Developing relationships in long term care environments: the contribution of staff

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ABSTRACT

Aims and objectives: The aim of this study was to consider how relationships in care homes influence the experience of older people, their families and staff. The main objective reported in this paper considers how these relationships are developed and the contribution that staff make to this process through the routines of care.

Background: Relationships have been found to be integral to experiences of residents, families and staff in care homes but little is known about how these relationships develop. Few studies consider relationships in care homes as their main focus and there are a dearth of studies that consider relationships from the perspective of residents, families and staff within the same care home.

Design: The study employed a contructivist design where the different perspectives held by participants were explored and shared in order to develop a joint construction of how relationships influenced their experiences.

Methods:. Data were collected from three care homes in England over a two year period between 2003-2005. Participant observation and interviews enabled a hermeneutic circle to be created between residents, families and staff. Data collection and analysis were conducted concurrently using a constant comparative method.

Findings: Staff adopted three approaches to care delivery and these influenced the type of relationships that were developed between residents, families and staff. The three approaches were described as individualised task centred,   resident centred, and relationship centred.

Conclusion : This study progress our understanding of the development of relationships between staff, residents and families in care homes by considering how the staff may support or constrain these relationships through their approach to care delivery.

Relevance to clinical practice: These findings have implications for developing practice in care homes to improve the experience of older people and their families by encouraging staff to develop a relationship based approach to care routines .

300 words

Introduction

The ageing of the population is a global phenomenon with the fastest growing age group being those aged over 80 years (United Nations (UN)2002). This age group also experiences a greater proportion of health related disability which is creating greater demand for long-term care (UN 2002, Howse 2005). It is estimated that 53.6% of the population over 85 reside in care homes within the United Kingdom (Beringeer and Crawford 2003). When older people, families or staff have been asked what is relevant to their experiences in care homes, they describe the impact of interpersonal interactions in the delivery of care and how they value the opportunity to develop relationships (Mattiasson and Andersson 1997, Raynes 1998, Bowers et al 2000, Kane et al 2003, McGilton et al 2003). This poses a considerable challenge due to the increasing frailty of the resident population (Bebbington et al 2001; Beringeer and Crawford 2003). Relationships have been described as integral to the caring process (Brooker 2004, McCormack 2003, Nolan et al 2004) but there remains little guidance in relation to how enabling relationships can be developed (Dewing 2004). While the importance of relationships is beginning to be acknowledged within the literature (Rantz et al 1999), little is known about the various contributions of residents, family members and staff (McGilton and Boscart 2007). This paper describes the how staff contribute to the development of relationships in care homes within the routines of care, drawing on the perspectives of residents, families and staff.

Background

In reviewing the literature there were relatively few studies that considered the perspectives of residents, staff and families in the same study and a dearth of studies that examined relationships as the key focus. Key relationships that emerged were between residents and staff or families and staff with some studies examining the relationships between residents.

Relationships between residents and staff

Given that the main goal of care homes is to provide care for residents, it is not surprising that studies which focus on caring have found that residents, families and staff all describe how relationships between residents and staff are integral to this process (Grau and Wellin 1992, Gjerberg 1995, Jackson 1997, Deutschmann 2001). While each of these studies had different objectives, a common theme was that the emotional aspect of caring was vital to caring relationships, leading to feelings of being 'connected' (Jackson 1997) and 'not being forgotten' (Deutchsmann 2001). Another aspect of the relationships between staff and residents was the giving of time. This included time to attend to small details or having the time to talk or walk with someone (Gjergberg 1995, Jackson 1997). Grau et al (1995) also found that residents often described their relationship with staff in terms of the way care was provided. For these older people, a good relationship inferred a good standard of care. This was similar to residents who gave examples of how their personal relationship with staff encouraged them to help within their care (Bowers et al (2001). Reciprocity such as this, also includes residents sharing their past with the staff enabling staff to use this information in the care routines (Grasser 1996, Hartig 1998, Bowers et al 2001). Staff involved in these relationships would also share personal information about themselves, with the potential for the resident to provide advice in return (Bowers et al 2001). Bowers et al (2000) found that staff delivering day to day care described the quality of this care in terms of the of relationships they were able to develop with residents.

