care supervisor conceded the nurses should be framed as leaders due to their highly qualified status. The use of the term 'gospel' however, to describe the instructions of nurses, suggested the respondent felt unable to successfully challenge or inform the perspective of the nursing team. Thus, the image of leadership within Somerset House was one constructed around hierarchy, with communication being as top-down and unidirectional. The reports of care workers who were frustrated with not being listened to by RNs reinforced these findings:

Not normally [consulted about resident's care by nursing team] ... no, although to be quite honest, we know more about the residents than they do, because we are the ones that are actually working with them (Interview with Danielle).

She [nurse] comes down here, spends 15 minutes on suite and thinks she knows more than me about what is best for them (Conversation with care supervisor, Amy)

In both these examples care workers felt they spent more time delivering care to residents, and therefore had a better grasp of their care needs. By setting their own knowledge of residents against that of staff in leadership roles, they indicated a feeling of deep disempowerment. For person-centred cultures of care to flourish it is vital staff members develop strong relationships with each other. For this to occur communication must flow upstream as well as downstream. Person and relationship-centred care theory detail how people with dementia need to feel their perspectives are valued, in the context of communications, for relationships to be meaningful and personhood to be

maintained. The same can be said about care workers. Staff retention, job satisfaction and staff burnout are all large issues in the care sector (as discussed in the introductory and literature review chapters). A hierarchical approach to communication is likely to exacerbate these issues. The extent to which they did is discussed in chapter 6 of this thesis. Moreover, it was possible hierarchical communication between leaders and care workers could have influenced how people with dementia were perceived and described. Findings were presented on the perception of people with dementia within Somerset House in section 5.6; throughout this findings chapter however, staff members are quoted describing people with dementia and their care needs in a non-person-centred way. Examples include the need 'feed', 'wash', 'toilet', 'get them up' and people with dementia being 'up and running around'. Whilst it is problematic to assign causality of this language to communication between staff groups, such communication undermined the construction of a person-centred care culture, and opened up space for a discourse that objectified people with dementia.

Nursing staff were reported in the quotes above to have less knowledge of residents compared to care workers. This makes sense when contextualised by RNs who described being too busy with task based responsibilities to spend quality time with residents. Earlier in this chapter, care workers described how nurses were responsible for the care guidance, produced in resident personalised care plans. It was mentioned how they were not as personalised as they could be, and residents were not actively involved in their own care planning. At this point in the chapter, enough evidence has been presented to make an informed judgement as to why that may be, namely; nurses were unable to spend enough time with residents to gain the knowledge needed to produce personalised planning for all residents. This was further problematised by the top-down communication described, as care workers reported detailed examples of having their perspectives undervalued. Poor communication between staff groups therefore may also have undermined the quality of individualised care planning, due to its hierarchical style.

5.9.3 Leaders with institutional backgrounds

The dementia lead expressed concern about the ability of the RN team to improve outcomes for people with dementia post assessment. This was due to the general nursing background of the team, implying a lack of dementia specific expertise:

I would have thought that it's [assessment and follow up] is part of their role, for example, you know, a lady... put on an awful lot of weight and has become very unmotivated and is on medication that actually needs to be reviewed, was reviewed by the registered nurse and the GP many times. But it would never go anywhere because there was sort of an assumption that, well, what can you do anyway... It is very skilled work, and you can't really expect people who haven't had any training in that area, or hardly any experience in communicating with someone who is in the earlier stages of dementia, to actually take up the baton there (Interview with Dementia Lead, Vera).

Reports from the care staff team indicated that attracting skilled RNs who could manage the implementation of person-centred care was problematic. One care worker described highly skilled RNs as like 'gold dust':

... it's very difficult to attract the calibre of nurses you need to effectively manage the suites... we haven't had nurses here that possible have got that experience, so they maybe felt overwhelmed, I suppose... they were very well-supported, because we had [person from Head Office] come out, and she supported the nurses themselves but I think it was...I don't know, we just didn't get the calibre of nurses that we really needed here (Interview with managerial level staff, Edith).

we've got two new RNs who have actually come from older, from backgrounds in nursing homes with a lot of the baggage that comes with years and years and years of just giving medication and giving some orders to the carers. So that's going to be a real real challenge to bring them up to scratch (Interview with Dementia Lead, Vera)

Due to pressures and recruitment challenges the 'value centred' approach to recruitment was suggested to have slipped by the recruitment of RNs with institutional 'baggage'. Whilst there is no suggestion nurses with this 'baggage' were incapable of adapting to a person-centred culture of care; it is questionable whether person-centred dementia care could be led by such nurses. A lack of RNs was reported to increase the workload of nurses, inhibiting their ability to spend time delivering leadership duties, such as leading by example on the floor with residents, or developing care worker practice:

Unfortunately, it's [workload] more clinical at the moment. This morning, for example, my drug round took almost three hours because I'm the only nurse, so I've also had to attend to emergencies that have happened and physical nursing needs like doing dressings and stuff. I think, because of the kind of practitioner I am, I've always had a person-centred approach to my care but there isn't enough time unfortunately to sit and have one to one conversations with the residents as much as I would like (Interview with Registered Nurse, Wendy).

As RNs were constructed as leaders at Somerset House the heavy clinical workload described in accounts such as this may have been detracting from the implementation of *EMBRACELIFE*. The RN seemed frustrated at the lack of time available to develop meaningful relationships with the residents she supported

The general nursing background of the nursing team was reported to be leading to a lack of concern for the emotional wellbeing of people living at Somerset House, as exemplified by the description of the handover process:

It's the registered nurses who hand over to each other the physical concerns about people, they then hand that over on a separate occasion to the carers; but it all remains very focused on the physical... It feels like an irritant, the times that I've attempted to bring that in [emotional wellbeing], it's like, well yeah we really haven't got time for this. Then when you want to bring out something about the family or something about the boredom that a person might be experiencing, or something

about...you know, it's...there isn't a culture that people want to listen to that, oh that is absolutely essentially part of our work (Interview with Dementia Lead, Vera).

Here the Dementia Lead RN reported experiencing resistance to the implementation of her care philosophy of improving emotional wellbeing during the handover process; described as 'focused on the physical'. The culture of care at Somerset House was literally described as one where 'people do not want to listen' to concerns surrounding the mental simulation of residents. A conflict therefore appeared to exist within the practices of nurses who wished to implement a more person-centred approach and those who believed they 'really haven't got time' for this.

5.9.4 Summary

RNs suggested care planning was a core aspect of their role as leaders, this was reflective of a hierarchical approach, where leaders deliver top-down guidance, despite care workers feeling they have more knowledge of the residents. This hierarchical approach was found to produce feelings of dissatisfaction and disempowerment within care workers. Care staff members reported a breakdown in communication between RNs and care workers, to the extent that there were examples of the opinions of care supervisors being dismissed, to the detriment of resident health. There was reported to be a lack of dementia specific expertise within the RN team, due to the difficulty recruiting nurses with mental health expertise, and a difficulty recruiting nurses generally. This led to an understaffing of RNs, and a high task based workload for nurses, to the detriment of their leadership and staff development duties. The general nursing background of the majority of the RN team was thought to undermine attempts to implement person-centred care. For example, a lack of assessments and care reviews were said to being carried out, centred on the emotional wellbeing of residents. This was evident in the analysis of care plans presented at the start of this chapter, and the dissatisfied way an RN specialising in mental health described the handover process. The leadership within Somerset House was therefore reflective of a culture of care centred

upon the completion of task, to the detriment of a more person-centred discourse.

5.10 What is the culture of care captured by the findings?

The finding presented and discussed in this chapter when considered holistically reveal a culture of care entrenched in task-based practice, to the detriment of care informed by person-centred care. This does not mean ‘flashes’ on person-centred care were not evident in the data set, rather the culture of care did not support these flashes, to flourish on a consistent basis and therefore become embedded within the culture at Somerset House.

Evidence was consistently presented throughout the themes, from the analysis of care plans, through to the findings related to leadership of a culture where the central pillar was reported and observed as task, informed by a disease-focused biomedical discourse of people with dementia and an institutional approach to care practice. For example, care staff tended to discern a difference between what they wanted or perceived their role should be and the reality they perceived. This distinction between what staff expected their roles to involve, and what they did in reality, indicated care staff had an alternative vision for the construction of care at the care home than what the dominant culture was perceived to be. The disparity between how some staff wished to construct their roles as care staff members and the reality of their roles suggested that in such cases it is not the agency, motivation or knowledge of the care staff that is responsible for how care is delivered but rather the cultural organisation of care at Somerset House, beyond the control of individual members of staff.

The findings suggested time pressures were key to the dominance of a task centred discourse of care. Staff described having to choose between delivering person-centred care, perceived as ‘the extra’ by several care workers, or fulfilling the tasks based duties, within a specific timeframe. The expectations of

those working on specific shifts seemed to have a large influence on this. For example, those on night shifts described having to 'get them all up and dressed' before the end of their shift and the arrival of the day staff team. A culture constructed around task was indicative of the lack of an effective implementation process, despite the creation of the *EMBRACELIFE* implementation strategy, described in section 4.1 of this thesis. Attention will now turn to exploring the possible factors that contributed to the ineffectiveness of this strategy.

Chapter 6- Why was *EMBRACELIFE* not fully implemented? Reflecting upon the workforce implementation strategy

6.1 Introduction

In the previous chapter the organisational culture of care at Somerset House was described. The data suggested a task centred approach to care was dominant where staff reacted to instances of negative wellbeing, such as anxiety, as opposed to attempting to actively prevent occurrences, in the first instance. This was evident in the language used to describe residents, and resident to staff interactions within care plans, observations of care delivery, contradicting the recommendations within Hollyfield's Engagement strategy (See chapter 4).

The cultural organisation of care envisioned by Hollyfield and symbolised by the *EMBRACELIFE* model was not fully implemented. In this chapter findings are presented that indicate why this might have been, beyond those already presented in chapter 5. To achieve this, the key implementation strategy 'Workforce' will be reflected upon and critically analysed, in the context of relevant findings. The influence of Somerset House's status as newly operational is assessed.

6.2 Workforce

In chapter 4 the key factors associated within the workforce implementation strategy of the *EMBRACELIFE* model were identified as the following: Staff recruitment, staff development, staff retention, flexible working practices, leadership and staff satisfaction. Below the evidence for how these factors functioned within Somerset House in practice, and the contribution each factor had upon the construction of care, is presented. It is argued the newly operational status of Somerset House put into motion a cascading effect due to

issues within the recruitment and staff development leading to a high turnover rate and a corresponding high percentage of temporary care workers on shifts.

6.2.1 Recruitment

A new care staff team was required to provide services at Somerset House. A large scale recruitment process was therefore undertaken by Hollyfield (Hollyfield, 2014). Care staff were recruited using a 'value based' approach (Hollyfield, 2014). The person-centred values of prospective care workers were prioritised, as the essential criterion for employment. Experience and a track record of working with people with dementia in a care setting was not an essential criterion. One implication of this approach was an influx of care workers from residential and learning disability backgrounds. Staff members reported the lack of dementia specialist expertise within the team as a concern:

I think as well a lot of the staff they recruited were from residential or nursing care backgrounds and, to be then faced with a naked man in the middle of lunch and they didn't quite know what to do because he might fling a chair at them, was a lot to ask from them. It's a massive difference, dementia care (Interview with managerial level staff, Edith).

I think some of the care staff members struggle, especially we've had a few incidents up on Bramber with some of the residents who do display some physically challenging behaviours, they appear quite scared of them, sort of giving a bit of a bad reputation to those residents and not really understanding that they're presenting this way because of their dementia and altering their care to meet those residents' needs (Interview with Registered Nurse, Wendy).

I know there was a few that come from a residential thing and obviously come here because perhaps pay was a bit better or it was all... I just think some ideas of dementia was a bit of a shock to them. I think in retrospect they assumed it to be perhaps a bit like Emma down there and like Geraldine, a bit repetitive, you know, oh, I've forgotten where I am, not to the escalation of, why are they

screaming or having paddies. It can be a bit, oh, we're not really used to that... if they've come from a residential suite nursing can be a bit like, oh, I can't cope with... if you've come from a residential that's all you, sort of, normally have because they'd move on (Interview with care supervisor, Charlie).

The first and third extracts demonstrated concerns over recruitment from non-dementia specific care homes due to the 'behavioural' challenges faced by the care team since the opening of Somerset House and the 'massive difference' of dementia care when compared to older residential and nursing care. In the second example, a proportion of staff were perceived to misunderstand why challenging behaviours occur, and how to prevent them. These findings were reinforced by care workers recruited from non-dementia specific backgrounds, who suggested they were unprepared for caring for the needs and challenging that can occur when for people with dementia, within a task focused organisation. This was discussed particularly in relation to a lack of understanding of how to prevent and react to instances where a person with dementia has become aggressive:

One of the other residents... could lash out, and that made me a bit wary where I didn't have it in my other home (Interview with Helen).

My other home was predominantly residential, we weren't expected to deal with people with challenging behaviour, so that was it (Interview with Henrietta).

The care workers were comparing their current experience of care with those in their previous residential home. In the first quote Helen indicated a fear of residents who have in the past 'lashed out'. It is possible care workers without experience of working with people with dementia were not prepared for aggressive behaviour either practically in terms of having strategies to prevent it, or emotionally. This indicated a need for staff development and support, something key to the workforce implementation strategy (section 4.2). This is explored further later in this section, under the theme of 'staff development'. The approach to recruitment therefore based upon person-centred values,

rather than experience caused issues for the residentially experienced care workers at Somerset House.

6.2.2 Staff development and Leadership

The ability of RNs and management to perform leadership roles and develop the practice of members of the care team was questioned by the nurses and Hollyfield central management:

And it, sort of, almost like you have to be physically doing it yourself on the suites to get an outcome, but then you'd hope that that modelling would be taken up by other people. But other people haven't got the confidence or the leadership, or there is, sort of, a general atmosphere (Interview with Dementia Lead, Vera).

The rest of the nurses here are general nurses and I think it would be good to get more mental health or learning disability nurses in because it is so much more about that person-centred care and about seeing the person holistically rather than just focusing on the person's physical care. I think this place could have all those needs met eventually but, at the moment, it hasn't got that met (Interview with Registered Nurse, Wendy).

The main barrier experienced for its delivery was our inability to recruit sufficient numbers of experienced care home management staff who were able to lead on the project within the home itself (Extract from head office in response to findings)

Given the reliance on the nursing team to provide leadership, as discussed in this section 5.3, it is questionable how care staff were supported in terms of the development of their person-centred care practice, when the skill set and experience of the majority of nurses was general clinical. The dementia lead suggested necessity forced her to approach leadership through a 'lead by example' lens, in the hope staff practice will be developed and embedded through observation. Simultaneously, she rejected this as a feasible and effective model of leadership and suggested an 'atmosphere' is a barrier. This

could be a reference to the culture of care she believed was mediating the interactions between care workers and residents.

