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What Works is What Matters:
An ethnographic study of how care workers in care homes learn to care for people living with dementia

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by

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Abstract

The core work of care homes for older people in the UK is increasingly dominated by dementia care. This trend is likely to continue as residential care is often the only option available to meet the needs of many people living with dementia, particularly in the later stages of the condition as a person requires 24-hour care. The day-to-day support provided in residential care is primarily delivered by non-professionally qualified staff, with in-work, competency-based training the key means of developing skills. Current policy, guidance and regulation emphasises the importance of formal training for care workers to improve the quality of care for people living with dementia in care homes. Care home organisations make decisions based on this guidance, and research primarily focusses on the effectiveness of that training and education.

Whilst there is evidence that training positively impacts on care practice and quality in some circumstances, broader understandings and investigations of workplace learning indicate that learning to work is not predominantly a formal experience shaped through training, but is instead characterised by informal opportunities linked to everyday events, interactions, and problem-solving in the workplace. These other factors are highly influential in determining the practices workers learn when engaged in their day-to-day work. However, there has been only limited research addressing this alternative view of learning within care work generally, or from the perspectives of care workers in the context of care homes and the needs of people living with dementia. Without an understanding of *'learning to care'* that includes the perspectives of those who live and work in the care home, and accounts for the impact of the care home context, there is a risk that attention and resources will be focussed on measures that may have only modest impact on the quality of care-giving.

This thesis addresses this gap by answering the question: ***how do care workers in care homes learn to care for people living with dementia?*** The study used focussed and critical ethnography to explore the landscape of learning to care within two care homes. Over a period of 14 months the researcher spent 1-2 days per week engaged in fieldwork. Overall, this produced 45 hours of ethnographic observation (encompassing weekdays, weekends and overnight shifts), 18 hours of observations using a focussed dementia-specific observation tool, and semi-structured interviews with 15 staff members, including 9 care workers. Data were analysed thematically both by hand and using NVivo 11 computer software.

The findings from this study showed that care workers experience a multi-level learning process, encompassing three key themes. At the micro-level, workers learn during the day-to-day conduct of their work through a mechanism labelled **"what works is what matters"** in which they apply, reinforce or reject learning based on whether it is of use in successfully resolving the situations they encounter. Employed within this micro-level process are three components representing the skills, knowledge and experience available to workers: *personal resources, resident influences* and *cultural knowledge*. Cultural knowledge consists of macro-level influences generated primarily from a worker's **"interactions with colleagues"** and secondarily their **"training".** Significantly, this interaction between the micro and macro level enables the organisational culture of the particular care home to strongly influence the care practice learned by workers. Furthermore, this process shows that informal means of learning predominate within the care home, often acting as a mediator on the impact of formalised training and instruction. In particular, the flexible, interpretive and relational work required by person-centred approaches to people living with dementia specifically emphasise these informal means.

Following description and discussion of these findings in relation to prevailing theoretical and empirical understandings of person-centred dementia care, recommendations are made for how to reconceptualise approaches to care worker learning in light of the study's discoveries. A Learning to Care System that maximises the opportunities provided by specified informal learning methods and responds to the influence of care home culture on learning will be better placed to enhance the quality of care practice and the care experiences of people living with dementia in care homes.

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My mum and brothers have followed my PhD goal and its demands on my time, finances, and good humour for more than 20 years. Thank you for teaching me to never give up.

This journey started in a care home many years ago and the influence of residents and staff I have had the pleasure of working with over the years is woven throughout these pages. A journey of a thousand miles begins with a single step, even if you don't realise it.

Dedication

*This is dedicated to **S** and **S** for your constant reminder of what is really important in life. Sitting at my desk writing this thesis was never as much fun as when you interrupted me.*

Also,

for Sarah J. who is a lighthouse in stormy seas and to whom I will always be grateful.

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Chapter 1: Introduction

1.1 Background to the study

Dementia is an international concern due to its current and projected prevalence (Alzheimer's Disease International, 2015). In the UK, there are an estimated 850,000 people living with dementia with this figure anticipated to rise to over a million by 2025 (Prince *et al.*, 2014). Of the £26 billion cost of dementia to the UK economy only £4 billion falls on the National Health Service, with the remainder accounted for by social care and individuals living with dementia and their families. Residential care costs are primarily included within these private and social care costs (Prince *et al.*, 2014). It is not the favoured care solution, with government policy and practice preferring care in people's own homes for both financial reasons and to promote service-user choice (Department of Health, 2009; *The Care Act*, 2014). Nonetheless, care home and nursing home placement is still an option relied upon by many, often towards the later stages of the condition when physical and psychological care needs increase and cannot be met without 24-hour care. 39% of people living with later-onset dementia reside in care homes, constituting approximately 70% of the care home population, having risen over the last decade (Matthews *et al.*, 2013; Prince *et al.*, 2014).

Defining and achieving quality in dementia care is therefore a necessary adjunct to these statistical and governmental pressures, with person-centred care established as the desired standard and captured in national policy, guidance and regulation for health and social care with increasing emphasis throughout the last decade (Commission for Social Care Inspection, 2008a; Care Quality Commission, 2010a, 2017; NICE, 2018). Improving quality and eradicating poor practice in residential care has long been a stated aim of care provider services, policy-makers and regulators (Commission for Social Care Inspection, 2008a; Department of Health, 2009; Care Quality Commission, 2015; Department of Health, 2016). However, whilst there have been improvements in the sector and outcomes for residents living with dementia, it remains a challenging goal with poor quality care being uncomfortably common (Cooper and Selwood, 2009; Care Quality Commission, 2010a; Baruch *et al.*, 2011; Cooper *et al.*, 2013; Tingle, 2013; Manthorpe, 2015; Manthorpe *et al.*, 2016).

Training for the social care workforce is identified as a primary route to improving the quality of care for people living with dementia (and others), particularly given the low pay, low status and

high turnover that characterise this workforce (Bottery, Ward and Fenney, 2019). Across the last decade the development of common induction standards (Skills for Care, 2010), national standards for training (Skills for Care and Skills for Health, 2013), and the Care Certificate (Health Education England; Skills for Care; Skills for Health, 2014; Skills for Care, 2016), indicates that building capacity through training for this 'unskilled'[1] workforce is viewed as a key performance indicator and a route for quality improvement. The Care Quality Commission (CQC) use formal training as a good practice indicator for the sector (Care Quality Commission, 2010b, 2010a, 2015, 2017). Specific to dementia care, the National Dementia Strategy emphasised the need for specialist training to improve person-centred care (Department of Health, 2009) and this was followed by substantial research into training practice (Surr and Gates, 2017; Surr *et al.*, 2017) and the development of a national dementia training framework (Skills for Health, Health Education England and Skills for Care, 2018). The forerunner to the CQC, the Commission for Social Care Inspection (CSCI) also established a significant relationship between staff training and the well-being of people living with dementia in care homes (Commission for Social Care Inspection, 2008b, 2008a). However, this emphasis on training belies an assumption that 'learning to care' is a process chiefly directed and influenced by formalised educational approaches. This assumption sits juxtaposed to empirical and theoretical literature related to learning within workplaces, in which the contexts, relationships and informal interactions of 'doing work' are identified as ubiquitous, inevitable and highly influential for individuals' practice (Billett, 1998; Rogers, 2003; Eraut, 2004; Marsick *et al.*, 2009). This academic juxtaposition is something that has also been paralleled in my own real-world experiences in dementia care.

1.2 The researcher

This brief overview of the dementia care scene provides the backdrop for my own personal and career journey, with this thesis a product of both external developments and my own involvement with them. I first (knowingly) encountered people living with dementia in 1997, in my first full-time job as a care worker in a residential care home. For the next 5 years I continued to work in this home and others, as well as domiciliary services. This period saw considerable

[1] I am uncomfortable with the 'unskilled' description often used for care work because I believe it ignores the highly skilled practice that occurs every day in the sector. However, it is a common description used to distinguish between roles with pre-requisite qualifications and those, like care work, that do not require them. Nonetheless, I hope this study will go some way to describe the skilled work inherent to supporting people living with dementia.

changes to the social care sector with legislation creating the National Care Standards Commission and for the first time establishing national minimum standards, registration and regulation of care homes in England (*Care Standards Act*, 2000). This followed a number of high profile cases of institutional abuse and neglect of vulnerable people (Department of Health, 2000; Pring, 2003). Unexpectedly, my experiences during this time, both good and bad, were to shape my future in significant ways.

I can still remember the names of many residents I cared for during this time, and particularly the moments of joy and despair that seemed to simultaneously accompany dementia for both carer and cared-for. I remember colleagues too, perhaps with more clarity, because it was they who shaped my practice the most, providing both positive examples and fostering bad habits and poor standards. These experiences had a profound effect on me as I struggled to reconcile my desire to be a good care worker with environments and influences that were often poor and occasionally terrible. I did not always succeed. Nonetheless, when the time came for me to leave the sector and begin, what was notably referred to as, a 'proper' job, I did not want to leave. I was also acutely aware of the opportunities I had that were not available to many of my former colleagues, primarily because of my education.

Since then, several roles in advocacy, training and research have brought me into contact with people from all walks of life who faced the challenge of dementia, and many, from more disparate backgrounds, who provided their care and support. In talking to, training and researching alongside these people my passion for dementia care and the workers who provide it has only intensified. In particular, I have been an active participant in the increasing attempts to improve care quality through standards, training and research evidence. All the while, however, I have been aware from both direct experience and my contact with care workers and care organisations, that providing good quality care is as complex as the people giving and receiving that care; and that this complexity is often underestimated by educators, organisations, policy-makers and society. Moreover, I have been continually reminded that that the strongest influences are those encountered every day, and that organisational and systemic deficiencies create the boundaries of what seems possible for an individual worker. Therefore, when the opportunity to finally embark on my PhD presented itself, I knew that I wanted to look beneath the surface of care work and excavate the circumstances that influence how a worker learns to provide care for people living with dementia, with the aim of harnessing this towards improved quality and explaining the expertise inherent to good dementia care.

1.3 The research problem

The conundrum I decided to examine within this study was therefore a product of both external circumstance (a strong rhetoric and resourcing of training as a route to quality improvement) and personal experience (that getting dementia care right, when viewed from the 'shop floor', can be complex and challenging). This coincidence is significant because it influenced both my topic and methodological approach by introducing key conditions for the study if it was to address my curiosity as well as provide an original contribution to knowledge in this area. These conditions were as follows:

- The findings needed to be grounded in the day-to-day reality of dementia care in care homes.
- The exploration process needed to prioritise the experiences of care workers themselves and their typical provision of dementia care alongside those who receive that care.
- The approach needed to be open to influences on learning that may not be allied to formal education and training and may not be conventionally understood as influencing quality of care.