Relationships between residents

Few studies were located that considered relationships between residents, but those that were, identified this as an important but often ignored set of relationships (Powers 1988, Reed and Payton 1997). Residents often develop relationships with other residents in care homes

(Powers 1991, Diamond 1992) although this does not necessarily imply friendship or intimacy and residents themselves recognised that a shared environment did not necessarily imply shared interests or outlooks (Abbott et al 2000). However, older people in care homes describe the significance of their social relationships, with the majority of residents indicating that it was important to engage in social relationships with fellow residents but found the opportunity to do so was unsatisfactory in the nursing home setting (Mattiasson and Andersson 1997). For example, Powers (1992) suggests that older people maintain a similar pattern of relationships within the home to those developed externally.

Relationships between families and staff

Families have described how they support staff in personalising the care of their relative, through sharing biographical information (Duncan and Morgan 1994). However, Hertzberg et al (2001) found that some families expressed uncertainty as to whether the information they shared was being used by staff. When staff relayed information to families about the resident's daily behaviour, this demonstrated to families the personal caring the resident was receiving and supported meaningful relationships between families and staff (Duncan and Morgan 1994). Further to this, families work very hard in demonstrating to staff how emotional or psychosocial care should be provided in addition to the more instrumental aspects of care (Bowers 1988, Duncan and Morgan 1994) and describe this as a joint responsibility between themselves and staff (Dempsey and Pruchno 1993).

Although these studies discuss how residents, staff and families see sensitivity, caring and respect as integral aspects of care, the part these attributes play in developing relationships appears little understood. Furthermore, there were few studies that considered relationships as the main focus or included the perspective of residents, families and staff in the same

study, which suggests the need for a study that focuses on relationships from the perspective of residents, families and staff.

Design

This paper draws from a study that adopted a constructivist approach (Guba and Lincoln 1989) to explore relationships in care homes from the perspective of residents, families and staff. A constructivist approach was relevant in the context of this study, since it assumes that each participant may hold a different perspective on their relationships, influenced by the time, the context and by others with whom they share relationships. The nature of what is real for those within this study is specific to the local context of the care home, dependent upon multiple and sometimes conflicting social realities. In a contructivist inquiry, the interaction between the researcher and participants shapes what emerges from the investigation and knowledge is then created jointly through this interaction (Rodwell 1998).

Study Setting and Participants

Three care homes were chosen incrementally to reflect variations in size, location and type of residents. In order to protect confidentiality, each care home was given a pseudonym (Table 1). Purposive sampling was undertaken within homes to ensure that participants were able to illuminate the research question (Stake 2000).

Ethical considerations

Madjar and Higgins (1996) suggest that, within the context of nursing homes, seeking informed consent to research is an ongoing process and consent will need to be continuously negotiated. This was achieved using strategies such as obtaining verbal consent at the beginning of each visit as well as seeking written consent at different times such as prior to a taped interview. As the study progressed, people who appeared to hold differing views were also approached to be involved to ensure a breadth of views within each home. This study

was reviewed by a local Research Ethics Committee and organisational approval was granted by the local Primary Care Trust.

Data collection

Data were collected over a two year period between 2003-2005 across three care homes using participant observation (n=256 hours) and interviews with residents (n= 10), families (n=18) and staff (n=25). As the interaction between the researcher and participant was a key aspect of this study, data collection was undertaken by one researcher for consistency. Participant observation was undertaken on different days at different times within each home in time slots between four and twelve hours each day. Prolonged engagement was achieved by spending between four and nine months within each home supporting the credibility of the study (Lincoln and Guba 1985). Being a participant in the home included activities such as taking residents to and from the dining room, helping to feed residents at meal times, having conversations with residents and participating in care routines. The range of activities supported the triangulation of data sources and credibility of the study. During these periods of observation, field notes were tape recorded verbally and then transcribed verbatim within the next 24 hours during which time simultaneous notes were made in a reflexive diary.