The development of a consistent person-centred narrative of care was undermined by a high turnover of care workers (discussed in more detail later in this section) and the 'brand new' status of the care team:

You have to get to know how the new person works and whether they are going to be up to the standard that you've... Because yeah, I come in here and I've done it for quite a number of years, so I know what to do, I come in here, I do what I have to do. But when you are on with somebody new, you're maybe on with somebody who's never done care work before and you've got to work around them, so you have to adapt as it were with any person, any new person that comes into the place, whether they've done care work or not or they've been doing it for quite a number of years (Interview with Care supervisor, Charlie).

I strongly believe it's [difficulty of model implementation] not to do with individual care staff but I think it's because the teams were all brand new, so you still had the gelling of the teams to do. The residents were brought in quite quickly. The actual home, the logistics of getting things from one end to the other was difficult. Staffing levels were good initially and then poor, I don't know... (Interview with managerial level staff, Edith).

The 'brand new' status of the care worker team; a necessity due to the newly operational status of Somerset House, was suggested to have negatively impacted upon the implementation of *EMBRACELIFE*. The key role of a cohesive care worker team for the implementation of person-centred care was noted. Moreover, the challenge of accommodating and caring for a host of new residents was stated. Although more established care homes welcome new residents on a regular basis, it is unlikely they face the challenge of welcoming tens of residents in a single wave. The need to 'get to know' new care workers on a regular basis seemed to undermine any attempt to form a shared

understanding of best practice, as the values, training and experiences of the new worker are interpreted as being discovered over time. The care worker suggested the ability of more experience staff to provide the care they wished to deliver was hindered by high staff turnover. Care workers discussed this further in relation to agency staff, as reported later in this chapter.

Care workers, recruited from residential care, felt the training they received prior to commencing their role at Somerset House did not adequately prepare them for caring for the needs of people with dementia. This was discussed particularly in relation to a lack of understanding of how to prevent and react to instances where the behaviour of a resident has been perceived as 'challenging'.

The different levels of dementia, especially the ones who have got challenging behaviour, because it [training] doesn't prepare you for dealing with really bad challenging behaviour that I have dealt with (Interview with Helen).

We were given relatively basic training in what to do if somebody sort of like comes at you and decides to hit you for whatever reason, but it was just very basic training, it doesn't help if somebody's going to suddenly throw a punch at you, to be quite honest, which he did on one occasion. So yeah, we didn't get what we would do in that situation, just very, very basic defence mechanisms to use and that was it (Interview with Henrietta).

Training was described as 'basic'. In the second quote Henrietta implied the defence mechanism training around how to manage a situation where a resident had become violent was not fit for purpose and did not help in practice. A common theme within the data set was for care workers to report instances of aggressive behaviour, suggesting a lack of mental and physical stimulation for residents.

Reports from RNs suggested they felt the care team at Somerset House were in need of more training and support to develop their knowledge of dementia and dementia care:

They (care workers) needed to be more trained, they need to give them more training, more information when it comes to dementia. I mean, although they have the basic background on care, but they need more training, yeah, more hands on training of what's dementia and how to deal with the challenging behaviours. So what stages they're going to go. What process (Interview with Registered Nurse, Wendy).

If they could get the structure of nurses right and the ground level training...you know, inductions, like we spoke about... where you did more roleplay, and people pay more attention to five minutes of being blindfolded and fed a yoghurt than they do to a whole hour in a classroom looking at slides, they absolutely do (Interview with managerial level staff, Edith).

Teach them the [EMBRACELIFE] model in a way that will appeal to them, that will interest them, will involve them, will make them want to think, actually, do you know, this will work. This will really work with such and such and such and such, and let them see that it would make their days better. They might want to come to work and not be off sick then (Interview with Dementia Lead, Vera).

Wendy raised a concern around dementia care knowledge with the care team. She differentiated understandings around 'care' from understanding around dementia. She went on to say such understanding would help to 'deal with' challenging behaviours again, indicating they are a key concern within Somerset House. The managerial level worker described getting inductions and training 'right'. She felt she could role play to facilitate this, suggesting a practical element to training, where emphasis is placed on developing empathy with people with dementia could help develop person-centred care practice. Finally, the dementia lead suggested developing training around the *EMBRACELIFE* model in a flexible, individualised way for care workers, to

better integrate learning into practice and increase staff satisfaction, as indicated by the comment on work absence.

The dementia lead nurse reported feeling uneasy with the amount of supervisory guidance members of care staff were receiving. She implied that she had to initiate the process of supervision for care supervisors, meaning that plans for organised supervisions were not in place or prioritised by the senior leadership team as a whole. It was highlighted that the care provider, was not providing a framework for staff development, contradicting implementation guidance, and alluded that care workers may have felt therefore that the care delivered was not acknowledged, at a senior management level.

I felt so strongly about the lack of supervision that these people were getting that I went ahead and, sort of, proposed that I would at least supervise the care supervisors, who were the people who were facing day to day huge challenges. And I gave leadership to care staff members that I felt deeply, deeply uncomfortable that weren't getting the supervision. So I've started that with five, six care supervisors and the feedback that I get is that there is a definite... It helps to contain anxiety, it helps to focus direction of thinking, but it equally has, for me personally, highlighted the fragility of that role in the context of an organisation that it isn't providing a framework for these people to develop and to feel supported, and to feel acknowledged in the very difficult work that they're doing (Interview with Dementia Lead Nurse, Vera).

By commenting she 'went ahead' with supervision the senior nurse indicated she made the decision independently from the management team at Somerset House. It seemed fair to assume therefore staff development in the form of mentorship and supervisory guidance was not of paramount importance to the management team at the time given the claim 'the organisation isn't providing a framework for people to develop'. The quote also indicated only care supervisors were in receipt of supervision, again indicating the development of staff and their care practice was not prioritised. One care supervisor discussed

her first supervision and suggested some care supervisors organised a peer support meeting every 4 weeks:

I had a... well, the [lead dementia] Nurse; I had my first one with her yesterday, actually. We have, like, these, sort of, meetings every four weeks where we discuss us as supervisors. We have individual ones with her, where we can discuss any problems anything that is going on and she asks us certain things... she goes through everything with you asking...telling you, obviously, they have spoken to other staff members, management, how you do your role and basically whether you are good or rubbish (Interview with care supervisor, Matilda).

The care supervisor reported having had a supervision the day before the meeting, indicating that the senior nurse was indeed taking an active role in the development of care supervisors. It is important to note however, that prior to this the supervisor had not received any formal supervision since first starting at Somerset House. This supported the claim staff development was not prioritised by management or anyone in the leadership team until the senior nurse acted upon her own initiative to begin supervisory processes.

Staff that were not in supervisory roles reported they were not being supported in their development. A lack of supervision and contact with people from the management team was disclosed. Contact with the management team was a particular issue for team members who solely work night shifts:

No, not exactly [had supervision] ...I'm expecting that...it's not happened until now (Interview with Registered Nurse, Caroline).

I actually made an appointment to see them, I made an appointment to see the manager... she'd double booked herself or she hadn't come in, she wasn't due in until later on in the day, after I'd booked an appointment to come and see her... I had a few issues about staffing, some of the night staff and nurses, and nothing's been done about it, nothing's been said (Interview with care supervisor, Daisy).

None at all... I never was introduced to anyone. I've never met the rota coordinator. I know the new one, but only because she's come from night shift to rota coordinator, but apart from that I've never met management (Interview with Danielle).

These quotes reinforced the finding observed throughout this theme that staff development was not prioritised as planned within the implementation strategy related to 'workforce'. In the implementation strategy (chapter 4) it was stated that for the values based approach to recruitment to be a success it must be underpinned by a strong programme of staff development. The findings of this thesis however, suggest this programme did not occur systematically or extensively in practice. There were a lack of examples of observations of care workers being supported with developing person-centred care. Only a minority of care supervisors reported being given supervision by the senior nurse at the care setting, and these supervisions were only arranged due to her 'feeling very uncomfortable' with the support being given to care supervisors, hinting that the rationale for these supervisions was reactive, rather than as indicator an attempt to implement a positive person-centred culture or care strategy. Staff who attended the training courses prior to the opening of Somerset House reported feeling the training was basic and did not prepare them for the experience of delivering person-centred care to people with dementia. There was a concern about the lack of mental health nurses working at Somerset House and the implications for the ability of nurses to lead by example and develop a person-centred ethos among the wider care staff team. Now attention will turn to the impact this had on staff satisfaction and retention before the influence of the newly operational status of Somerset House in these issues is assessed.

6.2.3 Staff Satisfaction

Staff perspectives on how satisfied they were working at Somerset House and how well supported and valued they felt were variable. Those staff members who were happy in their job suggested there was a high level of teamwork within the care team and the team was well supported:

Yeah, I think everyone works very well as a team here. I've been quite impressed, because I have worked in places where the teamwork is virtually non-existent and there's a real hierarchy of like them and us, kind of thing. And that is definitely not happening here. That's really good. There's a real sort of positive feel around the team here. Well, I think so. And I'm quite a positive person anyway. But no, I really like it. I think it's a great job, so I'm very happy with it (Interview with care supervisor, Zara).

Yeah definitely. All the nurses and managers and everything; they're all really supportive... I work really well with them [Nursing team], I think, they're really good. They listen really well to what we ask and what we say, like if we feel someone's in pain then they'll instantly kind of talk to you about what you think it is and how you think we can deal with it and they're massively...like definitely for me and [carer] they're really good at listening to us and, you know, listening to what we have to say and how we think we can change things (Interview with care supervisor, Matilda).

In the first quote Zara used her previous experience 'where teamwork was virtually non-existent' to help determine satisfaction with their current working conditions. In the second quote Matilda felt listened to and therefore valued by the leadership team. This suggested, in contradiction to previous evidence, that a proportion of care workers felt supported by leaders at Somerset House.

Care staff members suggesting they did not feel supported or valued pointed to a lack of support from RNs and managers, a lack of flexibility and notice of where they will be working when on shift.

The RN knew we were short downstairs...She knew that we were.....and had come down a few times in the night and yet hadn't offered any sort of relief in the morning, knowing our mornings and our evening are the worst parts. We can cope all the way through the night, but the first bit and the last bit are the worst two bits because they all get up at once, every single one of them... the RNs think that

it's easy down here [Ferndown Suite] (Interview with care supervisor, Daisy).

Here the care supervisor reported feeling dissatisfied by commenting on the 'worst parts' of her shift and the lack of support received during these times on shift from leadership figures in the form of RNs.

...we don't know where we're going to work until we actually come on any particular night, we don't know, we don't get any advance notice of what suite we're going to be on on any given night or...I was told afterwards because I was put on Ferndown and some of the other staff were saying, oh, you always seem to be on Ferndown and I said to the RN and she suddenly said it's because you are one of several staff who has had an altercation with this resident and it's best that you don't go on there as often. So yeah, I was told that's why, so yeah (Interview with Danielle).

In the second quote Danielle was discussing dissatisfaction through the lens of a lack of communication, in contrast to the care supervisor who felt listened too. Here the care assistant claimed she does not know where within Somerset House she will be working prior to arrival. She also mentioned a decision made to remove her from one suite due to having an altercation with a resident however, she was not informed of this decision and was only told when asking one of the RNs. Thus, the care worker was disempowered, indicating a hierarchal culture (See chapter 2). This evidence further reinforces the finding that communication between care workers and leaders is top-down, resulting in a high level of staff dissatisfaction (see chapter 5 section 9). The key role of Nurses as leaders at the care home, a strong theme throughout the findings of this thesis, is highlighted. Beyond this, it demonstrated a lack of desire to develop staff in terms of their dementia care practice. By removing care workers from the environment where an incident had occurred, the learning process seemed to be undermined. This could result in the lack of understanding about people with dementia, being solidified. Although removing care workers from the suite is technically a preventative measure, the environment itself is left unproblematised. If the care worker was the sole

stimulus that provoked the reaction, the lack of staff development and identification of the issue with their care delivery may lead to the same mistakes being made again, only within a different suite.

...we didn't think we'd had enough support from management as we thought we were going to have, to be quite honest, and I think that's why a few have left... I think there needs to be more support and I think more communication from the management at times than there is, to be quite honest (Interview with Helen).

The third quote above is similar to that of the second. Helen expressed dissatisfaction with the lack of effective communication and support coming from the management team, it was claimed this lack of support was directly influencing the staff retention rate.

An interview with one care supervisor suggested care supervisors felt underpaid after the pay of care assistants was increased to match the 'living wage' indicating they may feel undervalued by senior members of staff, representing the care provider:

At first they weren't going to up the pay, they there was a big hoo-ha about it and they agreed to match the living wage, but they didn't increase our pay. Now we [care supervisors] get paid 8 pence per hour more than care assistants (Conversation with care supervisor, Jack)

There was a lack of consistency in the responses of care workers on the issue of how satisfied, valued and supported they felt. Some staff members reported feeling underwhelmed with the support on offer from people in leadership roles at the home. One possible contributing factor to care supervisors feeling undervalued may have been the lack of a wage increase, to match that of care assistants, when their wages increased at a result of the living wage.

Communication was a strong theme in the data relating to staff satisfaction, those who reported higher levels of satisfaction had stronger and more open channels of communication with the leadership team, whilst those less satisfied felt they were not engaged with enough. Strong communication was identified

as a key factor in the 'engagement' implementation strategy for the *EMBRACELIFE* model.

6.2.4 Staff retention

The ratio of staff to resident on suites was observed to be in line with the guidelines set out by the care provider in the *cost of residential care* leaflet i.e. 1:4 in Ferndown and 1:2 in nursing suites (Hollyfield, 2015). The data suggests however that there was a high staff turnover rate:

Unfortunately, because of the fact that we have lost quite a few staff, yeah, we've had to use agency, although at the beginning when we had our training course before we started, Hollyfield said, oh no, we won't be using agency staff, but they've had to because they've lost so many staff. So yeah, it hasn't helped, hasn't really helped... (Interview with Registered Nurse, Wendy).

I'd actually come into the home before I started, before I was interviewed I actually came and took a tour round the home, which was very nice, beautiful, beautiful home. Yeah, I was I suppose expecting that they were going to have quite a few staff, that they wouldn't have any problem getting staff. It hasn't worked out like that. They have had problems keeping staff, which has been a shame because it is a beautiful home (Interview with Dementia Lead, Vera)

But yeah, from week one it was sort of like it started to get a bit where people were a bit unhappy about certain things, and then staff used to say, oh, well, this isn't right, that isn't right, and then staff started to become a bit despondent about working here and they started to say, well, I don't know whether I've made the right decision or not and that was it (Interview with managerial level staff, Edith).