Therefore, these stipulations resulted in an overarching aim to explore the insider and contextualised perspectives of those living and working in care homes in reference to how 'learning to care' takes place. This was with the intention to make recommendations for how to best influence and organise learning for care workers. This thesis therefore provides an account of my focussed and critical ethnographic study exploring the question **how do care workers in care homes learn to care for people living with dementia?**

1.4 Overview of this thesis

This thesis is written in seven chapters. Chapter 1 briefly introduces the research problem and the researcher, setting the scene for the whole study. Chapter 2 uses relevant literature to contextualise the research problem within what is currently known about dementia care, care worker learning and learning in the workplace. Chapter 3 situates my study within a methodological framework, addressing the foundations and implications of my choice to undertake a focussed and critical ethnography. Chapter 4 describes the specific methods used in the study through recruitment and selection, data collection, data analysis and ethical

considerations. Following this, chapter 4b introduces the reader to the two care homes I visited for the study. Chapter 5 presents my findings, demonstrating the three themes of the learning to care process. Chapter 6 discusses these findings within the context of current understandings of dementia care and learning, making recommendations for reconceptualising learning to care. Finally, chapter 7 concludes this thesis by summarising the study, addressing its limitations and identifying implications for the field and for myself as a researcher. References and appendices follow and are referred to throughout all chapters.

Chapter 2: Conceptualising learning to care - a review of the literature

This chapter considers the relevant theoretical and practice context of learning and dementia care. This is with the intention of outlining what is already known about learning to care and illuminating the gaps in knowledge. This literature review was initially conducted at commencement of the study (November 2012-March 2013), in order to demonstrate the proposal's originality. It was updated in January 2019 to re-conceptualise the study's relevance in light of the time that had passed since its inception. Details of the literature searches undertaken are provided in Appendix 1. However, it is important to note that the development of research interest, question and approach have been many years in the making and it is not a linear process from examining literature to formulating questions to undertaking fieldwork. Instead this process is best considered as iterative, in which each new discovery prompts a reinvigorated questioning of previous knowledge and a refocussing of future enquiry. This process was intensified as a part-time PhD, undertaken alongside work in the dementia care field that encompasses both education and research within care homes.

The topic of interest sits at the intersection of three areas of literature incorporating policy and practice guidance as well as theoretical and empirical studies:

1) **Care and care quality in the context of dementia**: It is necessary to establish what the prevailing standard of 'care' for people living with dementia in care homes actually is. Learning *how* implicates learning *what* and so issues of definition, differing perspectives and operationalising theory into practice are significant.

2) **Learning in care work**: It is important to explain and critique how learning by care workers[2] is currently understood, influenced and investigated in the field of dementia care.

[2] There are a several job titles synonymous with 'care worker' in UK and international literature, (e.g. nursing assistant, care assistant, support worker). For simplicity 'care worker/s' is used throughout providing the job role referenced was primarily responsible for providing direct care to residents and required non-specialist expertise (where specialist expertise is denoted by formal qualifications such as a nurse).

3) **Adult and workplace learning**: This body of knowledge, though not directly related to dementia care, has relevance for learning by care workers. As such it is necessary to identify concepts and methodologies that may be applicable to how care workers in residential care[3] learn to care for people living with dementia.

Each of these domains will now be reviewed in depth.

2.1 Defining care and care quality in the context of dementia

In examining literature addressing quality in dementia care it became clear that understandings as to what constitutes quality, as well as factors that determine its successful implementation, are varied and it appears to be a challenging concept to operationalise successfully. This has implications for the expectations and learning by those charged with delivering this quality care as their daily work. Within this section, questions of quality in residential dementia care are addressed, and factors associated with such quality explored, with the intention of drawing conclusions as to how care workers may learn such care and how best to investigate such a phenomenon.

2.1.1 Person-centred care: defining subjectivity

Theoretical understandings of quality in residential dementia care stem from the concept of person-centred care, (PCC) particularly in the UK. PCC is enshrined in national guidelines (NICE-SCIE, 2006; Department of Health, 2010; NICE, 2018) as the ideal for achieving quality care and well-being for people living with dementia. However, it is notable that, even at a theoretical level, debates exist regarding the concept and the ways in which it is, or should be, translated into care practice. Moreover, the complexities inherent in both defining and achieving quality care are further emphasised when examining different perspectives on quality, the variable impact of person-centred interventions on quality of life (QOL) measures, as well as practical challenges faced in implementation. Whilst notions of PCC for people living with dementia are well-embedded in the language and aspirations of policy-makers, care services and individual workers, at the very core of a 'person-centred' approach is a subjectivity that makes 'quality' complex to define, let alone enact. To a certain extent, quality care can be said to be in the eye of the

[3] Again, there are various terms for 'care home' in UK and international literature, (e.g. aged care or nursing facility). For consistency, the common UK terms 'care home' and 'residential care' are used throughout, unless the name indicates something specific (such as the nursing registration of a nursing home in the UK).

beholder: if quality is achieved by centring the person, then determination of that quality (particularly in terms of everyday actions as opposed to broad concepts) sits with the person themselves and their own unique needs and desires.

Challenging the then-dominant biomedical model of dementia care, Kitwood (1992; 1997) is acknowledged as articulating the foundations of PCC for dementia. Essentially, in PCC, well-being for someone living with dementia is achieved when care practices are directed towards maintaining the personhood of the individual, despite increasing cognitive deficits. It requires non-judgemental, supportive care-giver attention to different facets of a person, their relationships and their environment as opposed to a focus on the neurological and functional deficits caused by dementia (Kitwood and Bredin, 1992; Brooker, 2003). Kitwood (1997) identified practices, termed malignant social psychology, that occurred within care settings and which undermined the personhood of those receiving care. He saw these practices as habitual and unquestioned becoming endemic and normalised within an environment without efforts to counter them. More recently, Sabat (2019) highlighted that this malignant positioning remains familiar despite more sophisticated understanding of functional capacities in dementia and the communication practices that can enhance a person's remaining skills.

Within this understanding of PCC, quality of care and QOL are closely related, with this relationship intensifying as a person becomes more dependent on others for daily living. A study interviewing people living with dementia in care homes emphasised this interconnection as residents identified influencers on QOL (maintaining independence, being occupied and opportunities for social interaction) that were facilitated or restricted by the functioning of the care home (Moyle *et al.*, 2015). As such, "quality of care" becomes defined by the subjective experience of that care by those receiving it and by whether it results in a bolstering or undermining of their personhood. Therefore, achieving QOL for a person living with dementia in residential care requires a constantly attentive, reflective and flexible approach to care-giving that adapts to the moment-by-moment experiences of recipients. Cheston (2019) emphasises this need for flexibility and reflection when re-visioning Kitwood's work by highlighting the relevance of attachment styles (of both carer and cared-for) in interpreting and responding to behaviours that can occur in dementia.

Furthermore, PCC also requires an understanding and acceptance of 'personhood' as something tangible, achievable and the result of interaction and relationships with others from a stance of positive regard (Rogers, 1961; Kitwood, 1997; Brooker, 2003). Kitwood himself acknowledged the complexity stemming from such subjectivity, and placed its navigation by care workers at the

heart of successful quality care. Consequently, workers undertaking person-centred care had to be equipped for such navigation, demonstrating a "high level of personal and moral development" rather than merely "bolting on a body of knowledge or imparting a set of skills in a semi-automated fashion" (Kitwood and Brooker, 2019 pp 154). Building on Kitwood's psychotherapeutic take on staff development, Keady and Elvish (2019) highlight the more recent realisation of the significance of mental health and well-being on staff performance in caring professions. Moreover, a qualitative exploration of care workers' own personhood advances these issues, highlighting that workers' own personhood is often ignored by employing organisations (Kadri *et al.*, 2018), this adding another crucial component to the complexity of achieving personhood in care environments. Can someone whose own personhood is challenged really enhance another's in any sustainable way? This suggests that when considering how workers may learn to provide PCC, we need to look beyond conceptions of learning that focus on knowledge acquisition or task competence towards understandings that allow exploration of the care-givers' navigation of subjectivity, the resources they can bring to bear (including their own sense of personhood), and the workplace influence on these. It also suggests that exploration of this topic must centre worker perspectives and allow for the ever-shifting, social meaning-making processes that are inherent to maintaining personhood in dementia through relationship.

2.1.2 Person-centred care: perspectives

The challenge of neatly defining quality care is further emphasised when examining different perspectives on QOL and PCC that exist and play out within everyday life in care homes. A study examining the concept of PCC as described by people living with dementia, their family members and care staff suggests that PCC was seen from all perspectives as about promoting 'a continuation of self and normality', which required knowledge of the person, meaningful activity and personalising the environment (Edvardsson, Fetherstonhaugh and Nay, 2010). Whilst this would indicate that there is common ground in interpretations of PCC, this research explicitly focussed on coalescing views rather than highlighting divergences. Notably, in some of the concrete aspects of 'continuation of self and normality', subtle differences emerged within the different perspectives. In raising the need for flexibility and continuity in providing care, family and staff members spoke of a need for flexible routines in providing care, whereas residents living with dementia and family members raised a need for consistency in staffing and staff being able to be present with residents (Edvardsson, Fetherstonhaugh and Nay, 2010). Whilst this is not a drastic divergence in perspective, nor a suggestion that prioritisation of one aspect indicates rejection of another, it illustrates that understandings of PCC are multi-faceted and likely to be

based on consideration of different factors depending on perspective. This highlights that defining PCC is neither simple nor objective and may require negotiation of contradictory tensions related to people's unique experiences.

This complexity is reinforced by research examining perspectives on QOL more generally for people living with dementia in residential care. Quantitative studies have sought to identify factors associated with QOL ratings, comparing perspectives of residents and staff (Hoe *et al.*, 2006) and residents, family members and staff (Crespo, Hornillos and de Quiros, 2013) . These studies identified discrepancies between different perspectives, noting that neither staff nor family were appropriate proxies for residents. More significantly, when considering quality, higher QOL was associated by residents themselves with lower levels of depression and anxiety. However, whilst this association also existed in staff perspectives, both staff and family members associated QOL with physical independence and functional capacity, when residents did not (Hoe *et al.*, 2006; Crespo, Hornillos and de Quiros, 2013; Beerens *et al.*, 2016). Furthermore, lower family proxy-rated QOL was predicted by family contributing to care fees and longer residency (Crespo, Hornillos and de Quiros, 2013; Robertson *et al.*, 2017) and staff proxy-ratings were lower when their own distress was higher (Robertson *et al.*, 2017). Assessing QOL in severe dementia further demonstrates this complexity with Clare *et al.* (2014) concluding that variability in family-proxy ratings was rarely explained by the most commonly assessed aspects of resident experience. These studies not only demonstrate the challenges of measuring QOL but also emphasise again that understandings of QOL and care cannot be assumed as universal, because they are based in subjective, lived experiences: What a person considers to be QOL (and thus how that will be achieved within care-giving), is multi-faceted, and influenced by personal context. Furthermore, this indicates that quantitative approaches are methodologically ill-suited to exploring an issue as subjective as 'quality' and that extrapolating individual preferences from group findings is problematic.

A number of qualitative studies exploring QOL in residential dementia care further demonstrate that, whilst a broad consensus exists, differences remain in terms of concrete aspects of daily life. When such differences exist, care (and thus care workers) will need to manage and resolve them, resulting in shifting, context-dependent definitions of quality (Kalis, Schermer and van Delden, 2005; Dröes *et al.*, 2006; van Zadelhoff *et al.*, 2011). For example, using interviews with residents and professional care-givers, Droes *et al.* (2006) identified that people living with dementia were specific about aspects of life such as privacy, social contact and activity-type that contributed to quality whereas staff were more general in their understandings. Van Zadelhoff *et al* (2011) used interviews and observations to identify both similarities and differences in resident, family and

staff perspectives on QOL. Differences could result in practice dilemmas to be resolved as part of the day-to-day life of the home. Comparing care staff interviews with organisational mission statements, Kalis *et al.* (2005) state that, despite some overlap, different values existed resulting in necessary decision-making by staff to resolve them in practice.