Interviews were used to support the hermeneutic process of developing shared meanings between the participants and the researcher (Guba and Lincoln 1989). This was achieved through semi structured interviews that were pre-arranged, tape- recorded and transcribed. Following each interview, a reflexive diary was used to document thoughts and observations about this process and the data that emerged. This was intended to support an ongoing decision making trail, enabling the researcher to feed back thoughts and observations to

participants as the research progressed, ensuring confirmability of the study (Lincoln and Guba 1985).

Data analysis

Within a constructivist study, there is an iterative movement between data collection and analysis. As data were collected, transcription and coding were undertaken concurrently within each care home and proceeded in four stages following Lincoln and Guba (1985):

- Unitising- locating units of meaning within the text;
- Categorising-taking all the units of data and sorting them into ideas
- Member checks- feeding back the categorisation to participants
- Filling in patterns- searching for convergent and divergent opinion and seeking explanation for these discrepancies

Throughout this process, a methodological log was maintained to capture decisions as the research design emerged, providing an audit trail in an attempt to ensure dependability. (Lincoln and Guba 1985).

Findings

Three types of relationships emerged from the data (Table 2) and this aspect of the study has been reported more fully elsewhere (Brown Wilson 2007). The findings reported here reveal how the approach staff adopted during the process of care delivery became an important influence on the type of relationships that developed. These findings clustered around three methods of care delivery, described as individualised task centred, resident centred and relationship centred. The key processes within each method of care delivery revolved around how staff focused their care, either on the task, the resident or the relationships in the home.

For example, an individualised task centred approach meant that staff focused on the processes of 'Getting the job done' and' Getting to know the resident through the routines'often resulting in pragmatic relationships. Whereas a resident centred approach meant that staff focused on 'Finding out what matters to the resident' and 'Knowing why it is significant for the resident'created more personal and responsive relationships. A relationship centred approach focused more on the communal aspects of living by 'Developing shared understandings between staff, residents and families' and 'Developing an understanding of how 'we all' fit into the community'often enabling reciprocal relationships. Each of these processes and how they influenced relationships are summarised in Table 3.

Individualised task centred care

Getting the job done

Many of the staff who adopted individualised task centred care suggested that having a routine and 'getting the job done' ensured that the residents received good care. Staff who routinely worked in this way, did so because they believed this was the best way to deliver care to residents with complex needs. For these members of staff, the routines were particularly important:

> *'Well if you didn't have a routine, you wouldn't get the jobs done, like getting them washed and dressed in the morning, and getting them to breakfast for a certain time or making sure the pads are changed- because if they get into that routine, and if it is a certain time then you don't forget.'*
>
> *Ruth- Senior care worker- Holyoake*

Working in this way did not always provide staff with the motivation to develop personal relationships with residents as the focus was on the practicalities of the task:

'..we have four staff on constantly watching the residents. You have to be thinking about it(safety) at all times. So if a resident gets up and you know they're prone to falls you'll sit them back down, that way there's less accidents.'

Sally- Senior care worker- Holyoake

Some staff described how they built up knowledge about each resident through the personal care routines. This was particularly noticeable with new staff, which suggests that it was important for the staff to get to know the resident to ensure they received the individualised care that was needed.

Getting to know the resident through the routines

Staff described how they developed knowledge about each resident's personal care routine which sometimes occurred through a process of trial and error:

'You tend to know when he wants something because he's shouting. You guess, if he's in the dining room, it's because he wants another drink, he doesn't like what he's eating ...If he's in the lounge in the afternoon, and he's shouting, it's do you want to go to bed and sometimes he does, and then he nods his head...

Sian – care worker – Holyoake

Over time, staff became familiar with the personal routine of individual residents. In Chestnut Lodge, for example, some staff described how knowing the preferences of individual residents helped them anticipate what each resident might need:

Well everyone has a personal routine and you get to know when they like to get up or go to bed, or if they need a rest in the afternoon. Like now, it's getting near 10 so I know that James will need to go to the toilet, so I'll take him next.