I think my expectations are completely different to how it actually is, because obviously when they are showing you around before there are any residents here, they say oh, you know, we can...we are going to, you

know, if residents want to go to other suites they can go to other suites. And go...and for instance go in the music room, go do some sewing in one of the other rooms; they can go here there and everywhere. But, the reality is we can't allow them to come in here, because the noise they make would disrupt the people in this suite and it would make them aggressive (Interview with care supervisor, Matilda)

A difference was noted between the expectations of care workers prior to the home opening and the interpreted reality of care practice. This mirrored and reinforced the finding that a disparity between existed between how care workers perceive the care they wish to deliver and the reality in practice (See chapter 5). The difference between the expectation of care prior to the home opening impacted upon the retention rate once the home had opened due to care workers becoming 'unhappy'. Matilda provided evidence for this, suggesting care workers questioned their decision to join the newly assembled team. Edith contextualised the high turnover of care workers and her own expectations, within experience of seeing Somerset House for the first time. Similarly, in the first quote the care worker seemed to express disappointment at the promise around agency staff not being kept. When viewed collectively these findings indicated the newly operational status of Somerset House, through the expectations care workers had, prior to it's opening, produced a mediating impact on the higher than anticipated turnover rate. More evidence for this was found in the way one care worker described how they 'didn't realise' the difficulty of the work they were employed to carry out:

Some people I've seen and then they're gone [resigned]. I mean, I think it's because they were thinking, oh, this is a new environment it's...they pay quite fairly, I mean, and then you see them and then they disappear.... It's what I'm saying earlier, that because they didn't realise that the work is not that they expected, that it's going to be easy. Yeah. So they just...and of course it's because it's a new environment. It's a new home (Interview Registered Nurse, Nathan).

One issue that occurred as a result of high staff turnover was a reliance on agency care staff members to achieve the ratios of care staff members to residents required:

We have so much agency, and a lot of agency that come here and they haven't been here before...we're lucky to have some of them that do come back, but we have a lot of new agency which makes it really difficult when you're on shift trying to...because they have to work with somebody but sometimes it's frustrating when you know what you're doing and you're constantly having to show new people (Interview with Helen).

In the 'workforce' implementation strategy, Hollyfield stated that they would not be using agency staff. Nathan mentioned this, claiming the use of agency staff had been unavoidable due to losing so many staff. The high turnover of staff reported here was logical, given the low staff satisfaction reported in this chapter, and the disparity noted between what staff believe the care they want to deliver would look like and what it was in practice. The lack of staff development practices within Somerset House may also have played a role here.

Care staff members reported being dissatisfied with the variable standard of agency staff members, suggesting that a minority of agency staff members increased the workload of centrally contracted staff, reducing the quality of care delivered to residents while increasing the task of staff management:

On weekdays you can be...it's about 20 per cent of the day [staff are agency], I would imagine. There's at least one every day if not more, there's never a day without them. Then on the weekends it can be up to 50/50, which is really hard to manage (Interview with management staff member, Edith).

You'd maybe go on a shift and two of the staff are agency and two are regular. Not that there's anything wrong with agency staff, they work

very hard, but they're not familiar with the residents, so I think that's one of the areas where it fell down (Interview with Dementia Lead, Vera).

...some agencies are brilliant, especially if they come a few times they get to know them, not all, but if you've got somebody who doesn't know, it can make that obviously hard. If you're short staffed it's very hard to deliver what you want to deliver because then you're just getting [them] through the day rather than letting them live a day, if you know what I mean, but as I say obviously a problem, staffing (Interview with care supervisor, Charlie).

We have so much agency, and a lot of agency that come here and they haven't been here before...we're lucky to have some of them that do come back, but we have a lot of new agency which makes it really difficult when you're on shift trying to...because they have to work with somebody but sometimes it's frustrating when you know what you're doing and you're constantly having to show new people (Interview with Helen).

Here the care staff report issues with agency staff due to their unfamiliarity with the residents and the home itself, leading to frustration as the hiring of agency becomes an obstacle to delivering care. This is summed up in the second quote where the care supervisor claims 'it's very hard to deliver what you want to deliver... you're just getting them through the day, rather than letting them live a day'. This reinforced one of the main findings from chapter 5 that the care being delivered is often not what the staff believed was best practice. Here, the reasons for this were constructed in terms of extra workload that was perceived to come with a high percentage of agency staff being hired to ensure the staff-to-resident quota is met. This issue was perceived to be alleviated by the block booking of agency staff, who could then achieve levels of familiarity with the environment and the people living and working within it.

The issues around agency staff being unfamiliar to residents and the organisation of care at Somerset House were compounded by the arrival of a care team from the sister residential home 'Falcon Lodge'. These care workers

were easily detectable in the suite due to a distinctive uniform. They tended to have less dementia care experience and passion:

If I work with a new member of staff, like [care worker] tonight, I took him round and I introduced him to everybody, and as I was introducing him to them it's like with Donald, female carers only, he will not allow a male with medications, anything, but that's something that he needs to know so if Donald gets up in the night time he's not going to then try and put Donald back to bed and then have Donald wallop him. With Cynthia, she can be very restless and when she gets agitated she will pick up tables and throw them at you and she will be like a tornado picking anything up and throwing it just because she's agitated. But if he wasn't told that and she did it he might be like that. Because he works for Falcon Lodge. He normally does upstairs with the residential, he works in Falcon Lodge, so he doesn't have the experience of working with these sort of dementia kinds. And they just get thrown in at the deep end and people get moved to units that they don't feel comfortable in, they're not particularly happy in (Interview with care supervisor, Daisy).

Falcon Lodge staff, the majority of them want to stay working with Falcon Lodge residents because they don't feel comfortable working with dementia. Some of the Falcon Lodge [residents] they have dementia but the dementia that they have, on the top floor they've got two with dementia, possibly three, but they're very sort of tranquil, they're very chilled, they don't have that aggression, the physical and verbal aggression, so for them it's just like dealing with somebody that's a little bit cuckoo, if you know what I mean (Interview with care assistant, Danielle).

There appeared to be an element of sympathy for the Falcon Lodge care workers in these quotes. Falcon Lodge care workers were interpreted as not having the required knowledge or skill set to manage the residents. Less sympathy is directed towards the residents who were being cared for by carers without the knowledge required to offer person-centred care. There was no recognition of the possibility of the aggressive behaviour described being

increased, or more likely, as a result of the unfamiliar care workers, or their lack of skills or experience in dementia care. The cause of behaviour was therefore firmly located in the resident, rather than the environment of care, indicating a disease focused biomedical discourse of dementia was predominant in the perceptions of people with dementia in these care workers, who believed themselves to be skilled dementia care practitioners. This was reinforced by the language used such as 'dementia kinds' and 'cuckoo'. Dementia care is conceived as more demanding than residential care as portrayed by the description of caring for people with dementia as 'being thrown in at the deep end' and the clear distinction made between the 'chilled' residents cared for on the Silverburn Suite and the 'physical and verbal aggression' within Ferndown.

Care workers from Falcon Lodge were observed working in the Ferndown Suite throughout the 3 months I collected data there. It was reported in informal conversations between myself and permanent of the care team that the Falcon Lodge care team were given Somerset House uniforms, but preferred to wear the Falcon Lodge version. Care workers from Falcon Lodge were described in that context, suggesting a clear distinction between the permanent Somerset House team and those from Falcon Lodge. The idea to rehome the Falcon Lodge residents, along with their care workers was described as having a negative impact on the organisation of care at the home:

They need to take the Falcon Lodge residents back to Falcon Lodge to start with, because that was a bad idea from the beginning to bring them here. I know the other home needed work, but this home wasn't set out straight away like it should have been (Interview with Henrietta)

One care worker reflected on the importance of having standardised uniforms and familiar faces for people living with dementia. Suggesting visual cues and familiarity were important factors in facilitating communication was people living with dementia:

The residents really need at least two members of staff that they know, a regular face, because a lot of our residents down here, even

though they've got dementia, they still recognise certain faces, they recognise certain uniforms, certain colours, and they will, if there's somebody new here that they don't know... They won't take medication, they won't go to bed (Interview with Helen).

Despite this, there was a feeling the Falcon Lodge care workers and residents were required due to high levels of staff turnover at Somerset House. Somerset House was suggested therefore to have become dependent upon the care team and residents from Falcon Lodge to keep it operational:

They can move the Falcon Lodge residents back, but then if we still haven't got the staff, if we still have as many staff leaving as are continuing to leave we're not going to be even able to open... I think if they have to shut Silverburn I think it will mean they're not going to be able to stay open. It's not going to be sustainable for them to stay open. It's too big a home to be losing out on 24 beds. And they might be able to stay open, but the problem is it's not going to be good for the residents because they're not going to be getting the care that they need or that they should be getting because people just don't want to stay (Interview with Registered Nurse, Wendy)

This point was evidenced by correspondence from Hollyfield central management in response to an internal report detailing the findings of this thesis, suggesting finances were stressed during Somerset House's first 18 months of operation:

The reality of opening and staffing a 60-bed dementia care home alongside the financial pressures of building occupancy, an avoidable and critical financial driver during the first 18 months of operation, prevented the level of focus required to deliver the cultural change management programme needed to implement the model we had developed (Extract from head office in response to internal report)

The need to turn a profit or monetise Somerset House therefore was necessary and indicative of the reason the strategic decision to temporarily rehome the residents from Falcon Lodge was made. Hollyfield then unintentionally jeopardised the implementation of *EMBRACELIFE* by the decision to rehome residents from a non-dementia specific care home to Somerset House, shortly after became fully operational. The findings suggested the motive for doing so was financial and a necessity to keep Somerset House operational. The high levels of turnover at Somerset House meant care workers from both homes intermixed and delivered dementia specific care. This influenced practice negatively, with widely inconsistent examples of care observed. This was exemplified by the mealtime experience described in section 5.3.

6.2.5 Flexible working practices

Hollyfield aimed to implement flexible working practices to improve staff satisfaction and the overall staff retention in their workforce implementation strategy. The findings present herein however, did not demonstrate this. For example, staff reports suggested difficulties choosing what suite they work in or having a say in the matter. Staff felt restricted in the type of care they delivered. Further evidence surrounding how flexible working practices are can be found in terms of staff ratios on specific suites. Care staff members reported feeling that a number of residents on the Ferndown Suite required 1:1 or 2:1 care and the environment was unsuitable for their needs. They expressed frustration that the residents were not being accommodated on nursing suites due to a lack of bedroom availability. The 4:1 staff ratio was inadequate to provide person-centred care as residents that require 1:1 or 2:1 support heavily reduced staff capacity for the other residents in the suite:

...they all have their funny quirky little ways, like how abusive they can be. One of them gets wound up, as you saw earlier, by one very particular lady, and it has been like that from day one, but there's nothing you can do. We don't have the space to move them up like they said they were going to when they went downhill you could move them up or if they were a bit more feisty than they were meant to be they could be

moved up. We don't have the space or some of the residents on the other suites just wouldn't accept them up there, which is why we get left with them down here and have to cope with them down here. Down here was supposed to be the very early onset dementia, proper residential dementia. And we've got one lady out of 12 down here like that (Interview with Danielle).

Yeah, we've got somebody down here now who possibly they would put upstairs, but they can't because they haven't got the room at the moment, so she can't go upstairs, (Interview with Helen).

These staff perspectives are reinforced by reflections made of observations on Ferndown:

The need for 2:1 care for a resident has left [care supervisor] on his own on the floor. It was not possible for him to be everywhere at the same time (residents were divided between the lounge and dining room). Josephine was calling out for help repeatedly but [care supervisor] needed to aid a resident with personal care. This left no one [staff member] in the communal areas. Josephine's cries for help were disturbing Cynthia and Patricia and I was worried about this triggering conflict between residents. I ask Josephine if there was anything I could do, she explained that she wanted to go to bed, I told her I couldn't take her as I didn't work here and therefore did not have permission, I reassured her that someone would be down at some point soon to assist her (Extract from fieldnotes).

Incidents where residents would ask me for help, when no staff members were available, were common place during my observations on Ferndown. Over the period data was collected one resident was receiving palliative care in their bedroom. This required around the clock support from the care team. The need for palliative care on Ferndown suite may be a rare event, and one suite was closed during data collection, lowering the capacity of Somerset House. Despite this, the 4:1 staffing ratio did not appear adequate for the delivery of person-centred care on Ferndown during this time. This point was further demonstrated

by the hiring of private care staff members by 2 families of residents, living on Ferndown.

The care provider met their staff to resident ratio target. Despite this, reports from care staff members, particularly on Ferndown, suggested staff ratios were not high enough to provide person-centred care at all times. The complex needs of a minority of residents appeared to reduce the capacity of the care team, leading to long periods of inactivity for some.

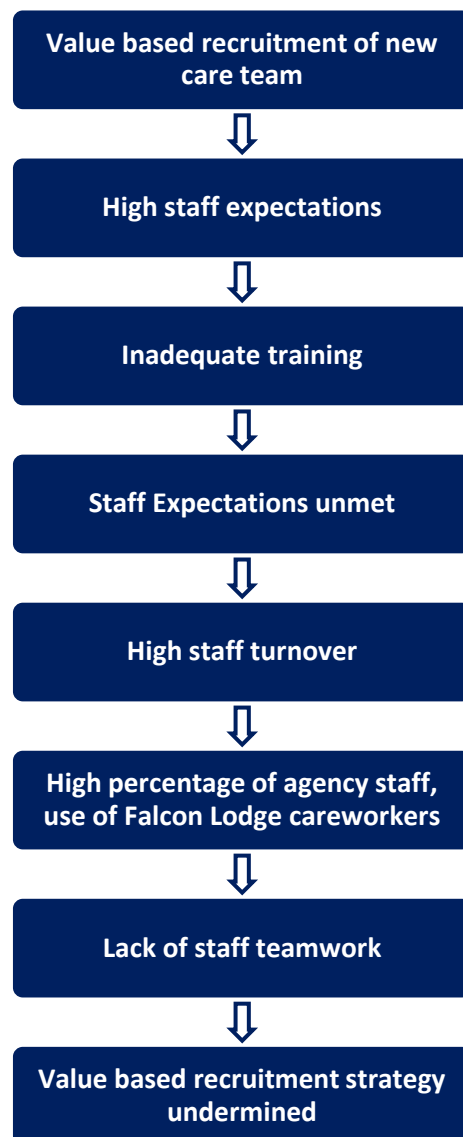
The hiring of private care staff members by families of people living in the Ferndown suite reinforced the perspectives of care staff members, as did the frequency I was asked for help by residents, due to a lack of care staff available in communal areas.