Even when examining specific aspects of care this variable and shifting concept of quality remains, seemingly aligned to the context and experiences of individuals, strengthening the argument that the inherent subjectivity in operationalising PCC creates potential for dilemmas that care workers have to solve in day-to-day practice. For example, focussing on the impact of the environment in dementia care, Garcia *et al.* (2012) used focus group data to establish that, despite shared opinions on barriers and facilitators, staff prioritised mix of residents and physical design whereas families perceived staff training as most significant to quality. Activity and occupation is another specific aspect of care shown to positively impact QOL for people living with dementia (Smit *et al.*, 2016). However, again, subtle discrepancies exist in the detail. Harmer and Orrell (2008) explored what staff, family and residents viewed as meaningful activity, finding potential contradictions: residents emphasised the psycho-social impact as essential to meaningfulness, whereas staff and family prioritised the physical nature. Further to this, higher passivity in activity engagement was found to be negatively associated with QOL (Beerens *et al.*, 2016) and residents engaged specifically in everyday activities (such as clearing the table, watering plants) had significantly higher QOL (Edvardsson *et al.*, 2014).

Furthermore, using a series of workshops with health and social care professional, Manthorpe *et al.* (2010) identified that dilemmas consistently arose in dementia care regarding views on dignity and QOL, again emphasising that commonly used concepts are far from universally understood and often contextually negotiated. Ethnographically investigating the dilemmas of dementia care in-situ, Hertogh (2004) explored interactions related to 'truth-telling'. She concluded that such moral dilemmas were regular occurrences and often resulted in difficulties in care-giving. A review into truth-telling within dementia care also emphasised that such dilemmas were common place (Kartalova-O'Doherty *et al.*, 2014). These common practice dilemmas would suggest that a fundamental aspect of quality care-giving for people living with dementia relates to how such dilemmas are negotiated in practice. Such dilemmas, whether the result of dementia (such as truth-telling) or the nursing home context (such as sharing resources), are argued to result in 'moral stress' for those having to resolve them on a daily basis. To resolve them effectively requires more than the competency of the worker themselves, and is dependent on a number of potential contextual constraints including organisational culture, structure and leadership (Bolmsjo, Edberg and Sandman, 2006; Killett *et al.*, 2016; Brooker and Latham, 2016).

In examining literature relevant to defining quality in dementia care, it is clear that interpretations of quality in real-life produce an ambiguous picture. Most importantly it is persuasive to argue that that they cannot hope to be unambiguous, because by its very nature, quality is subjective to the individual, their circumstances and experiences. In care settings this ambiguity is accentuated by the multiple perspectives and influences involved. This is not to argue that identifying and seeking quality is foolhardy or futile, but instead to assert that when examining how quality might be achieved, for example through staff learning, one must acknowledge this ambiguity and how it is negotiated in-situ. This directs towards an exploration of ambiguity, subjectivity and how meanings are created, shared and negotiated and this has consequences for how a phenomenon such as learning to care is both conceived and methodologically pursued.

2.1.3 Person-centred care: implementation

The complexities of defining quality in dementia care contribute to the challenges of implementing PCC at an individual and organisational level. Kitwood (1997) himself acknowledged the impact of the organisation on the successful achievement of PCC, particularly highlighting that the ways in which organisations interact with their staff determined how those staff could enact care-giving. In the context of a societal legacy of poor institutional care for vulnerable people, achieving quality outcomes for people living with dementia required a culture shift in how care-giving organisations conceived, organised and delivered care (Kitwood, 1997; Kitwood and Brooker, 2019). Building on these understandings and in recognition of the difficulties apparent in operationalizing them, a number of models developed to support desired culture change. Most notably, the V.I.P.S[4] framework attempts to articulate PCC in concrete terms highlighting the necessary relational value base, individualised approach to assessing and meeting needs, and the importance of supportive social environments that consider the perspective of the person receiving care (Brooker, 2003; Brooker and Latham, 2016). Relationship-centred care also emerged in the UK, influenced by US developments and due, at least in part, to the concern that implementation of PCC prioritised individualised care, relegating relational features of the initial vision that are essential to maintaining personhood (Nolan *et al.*, 2004, 2006; Bridges *et al.*, 2006). Coming full circle, Woods (2019) reflects upon Kitwood's original focus on the 'caring organisation' highlighting that twenty years later, the societal issues of care work status, low

[4] V.I.P.S stands for valuing, individual lives, perspective of the person, and socially supportive environments

wages, gender inequality and devaluing of older people present systemic challenges to creating a culture in which PCC can truly flourish.

The context-specific nature of achieving quality as played out in theoretical debates is also echoed within a limited range of studies examining the impact of PCC on QOL for people living with dementia. Lack of fidelity to an intervention within an organisation or the mediating impact of the organisational context on the intervention (such as staff shortages or changes in leadership) is cited as the primary explanation for the limited impact of PCC on chosen QOL measures (Boumans, Berkhout and Landeweerd, 2005; Chenoweth *et al.*, 2009; Argyle, 2012; Stein-Parbury *et al.*, 2012; Sjogren *et al.*, 2013). Notwithstanding the challenge these outcomes provide to theoretical attempts to define, prescribe, or measure quality, the fact that context affects outcomes, even within studies that are specifically aimed at changing that context, shows its powerful effect. The complexity of organisational culture and its mediating effect on QOL and care continues to be both theoretically and empirically demonstrated (Power, 2010; Killett *et al.*, 2016). Consideration of achieving quality of care and how care workers may learn to deliver that care must therefore acknowledge this influential factor, its composition and impact. The context in which care-giving takes place is multifaceted, encompassing the particular needs of residents themselves, the skills and abilities of staff, and the organisation in which the care is taking place.

A number of studies examine correlation between resident characteristics and QOL measures, identifying assorted factors such as depression, medications, physical impairment and cognitive function as related to QOL and trajectories for residents (Cordner *et al.*, 2010; Wetzels *et al.*, 2010; Goyal *et al.*, 2018). Whilst only correlation is addressed, these studies emphasise the range of issues that care-giving to achieve QOL needs to encompass. This is significant when exploring how good quality care practices are learned because mental, physical and psycho-social health relies on more than interactions between care staff and resident. It implicates other roles and factors (both internal and external to the care home) that will interact with staff activity to produce quality. Further to this, systematic reviews of psychosocial interventions also demonstrate the multifaceted nature of achieving quality outcomes. In so doing, they also highlight the difficulties of examining their impact through conventional positivist means (Olazaran *et al.*, 2010; Vernooij-Dassen *et al.*, 2010).

Organisational features associated with QOL and care have also been examined, establishing that good quality is associated more with facility-level characteristics (e.g. specialised roles, staff ratio, specialist units) than resident-level factors (e.g. staff attitudes or proportion of skilled staff) especially when examining impact over time (Zimmerman *et al.*, 2005; Kirkevold and Engedal,

2006, 2008; Joyce *et al.*, 2018). Moreover, aspects of the physical environment such as level of noise, lighting, staff access to equipment and environmental facilitation of communication are also associated with quality and resident experiences, suggesting that the interaction of physical environment with staff work, not least their ability to consider or affect such factors, is important (Cioffi *et al.*, 2007; Garre-Olmo *et al.*, 2012; Hunter *et al.*, 2016). Specifically examining PCC, highly person-centred settings evidenced particular physical characteristics (design, size) and personnel characteristics (regular supervision, social support) alongside only one staff education-related factor (Sjögren *et al.*, 2017).

These studies and my arguments do not dismiss the role of individual care staff or their skill and training in contributing to quality outcomes for residents. However, they do call into question a singular focus on staff education as a route to improving quality, particularly without corresponding organisational or contextual considerations. In fact, even when knowledge and skills of staff is seen to be the goal, this is not solely (or significantly) about education. Using focus groups with professionals regarding the challenges of achieving quality in residential dementia care, continuity of staff and a policy-level rationale for decision-making were highlighted as essential components to remedying deficits (Chang *et al.*, 2009). Specialist dementia services (as opposed to generic settings) are associated with positive staff attitudes to dementia (Lee *et al.*, 2013). Furthermore, whilst asserting the essential role of direct staff in achieving quality, Gilster *et al.* (2018) highlight that it is organisational factors such as staffing levels, flexibility of schedules, career growth and retention that need to be considered when implementing interventions.

The complex relationship between staff and the organisations within which they work is further illustrated by Caspar *et al.* (2013), examining the influence of individual staff characteristics and organisational features on staff's perceived ability to provide individualised care. Neither staff characteristics (e.g. education, length of experience) nor facility characteristics (e.g. ownership, staffing levels or model of care) predicted the ability to provide individualised care. However, variables related to empowerment of staff such as informal power, quality of workplace relationships, level of support for staff or access to resources were all predictive of perceptions of their ability to achieve individualised care (Caspar *et al.*, 2013). A survey of 352 care staff about resident behaviour identified that training and having time to listen/engage with residents were both fundamental for staff, with the latter being problematic (Mallon, Krska and Gammie, 2018). Furthermore, whilst staff attitudes to dementia do affect PCC (Gerritsen, van Beek and Woods, 2018) organisational and management factors are associated with issues such as burnout (Yeatts *et al.*, 2018) and job satisfaction (Schwendimann *et al.*, 2016). These findings demonstrate the

need to consider the actions of workers and their impact on quality from within their organisational context. Moreover, it crucially highlights the significant insights gained by prioritising the perspectives of staff themselves. As a study into care worker coping styles and QOL for people living with dementia concludes: "carers cope with caring challenges within a set of multi-level systems that determine how care is delivered and therefore how residents experience life," (Laybourne *et al.*, 2019 pp 6).

Studies that examine care-giving in situ highlight the interaction between staff and context and the implications this has for residents. They also demonstrate that attempts to examine quality without taking this interaction into account ignore a fundamental feature of care-giving for people living with dementia, therefore failing to represent the world adequately enough to draw conclusions or make prescriptions for improving quality. Using ethnographic observations in care homes adopting either a 'home-like' or 'medical-model' of care, Ryvicker (2009) saw that care-giving interactions provided barriers and opportunities for residents to maintain their identity regardless of the model adopted by the home. She concluded that there were potential 'trade-offs' within both models of care. This would suggest that it is the extent to which staff and residents are aware of and able to respond to such trade-offs that determine outcomes rather than pursuance of any particular model. Datler et al. (2009), using a single observational case study to examine communication patterns of staff and their impact on resident QOL, also demonstrate the interaction between context and individual that impacts on subjective resident experiences. For example, organisational processes within a care home can either help or hinder staff to deal with the consequences of connecting emotionally with residents in a state of cognitive and physical decline. Without appropriate organisational processes, communication practices tended to be task-focussed, and rarely related to the inner world of the resident (Datler, Trunkenpolz and Lazar, 2009).