Wayne -care worker Chestnut Lodge

My own observations suggested that for some residents, the consequence of having staff focus predominantly on the task was that their individual preferences were sometimes overlooked with the pressure of work. One resident in particular commented on the impact this approach had on her experience of meal times:

> *'I have dinner more or less on my own…I'm sitting there for ages before my meal and I have no-one to speak to. Then when I get it (my meal), the carers are always in a mad rush as though they haven't got time to do it.'*

Gwen-resident- The Beeches

Getting to know the resident through the routines was an important way for many staff to be able to deliver individualised care and for many residents and families, represented the bottom line. As this approach focused primarily on what needed to be done, it tended to result in pragmatic relationships between residents, families and staff. There were other staff who spoke about their care in terms of what was important to each resident. This suggested that they were focussing on the person rather than the routines, and this approach was labelled 'resident-centred'.

Resident centred care

Finding out what matters to the resident

Developing an understanding of the biography or life story of a resident, supported staff in seeing the resident as the person they had been, as well as the person they were now. This understanding appeared to emerge from stories that residents and families had shared or staff using belongings or photos to trigger conversations during care routines. Staff then recognised details of personal care that were significant to each resident. For example, one

staff member described how for one resident, maintaining her personal appearance was of great significance to her sense of identity:

> *'It's like Enid, with her earrings and necklace. You always ask which one do you want today and she'll say what do you think looks best and we have this little discussion and it's very important to her. She is 99, 98 now and that is a good thing that she is still interested in how she looks.'*

Ann Marie- care worker- the Beeches

Staff adopting this approach recognised the importance of doing 'the little things' in the residents' care routines and also recognised that these details had the potential to influence the quality of a family's visit. This attention to detail was commented on by some family members:

> *'There is some care taken with dress and it's just not go to the wardrobe and pull something out, but it does match and the earrings and necklace match.'*

Mark- son- the Beeches

Although these details were often small things, they had the potential to make a difference to each resident's experience:

> *'Well a little bit of lipstick, it cheers you up. Oh yes, I've always worn makeup and the girls, they'll sit on the stool and they'll put my cream on my face*.'

Dorothy- resident- Chestnut Lodge

Attending to details such as those identified in the preceding examples enabled staff to develop resident centred care routines. A further attribute of resident centred care was to

understand the residents' interpretation of what was happening in their daily life and how this influenced their behaviour and experiences.

Knowing why it is significant for the resident

In order for staff to understand what is important for each resident they needed to use the personal knowledge they had developed primarily through the care routines to interpret the resident's behaviour and responses. As staff developed their understanding of how each resident approached their life, they noticed when things altered for the resident and adapted their approach accordingly:

> *'Maggie gets very agitated because she needs to get back to her children and in her mind, they're young so she needs to get back and she's distressed. We can't tell her don't be so silly, the children are in their fifties now, because it's real to her. So we'll get the photo album out to try and explain how things have moved on and to relieve that distress.'*

Diane- care worker- Chestnut Lodge

Finding out what was significant to each resident and adapting this to the personal care of each resident supported the development of personal and responsive relationships.

Staff whose descriptions of their work suggested that they consistently adopted a resident centred approach to care delivery also described trusting relationships with residents and families. Many families also worked to support staff in 'seeing the person' by sharing personal details about the resident with them and acknowledging staff when they incorporated this information into the care routines. However, over the course of my observations in each home it became apparent that when the focus of care was exclusively on the resident, it did not always take into account the needs of other residents, staff or families.

Furthermore, in a communal environment it was not always possible to meet all the needs of individual residents at the same time. When this occurred, some staff were seen to use an alternative approach to organising care that seemed to take account of what was significant to all residents, as well as taking into consideration the needs of staff and where appropriate, the needs of families. This approach was labelled 'relationship centred care'.