6.3 Summary

The findings presented in the sixth chapter of this thesis suggested the implementation of *EMBRACELIFE* was undermined by an inability to carry out the recommendations of the 'workforce' implementation strategies in practice, once Somerset House had opened its doors. For example, the values based recruitment strategy was intended to be supported by comprehensive staff development processes. In reality however, supervision was found to be lacking for the majority of care workers, and training was described as inadequate.

The newly operational status of Somerset was shown to have a direct impact on the incomplete implementation of *EMBRACELIFE*, having a domino effect on the organisational issues that undermined the implementation process. This is summarised in fig 2 below.

Figure 2: Impact of newly operational status on implementation of *EMBRACELIFE*



Care workers described how the task centred culture of care did not match their expectations prior to the opening of Somerset House. The findings suggested this was a key reason for the high staff turnover rate, resulting in the presence of agency care workers and residentially trained care workers from Falcon Lodge making up the numbers. The strategic decision to temporarily rehome residents from Falcon Lodge was influenced by the financial incentive to utilise the new service at Somerset House and undermined attempts to foster a

singular narrative of person-centred care within Somerset House. Training was ineffective either due to care workers finding it 'basic' or feeling they could not embed the lessons learnt in practice. Finally, the high number of temporary care workers in the care home was a barrier to the construction of teamwork and strong care worker relationships. These findings then uniquely demonstrated the complex and nuanced interactions between staff recruitment, staff development and turnover, and the challenge this causes for the implementation of models of person-centred care. Now attention will turn to a discussion of the key findings of this thesis, in relation to the related body of literature.

Chapter 7: Discussion

The findings of this PhD study were informed by a multi method qualitative ethnographic approach to data collection. Data was collected bi-weekly over a 3-month period, with the aim of revealing the construction of care at Somerset House. This enabled an understanding of the process of implementing person-centred care, within a newly operational care home. The findings chapters have demonstrated how the care provider did not implement the model of care in full, as highlighted by the task oriented culture of care. Organisational issues such as the recruitment process, staff development, staff satisfaction, financial pressures, leadership, high staff turnover and a high presence of temporary care workers, contributed towards the incomplete implementation process. These issues were accentuated by the newly operational status of the care home. In this chapter the key findings presented will be situated within the latest academic literature, to ascertain what this study uniquely contributed to the field. The findings will also be discussed in relation to the research questions, developed at the outset of this study. Implications for future research, policy and practice are suggested.

The research questions that guided this study are as follows:

- 1) What is the dominant culture of care at the care home?
- 2) To what extent was the *EMBRACELIFE* strategy implemented within the care home and why was this the case?
- 3) How did the care home's status as newly operational interact with the implementation process?

The findings of this study will be reflected upon here, to provide answers to these underpinning research questions.

7.1 What is the dominant culture of care at the care home?

This PhD study contributed to the body of literature exploring cultures of care in care settings, through an analysis of care worker perceptions and interactions. Killet et al. (2014) noted studies that describe and locate specific cultures of

care, within care home environments, appear to be thin on the ground. This is despite calls for developing new methods of implementing person-centred care (CQC, 2014), and the continued need for improvement within the English care sector (CQC, 2017). The findings of this study have demonstrated that the culture of care at Somerset House was largely constructed around task. This resulted in a lack of emphasis on the personhood of people living at the care home. Specific findings will now be discussed, beginning with findings related to care planning.

7.1.1 Evidence from care planning

In common with previous research this study found the voices of people with dementia living in care homes, were underrepresented in care planning (Dellefield, 2006; Froggatt et al., 2009). All 6 of the care plans critically evaluated in this study were highly detailed in sections related to clinical and task based, personal procedures. In contrast they were filled generically or were empty in sections specified for 'resident goals'. Resident goals are inherently personal and require interaction with residents to understand. By having a section within the care plan for 'resident goals', the format and template did in principle facilitate and encourage the voice of each resident, to inform their care planning. The lack of personalised detail in this section however, was indicative of low user involvement in the planning and the delivery of care.

There is limited knowledge of how person-centred care planning can be achieved in care settings (Scales et al., 2017b). This PhD study contributed to the research base surrounding care planning, through gaining an understanding of the relationship between care planning, care worker perspectives around planning, and the macro level organisation of care. Previous research by Butterworth et al (2012) does mirror a finding of this thesis by suggesting care planning often involves writing in an institutionalised manner, and guidance to staff is therefore needed, to ensure care plans are person-centred. Such guidance is provided in the literature with factors such as individual values, cultures, recreational activities and plans for end of life postulated (Molony et al., 2018). In a recent study Scales et al. (2017b) found person-centred care planning requires a shared understanding of its importance, and a commitment

to work as a team, to make it a reality. The finding of this thesis support this point. Mixed perspectives were reported on the importance of care plans, with some care workers suggesting they 'didn't really read them', whilst others appeared to recognise their importance. This recognition however, did not result in person-centred care planning being carried out on a consistent basis, suggesting a lack of shared understanding may have contributed. Positive staff relationships and team bonding have been found to be associated with the production of individualised care plans (Colon-Emeric et al., 2006). The care staff team at Somerset House were found to lack a unifying and strong care narrative, as exemplified by the three distinct staff groups: permanent Somerset House, Falcon Lodge and agency, and their perspectives of one another. This may also have contributed to the lack of guidance around how to maintain the personhood of residents within care planning. Further, care workers indicated that a lack of proactive leadership at Somerset House, contributed to a consistent absence of personalised and meaningful guidance for each resident. Thus, highlighting the key role of leadership to foster consistent perspectives around care practice, so shared understandings can emerge.

The link formed in this thesis between care worker perspectives around care planning, the discourse of care within care the care plans, the interpreted reality of care in practice, and the organisational context of care, have created a nuanced understanding of how the text within care plans can be reflective culture. A priority for future research should be to further address the gap in knowledge that exists, surrounding how to achieve person-centred care planning in practice.

The evidence collated around care planning provided a novel insight to the wider literature surrounding the implementation of person-centred care cultures, as discussed in section 2.3 of this thesis. There, it was suggested a lack of managerial input into working practices was likely to lead to conflicting approaches and perspectives to care (Jones and Moyles, 2016). This is demonstrated in the discussion above, by exploring the reasons for a lack of person-centred care planning at Somerset House. This study therefore contributed to the literature, helping to establish the utility of care plans as an

evidence source, when attempting to evaluate the implementation of person-centred care models.

7.1.2 Evidence from the activity observed at Somerset House

The present study has demonstrated how challenging it was to provide individualised, person-centred activity that matched the interests and cognitive abilities of people with dementia, living in care home environments. This is despite evidence people with dementia find meaningful activity essential for their wellbeing, self-esteem and identity (Phinney et al., 2007; Orrell et al., 2008) and everyday activity being shown to support personhood (Bjork et al., 2017). This thesis advanced our understanding in this area by emphasising the difficulties and challenges associated with ensuring meaningful activities, in the context of a task-orientated care culture, and lack of managerial focus upon a person-centred approach.

The present study demonstrated how a lack of stimulation and the boredom experienced by residents was leading to the occurrence of anxiety as an expression of ill-being. These findings contribute to previous research suggesting the majority of care home residents with dementia, spend the vast majority of the day unstimulated and sedentary (Murphy et al., 2017), and the involvement of people with dementia in everyday activities is low (Edvardsson et al., 2014; Smit, 2017). Within section 2.3 of this thesis a lack of activity planning was shown to be symbolic of task-centred care (Kuhn et al., 2002). There was no activities schedule produced on the Ferndown Suite, hence this study reinforces the literature in this regard. As discussed in section 2.1, studies have shown people with dementia, less active in their care delivery, and lacking physical and mental stimulation, are more likely to experience a lower quality of life characterised by depression and 'problematic' behaviours (Anderson et al., 2003; Vogel et al., 2006). The findings of this study reported frequent occurrences of anxiety, aggression and agitation. When coupled with the lack of mental and physical stimulation observed, the findings of this PhD support those reviewed in the research base.

Regular, meaningful activity has been shown to be an indicator of wellbeing in care home settings. Moreover, providing activities that meet the personal

preferences and abilities of residents is key (Smit et al., 2015). Indeed, the findings from this thesis suggested on the occasions residents were engaged in stimulating activities, their wellbeing was observed to noticeably improve; such as during the 'weekly sing-a-song' session. The lack of personalised activity for the majority of residents however, coupled with the staff reports of feeling dissatisfied with the quality of the activities provided, suggested providing meaningful activity was not culturally embedded at Somerset House. This corresponds with the evidence from the research base, suggesting care home residents spent the vast majority of their time, unstimulated and sedentary. A lack of personalised and individualised activity for residents is typical of care settings with an institutional culture, based around task. The findings around activity suggest the culture of care is organised around tasks, and not the people living at Somerset House. The evidence related to activity suggests *EMBRACELIFE* was therefore not supported in practice.

7.1.3 Outdoor space

Access to outdoor space has been shown to reduce agitation and aggression in people with dementia in care homes (Abraha et al., 2016), enabling residents to thrive (Patomella et al., 2016). Despite this, outdoor space is limited for people with dementia living in care homes (Evans et al., 2018). This body of research is supported by the findings of this thesis, where aggressive behaviour was reported as common by care workers, and outdoor access was limited. As with personalised activities, this thesis furthers our understanding of the barriers to outdoor access, by contextualising them in the organisation of care. For example, the design of the care home, both from an architectural standpoint and the way care was organised, hampered care workers in their efforts to assist residents outside. Care workers discussed the lack of time available to assist residents downstairs to access the garden area, particularly for residents with mobility issues. The residents at Somerset House expressed a desire for outdoor access, one resident for example discussed his desire to visit the beach, whereas another proclaimed 'I'll be like an Irish Jewel!' in response to being questioned about her desire to go into the garden area. This finding found common ground with previous research suggesting a connection with the

outdoors was important to the sense of identity of people with dementia (Innes et al., 2011; van Hoof et al., 2016).

Staff support is thought to be key in facilitating outdoor access for people with dementia in care homes (Chaudhury and Cooke, 2014). It was reported in this thesis that individual care workers were observed assisting residents on a one-to-one basis outdoors, either using balcony spaces or the garden area. At times it was evident this was in an attempt to reduce visible anxiety or agitation within a resident, reinforcing the earlier findings around a reactive approach to care, and the utility of outdoor space, in reducing or alleviating anxiety, aggression and agitation.

No evidence of an organisational approach to providing access to outdoor space was observed, indicating a lack of a shared approach to care. Strategies to facilitate outdoor space access were not found in the care planning documentation analysed.

7.1.4 Care Delivery

The task based dominant culture of care was being challenged and subverted by some care workers. This was evidenced by the lack of a united, singular care narrative and the presence of multiple discourses of care being detected in the findings of this study.

The previous training of care staff members appeared to mediate in determining whether they would challenge and express satisfaction with the culture of care. For example, care staff with mental health training felt the culture of care was dissatisfactory, to a higher extent than their colleagues. It is important to note that a key indicator of a positive and effective organisational culture is its consistency and presence throughout the care team (Killet et al., 2014). That past experience and training appeared to be an indicator of role perception suggests that such experiences are impacting upon staff outcomes. The culture of care did not support the education or development of staff with task-centred attitudes or working practices.

Previous research has explored care worker's perceptions of cultures of care (Stockwell-Smith et al., 2011). By identifying the divergence between how care worker constructed their roles, and the subjective reality of practice however; a novel insight has been contributed to the research base. Thus revealing an insight into the challenges faced by care workers, in attempting to subvert dominant task-based cultures of care. It has also uniquely been demonstrated that the way care workers construct best practice may be aligned to a person-centred approach, even when this is in contrast to the culture of care within which they work. The pressure and amount of clinical and task-based workloads were cited as key reasons, detracting from attempts to foster a person-centred care culture of care. The care delivered was perceived as 'basic', and person-centred care was perceived as 'extra'; difficult to achieve due to time constraints and peer pressure to complete tasks. This finding reinforces conclusions made by Stockwell-Smith et al (2011) who found time pressures to be a key reason for the prominence of task orientated care. Interviews with RNs in particular, revealed dissatisfaction with what one nurse described as feeling like they 'popped pills all day'. The findings of this study therefore reinforce those reported within section 2.3, suggesting tasks ensuring physical health and safety are prioritised, over psychological wellbeing (Kuhn et al., 2002; Hancock et al., 2006; Moyle et al., 2011; Cadieux et al., 2013). More recent research in Canada has similarly found care staff members to report difficulties with maintaining the personhood of residents, due to the heavy work burden associated with task-based care cultures (Banerjee et al., 2015). Brewer and Talbot (2016) also reported negative staff perspectives on workload, mainly due to what was perceived as understaffing. This thesis finds common ground with the findings of these studies, where care staff routinely described person-centred care as being unfeasible, when contextualised by what was perceived as a high task based workload.

Care staff members described care arranged in an institutional manner, causing those with a strong understanding and background in providing person-centred care, to experience low levels of job satisfaction. They also lacked belief in their ability to practice the care principles they were trained in. This finding corresponds to studies suggesting organisational cultures of care should focus

on improving the self-efficacy of care staff members, by relieving pressure and supporting staff autonomy; thus reducing carer strain and stress in the workplace (Karantzas et al., 2016).

Following Social Constructionist epistemologies, communication is key to forming the realities within which we live. It is possible therefore to gain a picture of the culture of care at Somerset House, through a critical assessment of interactions between staff members and residents, and an analysis of how care workers describe residents. My findings suggest a proportion of the care team did interact with, and describe residents, in a person-centred manner. Others however failed to respect the personhood of the residents at the care home. Reasons for this are myriad and interact with each other, as identified within this thesis. They are intrinsically related to the organisational barriers to staff development within Somerset House i.e. due to poor training, a lack of supervision, downstream communication from leaders to care workers, a lack of capacity for nursing staff to engage in leadership practices, care worker disempowerment, high staff turnover, and the recruitment of RNs with general nursing, rather than mental health, backgrounds. The impact of *EMBRACELIFE* was therefore obstructed, and failed to effectively guide the culture of care at Somerset House in a person-centred direction. Discussion now turns to what extent the *EMBRACELIFE* model was implemented, and why this was the case.

7.1.5 Choice

In section 2.1 of the literature review, methods of care informed by the biomedical construction of dementia, were reported to result in a corresponding decline in social interaction and stimulation for residents (Koehn et al., 2011). This thesis finds common ground with this finding suggesting biomedical discourses of dementia still permeate into practice (Dupuis et al., 2012b). This thesis furthers understanding by finding biomedical approaches to be experienced by residents, constructed as being in the 'later stages' of dementia.