In discussing the theoretical and empirical literature relevant to quality in residential dementia care settings, the complexity inherent to both defining and achieving such quality through PCC for people living with dementia has been demonstrated. Moreover, this complexity is identified across different countries, suggesting that it is not a function of UK culture or care system. This complexity relates to three key features: the subjectivity at the heart of 'person-centred' approaches; the different, sometimes contradictory, perspectives that are relevant to QOL in dementia; and the multiplicity of factors affecting the success of PCC implementation within care settings. It has thus been argued that that this complexity suggests that caring well for a person

living with dementia necessitates an acceptance and negotiation of subjectivity and contradiction; a state of affairs that requires navigation within the day-to-day practice of care staff if 'quality' is to be achieved. Furthermore, it has been highlighted that achieving quality for a person living with dementia is highly dependent on the context within which that care-giving is taking place, especially given the aforementioned navigation. Moreover, it is persuasive to argue that, in the real world, theoretical understandings cannot be separated from lived experiences and thus a multiplicity of understandings of QOL and care may exist.

Therefore, looking towards this study the conclusion is drawn that, in order to examine how dementia care is learned by care workers, this multiplicity and its dynamics must be acknowledged and incorporated within any investigation. This has both focus (what care is the subject of investigation) and methodological (how best to examine the learning of that care) consequences. This would favour an approach that allowed for exploration of subjectivity and context because to separate learning to care from its contextual and interpersonal circumstances would ignore fundamental features of achieving quality in dementia care. It is now important to address the literature that specifically focusses on care worker learning and establish how well it responds to these issues and answers the question 'how do care workers in residential care learn to care for people living with dementia?'

2.2 Learning in care work

When exploring existing literature relating to learning and care work, its most immediate and obvious feature is the sheer volume of empirical studies which refer to training and education as a route to improving care for those living with dementia in residential care. The breadth of this literature is noteworthy in its own right because, when delving further, a large proportion of studies simply reference the need for training or education of care staff as conclusions rather than directly exploring learning themselves. For example, a study examining spiritual needs of people with dementia living in care homes concluded that training for care staff was necessary, despite the study itself addressing perspectives on spirituality, not learning or education (Powers and Watson, 2011). This issue is significant because it lends weight to concerns that a discourse exists in the care field (from both researchers and practitioners) that uncritically promotes training as a 'cure-all' for the challenges and deficits in care for people living with dementia. Such a strong discourse could influence decision-making of practitioners, regulators and policy-makers over and above the evidence-base related to educational interventions and their effect.

Nevertheless, within this broad corpus of literature there is a significant collection of studies that explore constituents of learning by care workers and the impact of interventions designed to influence their learning. Exploring these will help to understand how learning and its impact is currently conceptualised within the field and thus delineate the boundaries of what is already known and what requires further investigation. This body of literature can be divided into two main categories: Evaluations of training/educational interventions relevant to dementia care/care homes; and studies that examine other aspects of learning relevant to care work in residential dementia care.

In the first instance, evaluations of training/education interventions dominate the field, comprising studies of a wide variety of topics, length and breadth of training intervention as well as divergent methodologies, study design and outcomes measured. Their subsequent quality also varies, with recent systematic reviews highlighting the high attrition rate (Fossey *et al.*, 2014) and questioning the insight to be gained from such positivistic approaches in this field (Nguyen *et al.*, 2018). Nonetheless, as this chapter aims to describe the field as a whole, this variety remains relevant. Four types of intervention are evident across this literature, best differentiated by the complexity of the intervention utilised and shown in Figure 1. This categorisation of interventions is used to structure discussion of the issues arising.

Type 1: Predisposing interventions. These involve only communication/teaching of information (outside of practice) with an intention of modifying knowledge, beliefs or attitudes.

Type 2: Predisposing and enabling interventions. These involve predisposing elements and conditions/resources in the environment which prompt or enable a person to implement new skills, such as changes to work schedules or opportunities to practice skills.

Type 3: Predisposing and reinforcing interventions. These involve predisposing elements and efforts to reinforce use of those skills in everyday practice, such as feedback, supervision or financial incentives.

Type 4: Multifactorial interventions. These interventions have a number of components within the same intervention, involving types 1, 2 ***and*** 3: Provision of teaching/communication outside of practice that is then enabled by changes to conditions/resources in the setting and reinforced through others' action in the setting.

Figure 1: A typology of educational interventions
(adapted from systematic reviews of care home educational interventions (Aylward et al.*, 2003; Kuske* et al.*, 2007)*

Significantly for this thesis, the second category of literature that conceptualises learning more broadly helps to illuminate what else may be going on within the care home or for a care worker that may mediate the impact of educational interventions of differing types. Therefore, in this section the picture of 'learning to care' is discussed in relation to different types of intervention, drawing on literature with a broader conceptualisation of learning to critique where appropriate. As will be seen, it is notable that despite the different types of interventions or topic of study, similar issues emerge regarding the nature of care work, the impact of organisational context and alternative mechanisms for learning that may exist.

2.2.1 Predisposing interventions

Those studies that examined the impact of particular training approaches provide a mixed picture as to the effects of training on care staff and practice. Whilst some of these differences may be explained by methodological choices and weaknesses, overall, they suggest that the impact of training (as knowledge provision) alone is limited. In addition, the focus of evaluative studies betrays some implicit assumptions about both the nature of care work and the impact of training that are emphasised when considered together with studies that look beyond evaluation of a particular approach.

On first examination, training, regardless of topic or format, appears to have a positive impact on knowledge, confidence or attitudes of care workers. Studies examining immediate impacts of training through self-report and staff-focussed measures have demonstrated statistically significant increases in: understanding of dementia and PCC (Gould and Reed, 2009); positive, person-centred attitudes to dementia care (Passalacqua and Harwood, 2012); increased confidence (Bhaduri and Sutcliffe, 2007) knowledge of generic older person's care (Lerner *et al.*, 2010); and knowledge and self-efficacy regarding depression in older people (McCabe *et al.*, 2008). These findings are affirmed by large surveys of care staff that showed receipt of dementia training was associated with higher confidence (Hughes *et al.*, 2008), and more positive attitudes to dementia (Islam *et al.*, 2017), and that training in challenging behaviour[5] in dementia was identified as helpful resulting in staff wanting more training opportunities (Mallon, Krska and Gammie, 2018).

[5] The term 'challenging behaviour' is used throughout so as to ensure consistency. However, whilst 'challenging behaviour' is commonly used, various terms exist (e.g. 'behaviour that challenges', 'distressed behaviours'). No judgement is inferred as to their cause, acknowledging the current debate regarding how best to describe such behaviours, being as they are most often signs of unmet need and distress from the person living with dementia

Initially, these findings - notwithstanding methodological flaws - may suggest a powerful impact of training, but there is a questionable assumption inherent within their design; that improved knowledge, confidence or attitudes of care workers will result in improved practice by them and lead to more positive care experiences for residents. Whilst the majority of authors acknowledge this limitation, this does not prevent them drawing conclusions that advocate training for care workers as a route to improving practice. This assumption is flawed because practice could be affected by factors in addition to (or more influential than) knowledge or attitudes. Studies using only self-report and/or staff-focussed measures do not account for any of these other factors and therefore understandings derived from them should be treated with caution, particularly when extrapolating to conclusions about behaviour and practice-change over time. To emphasise this point, in a study measuring the impact of dementia training designed to alter workers' coping strategies in response to challenging behaviour, Featherstone *et al.* (2004) demonstrated that training led to significant improvement in knowledge and attitudes, but did not result in a significant change of preferred coping style. This would suggest that other factors may determine how a person acts, such as personality, experience or circumstances. A small-scale survey of care workers regarding training in the Mental Capacity Act (2005) established that training did not result in correct application of the principles when demonstrating practice responses (Manthorpe *et al.*, 2011). Furthermore, a systematic review of the impact of dementia care training on staff outcomes concluded that whilst training was most effective at improving knowledge this was not sustained over time (Spector, Revolta and Orrell, 2016).

If the assumption that improved knowledge or worker attitudes leads to better practice was accurate, a similar picture of training impact should emerge from studies that use alternative (non-staff) measures. However, the picture here is significantly more complex, illuminating common confounders and assumptions. For example, studies of educational interventions to improve staff responses to challenging behaviour from residents have found significant decreases in care worker burden but not resident dependency or staff burnout (Fukuda *et al.*, 2018) and a decrease in resident behaviour post-training that was not sustained over time (Chrzescijanski, Moyle and Creedy, 2007) leading authors to recommend long-term training. Kuske *et al.* (2009) established that dementia training was significantly associated with reduction in use of restraint at immediate-post and 6-month follow-up, but only impacted staff knowledge initially not at follow up, suggesting that practice change is not simply related to knowledge acquisition. These studies do not consider other factors in the workplace that may mediate training effect (for good or bad). If a care worker does not act appropriately, it does not necessarily mean that they do not know how to act appropriately, it could be that they are prevented from acting appropriately by

other factors. A recent systematic review and case study examination of effective dementia care training identified that, whilst certain delivery styles and approaches improved efficacy, implementation of learned practice remained challenging due to organisational-cultural factors (staff time, opportunities for feedback) and care quality was still inconsistent (Irving *et al.*, 2017; Surr *et al.*, 2019).

The translation of education into practice has been shown to be determined by organisational factors such as management support (Stolee *et al.*, 2005) and impacts on resident outcomes are limited unless there are significant additional components to an intervention (Bauer *et al.*, 2018). However, when failure to attend training results in a training intervention's failure (Beer *et al.*, 2011), the extraneous consequences of such issues are not always considered: Circumstances that result in poor adherence to intervention (e.g. poor communication, insufficient staffing) are likely to compromise resident care independently of the training under study. This bears particular consideration in relation to other possible mechanisms for workers to learn because organisational conditions that impact fidelity to an intervention are also likely to impact these as well. For example, a large-scale survey of UK care workers established that over 90% identified means other than training (such as observing others) as most the useful methods of acquiring work skills (McFarlane and McClean, 2003), and Nishikawa (2011) established that care quality increased when worker and client shared 'better contexts' through sustained contact. Individual practice variation by dementia home-care workers who had received the same training were accounted for by workers reflecting on the different histories of the people living with dementia and their own experiences (Riachi, 2018). The availability, quality and mediation of these sorts of aspects will be compromised by organisational deficiencies. Whilst caution is needed in directly relating the findings of these qualitative studies to the residential dementia care workforce (given the age, setting and cultural context of the studies), they raise important issues when considering the impact of organisational contexts on the practice and outcomes of care work that appear under-acknowledged in studies evaluating training approaches alone.

2.2.2 Predisposing interventions together with enabling or reinforcing elements

Evaluations of interventions falling in to type 2 or 3 serve to emphasise the importance of context in mediating the effect of formal educational initiatives on day-to-day work of staff. Lyne *et al.* (2006) provided training in care planning to reduce depression in older people living in residential care, enabling application by allocating staff a particular resident with which to plan. Findings demonstrated a statistically significant positive impact on self-rated depression for residents receiving the intervention as compared with training alone. Two training programmes focussing

on reducing anti-psychotic medication use in care homes through improved management of challenging behaviour, used an enabling approach resulting in positive outcomes for residents. Both the HALT (Halting Anti-Psychotic use in Long-term care) (Chenoweth *et al.*, 2018) and FITS into Practice (Focussed Interventions Training and Support) (Brooker *et al.*, 2015) programmes trained 'champions' who were allocated specific time in which to train others and work with prescribers. These studies would suggest that it is the context in which training is later implemented that is at least partially determinant of its success, such as measures to encourage application, raising awareness of other staff, or liaising with prescribers.