Relationship centred care

Developing shared understandings

The process of developing shared understandings included the planning and organisation of care routines to take into account the needs of all residents, staff and families. For example, care routines were organised in ways that acknowledged the personal priorities of each resident. This enabled all staff to be in the right place close to the right time when specific residents would need support. Staff who worked in this way described their satisfaction in being able to achieve this with the shift running smoothly. Families appreciated the efforts of staff to meet everyone's needs and recognised that the staff were trying to do the best for all residents in the home. Therefore, anticipating each resident's needs had the potential to ensure that everyone's needs were met:

> *'They'll tell you, I like to go to bed at 8 or I prefer 9-half past, so that's how you arrange things.. and we know if they prefer their baths earlier or later. For example Mary, you know to go to her on a Tuesday at 8 sharp, you just know for instance it's Mary's bath and she likes it first so you go to her first.'*

Jay- Senior care worker – the Beeches

When the work was organised to take into account the personal routines of each resident, it was possible to develop a communal routine throughout the home. Many residents were

then able to see their own routine in the context of the communal routine. This had the potential to lead to a shared understanding between staff and residents:

> *'Mary asked me today if Gwen was up yet, I said 'no', so she said 'fine, I know you'll come to me when Gwen is up' and went back into her room. I was surprised at that.'*
>
> *Jilly- Senior care worker- the Beeches*

This suggested that having a communal routine allowed for acts of reciprocity on the part of residents and families that went beyond the cared-for / caregiver relationship.

Shared understandings also appeared to lead to negotiation and compromise, which had the potential to support the development of reciprocal relationships. For example, in the Beeches, if the needs of a resident could not be met in a way they would expect, staff began a dialogue with the resident which moved beyond a simple statement such as, 'there are others I have to deal with first' to include an explanation of why the needs could not be met at that time with alternatives being offered. As the needs of both the residents and staff were identified, this enabled a compromise to be reached that provided for everyone's needs within the relationship:

> *Just now I asked and they said can you wait until we get Gwen down and I said yes, so they got Gwen down and then they took me. I would hate to think that Gwen was stuck upstairs because I had to go to the toilet.'*
>
> *Betty- resident – the Beeches*

This comment suggested a shared understanding of the needs of others within the home, providing this resident with the opportunity to engage in reciprocal activity within her relationships with staff and other residents.

Getting to know how we all fit into the community

A feature of relationship centred care was the ability of staff, residents and families to recognise themselves as members of the community within the care home. This process began with the recognition that they and others were able to make a valuable contribution to the community within the home. This was particularly noticeable when staff involved both residents and families in social exchange that included the use of humour:

> *'A few of us carers, we have a sense of humour and we bring that to our work. I think it is good to get the adrenaline going in older people. It shows what spirit they have left.'*
>
> *Gayle – care worker Chestnut Lodge*

I also observed that the use of humour enabled residents and families to contribute towards the atmosphere in the home, developing relationships at a social level. This was further supported by staff recognising the contribution that residents were able to make to life within the home through relationships they developed with each other:

> *'..it did evolve, as time has gone on, Gwen's mental state has improved and obviously you want to put two like minded people together and it just crept up on us really that they could talk to each other. And then you want to put people where they can converse with each other and she can hear Freda.'*
>
> *Jane- Deputy Matron(Registered Nurse) – the Beeches*

At the Beeches, this approach was observed fairly consistently with different groups of residents. Within the shared understandings that developed, the needs of staff, residents and families were acknowledged. Staff, residents and families each felt they were able to make a contribution towards the care of themselves or others, which supported the development of reciprocal relationships.

Discussion

The findings reported in this paper suggest that relationships often develop in the context of care routines and the approach staff adopt in the delivery of care is an important influence on these relationships. Each of the methods of care delivery (Table 3) were evident across the three homes. However, it was the method routinely adopted within each home that appeared to influence the type of relationships that developed between staff, residents and families. When staff adopted a resident centred or relationship centred approach to care, there was some evidence to suggest that these methods of care delivery supported the most positive experiences for residents, their families and staff. Although residents and families often made contributions towards the different types of relationships, unless these contributions were recognised by staff, it became difficult for residents or families to influence the relationships that developed (Brown-Wilson 2007).