Choice was the theme within the findings that best reflected the continued existence of the biomedical model of dementia in care settings. For example, at mealtimes choice was more likely to be offered to those who could verbally communicate, and care workers were not provided with visual cues, to aid their

communication. Lung and Chaudhury (2011) identified outpacing, withholding, invalidation and ignoring, all of which are included within Kitwood's 17 points of MSP. They found these detractors to represent key reasons for personhood being undermined during mealtimes. They also found mealtimes could be used to promote positive person work (Kitwood, 1997). Barnes et al (2013) identified two approaches to mealtimes in care homes, framed as 'task vs resident-centred', finding small changes to mealtime delivery can improve resident wellbeing. This thesis contributes to research exploring how mealtimes can detract or enhance personhood, through the observations of dining experiences within the Ferndown suite. It builds upon the work of Lung and Chaudhury (2011) by identifying the mealtime experience as a potential site for banishment, mockery and infantilisation, and finding people with communicative difficulties were more likely to be subject to MSP during mealtimes. Similarly, to Barnes et al (2013), small differences in care worker practice, including the use of props and engaging residents in conversation, seemed to improve the mealtime experience for residents.

7.2 To what extent was the EMBRACELIFE strategy implemented within the care home and why was this the case?

7.2.1 Leaders

Organisation culture and workforce improvement have been found to be critical to the implementation of person-centred care (Callaghan and Ritchie, 2017). The findings of this study suggest there were limited organisational interventions in place to guide care delivery, demonstrating a lack of leadership at a senior management level. Leadership has been reported in the literature as the key factor influencing the effect of implementation strategies for person-centred care (Jacobson et al., 2017). Lynch et al. (2018) evaluated the use of a person-centred leadership framework, producing a 7 point criteria for leadership, supportive in this context. This included going beyond a vision to action; balancing concern for compliance with concern for person-centred care, listening to care workers and collaboration through trust and appreciation.

Similarly, Backman et al (2017) reported managers who attempted to be innovative, worked closely with care workers, played a supervisory role, and resolved conflicts within teams, made effective leaders. The findings in this thesis, support the notion of these attributes aiding the implementation of person-centred care. Such attributes were lacking in the leadership observed and described. For example, care workers described being disempowered by leaders, who they felt knew less about the needs of residents compared to them, suggesting a feeling of being underappreciated. Indeed, a lack of support from management was reported as a key reason for the high staff turnover at Somerset House. RNs, framed as leaders in Somerset House, described feeling unable to practice person-centred care, due to a heavy focus on clinical compliance. The disparity between the care, workers felt they should be delivering, and the reality they perceived in practice, also suggested an imbalanced focus, with an overemphasis compliance. This was left unaddressed by the leaders at Somerset House.

The quality of relationships people with dementia have, has been theorised in both the literature and the model of care in question, as key to their wellbeing (Nolan, 2008; Brown-Wilson, 2013). Care staff have a crucial role in facilitating positive relationships. Although there was evidence in this study that a minority of care staff actively attempted to build relationships with residents, these efforts appear to have been undermined by a myriad of organisational barriers, identified in chapter 6 of this thesis, and noted throughout this discussion. These barriers were interlinked and interacted with each other, compounding the issues.

The presence of a large temporary non-dementia specific workforce may be a contributing factor to the turnover of permanent care staff; one of the organisational barriers to model implementation identified. The literature suggests conflict within the staff team and concurrent issues with teamwork, are organisational barriers to care staff delivering person-centred care (Scales et al, 2017b). The disparity between the care that staff wanted to deliver, and the reality of care they perceived, was a key finding of this study. The stigmatising perspectives of people with dementia, held by the Falcon Lodge staff team,

meant they were unlikely to engage with people with dementia; as one staff member told me: 'You can't really have a conversation with them'.

There was clear evidence the task-based organisation of care was leading to high turnover of care workers, who were passionate about the delivery of person-centred care. One care worker who, shortly following data collection, resigned from their position, was regularly seen attempting to relieve the anxiety of one resident, who was often the subject of MSP. The temporary nature of the residential staff team, coupled with a high agency staff presence, may have contributed towards creating a culture where relationship building was deemphasised. The Falcon Lodge care workers would refer to 'their resident's upstairs'. They were thus creating a distinction between the residents whom they were invested in, and the people with dementia, who they were not.

Making conclusions around the construction of how staff perceived residents is problematic, due to the inconsistent way care was delivered, during the time data was collected. Evidence suggested there was a lack of a strong singular person-centred narrative, due to a lack of effective leadership. Indeed, care workers described 'just getting on' with their responsibilities in the absence of guidance. The presence of a residential staff team, including staff in leadership roles complicated matters, resulting in the delivery of non-dementia specific, task-based care practices. This appeared to lead to an increase in MSP interactions at the care home.

7.2.2 Recruitment

This PhD study has uniquely demonstrated the complex way staffing issues interact, in the context of a newly opened care setting. The reality depicted by the findings of this thesis, indicated the recruitment of care workers with a strong person-centred value base, worked against the creation of a positive person-centred culture. This is due to incentivising staff turnover, due to the unmet expectations of recruited care workers. The research of Kirkley et al (2011) recommended that care providers recruit staff members with person-centred values. Whilst, Häggström et al (2004) reported broken promises from leaders at recruitment, led to workplace dissatisfaction. The findings from this thesis expands upon these points. It was found a recruitment policy based upon

values will not effectively engender a positive person-centred culture, if care workers feel unable to overcome barriers to applying person-centred care, in practice. This is due to the tendency for such staff members to become burnt out and seek alternative employment. The lack of a direct on-going attempt to implement the model of care in question appeared to be a contributing factor.

By critiquing value based recruitment in this way, I am not suggesting that in theory it is an unhelpful approach, rather it needs to be supported by an on-going, well executed and proactive, wider strategy. This finding was supported by staff comments around unmet expectations at the recruitment stage. Care workers recalled being drawn in to working at Somerset House by the pitch given at interviews and at the induction, and being let down by the reality of care delivery at Somerset House. This was given as a key reason for the high turnover rate. These findings, to the best of my knowledge, add to the literature around the implementation of positive person-centred cultures, wherein prior to this study, the recruitment of staff with a strong person-centred value base had been recommended uncritically, in isolation from wider cultural and organisational issues. The ethnographic, multi method approach to research has enabled findings to be placed within the wider context of care at Somerset House, thus producing unique findings around issues already well documented within the literature.

Care staff members described 'losing a lot of the good ones', again indicating the impact of previous work experiences on carer job satisfaction and the inevitable impact on staff turnover. Indeed, research has shown care staff turnover to be related to a lack of opportunity to meaningfully engage with residents, care regulations, and inflexible working practices (McGilton et al., 2013) and job satisfaction is reported as the most prominent cause of care worker resignations (Gilster et al., 2018). In my PhD study little evidence was found to suggest care staff felt valued, or supported to undertake autonomous, flexible working practices. Evidence for this can be found throughout chapter 5. For example, a lack of autonomy was demonstrated by the disparity between role perception and the reality of the role, and further, by accounts of the night staff team, who described feeling pressured to complete specific tasks prior to the end of their shift. This study has therefore furthered knowledge around

staffing issues by exploring the complex ways such issues interact with, and compound each other.

High staff turnover has been linked to a higher number of deaths in care homes (CQC, 2014). In this study, the high staff turnover rate at Somerset House contributed towards the creation of a staff team with a high ratio of agency staff, lessening the impact of the training and induction phase of model implementation. The link between staff burnout and high staff turnover is well established, particularly within the field of dementia care (Karantzas et al., 2012; McCabe et al., 2017). A recent study has also linked how competent staff feel to increased levels of burnout; in turn suggesting perceptions of self-competence are linked to high staff turnover (van der Lee et al., 2017).

The 2 week induction and training period was the last time the *EMBRACELIFE* model was directly and proactively attempted to be implemented at the care home. Although some guidance or principles within the model were observed after this point, the use of the word *EMBRACELIFE* or the visibility of *EMBRACELIFE* as a guiding or implementation tool was minimal. This meant a high proportion of care staff members at Somerset House were not introduced to the model of care in any meaningful way. As Killest and colleagues (2014) point out, for a positive organisational culture to be achieved, attempts to foster such a culture must be an on-going process. Care workers described the burden agency staff presence placed upon them during shifts. One participant went as far as to suggest some agency staff had 'never worked a day of care in their lives', prior to their first shift at Somerset House.

7.2.3 Teamwork

Care workers suggested a lack of a shared understanding of care was significant. There was a divide around the care practice, experience, passion and training for dementia care, between the care workers at Somerset House. The residential staff members were described by Somerset House staff as a single homogenous group, either in interviews or observations of care staff communications; demonstrating a perceived difference between the two groups. Teamwork that engenders positive organisational outcomes in care settings, has been described as requiring staff to have complementary

backgrounds, skills, and common interests (Xyrichis and Ream, 2008; Ericson-Lidman and Strandberg, 2015). The evidence from this thesis suggested that despite an approach to recruit based on values, there were key differences between the experience, values and skills of care workers. Adams et al (2017) found social support to be a key enhancer of staff satisfaction among nursing staff. The lack of strong team bond therefore may have contributed to poor job satisfaction at Somerset House. Mariani et al (2017) reported care worker collaboration is important for involving residents with dementia in care planning. A lack of teamwork may have contributed then, to the limited involvement residents had in their care planning, discussed in section 7.1. When these findings are contextualised by the literature therefore, it seems plausible a lack of teamwork contributed to the inconsistent culture of care depicted at Somerset House. A further key example was the difference in the skillsets and backgrounds of RNs, with the physical, general nurse approach to care delivery causing conflict with those with a mental health background; undermining attempts to foster a consistent positive organisational culture. A core multi-disciplinary leadership team has been shown to be a positive contributor to organisational culture, if the specific skill sets are facilitated to complement each other (Emilsson, 2012). In this case however, a divergence of care principles led to separate care practices, causing conflict surrounding whose care practice was in the best interests of the residents. This issue was not resolved at management level, to the frustration of the senior RN.

The findings of this thesis therefore contribute to understandings around how a lack of teamwork impacts upon the implementation of person-centred care. It has been demonstrated that teamwork is essential for care planning, staff satisfaction, and an empowering approach to leadership.

7.2.4 Training

Barriers within the organisation of care prevented learning being embedded in practice. The findings of this study therefore do not fully support previous research that training can have a positive impact on the care practice (Spector et al., 2013; Fossey et al., 2014; Ballard et al., 2018) and wellbeing (Chenoweth et al., 2010) of formal care staff members in care settings. A caveat should be added however; the training given to the initial staff cohort, prior to the opening

of Somerset House, was perceived as poor. It is unlikely therefore that the training would have positively influenced care practice. In this context, whilst the findings of this thesis do not support the cited previous research, it cannot be said the findings are sustainably contradicted. Indeed, those with extensive training in areas such as mental health and learning disabilities, exhibited more person-centred attitudes and practices, than those with a more general or residential background.

The findings do reinforce the conclusions of Mekki et al (2017), who point out that the impact of training is lessened if it occurs in a contextual vacuum. A contextual vacuum is interpreted here as training that does not take into account the idiosyncrasies of the specific care setting, where the care workers practice. Learning was therefore unfettered by the barriers and restraints of the organisational culture of the setting. Mekki et al (2017) maintain that the interaction between evidence, context and facilitation, gives rise to organisational factors that can inhibit the impact of training courses on the practice of formal care staff. Leadership was cited as the most important facilitator in the context of practice based care delivery. In a similar vein Talbot and Brewer (2016) found care staff reported training to not be as important as the practical experience of care. Moreover, Viau et al (2013) found care workers to report pressures from peers and time constraints blocked the transfer of person-centred care principles, learnt in training, being implemented in practice. The findings of this thesis support these findings. Many care workers in this study indicated a knowledge of person-centred care and a willingness to implement it however, in practice, they were inhibited from doing so. This study goes further by findings peer pressure was likely to be felt between care workers on different shifts at the point of handover. The importance of training, tied to the practice realities of care settings was therefore reinforced, as even if learning does alter care worker perception, this does not necessarily mean culture will be enhanced, due to organisational barriers. A growing body of research is forming suggesting positive cultural change is likely if training has a practice based element, whereby care workers are support to embed their learning in their care settings (Edvardsson et al., 2014; Brooker et al., 2016). A second method postulated is the development of

training, flexibly designed and tailored, to the specific care setting (Surr et al., 2017). These studies correspond with research suggesting organisational and cultural change is an on-going process, requiring a proactive approach (Killet et al., 2014). The findings of this thesis therefore support previous research, suggesting approaches to training should be individualised and tailored to the care setting in question.

Mekki et al (2017) suggest the largest organisational factor associated with reducing the impact of training is leadership. My study reinforced this, as one care staff member alluded to: 'We had the training to begin with... they said it was not going to be task-focused... residents slowly came in but we didn't have anything, there was nothing in place.' By 'nothing in place' the care worker was referring to care delivery guidance and support with care practice. A lack of supportive and proactive leadership therefore was a determining factor, leading to an ineffective implementation process, and the subsequent inconsistent organisation of care at Somerset House.

7.2.5 Summary

Findings indicated the primary reason for the ineffective implementation process was an absence of a proactive attempt to implement the model of care, post the recruitment and induction phase, by Hollyfield and Somerset House leaders. This was compounded by the influx of a residential care staff team with no formal dementia training or experience, conflicts within care teams, a high turnover of dissatisfied 'good' care staff with person-centred values, a high agency staff ratio and an absence of staff development practices, such as supervisions. Now discussion will turn to Somerset House's status as newly operational, to determine what impact this had on the implementation process, and provide an answer to the third primary research question of this thesis.

7.3 How did the care home's status as newly operational interact with the implementation process?

To the best of my knowledge, this thesis represents the first research study in the UK to critically evaluate the implementation of a model of person-centred

dementia care, in a newly operational care setting. It thereby contributes towards filling a key gap in knowledge, simply through exploring the culture of care that developed within the setting, and the organisational context of care in a new care home.

The findings discussed in 7.2 around how implementation strategies of person-centred care often run into organisational barriers, whilst reinforcing the research base, are not unique in and of themselves. The main unique contribution to knowledge of this thesis is how these organisation barriers have been found to undermine the implementation of person-centred care in newly operational care homes. The newly operational status of the care home accentuated these issues for three key reasons: First, the requirement of assembling and recruiting a new staff team. Second, the need to financially gain for the new service, and third, due to the pressing need to be compliant with health and safety regulations. The 'real world' research conducted played a key role in gaining an understanding of the interplay, between the implementation process within this new care home, and the organisational factors that have impacted upon it.