Crucially for the purposes of this review, these three studies included contextualising, qualitative elements to explore staff experiences of the intervention and its implementation, identifying similar themes (Lyne *et al.*, 2006; Brooker *et al.*, 2015; Latham and Brooker, 2017; Chenoweth *et al.*, 2018): Firstly, the trained staff reported substantial difficulties in securing time for implementation, often relying on their own personal resources to do so. This is not a sustainable model and illuminates a potential deficit within the system which could have more widespread implications for formal educational interventions and their impact. Secondly, they all highlight organisational barriers and facilitators, such as management support, as crucial to the success of implementation, emphasising the important of context in determining impact. Finally, they all describe an indirect impact on residents and staff not participating in the intervention transferred by means such as supervision, informal interactions and staff meetings. This is significant because it suggests that formal interventions can have an impact beyond their direct intentions through other avenues of learning.

In an ethnographic case study of 13 care workers through their first 12 months of work, Somerville (2006a) identified that learning from experienced workers and by doing the job were the primary modes of learning, over and above formalised training. In a qualitative review of an educational intervention involving dementia training, reflective practice and improved management processes, findings showed that participating in the programme appeared to help staff recognise and use their "tacit knowledge" in addition to teaching new knowledge (Prahl, Krook and Fagerberg, 2016). This suggests interaction between formal education and informal mechanisms that is worthy of further exploration. These issues also highlight an important methodological lesson for this study: when investigating a situation as complex and open as care-giving in residential care it is vitally important to acknowledge and explore the contextual factors which may influence outcomes. Without this element, findings can be misleading resulting in failure or perpetuation of system deficits when translated into real-world applications. This can

only be captured through engagement with individual experiences of those involved by use of qualitative means.

There are a number of other studies which demonstrate that combining training with enabling or reinforcing measures can secure positive impacts on staff and residents, even over extended periods of time. Chenoweth *et al.* (2015) identified via randomised controlled trial (RCT) that PCC and 'Person Centred Environments' training, combined with expert support for managers to plan and supervise changes, resulted in significant improvements on residents' QOL and agitation compared with control-arm which were sustained at 6 months. Rokstad *et al.* (2017) implemented the 'Dementia ABC' training programme, which includes the enabling element of facilitation of regular in-house discussion groups. This significantly increased PCC and staff satisfaction, sustained for 24 months. Again, these two studies reflected on similar organisational facilitators and barriers to successful implementation as previously highlighted. However, neither appear to consider the impact of their enabling elements independently of the training element. It is possible to argue that the support for managers to plan and supervise change (Chenoweth *et al.*, 2015) and regular discussion groups (Rokstad *et al.*, 2017) could be the significant element irrespective of the training they are attached to through changing leadership style or encouraging reflective practice.

Successive RCT studies explored similar issues by using a peer support group in addition to a training intervention. Davison *et al.* (2007) compared the impact of training and training-with-peer-support to address challenging behaviour in 6 facilities. Neither arm showed significant impact on resident measures of behaviour, QOL or staff burnout. Staff attitudes regarding their self-efficacy improved following training but there was no additional impact of peer support. The performance of staff groups (as rated by senior staff) was increased for those participating in the intervention, with peer support having the most impact. However, senior staff were not blind to group participation. In follow up, Visser *et al*. (2008) again showed no significant impact on resident or staff measures, with all groups reporting increased barriers to change at 3 and 6-month follow up, emphasising the contextual issues identified earlier. Further to this, Zwijsen *et al.* (2015) showed that a programme for challenging behaviour (involving training for staff and process changes in the services) resulted in a significant positive effect on job satisfaction but not on other measures. Again, significant contextual problems were identified that negatively affected implementation, including staff turnover and lack of time. The authors conclude that future interventions should be tailored to the specific needs and issues of each unit (Zwijsen *et al.*, 2013).

Two further RCTs introduced additional aspects alongside training, providing a reinforcing element in practice that appeared to positively impact resident measures. Chenoweth *et al.* (2009) explored the use of PCC training and Dementia Care Mapping (DCM) (Brooker and Surr, 2006) in care homes and found that facilities receiving both DCM and PCC training showed a significant decrease in resident agitation compared with usual care or training alone. In Norwegian nursing homes, training in both DCM and the VIPS practice model (which includes a structured, facilitator-led reflection process) showed significant positive impact on secondary measures of depression and QOL, compared with usual care or training alone (Rokstad *et al.*, 2013; Rosvik *et al.*, 2013). A simple pre-post assessment within one Japanese care home also showed DCM/PCC training resulted in an improvement of residents' well-being (Yasuda and Sakakibara, 2017). However, a larger and more recent RCT of DCM in UK care homes, with DCM implementation cycles the responsibility of care staff not researchers, showed no significant impact on resident measures, citing low fidelity to the intervention by care homes (26%) as explanation (Surr *et al.*, 2018). Furthermore, a 2017 study in German nursing homes showed that DCM had a negative impact on staff attitudes and burnout, again citing poor adherence to the intervention as explanation (Dichter *et al.*, 2017).

The variable and sometimes muted impact of these enabling/reinforcing-type approaches again demonstrates the importance of workplace context in mediating the impact of training or other interventions, and authors acknowledge that implementation without considering (and supplementing) context, such as management support or time available, is ineffective (Davison *et al.*, 2007; Visser *et al.*, 2008; Røsvik *et al.*, 2011; Dichter *et al.*, 2017; Surr, 2018). Bolstering this, a recent systematic review showed limited impact of staff education on resident outcomes, with more successful interventions including multi-faceted components in addition to training (Bauer *et al.*, 2018). This is particularly significant when considered in relation to advocates for training on the basis that it improves staff knowledge and attitudes. Staff may have learned the skills and possess the will, but they may not have (or be able to control) the means with which to put it into practice. For the purposes of this study, this lends weight to the suggestion that the context of the care environment may not be significant simply in relation to training, but also in its own right, perhaps through the way it inhibits or enhances opportunities for learning practice through other myriad means.

When examining the characteristics of Scandinavian care organisations Hauer *et al.* (2012), established that a worker's view of the 'learning climate' of their organisation affected their perceptions of the usefulness of knowledge gained through training. Workers in organisations characterised as having a 'constraining' learning climate perceived new knowledge to be less

useful than those working in 'enabling' environments. Hauer and Westerberg (2009) and Ellstrom *et al.* (2012; 2018) emphasise the role managers play in creating the workplace learning climate through their organisation of work, relative focus on performance or innovation and style of leadership. These understandings not only implicate the need to focus on the context in which people work when addressing practice change or instituting training, but it also begs a more fundamental question that little research addresses; what are the consequences when staff learn what good care is, but cannot implement it in practice? Somerville (2006a) suggested that a mismatch between what was taught through formal education and what was learned in the reality of frontline work could lead to resignation. Furthermore, the FITS into Practice qualitative evaluation identified that when trained staff experienced insurmountable barriers to implementation it negatively affected their expressions of well-being (Brooker *et al.*, 2015; Latham and Brooker, 2017).

2.2.4 Multifactorial interventions

The mediating effect of other factors on education is increasingly understood to be an important consideration when designing interventions to improve care experiences, leading to multifactorial interventions in which training is accompanied by enabling and reinforcing elements to aid implementation. The necessity of such a multifactorial approach, however, is not new. Woods (2019) reflects on an early intervention in which Kitwood himself provided the educational element (Lintern, 2000; Lintern, Woods and Phair, 2000) which required successive rounds of observation, action-planning and organisational change in order to translate staff attitude change into PCC experiences for residents.

For some multi-factorial interventions, the training element was pre-determined and standardised. In an intervention designed to increase staff understanding of awareness in advanced dementia, training was supplemented by resident observations and group/individual supervision, resulting in a significant increase in family-rated QOL (Clare *et al.*, 2013). Noguchi *et al.* (2013) augmented challenging behaviour training with individualised care plans and feedback, resulting in a decrease in residents' target behaviours. Examining generic older person's care training, Morgan and Konrad (2011) also introduced supervisory skills training and financial incentives for staff, resulting in significant improvements in staff-assessed quality of care related to team work, care delivery and leadership. However, in each of these studies not all measures improved, with the organisation again appearing a capricious element, suggesting that it is elements other than the training itself which mediates impact (Noguchi, Kawano and Yamanaka, 2013).

Other multifactorial interventions use bespoke training within a package of other elements designed to take a holistic view to the care environment. It is these interventions that often show the most positive effect. The training elements were either designed based on needs assessment and/or delivered by someone embedded within the care home throughout the course of the intervention. Fossey *et al.* (2006) placed an external practitioner in each intervention home to review training, supervision, support of staff, and provide expertise. This RCT showed a positive impact by reducing neuroleptic prescriptions for residents with dementia in the intervention homes. A further RCT of a similar, although less intensive, in-reach expert practitioner model showed positive outcomes on quality of life, agitation and interactions (Ballard *et al.*, 2018). The Enriched Opportunities Programme (Brooker and Woolley, 2007; Brooker, Woolley and Lee, 2007) also utilised a specialist role and expertise in extra-care facilities to deliver bespoke training and facilitate care planning and review. This RCT showed positive effects immediately post-intervention and at follow-up on DCM ratings, resident engagement and reduced depression. However, all three of these studies still highlight the inherent difficulties in affecting the overall culture of a care home, identifying care home level differences in the outcomes achieved (Fossey *et al.*, 2006; Brooker *et al.*, 2011a; Ballard *et al.*, 2018) . In addition, negative occurrences still occurred, even in the context of these improved outcomes (Brooker *et al.*, 2011a), suggesting that simultaneous positive and negative occurrences can occur within the same setting carried out by the same staff.

These multifactorial interventions and their impacts serve to elaborate issues illuminated previously through other less complex interventions. Firstly, whilst broadly positive in their effects, they evidenced positive and negative care experiences co-existing, suggesting that even in environments undergoing intensive and complex interventions, delivery of good care remains complex, highly individualised and influenced by a myriad of factors. Good care, and thus how it can be translated from theory into practice within interventions, is not straightforward. Brooker (2019) emphasises this in examining the development and increasing complexity of quality standards and measurement across the last two decades. This complexity has implications for the ways in which care is (or should be) learned by care workers. In one of the few studies to explicitly explore care workers' own experience of residential dementia care, Talbot and Brewer (2016) highlight that organisational interpretations of good care clashed with those of staff. Staff cited time restrictions, staffing levels, organisational communication as well as insufficient training as contributors to stressful workload. Further to this, small-scale qualitative studies revealed a conflict in practice for staff between providing appropriate care and protecting their

own safety (Somerville, 2006b, 2006c; Sheridan and Agim, 2014). This again suggests that different facets of "good" care may be incongruent, requiring resolution in practice.