Across the care homes in this study, care routines were described by many residents, families and staff as markers in the day providing structure and organisation. Zisberg et al (2007) suggest that the need for structure and routine may reflect an individual's lifestyle or identity. Within the study reported in this paper, many staff attempted to support residents in maintaining their personal routines. This enabled staff to provide individualised care, which was often described in terms of the residents' needs for personal hygiene and support with eating and drinking. Individualised care has a strong tradition in nursing as a means of

humanising care and increasing job satisfaction of nurses (Reed 1992). Creating an individualised but practical routine of care was most evident where staff identified the value of being able to meet the complex needs of residents through having a clear structure to the day. Indeed, having a structure to the day has been described elsewhere as enabling staff to focus more on the individual needs of residents (Haggstrom et al 2005). The current study suggests that care can be individualised, but that if the focus is on the task, rather than why it is important to the person, then pragmatic relationships will develop. While some staff, residents and families preferred this method of care delivery, there was also some evidence to suggest that it provided the least positive experiences for residents and families within this study.

Many residents, families and staff in this study valued the development of personal and responsive relationships, which were developed when staff engaged in resident centred care. The process of finding out what mattered to each resident moved the focus beyond the instrumental notion of individualised care to understanding the implications of care for that person. Bowers et al (2001) describe a similar approach as ‘care as relating’ where care workers’ used their personal relationships developed in the care routines to attend to the little things residents found important. This was also described by staff in the study reported in this paper, who recalled stories shared by residents and their families which helped them understand the type of person the resident had been and what was important to them now. This information was then used to improve the experience of the resident in ways that were meaningful to them. Hartig (1998) also described how expert Nursing Assistants (NA’s) encouraged residents to reminisce as a way of developing personal knowledge that could be used in personal care routines. This was described as individualising care through combining functional care activities with a resident centred care approach, which led to positive

relationships (Hartig 1998). Residents who experienced resident centred care in the current study also described personal relationships with these members of staff framed in terms of friendship, love and caring.

Residents and families in my study also described how they developed confidence in staff members who did what they said they would do. Relationships have been found to be enhanced for residents and families if caregivers are reliable, empathic and consistent in their approach (Sandberg 2002, McGilton et al 2003). Developing confidence in staff was generally based on their past experience and contributed towards the development of trusting relationships. The development of trust has also been described in the context of close and personal relationships between care providers and residents in care homes by McGilton and Boscat (2007).

In the study reported here, when staff engaged in relationship centred care, the care routines were organised in a way that anticipated the needs of individual residents in the context of other residents and the wider organisation. This enabled the development of reciprocal relationships. Ronch (2004) suggests that reframing the emphasis from the task of care onto the relationships between residents and staff has the potential to benefit those in the relationship. Within the current study, this became apparent when residents and staff spoke about their relationship in terms of the care being provided and what each brought to the relationship. Reciprocal relationships emerged as staff engaged in negotiation with residents and families and other staff as each person in the relationship was able to recognise their contribution and how it affected others within the community. Moreover, residents and

families appeared to be encouraged to enter into reciprocal relationships when staff adopted a relationship centred approach to care.

Implications for practice

Transforming findings from research into clear messages for staff, residents and families is necessary if we are to influence experiences within care homes. How relationships are developed, is often difficult to articulate and placing this into an everyday context is the first step in making the findings from this study accessible. Furthermore, Ronch (2004) suggests that putting the spotlight on the everyday practice of staff has been found to be a powerful way of setting the process of change in motion. This study has described how the staff approach to care delivery has the potential to develop different types of relationships within care homes that may improve the experience of residents, families and staff. Therefore it is essential that care staff critically examine the approach they are adopting to ensure that it is consistent with the most positive care experiences.