The organisational issues were more significant in a newly operational care home, as they stretch beyond the confines of the specific care home, to the care provider running the home. It is the contention of this chapter that person-centred care is socially constructed as a lower priority to care providers, in the context of other organisation challenges. The main findings that contribute to this point are as follows:

- The influx of non-dementia specific residential care staff and residents from a sister care home (profit)
- Task-centred personal care guidance (personhood)
- The need for a new staff team to be recruited, trained and developed (personhood)
- The challenge of creating staff relationships in a diverse new care team that foster teamwork, collaboration and shared understandings (personhood)

- An influx of new residents, and the regulatory requirement for the production of physical health and personal care documentation and assessments (profit and compliance)

I will demonstrate below how profit and regulatory compliance were prioritised over what I have interpreted as the 'personhood' responsibilities of Hollyfield, when opening Somerset House. I have defined the findings related to the recruitment, training and development of care staff teams (and the engendering of teamwork within that team), as related to personhood for two primary reasons. Firstly, to reframe and place discussion within the context of person-centred care literature. Secondly, to imply that despite the rhetoric of CQC and NICE guidelines, the maintenance of personhood is still deemphasised within regulatory and legislative frameworks.

A key organisational decision made by the care provider during the time data was collected, heavily contributed to an increased diversity of staff values, background and experience. This was to introduce care workers and residents from a residential sister care home, to enable that home to be completely refurbished. The temporary placement of the residential team would not have occurred if Somerset House was fully occupied. However, the newly operational status of Somerset House meant it was below full capacity. This was further evidence therefore that the newly operational status of Somerset House was a large contributor, to the issues that blocked the implementation of person-centred care.

The original plan upon merging the staff and residents of the homes was to keep the two teams of staff separate; as was the case in terms of the residents. The staff teams however, did interchange, resulting in care staff members with no formal background, training or experience in dementia care, caring for people with dementia. This came as a surprise to the CEO of Hollyfield, when I mentioned this at a post data collection meeting, confirming the ad hoc, unplanned nature of the intermixing of staff, including those with leadership roles. This also suggests a breakdown in communication between the executive staff at Hollyfield and the management at Somerset House, during the time data was collected. The residential care staff appeared to resent having to work with

people living with dementia at the care home. An increased prevalence of MSP was observed at Somerset House, when the care supervisor on Ferndown was from the residential care home. This included the banishment and punishment examples from observations of the dining experience. This finding is reinforced by reports from care staff members suggesting shifts were inconsistent in terms of the style of care delivery. My own observations found common ground with this point: examples include staff and resident interactions during the meal time experience, the presence or lack of a key worker approach, and the arrangement of furniture in the communal lounge.

7.3.1 Regulations and compliance

Although breaching CQC guidance around person-centred care practice could result in a lower audit rating from the CQC, there is currently no way of legally prosecuting a failure to provide a person-centred culture in care homes. In contrast, care providers who fail to ensure the physical safety of residents in their care can be prosecuted. This is not to suggest the physical health and safety of residents should be treated in a lax fashion, but rather that it should not come as a surprise that the mental wellbeing of people with dementia, living in care homes was deprioritised given this regulatory context.

It is hoped an awareness of the imbalance between physical and mental wellbeing will have implications for policy and practice. This is not to suggest more punitive measures should be in place for breaching person-centred regulations however, it does identify an inherent bias in the regulatory framework that needs to be understood and addressed if person-centred cultures of care are to thrive. That the data informing this thesis was collected in a newly operational care home, provided a unique opportunity to study what elements of care delivery the care provider prioritised, when faced with a multitude of practical and organisational challenges at the outset. An inherent bias towards the physical and medical tasks required, when caring for people with dementia, over care aimed at improving emotional wellbeing, was therefore exposed. This was reflected in correspondence from central management at Hollyfield, hence warranting discussion. It is argued therefore that a key contributing factor, of the dominant task-based culture of care at Somerset House, was the regulatory framework in England, when contextualised by the

challenges of operating a new dementia specific care home and the incomplete implementation of person-centred care.

Griffiths and Tenginah (2010) point out that failure to meet care standards, presented in the CQC regulations, is punished by fines, censure and in extreme events, closure. What constitutes an extreme case, however, was not discussed. Under regulation 9 of the Health and Social Care Act 2008, care providers are mandated to work in partnership with residents, or a person acting on their behalf to produce care planning, to review care, and to ensure care is personalised (Health and Social Care Act, 2008). Despite this, the CQC state they cannot prosecute if this regulation is breached (CQC, 2015).

Conversely, they can prosecute care providers if they breach regulations 12, 13 and 14. Regulation 12 is related to the 'safe' care and treatment of residents. Traditional constructions of safety, in this context, centre upon a physical definition. Regulation 13 is related to the safeguarding of residents from abuse and improper treatment. Regulation 14 is focused upon meeting nutrition and hydration needs. It is positive that the CQC can prosecute care providers who are not fulfilling the duties of care, related to regulations 12-14. However, the hierarchy created by a lack of prosecution rights, related to explicit person-centred regulations, detract from the person-centred discourse that features so heavily within best practice guidance, and the implementation of the model of care in question. The care planning documentation at Somerset House was reflective of this. Under sections related to personal care, medical and physical health, clear and detailed guidance is observable and consistent throughout. As discussed, sections relating to resident goals however, are filled with generic comments, that demonstrate a lack of engagement with the resident, or a proxy, despite the regulations passed down in the Health and Social Care Act, 2008. Care staff members have described person-centred care as 'extra' and task-based responsibilities as the 'basic'. This also suggests that the care was not necessarily required to be person-centred, in the same way it was required to fulfil the medical and physical needs of residents.

CQC regulation 18 is designed to ensure care staff teams are of appropriate resident to staff ratio, under programmes of staff development, and suitably

experienced and qualified. The CQC do not have the power to prosecute for breaches of this regulation (CQC, 2015). Whilst the findings of this study suggest that resident to staff ratios were maintained, little evidence was found to suggest staff were being regularly supervised. Moreover, an entire staff team were brought in from a sister residential home with no experience in dementia care, without prior training. The high agency staff ratio could also be interpreted as a breach of this regulation, due to the lack of control care providers have over the training, experience and development of agency care staff. The findings indicated staffing issues caused the quality of care at Somerset House to be undermined. Examples include MSP prevalence and an inflexible approach to staffing levels that caused understaffing in the Ferndown suite, in instances where residents living in the suite were in need of palliative care. The CQC, upon inspecting Somerset House in the autumn of 2016, corroborated these findings, after their assessments found Hollyfield to be in breach of regulation 18.

The legal and regulatory institutions, are key societal pillars, playing roles in the creation of common knowledge, informing dominant social constructions. In turn they affects how social actors perceive reality, impacting upon communication, interaction and behaviour (Berger and Luckman, 1966; Rice, 2002). Dominant constructions of care within organisational cultures are therefore shaped by legislation and the sanctions imposed, when regulations produced as a result of legislation are breached (Duarte, 2007). Law then interacts with regulation, to play a role in specifying under which conditions care is deemed to constitute varying degrees of malpractice.

The evidence from this PhD study suggested that regulations aimed at supporting the personhood of people with dementia, living in care homes, may be undermined, due to an imbalance between CQC prosecution rights for breaches in regulations. This may be leading to person-centred care practice being deprioritised, amongst the myriad of organisational challenges care home providers are faced with; including issues around compliance and profit. In the case of this PhD the imbalance of punishments within the CQC regulations coupled with the financial pressures of opening a new care home, appeared to deprioritise the implementation of person-centred care philosophies of care.

The main example of this was the strategic decision to introduce a residential care staff team into a dementia care environment. Furthermore, within Somerset House, staff development was lacking, and largely task-based care plans were produced. Possible risk factors, likely to pose challenges when opening a new dementia specific care facility, should be pre-empted and solutions designed to reduce the risk caused. The idiosyncrasies of each care provider and case should be kept in mind. Whether supporting care providers in this manner is the responsibility of the CQC, or whether a new independent body needs to be formed for this purpose is open to debate. Either way what is clear is that the current system of regulatory input and support, whereby a care home is operational for several months (in this case between 7 and 8 months) before being audited, and subsequent actions being taken, does not support care providers to implement person-centred care.

It should be noted that Hollyfield sought academic evaluation of the implementation process of their new dementia care model. They were very keen for the *EMBRACELIFE* model to be implemented effectively and to learn the lessons necessary to ensure stronger implementation processes in future. These breaches in the CQC regulations did result in an audit score of 'Requires Improvement' for Somerset House, something Hollyfield did take very seriously. For some of the residents at Somerset House however, the reforms may have come too late. The several incidences of MSP described within the findings of this thesis were symbolic of this. If person-centred cultures are to be developed in newly operational care homes, policy and regulatory frameworks will need to further support the translation of person-centred care, from rhetoric to reality.

7.4 Summary

This thesis represents the first attempt, to document the complex process of implementing a person-centred model of dementia care, in a newly operational care home. In doing so three core aims have been achieved: first, to explore a culture of care in a newly operational care home, evaluating the functionality of the implementation process. Second, to understand why the implementation

process not incomplete, locating organisational barriers; and third, to reveal how the newly operational status of the care home mediated in the implementation process.

My findings demonstrated that despite person-centred constructions guiding the perceptions of some care workers, they felt disempowered and unable to consistently practice in a person-centred manner. This, along with an understanding of the discourse of dementia care prevalent in care planning, and the interactions and events observed in the care home, suggested the dominant culture of care was constructed around task. Therefore, *EMBRACELIFE* was not fully implemented. Organisational barriers identified in this thesis that significantly contributed to the incomplete implementation of person-centred care. These were staff recruitment, unmet staff expectations, inadequate training and staff development, difficulties in developing teamwork, ineffective leadership, high staff turnover, high agency staff presence, a residential staff influx, financial pressures, and a focus on compliance. These issues were accentuated by the newly operational status of Somerset House, as this meant a new care team was in need of assembly, making the process of recruitment, training and team development more difficult. The newly operational status of Somerset House therefore, had a domino effect on creating and exasperating the organisational issues that impacted upon the implementation of *EMBRACELIFE*.

These findings support and further understandings around cultures of care in care homes (Killet et al., 2014) the implementation of person-centred cultures of care (Shier et al., 2014) and the organisational issues found to impact upon this i.e. training (Mekki et al., 2017), leadership (Jacobson et al., 2017), teamwork (Ericson-Lidman and Strandberg, 2015), recruitment (Kirkley et al., 2011) and staff turnover (McGilton et al., 2013). This thesis goes beyond these studies by exploring all these issues simultaneously, in the context of a newly opened dementia care home, with wide implications for policy and practice. Lessons can therefore be learnt that are highly relevant to any care provider, wishing to open and operate a new dementia specific care home in the UK. Recommendations are provided based on the findings of this thesis for

research, policy and practice in section 7.6. Now however, attention will turn to how this thesis has contributed to knowledge.

7.5 Contribution to knowledge

This PhD study has produced methodological, theoretical and practical contributions to the field of dementia care. These are summarised below.

7.5.1 Methodological contribution

This study was undertaken using an ethnographical approach (Hammersley and Atkinson, 2007), informed by discourse analysis principles (Potter, 1996), using unstructured non-participant and participant observations, semi-structured interviews and document analysis of care plans. This approach enabled me to gather a richer, more nuanced, contextualised and deeper data set than if I had utilised a cross-sectional design, with a single research method. I was therefore able to construct a picture of the cultural of care at Somerset House that incorporated written communication and guidance, interactions and events at the care home, and care worker perceptions. Thus, I was able to record how guidance and perception reflected the interpreted reality of care interactions observed, gaining a holistic evidence base that could trace the construction of care in a multitude of facets, revealing organisational issues.

The focus on the discourse and meaning behind the language within care plans, and the interactions or perceptions of care workers, revealed competing discourses of dementia care. This enabled layered findings to emerge, capturing the complexity of the culture of care and the frustrations of care workers attempting to subvert the dominant culture.

By applying the principle of discourse analysis to uncover the meaning of texts, to an ethnographic approach, I have developed a novel way of interpreting cultures of care, implementation processes and organisational challenges. I have therefore contributed to methodological understanding of exploring dementia care settings.

7.5.2 Theoretical Contribution

This PhD study has made a theoretical contribution to the field of dementia care, by demonstrating the benefits of a social constructionist theoretical perspective, when exploring cultures of care in care homes. The epistemological principles of social constructionism (Berger and Luckmann, 1966) have enabled me to conceptualise care worker perceptions, interactions and communications, to analyse the dominant construction of care culture within Somerset House. Care worker perceptions of best practice within dementia care were not found to be consistently linked to the task based culture at Somerset House. Despite this, the focus on perception enabled an understanding to emerge of the dominant culture of care through exploring the disparity between perceptions of best practice, and how care workers interpreted the reality of the care they delivered. This thesis provides a novel theoretical contribution therefore, by demonstrating the utility of understanding how care workers constructed and positioned themselves, in relation to the wider culture of care, and the challenges this posed for them. This enabled an evidence base to emerge not only of culture, but of staff satisfaction, staff turnover, teamwork, and the need to implement training programmes that are informed by organisational constraints. The difference between care worker thought and practice was observed through the character of interactions and events at Somerset House, which while inconsistent, tended to be focused on task.

This PhD study represents the first attempt to explore theoretical implementation processes, informed by person-centred care theory (Kitwood, 1997), in a newly opened dementia specific care home. Despite this, the findings derived from my social constructionist perspective and ethnographic approach, informed by discourse analysis, have supported the wider evidence base around the implementation of person-centred care in care settings. The majority of organisation issues, accentuated by the newly operational status of Somerset House, have been found to have common ground with those that have occurred in more established settings. These include issues with fostering teamwork (Ericson-Lidman and Strandberg, 2015), training (Mekki et al., 2017), leadership (Jacobson et al., 2017), recruitment (Kirkley et al., 2011) and staff

turnover (McGilton et al., 2013). Moreover, new understandings have emerged of the financial burden, and the pressures of compliance, that opening a new care home can place on care providers. A link between these pressures and the organisational issues outlined above, has also been contributed to the evidence base.

Previous research suggesting the importance of a person-centred values approach to recruitment (Kirkley et al., 2011), has been contextualised within the organisational challenges of opening a new care home, by the findings of this study. A values based recruitment strategy was found to have increased staff turnover, due to recruited care workers without dementia care experience, having their expectations unmet. A more nuanced understanding around staff recruitment in dementia care has been contributed therefore.