Secondly, each of these interventions alter the workplace context in which training is put into practice, in recognition that this context matters. This is to their strength, but it does highlight that conceiving education, learning or practice change without consideration of workplace and workforce context ignores important influences on outcomes, particularly with regard to sustainability. Colon-Emeric et al. (2016) and Lawrence et al. (2016) explored the factors that successfully facilitated implementation of complex interventions and psycho-social interventions respectively. Both identify that interventions must flexibly adapt to the circumstances of the care home itself and consider whole-home issues in order to be successful. This emphasises the multiple factors that can affect what occurs within a setting, regardless of (or in interaction with) individual staff practice and their training. It also raises the possibility that this context matters more than the educational aspects of the intervention in determining practice learned by staff.

Several factors determine the 'learning climate' of a particular organisation as discussed previously including: how tasks are oriented; the perceived purpose of tasks; the ways in which work is planned; the accessibility of management and leadership; and the focus of first-line managers (Ellstrom, Ekholm and Ellstrom, 2008; Ellstrom, 2012) . Two thirds of first-line managers in one study were identified as having a leadership style that fostered work climates that constrained learning (Ellström and Ellström, 2018). Furthermore, Somerville and McConnell-Imbriotis (2004) identified that a number of features of 'learning organisations' were absent in a care home, resulting in power dynamics and pressures on workers when trying to implement learning from training. In addition, these features could result in workers carrying out poor practice despite training, due to influence of more experienced workers (Somerville, 2006a). Whilst multifactorial interventions accept and respond to the impact of context on effectiveness, it could be argued that they do not go far enough in exploring how organisational aspects may affect learning and subsequent practice irrespective of the formal education that is delivered. This is particularly important when outcomes of successful research interventions can result in recommendations for particular training packages or approaches.

Thirdly, and most significantly, the contextual changes that occur as part of these interventions are not simply mechanisms that support translation of training into practice. These are mechanisms that can also create opportunities for learning to occur in other, less formalised ways such as through interaction with peers, problem-solving, reflective space or sustained relationships with residents. It is possible that it is these alternative means of learning that are

most significant in contributing to care delivery and care experiences. Intentionally or otherwise, the success of these interventions is often tied to the training element - as the easiest aspect of the intervention to operationalise and replicate - without acknowledging the informal mechanisms that may occur and impact practice either in conjunction with education or independently of it. It is persuasive to argue that there is a need to understand the complexity of all these learning mechanisms, independent from the training aspects of interventions, as they may well be significant in their own right. For example, studies examining the impact of creative arts in care settings often identify an indirect effect on care practice as a result of staff witnessing different interactions and relationships with residents (Broome *et al.*, 2017; Guzmán *et al.*, 2017). In a small qualitative action-research study that introduced 'mental-health huddles' (short, frequent reflective briefings for direct care staff) on dementia care units, staff reported improved teamwork, collaboration and better responses to challenging behaviour (Wagner *et al.*, 2014). Drawing broad conclusions from these small-scale studies would be foolhardy. However, they are notable because of a uniqueness in examining a learning-focussed intervention without tying it to a formal training component.

This section has demonstrated that very little research examines the dynamics of these informal elements of learning within the care home environment and few studies explicitly examine the views and experiences of care workers independent of specific education approaches. This absence is even more obvious when juxtaposed with the volume of literature presented here that relates to evaluations of training interventions. Without in-depth exploration of these alternative mechanisms for learning, learning for direct care workers will continue to be conceived solely in relation to formalised education and any potential impact will remain unconsidered and this can only be to the detriment of care workers, organisations and those receiving care. Therefore, as these issues are inadequately explored within literature specific to care work, this chapter now turns to the theoretical and empirical literature regarding learning in the workplace more broadly.

2.3 Learning to work

The dominance of accounts of care worker education interventions and their assertions that quality of care for residents living with dementia can be improved through such interventions are built on the assumption that 'learning to care' is a process primarily directed and influenced by formalised education. This is not a surprising assumption given that policy and regulatory direction focuses on formal education as a route to monitoring and improving quality in both

residential and dementia-specific care as outlined in the introduction to this thesis (Care Quality Commission, 2010a, 2015, 2017; Skills for Care and Skills for Health, 2013; Health Education England; Skills for Care; Skills for Health, 2014; NICE, 2018; Skills for Health, Health Education England and Skills for Care, 2018; Skills for Care, 2019). However, the dominance of this assumption is surprising when contrasted with existing theoretical and empirical understanding of how people learn within the workplace as will now be discussed.

2.3.1 What is learning?

In the first instance, it is necessary to unpick what 'learning' means within this thesis because, whilst discussions and theories of adult learning abound, they are often heavily intertwined with prescriptions for how that learning should be facilitated through formal teaching and education. This helps to explain the similar linkage within the care field described above. However, conflation of understandings of learning and provision of learning opportunities are problematic because they excessively narrow the lens through which learning is viewed, by equating a process with a particular type of activity designed to affect that process. In so doing, this directs attention away from considerations of what may occur outside those activities and what the person and their context may bring to bear both within those activities and outside them. A focus on the process of learning, separated from the provision of learning activities, may open up understandings of how it occurs and what may influence and affect it.

Definitions of learning vary, but all have at their core a process which results in change. This change may be viewed in behaviourist terms as changes in observable behaviour as a result of an experience (Knowles, 1998) . It can also be viewed more broadly to include any change in the cognitive (such as knowledge, skills and meaning) and emotional (such as motivation and attitudes) capacity of the person (Illeris, 2003). This wider conception allows for consideration of learning which may be harder to observe in overt behaviour, or which may not result in an observable behaviour change but nonetheless occur within the person's thoughts and feelings. Once learning is understood as a process that results in change for a person (however that change is manifest) and distinguished from particular activities intended to affect that learning, four key considerations regarding both how learning takes place and what may affect that learning arise.

Firstly, learning is a process involving both the individual and their experience which is characterised through both the outcomes (cognitive, behavioural or emotional change) and inputs to that process over time (the individual and experiential context) (Jarvis, 2010). This would suggest that examination of 'learning to care' or recommendations of how to affect such

learning, need to account for and explore the interactions between individual and context in the act of caring, and would guard against an approach that considers one type of input (an educational intervention) as having primacy.

Secondly, learning is something which has the potential to happen when individuals and experience meet. This makes learning ongoing (Billett, Fenwick and Somerville, 2006) and opens up a huge variety of influences on how and what a person learns and what one must consider if seeking to establish how a person may learn to think, feel or behave in any given domain. Moreover, acknowledging the ever-present potential for learning highlights the hazard of uncritically foregrounding one particular activity type as the route to affecting learning, particularly if it neglects other factors that may be at play. As Rogers states when exploring the difference between learning and teaching, "Everyone is engaged with learning. They may not be learning what we want them to learn, but they are all learning," (2003, p. 10).

Thirdly, learning can be both an intentional, purposeful process and one which occurs without planning, unintentionally or unconsciously (Reece and Walker, 2007). Therefore, learning may occur when a person is focussed on something other than learning itself, such as responding to events, completing a task or solving a problem (Rogers, 2003). This is of obvious relevance when one considers workplace learning and the everyday reality of 'doing' care work. In addition, it further highlights the impact of context on how and what learning may occur. Moreover, even 'intentional and purposeful' learning is not confined to events that are formal learning activities, such as training. A person may actively decide to engage in learning about something, but where and how they go about that learning is hugely varied. Whilst formalised education may be influential in the outcomes of both deliberate and unintentional learning, it does not follow that it is the only or most significant factor at play.

Finally, and most significantly, whilst individualistic understandings of learning exist, focussing on reductive behavioural or cognitive processes, constructivist theories assert that learning is fundamentally a social activity. An individual's experience is central, but learning is a process by which individuals construct their own meanings from their experiences, and crucially, this is done in interaction with the world. Therefore, what and how something is learned is dependent on the context (both proximal and distal) within which the experience takes place. Thus an understanding of that context, its all-pervasive influence and its ever-changing nature is essential if one is to explain and affect that learning (Illeris, 2003; Rogers, 2003; Sharma and Tomar, 2005; Jarvis, 2010). Indeed, for Bandura's social learning theory (2006, 2012, 2018) all human behaviour

results from an interplay between personal, behavioural and environmental determinants, with social modelling of behaviours being highly influential.

Social learning theory posits that all learning is a situated activity, and as such any attempt to separate learning from the situation is limited in insight (Lave, 2009). Instead, learning is viewed as a consequence of social participation in everyday interactions (Wenger, 2009). This is particularly relevant when one considers the interactive, social nature of 'doing work' generally and is emphasised when examining care work specifically because care-giving is a social activity in both product and conduct. As highlighted earlier in this chapter, maintaining personhood in dementia as the aim of PCC is achieved through *relationship* (Kitwood, 1997; Brooker, 2003, 2007). Simply in examining the definition of learning its complexity is apparent. Therefore, it is important to further consider the social context of workplace learning before moving on to explore the body of literature on workplace learning and non-formal learning opportunities.

2.3.2 The relational context of workplace learning

Investigations into workplace learning emphasise the influence of context on how and what learning takes place. Significantly, translating social learning theory into this real-life sphere further explicates the different levels of context and the nature of their impact. Contexts influencing learning exist at both a local level (day-to-day interactions in the workplace) and at a broader organisational-structural level (the features of the work, workplace and societal factors influencing these). These levels are not distinct from each other, but instead interact to shape and create the circumstances in which workers learn.

The influence of local context on workplace learning relates to the relationships and interactions that take place as part of the daily practice of work, highlighting that 'work' fundamentally requires negotiating relationships, hierarchies, routines and customs of a particular setting. Learning of that work cannot be separated from social activities, because work itself is these activities (Somerville, 2006c; Billett, 2014a; Bandura, 2018) . The concept of Communities of Practice (COP) exemplifies such a view (Lave and Wenger, 1991). COP exist whenever practitioners share a domain and engage with each other as part of day-to-day action. Whilst initially narrowly focussed on the transition of apprentices into the world of work, COP provides important insight which needs to be acknowledged when addressing how and what someone may learn.

Firstly, it illuminates the fundamentally social nature of the daily interactions that are the basis of 'doing work'. It suggests that the nature of the community and how it constructs and communicates practice is more influential on learning than any objective conceptualisation of the practice itself. This obviously creates a strong challenge to any model of learning which prioritises the teaching of 'practice' (such as good care) as an objective notion without consideration of the community in which that practice is learned and enacted (Lave and Wenger, 1991; Billett, 2014b). For example, in an ethnographic study of diverse professions, Collin and Valleala (2005) established that social interactions were fundamental to learning what work entailed. Problem-solving, maintaining team interaction and classifying work through communication shaped what 'work' was in each situation and were central to how newcomers were socialised. Billett (2014b) highlights that understanding these interactions and the need for different actors to recognise the inter-subjectivity of work is particularly relevant within healthcare when individual roles form part of a whole (the patient's experience). Moreover, increasing complexity in health and social care (of which dementia-related need is a contributor) is likely to diversify the necessary membership of workplaces and the corresponding challenges for achieving inter-subjectivity through learning (Kuipers, Ehrlich and Brownie, 2014).