Brooker (2004) suggests that developing person centred care for people with dementia, requires valuing the person and those who care for them, looking at the world from the person's perspective and promoting a positive social environment that supports the well-being of the person. These principles have also been identified as having relevance to all older people in care homes (Ashburner 2004) although there remains limited guidance in the literature as to how this might be achieved. Examples from everyday care routines described by staff, residents and families as resident centred care in this paper suggest how these principles could be embedded in the daily care routines of care homes.

Nolan et al (2006) suggest the value of taking into account the interdependence of relationships in care environments for older people, using relationship centred care. Relationship centred care as described in this paper involved negotiation that took into account the needs of everyone involved, as well as the context of the wider community. This meant that the contributions of residents, families and staff were valued, encouraging each person to make a contribution to the wider community of the home. This suggested interdependence between residents, families, staff and the wider community of the care home. Therefore, care routines may be a useful starting point to support the development of relationship centred care when caring for older people.

This study has the potential to encourage staff to see resident centred and relationship centred approaches to care as part of the everyday routines rather than doing anything 'extra'. If the experiences of older people, families and staff are to be improved in care homes, a starting point may be to adopt a relationship centred approach to the care routines. There have been few studies that consider how relationship centred care could be delivered in care homes. The findings from this study provide a starting point in demonstrating how enabling relationships may be developed within care homes creating a positive experience of care for residents, families and staff. This would suggest that the study reported here progresses our understanding of how resident centred and relationship centred care might be operationalised within care homes for older people.

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Table 1: Key features of care homes

FEATURE	CARE HOME 1 The Beeches	CARE HOME 2 Holyoake	CARE HOME 3 Chestnut Lodge
Number / type of places	28 places Self funding residents with complex physical health care needs and some with cognitive frailty. A high proportion of residents requiring full time registered nursing care	70 places Home for residents with enduring mental health issues and complex health care needs. A high proportion of residents requiring full time registered mental health nursing care	28 places Residents with complex health needs including mental health problems. A high proportion of residents requiring full time registered nursing care
Ownership	Family owned home with employed Matron	First home acquired in a large chain	Family run home with Owner/Matron
Location	Rural area, poorly served by public transport	Situated on an industrial estate in an outer suburb	Rural area poorly served by public transport
Buildings	Converted Georgian Manor	Purpose built with recent extensions	Converted farm buildings
Staff	There was only one registered nurse on duty each shift. Many care staff were mature with life experience but no formal qualifications. Senior care workers had a National Vocational qualification in care work and were designated to	There was one registered nurse on duty for each unit each shift,with at least one Registered nurse in the home having a specialist mental health qualification, on each shift. Senior care workers had a National Vocational qualification in	There was only one registered nurse on duty each shift. Many care staff had a national vocational qualification but there were no designated senior care workers managing the day to day sift

	manage the delivery of personal care	care work and were designated to manage the delivery of personal care	

Table 2 Typology of relationships

Pragmatic relationships	focused on the practical nature of caring, with communication revolving primarily around the task at hand
Personal and Responsive relationships	focused on respect for who the resident was, with communication involving social conversations with both residents and their families
Reciprocal relationships	featuring negotiation and compromise which took the needs of staff, residents and families into account within a trusting relationship.

Table 3: Summary of the three types of care

The type of care	The key processes involved
Individualised task centred care- where the staff developed an understanding of the residents' personal preferences and how to provide for this in their care.	• Getting the job done • Getting to know the resident through the routines. • This approach often resulted in pragmatic relationships between staff, residents and families.
Resident centred care- where the main focus was on why the routines or important details were significant to that resident as a person.	• Finding out what matters to the resident • Knowing why it is significant for the resident. • This approach often resulted in the development of personal and responsive relationships between residents, staff and to a lesser extent, families.
Relationship centred care- the focus moved beyond the needs of individual residents to recognise the significance of all members of the care home community and the relationships between them.	• Developing shared understandings between staff, residents and families • Developing an understanding of how 'we all' fit into the community. • This approach seemed to develop reciprocal relationships.