7.5.3 Practical Contribution

This thesis represented a practice example of the strategic attempt to implement a model of person-centred care in a dementia specific care home. A focus upon the newly operational status of the care settings, has demonstrated common organisational barriers, to the implementation of person-centred care in more established settings. This thesis contributes to practice however, by finding these issues were accentuated when opening a new care home and further, that pressures related to finance and compliance were compounding factors. Reflections on the English regulatory body are therefore made. It is suggested the imbalance between person-centred, and health and safety regulations are addressed, to deprioritise biomedical and institutional approaches to care in favour of a more person-centred discourse. It is important for practitioners to recognise and reflect upon how this imbalance mediates within the organisational culture, dominant within their care settings. Practitioners can therefore use the lessons learnt, and recommendations produced to guide implementation processes, in both new and more established care settings. In doing so they may be able to anticipate the organisational barriers that prevented the full implementation of *EMBRACELIFE*, through the development of strategies, explicitly focused on the associated pitfalls.

This thesis has identified person-centred care to be present in the theoretical understandings of care workers, who felt disempowered, and could not apply their understandings in practice. The challenge of implementing person-centred care in care settings therefore, has been found to be enhanced through collaboration with care workers, to identify barriers within practice, addressing their disempowerment. A period of induction, and a recruitment policy based upon person-centred values, has been shown to not be enough to establish person-centred care. Support has been established therefore, for the innovation of training practices, discussed in section 7.2.

An argument has been presented for the need to support care providers when opening new care homes. There is a danger that the need to recruit a new care team can set in motion a domino effect of organisational challenges, related to staffing, if the expectations and staff development needs of new care teams are not managed. By identifying the central role of developing a team ethos, and a shared understanding of dementia care, this thesis theorises a method for overcoming key organisational challenges that block the implementation of person-centred care.

7.6 Recommendations

7.6.1 Recommendations for practitioners

It is suggested practitioners:

- Continue to commit resources and proactively support the implementation of person-centred care, beyond the opening of a new dementia care setting. The findings of this study suggested the organisational and systematic process of implementation ceased once Somerset House was operational, resulting in a lack of model visibility within the care home.
- Critically review the interactions that occur between the services they provide, when attempting to facilitate cultural change, within an organisation. This study has exemplified the possible implications for the quality of care delivered to people with dementia when care providers

attempt to fulfil several organisational objectives simultaneously. A key example of this was the implementation of a residential team of care staff members, along with residents from a sister, non-dementia specific care home. This undermined the fostering of a dementia specialist person-centred culture within Somerset House.

- Hold ongoing consultation with care staff members to ensure they feel valued, and any organisational challenges to implementing person-centred care practice are identified and resolved. The findings of this study suggest this is key to achieving low staff turnover and maintaining staff who are invested in providing person-centred care.
- Attempt to recruit care leaders, such as RNs and managers who have a background or training in caring for people with mental health needs, such as dementia, to ensure person-centred care is embedded and supported by leaders within individual dementia care services.
- Actively support and develop a team ethos within dementia specific care homes, to facilitate the fostering of a person-centred care culture. This is particularly important for leadership teams where previous experience and skillsets may differ, leading to competing care principles being embedded in care settings. Differences in practice may detract from efforts to implement a consistent person-centred culture, and should therefore be identified and worked through, for positive outcomes to be achieved.
- Clear lines of communication should be established between operational leaders of care providers and care home management staff to facilitate implementation once the care home was opened.
- Supplement recruitment and training implementation phases by supporting leadership staff within care homes to foster person-centred cultures once a home is fully operational.
- Ensure training cycles involve a practice based element within care homes, during care delivery. This would support care workers to transfer their learning from the class room, in practice.

7.6.2 Recommendations for policy

It is suggested policy makers consider:

- Recognising the hierarchical relationship embedded in the CQC regulations between, physical and clinical compliance, and the provision of person-centred care.
- Developing methods of elevating the provision of person-centred care to that of physical care, without increasing the sanctions that apply to breaches of person-centred care regulations.
- Reframing or expanding current dominant constructions of health and safety to incorporate elements of mental health. This would promote the prevention of mental health issues such as anxiety, loneliness and depression in care settings.
- Reflecting the potential negative impact of placement in newly operational care homes for the wellbeing of people living with dementia. This could be achieved by providing methods of supporting care providers in the first year of opening a new service. For example, through developing policy and funding streams that support care providers to implement person-centred care cultures.

7.6.3 Implications for future research

Below suggestions are made for future research, based on the findings of this thesis:

- The findings of this PhD thesis suggest that despite Hollyfield producing an implementation strategy for person-centred care, they were unable to actively support the implementation of *EMBRACELIFE* once Somerset House was operational, due to organisational challenges. Future research should look to explore solutions to organisational challenges that act as barriers to implementing person-centred care. For example, the design or evaluation of models that have the core aim of laying the foundation for the implementation of person-centred care principles, for people with dementia in care settings. Such research would further understandings of the interactional relationship between cultures of care and organisational factors.

- The idiosyncrasies of this study mean it cannot be fully replicated. An exploration of English care provider's strategic attempts to embed and be compliant with CQC regulations however, would build on the policy implications of this research. This would enable further understanding of how care providers interpret and follow regulatory frameworks to emerge.
- This study has demonstrated the importance of fostering a positive team ethos, for the implementation of person-centred care, in newly operational care homes. The design and evaluation of frameworks that specifically attempt to develop a shared understanding of dementia care, and strong bonds between care workers, is called for. This would help establish best practice in this area, and aid the implementation of models of person-centred care.
- Critically evaluate alternative strategic attempts to implement person-centred care, thus build upon the findings of this study and further addressing this gap in knowledge. It would also provide a point of comparison to the findings of this PhD study, to determine whether the organisational challenges that prevent the effective implementation of EMBRACELIFE, are replicated elsewhere.
- Further explore the challenges associated with providing and fostering a person-centred care culture, whilst commencing the operation of a new dementia care home service. This study represents, to the best of my knowledge, the only evidence based attempt to evaluation the implementation of a person-centred approach to dementia care, whilst dealing with the organisational challenges posed by opening and operating a new dementia care service. Further research studies documenting this process are needed, to reinforce or raise questions, over the generalisability of the findings of this small scale exploratory study.
- This PhD study could be utilised as a case study of the English dementia care, policy and regulatory context, when attempting to implement person-centred care in care home settings, or when opening a new dementia care service. A comparison with a case within the context of

another country could hold implications, with shared learning being derived, that could have a positive impact on policy and practice.

7.6.3- Implications for the *EMBRACELIFE* model.

Below implications of the findings for the effectiveness of the *EMBRACELIFE* model are posited:

- Given the findings around the impact of the design of Somerset House, *EMBRACELIFE* would have benefited from a focus on how this can support or detract from attempts to foster person-centred care. For example, it was found the flooring system at Somerset House was resulting in those on the upper floors having less access to outdoor space, when compared to those on the ground floor. This was compounded by people with poorer mobility, and general health, being placed on upper floors.
- A further point on design was how it interacted with staffing flexibility. The suite based system meant multiple staff teams were essentially created, and physically separated from each other by the built environment. This created a situation where more staffing was needed on Ferndown at some times, particularly when palliative care was being delivered. It also created a leadership void due to the limited number of RNs available across the home, relative to the number of suites. The *EMBRACELIFE* model may have benefited from a recognition of this, through an explicitly focus on the pitfalls of a suite based approach, for issues such as staffing flexibility and leadership.
- For a model such as *EMBRACELIFE* to be implemented a proactive focus from the care provider, from the executive level staff downwards, is necessary. In the case of Hollyfield, this proactive focused stopped once the home had opened. Up until this point *EMBRACELIFE* was supported organisationally. This suggests the focus on model implementation was displaced by organisational issues that consciously or not, became a higher priority. The danger should be explicitly addressed in *EMBRACELIFE*, and other person-centred care implementation frameworks.

- The findings suggest training is more likely to impact care practice if tied to the practical realities of the care setting. *EMBRACELIFE* and similar models could benefit from an awareness of this. This could aid the conceptualisation of training and staff development as a higher priority, post the opening of a care setting, or recruitment of new care workers. Training would be therefore ongoing, reactive and dynamic.
- The organisational factors that undermined values based recruitment should be recognised in the *EMBRACELIFE* implementation strategy. This would help recruiters be more aware of the danger of over promising and under delivering for factors such as staff turnover, and the impact this can have on the development of teamwork.

7.7- Ethical Dilemmas

When in the field a number of dilemmas occurred, whereby I had to make decisions with ethical and moral implications. Given the vulnerable status of the people living at Somerset House, and the problematic staff perspectives reported rather than observed in the data, this is perhaps unsurprising. In this section I describe those dilemmas and discuss the rationale behind how I resolved them.

When in the field I witnessed instances of what I interpreted as severe malignant social psychology. Examples of this were given in chapter 5. The dilemma I faced was twofold. First, when and who to report this to, and the level of detail about the staff member I gave when reporting the incident. First, I had to decide at what level I escalated this to. The options I felt I had were as follows: to report to the general manager of the care home, the assistant CEO, or the dementia lead nurse who also acted as my gatekeeper. I had a limited relationship with the care home manager, who I did not engage with or see very much. I therefore decided against disclosing to that person. The assistant CEO I did trust and felt I had a good relationship with, the same was true of my primary gatekeeper. I met both of these individuals on numerous occasions

during data collection. We would discuss my issues such as my wellbeing, recruitment, some initial thoughts on care practice and issues they perceive to exist in the home, among other things. I felt I would raise what I perceived to be the observed MSP at these meetings. The trust I felt I had in both made me feel comfortable to do so.

The question remained as to whether I would identify the individual or not. The ethical dilemma I had to resolve therefore, was whether or not to break ethical protocol to reveal the person in question, as a result of a welfare issue. I was acutely aware of the cascading effect this could have on the outed person. For example I was worried about how this would impact their job. I was also weighing up the impact it would have on the study. I questioned whether I would be able to continue collecting data at the care home, post revealing the individual. Ultimately however, the key factor influencing my decision was the theoretical belief that by appointing blame to the individual, the prevailing culture that facilitated the occurrence of the MSP was at risk of going unchallenged. I therefore reported the incidents observed anonymously. I had complete faith that the senior staff would address the MSP observed to the staffing team collectively. This eased concerns about the wellbeing of residents. I felt identifying the individual was by no means a more effective strategy than a group discussion. Finally, during data collection there was an agreement in place that I would personally conduct workshops at Somerset House, based on the findings of this thesis. I therefore felt that even if the people I reported the incident to did not address it, I would personally be able to do so.

As alluded to in section 3.4.4, there were regular occasions where I would have to think through my observer role, in terms of where I was on the spectrum from non-participant to participant. This included being cognisant around what cues I would take to move closer to being a full participant observer, and what responsibilities would be placed upon me in the process. In section 3.4.4 I stated I would consider what I was being asked to do, by whom, and the impact my participation would have on others, before deciding whether to cross the line between purely observing and participating. I stated that at times residents would ask me to help them in the same way a care worker or nurse would. This became an ethical dilemma when there was no care staff

member on hand to support the resident with their needs. I will discuss an example here, to illustrate the ethical dilemmas, and how I typically went about resolving them.

Care staff members would encourage me to get involved with non-personal communally based supportive interactions, such as making drinks for residents, aiding them to the dining room, and playing games with them. This enabled me to go into a participant role, akin to that of a volunteer that did not present any ethical dilemmas around factors such as safety. On one occasion however, as reported in section 4.2, I aided outdoor access for a resident after becoming deeply dissatisfied with the level of mental stimulation and physical activity, being afforded to the residents. This was due to care workers being at full capacity, as there were residents with palliative care needs living on the suite, at that time.

My decision to assist a resident outside was an ethical dilemma, as I first had to decide how many residents I could safely facilitate outdoor access to. Safety is a responsibility of a staff member, not an external researcher. In taking this on I therefore weighed up the physical health risks, involved with what I interpreted to be a basic human right, i.e. that of having a choice of indoor and outdoor space. As a result I felt I could only safely assist one resident outside. The person I chose Colin, was relatively fit and a strong walker who I felt had minimal risk of falling. I asked a member of staff for sunscreen and a hat for Colin prior to going outside. The staff member did find the time to help Colin apply the sunscreen on his skin. We walked around the garden for a short time, perhaps 5 to 10 minutes. I recall him seeing a dragonfly and expressing great pleasure at the sight. He also enjoyed touching the blue painted rowing boat located in one corner of the garden. Then I sat with Colin, who I knew had been a keen artist all his life, and handed him a pencil and some paper. He began drawing the red post box situated in the garden. After we went back inside I helped Colin walk to the dining room. After lunch I vividly recall him sitting in the communal lounge and contently sleeping for the rest of the afternoon. This was somewhat unusual for Colin, who was often quite restless, and had previously been observed standing by the locked exit to the suite, looking anxious to leave.

Despite taking on a participant role that could have been perceived as putting the physical health of Colin in danger, I felt (and still feel) fully justified in doing so, due to the positive wellbeing outcomes described. On reflection however, my decision and rationale mirrored those made by care staff, when considering outdoor access, as reported in section 4.2. Colin after all was physically strong and a good walker. Therefore, when acting in a staff based role my decision was symbolic of the unequal access given to those who are more physically able in the care home. This has given me a stronger degree of empathy for the difficult decisions care workers have to make and live with on a daily basis. Moreover, I now also have a better understanding of the practical factors that influence decision making, and the implications of those decisions for staff outcomes, such as burnout and satisfaction. It also made me reflect on the huge challenge associated with respecting the human rights of all living in care, and their needs and desires to be met.

There was one event where data was collected in the presence of residents, and their family members, who did not give informed consent to participate in the research. This was the sing-along structured activity that took place in the West Moors Lounge; where residents were assisted out of their bedrooms, in their beds, to take part in the session. I made the decision to make field notes that indicated the presence of these residents and relatives. This decision represented a key ethical dilemma, posed in the field. My rationale was based on the strong positive emotional response of the relatives to the session, and their loved ones reaction to it, despite being in poor health. I found this to be quite profound and felt I would be misrepresenting the care staff, and the culture of care in Somerset House that facilitated the event, if I did not find a way of recording it within the data. The decision was therefore interpreted by myself as the right thing to do morally and for the integrity of the research, if not strictly adhering to ethical protocol.