Secondly, in a COP, the ability to work 'successfully' becomes more than the ability to perform tasks, but is instead a more holistic ability to function within a given community. In a study of social work students transitioning from formal training into work, it was established that proficiency as a social worker was viewed as the ability to engage effectively in the cooperative processes of varied groups (Pave and Le Maistre, 2006). Again in social work, Arby (2015) identified that professional practice was achieved through an interaction between explicit formal knowledge and collegiate interaction and sense-making in the workplace. Nurses' perceptions of the 'safety' of their work environment helped determine the extent to which they engaged in team-learning processes such collective reflection, with 'safe' climates predicting more frequent team learning activities (Leicher and Mulder, 2016). Moreover, Newton *et al.* (2015) identified that high 'entrustability' of teams enhanced nurses workplace learning.

This challenges the view of work as being primarily about ability to perform an 'expert practice' and therefore any approach to learning that centres on teaching such 'expert practice'. Instead, it demands that 'expert practice' must be broadened to incorporate how to negotiate, participate effectively and shape the work team/COP. Little is known empirically about the nature of the COP in which care workers deliver care for people living with dementia in care homes. Uniquely to care-giving situations, residents themselves (and others) form part of this COP and thus affect learning that takes place; this dimension remains completely unexplored. Moreover, this situated

view of learning strongly challenges the dominant modes of thinking regarding learning to care which focus on proficiency as 'good care' and neglect aspects of work conduct which are concerned with functioning as part of a community. It fails to account for and address workplace interactions which may facilitate or undermine learning that leads to good care or poor care.

Criticisms of COP exist, although notably they centre on the insufficiency of the concept rather than its unsuitability (Illeris, 2003; Fuller *et al.*, 2005). However, these are important to bear in mind when exploring its relevance to learning to care. Firstly, whilst later extended (Wenger, 2009), its original focus was on the ways in which apprentices learned to become fully-fledged workers (Lave and Wenger, 1991). Therefore, it considers learning to primarily take place on a journey from the periphery of working life rather than on a continual basis. It therefore fails to address how learning may take place for established workers (Fuller *et al.*, 2005). Understanding of established workers' learning is important, not least because they influence the community in which newcomers participate. Moreover, it is of particular importance when considering how existing, embedded practice may be changed, an essential component of improving care quality and a key aim of many care work educational efforts.

In the second instance, it focuses on relatively stable work communities and work type, something that is challenged by newer working practices (Fuller *et al.*, 2005). COP characterised by frequent membership turnover, such as dominate the care sector, may operate in very different ways. Moreover, the work 'output 'of care is highly changeable, dependent on resident need and circumstances, and thus learning this work involves learning the response to such change, which may not characterise work that has a more settled output, (such as manufacturing). Boud and Middleton (2003) investigated a variety of worksites within a single organisation using the COP model and highlighted that differences in the structure of workload or its contingencies altered the learning potential within the COP.

This highlights the third challenge to COP; that whilst it is invaluable in highlighting the relational nature of learning and work, it does not explicate the many and varied learning processes, particularly informal ones, which such a community produces (Fuller *et al.*, 2005). A better understanding of these would help in explaining the different affordances available within different COP and to different workers. This lack of detail perhaps also exacerbates a fourth challenge to the concept; the apparent absence of individual agency and influence. It seemingly relegates the individual to a subject of the community rather than an active member within it (Illeris, 2003). Both these aspects are of particular importance in investigating how learning may be affected towards certain outcomes such as good care practice. Finally, within the concept

there is little consideration of organisational and structural factors which can affect (incidentally or deliberately) the composition and functioning of any community of practice and its members (Thomas, 2017). Therefore, this will now be discussed in depth.

2.3.3 The organisational context of workplace learning

The local and relational context in which work is performed and learned does not exist in isolation, instead it is influenced by (and in turn influences) the wider contexts such as internal organisational factors, and external socio-economic and political factors. Thus, it is insufficient to explore learning within any setting without acknowledging and accounting for such factors. Internal organisational factors relate to the ways in which work is defined, structured and conducted within a particular workplace and may depend on such issues such as the content of work, division of responsibilities and organisational hierarchy. The consequences of such issues impact learning not simply through decision-making about education for workers but because they shape the opportunities that exist through the day-to-day conduct of work and work relationships. Evans *et al*. (2006) examined a wide range of workplace research seeking to critique and develop the COP model. He identified a range of organisational factors that were determinant of learning and development opportunities afforded to employees. These factors contributed to either a restrictive or expansive approach, in which an expansive approach produces the fullest range of opportunities for worker learning and thus the greatest potential for affecting that learning toward particular outcomes.

Expansive and restrictive features exist on a continuum and relate to both formalised education and less formal opportunities within the conduct of work. For example, expansive organisations were characterised by employee-access to a wide range of learning, with restrictive organisations having a more narrowed access to competency-based qualifications only. In expansive organisations, educational opportunities were used to align the development goals of both an individual and the organisation, whereas restrictive organisations used educational opportunities to tailor an individual's capability to the organisation's goals. Expansive environments encouraged team work and cross-boundary communication, whereas restrictive environments exhibited rigid roles and little boundary crossing in daily work. Wide-ranging expertise and innovation were valued within an expansive approach whereas restrictive organisations had a hierarchical approach to expertise and did not value innovation (Evans *et al.*, 2006; Fuller *et al.*, 2007). There is similarity here with the enabling/constraining learning climate identified within care environments and influenced by managers' orientation as discussed earlier (Ellstrom, Ekholm and Ellstrom, 2008; Westerberg and Hauer, 2009; Hauer, 2012).

Understanding the various ways in which an organisational structure or decision-making may affect learning for employees is significant because it illustrates that creating and influencing learning is not solely a matter of defining and delivering what needs to be learned, but also most significantly, about considering how the organisation itself may shape what and how work is learned. It also highlights that a holistic view of learning in an organisation (as opposed to a narrow focus on training) is necessary to ensure that the various opportunities are complementary rather than contradictory. Management and workers may have very different ideas as to what, when, how and with whom learning should occur (Parding and Berg-Jansson, 2018). For example, Bridges and Fuller (2015) explicitly focussed on creating expansive learning environments in an intervention aimed at promoting compassionate care on hospital wards, recognising that this environment influenced practice through the team's ways of relating. For the purpose of this study, an awareness of such factors within a care home organisation enables that organisation to maximise opportunities for learning and ensure that they are affected toward learning good rather than poor care practice. Of particular importance in such a resource-strapped sector is the extent to which many factors do not necessarily require additional resources and, if unconsidered, may result in negation of resource-intensive training.

Awareness of these factors and how they manifest within specific workplaces or work types therefore demands an intimate knowledge of work and work context in order to best understand and thus influence learning. For Jarvis (2010), events that create 'disjunction' between existing understandings and reality are particularly significant in compelling learning. For example, work content itself affects learning because it determines the meaning people make of their work and thus how they may resolve contradictory requirements such as quality and speed. As Illeris describes; "being able to handle such contradictory requirements in the workplace often means learning how to adapt oneself without being squeezed or ending up in unpleasant situations," (2011, p. 33). This is particularly important for work that involves continuous navigation through complexity and ambiguity as Cherry (2014) highlights in a study of police officers' learning. The significance of these contradictions and complexity for residential care for people living with dementia is clear, particularly in light of my earlier characterisation of PCC as inherently complex and subjective, requiring negotiation by workers in their daily practice. It suggests that efforts to influence care worker learning must be underpinned by an understanding of such meanings and daily dilemmas that characterise the work.

Moreover, the division of labour, opportunities for autonomy and problem-solving and the possibilities for social interaction inherent to the work type and afforded by organisational structuring of work practice all affect what learning opportunities, their quality and impact may

exist (Illeris, 2011). For example, opportunities for feedback and cooperation were identified through survey as an important predictor of nurses' learning (Kyndt, Vermeire and Cabus, 2016). Possibilities of feedback from colleagues and high levels of work pressure were associated with more frequent informal work-based learning opportunities for Dutch police officers (Doornbos, Simons and Denessen, 2008). In a qualitative study of the impact of nursing home placements on Norwegian nurses, authors identified that those who experienced few opportunities to communicate with colleagues and critically reflect on their work developed poorer attitudes to working with older people in the future and learned 'getting work done' as the most valued skill (Skaalvik, Normann and Henriksen, 2012). Furthermore, a study of Dutch home care managers established that the level of social support offered by colleagues and superiors had a significantly positive effect on informal learning by those managers, nullifying the poor impact on learning of a high-strain job (Ouweneel *et al.*, 2009). Rausch and Seifried (2017) identified that organisational opportunities to discuss errors, reflect and seek advice was significant to individuals learning from those errors. A lack of reflective opportunities, lack of shared vision between mangers and staff and hierarchical decision-making were all identified as reasons why individual learning did not translate to organisational changes in residential care workplaces (Augustsson, Tornquist and Hasson, 2013).

Whilst internal organisational characteristics affect potential learning opportunities and their impacts, these characteristics are influenced by and contribute to a wider context of social-economic and political factors. Within the care sector in particular, the ebb and flow of ideological and circumstantial changes such as privatisation, decentralisation, ownership, regulation and financial austerity have well-documented impacts on the composition and decision-making within the sector (Knapp, Lemmi and Romeo, 2013). These issues not only affect the organisational and local context in which work (and thus learning) takes place, but also have direct influence over prevailing understandings directly affecting learning. This is particularly apparent when examining literature on 'competency' approaches to work-based learning.

A competence development approach identifies the components of successful work practice, (as knowledge, attitudes or behaviours), and designs educational inputs towards their achievement and measurement (Gonczi, 2004; Illeris, 2011; Bound and Lin, 2013). Learning to work in this view is the process of learning to carry out practice as described in competencies. It is a favoured approach to standardising education and continuing professional development in many sectors and organisations (Reich, Rooney and Boud, 2015). Each iteration of national standardised qualifications for social care work in the UK since their initial inception has been at least partially conceived in competency terms, albeit ones articulated in increasingly nuanced ways (Health

Education England; Skills for Care; Skills for Health, 2014; Skills for Care, 2016, 2019). The primary criticism of the competency approach to workplace learning relates to the ways in which competency itself is conceptualised. Due to its behaviourist foundations, the focus in a competency approach is most often on developing actions and behaviours that are observable. More sophisticated approaches may extend this to include knowledge and attitudes that underlie behaviour but that are nonetheless quantified and measurable. However, this is not an accurate reflection of current explanations of how professional practice is learned through interacting with others in the process of doing work (Reich, Rooney and Boud, 2015). Moreover, as Gonczi highlights, "much of what makes people competent, resourceful...is largely tacit, instinctive, intuitive, difficult to pin down," (2004, p. 20). Furthermore, this neglects the social and situational nature of work as highlighted previously. This is of particular relevance when considering successful dementia care-giving and the subjective, relationship-focus of person-centred care. 'Learning to care' through a competency framework becomes learning to achieve certain competencies rather than learning to deliver care and function within the social situation of residential care-giving.