I was sure to introduce myself to everyone present at that signing activity session beforehand. I explained who I was and why I was there. The relatives did know about the study taking place prior to this, due to emails being sent out by the Somerset House administrator. However, I cannot say for sure that all the residents present were aware of the study, and who I was, despite my

attempts to explain this. I had to be comfortable therefore with the families' verbal blessing that it was OK to observe the session and make field notes. I was sure to make general notes that did not describe the relevant residents or relatives in any identifiable manner. I commented that they were present, that the staff team worked hard to accommodate this, that the event encouraged family visitations for all residents, irrespective of their care needs, and how meaningful I interpreted the event to be. I felt strongly that the reporting of events such as this, was and is vital to challenge the perception of organising meaningful activity for people with dementia, at all points in their journey. I therefore felt reporting this as an example of best practice could benefit Hollyfield as a care organisation, for the staff at Somerset House, and for the wider care community. Writing this today I still it was the 'right' thing to have done. For this to be the case however, it is vital that I am able to disseminate the findings of the research to practice based audiences, and the findings of this thesis are used to inform care practice under the Hollyfield banner. I owe this to all the people with dementia who I collected data upon, and who welcomed me into their home during the data collection period.

7.8 Closing statement

This thesis has documented the findings of an ethnographic multi method study, exploring the implementation process, of a model of person-centred care, in a newly opened dementia specific care home.

The findings of this PhD thesis have uniquely contributed to the field of research related to the implementation of person-centred dementia care models. This process was critically evaluated in a newly operational care home, with a focus on care culture understood, through care worker perceptions, communications and interactions. Thus, this thesis makes an original and timely contribution to the literature surrounding improving the lives of people with dementia, living in care homes.

Within this thesis it has been shown that newly operational care homes are subject to the same implementation barriers as more established care homes.

These barriers included leadership and management issues, staff dissatisfaction, task focused care planning, recruitment, the development of teamwork and high staff turnover. It has been uniquely demonstrated however that these organisational issues are accentuated by the challenge, inherent to newly operational settings, of assembling a new workforce.

The financial pressures, of occupying newly operational care homes with residents, has been shown to complicate the implementation of person-centred care. This barrier was shown to have the potential to influence care providers to make decisions that actively undermined the implementation of a person-centred model of care. Finally, a novel insight has been gained into the stage of establishing a new service when issues surrounding implementation begin. This reinforces previous research, suggesting attempts to implement person-centred care, such as training interventions, should consider the barriers of individual care settings to embed learning in practice (Mekki et al., 2017; Surr et al., 2017).

Care providers are in need of more support if they are to overcome institutional cultures of care. Organisational barriers, accentuated by the challenges of opening a new care home, were found to inhibit the achievement person-centred cultures of care in such settings. The recommendations produced in this thesis represent an attempt to put this key issue into focus, and provide the impetus for future research to be undertaken; expanding the evidence base needed to promote widespread practice based impact. The policy and practice focused recommendations, found within this thesis, have the potential to contribute towards making person-centred care a reality, for the people who live and work in care homes across England and beyond.

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9 Appendices

Appendix 1: The 17 forms of MSP. Adapted from Kitwood (1997)

No.	Type	Description
1.	Treachery	using forms of deception in order to distract or manipulate a person, or force them in to compliance.
2.	Disempowerment:	not allowing a person to use the abilities that they have; failing to help them to complete actions that they have initiated.
3.	Infantilization:	treating a person very patronizingly (or 'matronizingly'), as an insensitive parent might treat a very young child.
4.	Intimidation:	inducing fear in a person, through the use of threats or physical power.
5.	Labelling:	using a category such as dementia, or 'organic mental disorder', as the main basis for interacting with a person and for explaining their behaviour.
6.	Stigmatization:	treating a person as if they were a diseased object, an alien or an outcast.
7.	Outpacing:	providing information, presenting choices etc., at a rate too fast for a person to understand; putting them under pressure to do things more rapidly than they can bear.
8.	Invalidation:	failing to acknowledge the subjective reality of a person's experience, and especially what they are feeling.
9.	Banishment:	sending a person away, or excluding them – physically or psychologically.
10.	Objectification:	treating a person as if they were a lump of dead matter: to be pushed, lifted, filled, pumped or

		drained, without proper reference to the fact that they are sentient beings.
11.	Ignoring:	carrying on (in conversation or action) in the presence of a person as if they were not there.
12.	Imposition:	forcing a person to do something, overriding desire or denying the possibility of choice on their part.
13.	Withholding:	refusing to give asked-for attention, or to meet an evident need.
14.	Accusation:	blaming a person for actions or failures of action that arise from their lack of ability, or their misunderstanding of the situation.
15.	Disruption:	intruding suddenly or disturbingly upon a person's 'strange' actions or reflection' crudely breaking their frame of reference.
16.	Mockery:	making fun of a person's 'strange' actions or remarks; teasing, humiliating, making jokes at their expense.
17.	Disparagement:	telling a person that they are incompetent, useless, worthless etc., giving them messages that are damaging to their self-esteem.

Appendix 2: Interviews and observations information sheet for staff team members

Interviews and Observations: Information sheet for staff members.

My name is Chris Poyner and I am asking if you would help me with my PhD research. I am a student at xxxxxxxx. Working with Hollyfield, I am interested to look at how Hollyfield provides care for residents here in Somerset House. So that I can do this I would like to be around in the care home for 3 or 4 days at a time once every 2 weeks. While I am at the care home I would like to make notes on what your experience of working in the care home is like, based on what I see and the conversations I have with you. xxxxxx, the senior Admiral Nurse and dementia lead at Somerset House, has kindly offered to be the point of contact for myself during this study. I will contact xxxx to arrange visits to the care home. She has informed me about the capacity of residents at the care home. She has also played a key role in introducing me to residents and staff members. As a member of staff here at Somerset House, getting to know what your working day is like here would be very useful to my research study. This will help me understand how Hollyfield provides care for residents here and hopefully help Hollyfield improve the care they provide in the future.

While observing staff and residents I will make notes about how Hollyfield caters for the needs of people living in the care home. I will also try to understand what issues occur when you are trying to provide the best possible care to residents. However, I will not record any personal information such as your name, so that the information I use will be kept anonymous, and all information that I record will be kept confidential. I will stop my observations if any incidents occur that, involving personal care, to ensure the privacy and dignity of residents at Somerset House are protected. All the information I collect will be seen only by myself and if needed by my supervisors, and will be held securely at xxxxxxxx. When I am staying at the care home all the information I collect will be secured held in a padlocked bag within a locked room. When I write up the findings from the study I will not include any information that could reveal your identity. If you are interviewed I will ask to

use an audio recording device. You do not have to be audio recorded and can opt out of this if you wish. If you allow me to record the interview the audio file will be kept on a password protected computer file until it is transcribed. The audio recording will be destroyed once it has been transcribed.

We very much hope you will choose to participate in this PhD study however, you do not have to and if you decide to withdraw from the study you can do so at any time prior to the data being anonymised without having to give an explanation. Participation is completely voluntary. Your job role will not be affected by taking part or refusing to take part in the study. If you have any questions or concerns, please feel free to contact me on the details below.

If you have any questions about the conduct of this research or wish to make a complaint, you may contact the Deputy Dean of Research and Professional Practice at Health and Social Science.

Thank you for reading this. If you would like to take part in this study, we will ask you to sign a consent form.

Chris Poyner

Appendix 3: Information sheet for people living at Somerset House

Interviews and Observations: Information sheet for people living at Somerset House.

My name is Chris Poyner and I am asking if you would help me with my PhD research. I am a student at xxxxxxxxx. I am interested to look at how Hollyfield provides care for people living here in Somerset House. So that I can do this I would like to be around in the care home for 3 or 4 days at a time once every 2 weeks. While I am at the care home I would like to make notes on what your experience of living in the care home is like, based on what I see and the conversations I have with you. xxxxxx, the senior Admiral Nurse and dementia lead at Somerset House, has kindly offered to be the point of contact for myself during this study. I will contact xxxxx to arrange visits to the care home. She has played a key role in introducing me to people living at Somerset House and the staff members at Somerset House. As a resident here at Somerset House, getting to know what your life is like here would be very useful to my research study. This will help me understand how Hollyfield provides care for residents here and help Hollyfield improve their care in the future.

While observing and speaking to people I will make notes about how Hollyfield caters for the needs of people living and working in the care home. However, I will not record any personal information such as your name, so that the information I use will be kept anonymous, and all information that I record will be kept confidential. I will stop my observations if any incidents occur that, involving personal care, to ensure the privacy and dignity of people living at Somerset House are protected. All the information I collect will be seen only by myself and if needed by my supervisors, and will be held securely at xxxxxxxxxxxxx. When I am staying at Somerset House all the information I collect will be held in a padlocked bag within a locked room. When I write up the findings from the study I will not include any information that could reveal your identity. If I speak with you on a one to one basis I may ask to record our conversation. You do not have to be recorded and can opt out of this if you

wish. If you allow me to record the interview the audio file will be kept on a password protected computer file until it is transcribed or written up. The audio recording will be destroyed once it has been transcribed.

We very much hope you will choose to participate in this PhD study however, you do not have to and if you decide to withdraw from the study you can do so, before the point that I remove all names and personal information from the information I use, without having to give an explanation. Participation is completely voluntary. Whether you choose to participate or not, the care you receive will remain the same as before. If you have any questions or concerns, please feel free to contact me on the details below.

If you have any questions about the conduct of this research or wish to make a complaint, you may contact the Deputy Dean of Research and Professional Practice at Health and Social Science.

Thank you for reading this. If you would like to take part in this study, we will ask you to sign a consent form.

Chris Poyner

Appendix 4: Document analysis information sheet

Document analysis: Information sheet.

My name is Chris Poyner and I am asking if you would help me with my PhD research. I am a student at xxxxxxxxxxxx. Working with Hollyfield. I am interested to look at how Hollyfield help provide care for residents here in Somerset House. An important part of that is to see how well this is done in resident's personal care plans. My research is on behalf of Hollyfield and the team at Somerset House.

As a new resident here at Somerset House, your personal care plan would be very useful to my research study. This will help me understand how Hollyfield plan and review their care for residents here.

While reading your care plan I will make notes about how Hollyfield cater for people's different needs. However, I will not record any personal information such as your name, so that the information I use will be kept anonymous, and all information that I read will be kept confidential. All the information I collect will be seen only by myself and if needed by my supervisors, and will be held securely at xxxxxxxx xxxxxxxx. Your personal care plan will not leave the building and will be held by staff as normal.

We very much hope you will choose to participate in this PhD study however, you do not have to and if you decide to withdraw from the study you can do so at any time without having to give an explanation. Participation is completely voluntary. Whether you choose to participate or not, the care you receive will remain the same as before. If you have any questions or concerns, please feel free to contact me on the details below.

If you have any questions about the conduct of this research or wish to make a complaint, you may contact xxxxxxxxxxxxxx Ethics Committee.

Thank you for reading this. If you would like to take part in this study, we will ask you to sign a consent form.

Appendix 5: Consent form: Interviews and observations

Consent Form

Hollyfield PhD study: Interviews and Observations

Please initial box

1. I confirm that I have read and understood the information sheet for the above study and have been able to ask questions	
2. I understand that my participation is voluntary and that I am free to withdraw up until the point data are anonymised	
3. I understand that all information will be kept confidential	
4. I agree to focus group/interview being recorded on a Dictaphone	
5. I agree that the data can be used on condition that they are kept confidential and anonymised	
6. I understand that all data will stored safely and will be seen only by the research team	
7. I agree to take part in the above study	

Participant Name:

Signature:

Date:

Researcher Name:

Signature:

Date:

If you have any questions about the conduct of this research or wish to make a complaint, you may contact the Deputy Dean of Research and Professional Practice at Health and Social Science.

Appendix 6: Consent form: Document analysis

Consent Form

Hollyfield PhD study: Document Analysis Consent

Please initial box

1. I confirm that I have read and understood the information sheet for above study and have been able to ask questions	
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason	
3. I understand that all information will be kept confidential	
4. I agree that the data can be used on condition that they are kept confidential and anonymised	
5. I understand that all data will stored safely and will be seen only by the research team	
6. I agree to take part in the above study	

Participant Name:

Signature:

Date:

Researcher Name:

Signature:

Date:

Appendix 7: Debrief form: Interviews and Observations

Hollyfield PhD study interview and observation phase: Debrief form for participants

Thank you for taking part in the interview and observation phase of this PhD study.

If you wish to withdraw all data gained from your participation, please inform Chris Poyner using the contact number given below. Withdrawal must be made before the information used is anonymised. A withdrawal will be handled confidentially.

Taking part in this research should be a stress free experience. It is therefore not anticipated any mental or physical distress will be caused by your participation. However, if you do experience distress of any kind please discuss this with xxxxxxx, senior admiral nurse and dementia lead, who is the point of contact at Hollyfield for this research project.

An anonymised report detailing the findings of this phase of the PhD study will be made available to all participants, should they wish to access one. To reserve a report please call or email Chris Poyner using the contact details below.

I hope your involvement has been a pleasant and trouble free experience however; if you have any queries or concerns or concerns, please feel free to contact me on the details below.

If you have any complaints about how the research was conducted, please contact the Deputy Dean of Research and Professional Practice at the School for Health and Social Science.

On behalf of xxxxxxxxxxxx, I thank you again for your valuable input and participation.

Appendix 8: Debrief Form: Document Analysis

Somerset House PhD study Document Analysis phase: Debrief form for participants

Thank you for taking part in the document analysis phase of this PhD study.

If you wish to withdraw all data gained from your participation, please inform Chris Poyner using the contact number given below. A withdrawal will be handled confidentiality.

An anonymised report detailing the findings of this phase of the PhD study will be made available to all participants, should they wish to access one. To reserve a report please call or e mail Chris Poyner using the contact details below.

I hope your involvement has been a pleasant and trouble free experience however; if you have any queries or concerns or concerns, please feel free to contact me on the details below.

On behalf of Hollyfield and the xxxxxxxxxxxxxx I thank you again for your valuable input and participation in the documentary analysis phase of this PhD study.

Chris Poyner

Appendix 9: Interview schedule for care workers

Interview schedule for care workers

Opening:

- Introduce self;
- Explain the research and consent form fully;

Recording

- Can you tell me your background in care?
- And how long have you worked here?
- What are the main differences between this and previous care settings you have worked within?
- What were your expectations prior to beginning work here?
 - Probe around induction, interview experience
- How would you define the care you deliver here?
 - Probe around role and relationship to residents
- How satisfied are you with the management and leadership within the home?
 - Probe around support and communication
- What is staff turnover like at Somerset House?
 - Probe around factors that may be responsible for turnover rate
- What is the percentage of agency carers here?
- Does this effect your everyday care delivery? If so, how?
- How strong is the team ethos here?
- Can you describe your shift patterns?
 - Probe around the differences between shifts and any issues between shifts
- How would you define the type of care that typically is carried out here?
- How often are care plans used or updated?
- Do the residents get access to outdoor space?
- Are you happy with the built environment of the home?