The fixed conceptualisation of work as a series of competencies can contribute to restrictive learning environments because they draw attention away from responding to the ever-changing individual and social opportunities arising within the conduct of work (Evans *et al.*, 2006; Reich, Rooney and Boud, 2015). This is not to say that standard-setting through competencies is impossible or undesirable but that it should be based within an understanding of the nature of learning within the workplace and work practice in order to achieve effective outcomes (Reich, Rooney and Boud, 2015). In further illustration, Bound and Lin (2013) investigated competency development in a variety of professions and highlighted that the extent to which trainee workers were provided with opportunities for exercising autonomy and judgement within their practice was reflective of the ways in which their work competencies were conceptualised. Competencies could be viewed in narrow and behaviourist terms or at the other end of the spectrum, directed towards developing and exploring the meaning of work. They noted that the dominance of the 'buddy system' in the training of care assistants reflected and perpetuated the task orientation of work practice, as it did not afford opportunity for individual meaning-making (Bound and Lin, 2013). This highlights the dangers inherent in narrowly defining the nature of work practice and unquestioningly adopting certain approaches to learning of that work practice. Understanding how 'learning to care' is understood and enacted within the workplace by individuals and workforce communities is therefore essential to mitigate such missed opportunities

2.3.4 The individual context of workplace learning

The previous body of literature emphasised the interaction between the individual and their workplace contexts, and warns against an over-emphasis on individual workers' agency in receiving and deploying their learning in the workplace. However, as Evans *et al.* (2006) suggest, the risk lies in not recognising the balance between organisational and individual factors. In particular, they highlight the extent to which people bring skills, abilities and attitudes to bear on work practices, producing a 'strong tacit dimension' to work performance which is acquired 'unconventionally' (not through formal education or work-related means). Billett (1998, 2014b) describes learning occurring as the outcome of an individual's capacity for engagement interacting with the affordances of the workplace context. Examining the impacts of demographics on workers' perspectives of workplace support for learning, Harteis *et al.* (2015) conclude that a workplace's learning potential is related to both individual and work-related factors.

For example, a study of 14 small/medium enterprises established that, particularly in care organisations, there was a strong overlap between workers' private-life experiences and their work and that this led to workers valuing informal opportunities to learn from each other. Expansive work organisations recognised and maximised these opportunities, and thus were better able to engage with workers who were 'reluctant learners' and thus achieved better learning outcomes than restrictive environments (Ahlgren and Tett, 2010). Pool *et al.* (2015) found that nurses identified personal life experiences as being a significant trigger for their continuing professional development. Moreover, the ways in which the physical space influences learning by circumscribing when and how individuals encounter one another, thus mediating between the individual and organisation, are increasingly recognised (Gregory, Hopwood and Boud, 2014; Kersh, 2015; Parding and Berg-Jansson, 2018). This suggests therefore that if this study is to understand and make recommendations for learning in a particular workplace, it must investigate the individual and contextualised interactions that occur within that work space.

Further evidence of the interaction between individual workers and their context is seen when investigating inhibitors to learning at work. In an interview study of nurses and designers, Collin *et al* (2008) identified very few individual barriers to learning a professional identity. Instead, the most dominant inhibitors were social in nature and located at local and structural level. Structural inhibitors included a hectic work pace, high competition, or insufficient resources. Local factors related to problems disseminating information, poor team work and lack of appreciation.

However, whilst the inhibitors were not individual, strategies workers employed in response to those constraints were and these affected the professional identity and practice the person developed. These strategies included: building good relationships with colleagues, maintaining standards, increasing the status of other non-work areas of life, or giving up efforts to professionally develop (Collin *et al.*, 2008). These findings would suggest that the influence of individual and contextual factors on learning is intertwined and that to separate the two ignores a fundamental feature of how learning occurs within working life.

Without accounting for the interaction between work, learning and personal identity important insights may be lost (Billett and Somerville, 2004). For example, Somerville (2006b, 2006c) investigated the processes by which safety was learned in a number of professions, including care. She established that 'storylines' about what it means to be a worker were a key way in which workers learned practice, created their own identity, and participated in the work community. However, these storylines were often incompatible with safe practice. Educational approaches to manual handling training consistently failed to ensure safe practice precisely because they failed to engage with the experiences of workers themselves in learning their work and creating an identity as a worker (Somerville, 2006b, 2006c,). This would strongly suggest that, in order to be effective, efforts to influence learning of care workers must start from an understanding of the experience of care workers themselves within the practice of doing their work and being a care worker. Without this basis there is a risk that efforts not only fail to have optimal influence, but actually reinforce and perpetuate aspects of worker identity and practice that may be harmful and contribute to poor care-giving.

Thus far it has been argued that research into how adults learn in the workplace show that learning to work is highly influenced by the context in which work takes place, and the ways in which individuals engage and interact within such contexts. How care work in particular may embody this complex relationship has also been illuminated. This challenges the prevailing model within the care field which focuses on the delivery of formal educational interventions to individual workers in an effort to alter and influence work practice. Instead, in wanting to investigate this topic, it guides towards a fuller explanation for the relationships and interactions within care work that influence what and how care is learned. Further to this, the complexities inherent in workplace learning have begun to hint at the wide variety of mechanisms for learning that need to be explored further.

2.3.5 Informal learning

The literature related specifically to care worker learning discussed previously showed a lack of attention to learning which is non-formal in nature. This neglect is significant given the extent of learning which is estimated to take place by informal means. Marsick *et al.* (2009) argue that informal learning accounts for up to 80% of workplace learning, contrasted with 80% of organisational learning budgets typically invested in formal learning. They therefore characterise informal learning as "powerful yet taken-for-granted resources that appears to be deployed only by default," (2009, p. 593). Moreover, the most significant reason for investigating informal routes of learning is that, taking place as it does in many unplanned, day-to-day and incidental ways, it is embedded within the accepted norms and culture of a workplace and as such is validated by what works within that setting (Rogers, 2003). Therefore it is, if unattended to, a potential route of learning poor work practice (Billett, 2014b). This suggests that it should be an essential component of any effort to improve care quality. Simply because informal learning is not purposefully arranged it does not mean that it is unmalleable. Organisations and individuals can foster and influence such events and their outcomes (Kyndt, Vermeire and Cabus, 2016; Sparr, Knipfer and Willems, 2017). Indeed, Clardy (2018) argues for the need to better structure and take advantage of these types of learning experiences, rather than focussing on formal training programmes.

Definitions of non-formal or informal learning abound and exacerbate the difficulty in understanding, and recommending interventions to address it. Distinctions between formal and informal events, characterised by location of the activity (classroom or workplace) or sponsor (employer or employee) create a false barrier between different learning opportunities, and underestimate the extent to which attributes of formality and informality may simultaneously exist and interact (Malcom, Hodkinson and Colley, 2003; Eraut, 2007; Manuti *et al.*, 2015). Responding to this theoretical quagmire, Manuti (2015) argues for more empirically grounded case studies to better describe the actual experience of formal/informal learning. More comprehensive classifications have recognised the continuum on which learning opportunities sit, suggesting that better classifications may be to distinguish between learning opportunities on the basis of whether the event is specifically intended for learning (Rogers, 2003; Kyndt, Vermeire and Cabus, 2016). Rogers (2003) describes a spectrum in which formal events ('learning-conscious learning') exists at one extreme and unintentional, accidental learning events at the other. Opportunities for learning in which the learner is primarily concerned with something else, such as completing a task, '(task-conscious learning') but learn as a by-product of those experiences, exist between these two poles, and are termed acquisition learning.

Conceiving learning in this way allows for the ongoing and overlapping nature of learning that takes place in the workplace and better illustrates the potential for contradiction between different sources of learning and the possibility of actively influencing learning taking place at any point on the spectrum. It also illuminates the inherent risk of focussing exclusively on formal learning, without awareness and attention to the nature and impact of other sources. For example, a care worker may take part in formal learning, such as training, but they may also seek their own self-directed learning about a particular situation by discussing it with others. Both of these are learning-conscious learning but may produce very different outcomes. In undertaking their daily work, a care worker will learn the 'best' way of completing tasks, but the nature of 'best' outcome will be highly individual and context-dependent perhaps actively contradicting training, creating dilemmas to be solved in-situ. Unexpected problems or crises will also provide opportunities for learning which may influence future decision-making and task completion. Accidental, unconscious learning could occur throughout all of these activities, absorbing understandings through language used, social interactions, rewards and feedback. Without considering these different mechanisms within any setting it is impossible to affect, reinforce or negate the learning that take places. The body of workplace learning literature suggests a number of key mechanisms through which acquisition-type learning frequently occurs in the process of doing work. These include: socialisation and day-to-day interactions; performing the job; reflection and feedback; trial and error; and tacit knowledge and implicit learning. Each of these will now be described alongside their potentials and relevance within learning to care.

Socialisation and day-to-day interactions

Socialisation into the workplace is a persistent and influential form of acquisition learning in the workplace. It occurs through the day-to-day interactions within the workplace because, crucially, in learning how to work, workers are not learning simply learning how work practice is carried out, but how that practice is carried out *within a particular workplace* (Rogers, 2003). Billett (2006) suggests that the norms and practices of a particular workplace essentially create a curriculum for workers to learn the work, by structuring what experiences are available in day-to-day practice. This has unintended consequences for what is learned because the workplace culture may not coincide with ideal or expected practice. Hunter *et al.* (2008) investigated how neonatal nurses learned within their workplace and discovered that a key feature was learning the 'ethos' of the workplace; 'how we do things here'. Formally learned knowledge from training was often superseded by such new knowledge as the worker became part of the sub-culture of the workplace and incorporated prevailing beliefs, values and subsequent practices. Further to

this, Ajjawi and Higgs (2008) investigated the ways in which health professionals developed clinical reasoning, highlighting that workers modelled their reasoning practice on others' behaviour and thus the workplace culture shaped the behaviours a person learned. Investigating social work practice, Avby (2015) identified that practitioners learned by making sense of what they experienced whilst doing the job alongside others.

This enculturation process implicates day-to-day interactions with people in the workplace because this cultural knowledge is not codified but instead embedded in taken-for-granted social activity, (including non-work interactions such as eating or smoking), meaning that the ways in which people communicate and relate to one another are highly significant (Boud and Middleton, 2003; Eraut, 2007; Rooney, Manidis and Scheeres, 2016). Through this, culture determines the ways in which a worker may frame their understanding of work situations and the extent to which that understanding is open to reframing (Marsick *et al.*, 2009). In a study of nurses, interpersonal relations were identified as a key workplace characteristic that influenced learning because these relationships provided sources of specialist and experienced knowledge (Skar, 2010). Further to this, newcomers in particular look to learn from existing colleagues who they perceive as safe, leading authors to conclude that interpersonal skills of staff were of particular significance because "psychological safety is a sine qua non condition for learning," (Mornata and Cassar, 2018, p. 571).

Examples of such cultural learning have been highlighted in professions and roles similar to care work. In a study of managers in older-persons care, it was identified that particular communication strategies served to 'activate' workers and involve them in day-to-day decision-making, and thus learn a culture of involvement and pro-activity (Fejes and Nicholl, 2011). Examining nurses and designers, Collin *et al.* (2008) showed the importance of the categories workers used to describe their work because it was how they communicated values and beliefs, such as whether it was important or permitted practice. In a study of a dementia care unit, staff communication transmitted the relative value given to explanations of resident behaviour and subsequent care practice in terms of what 'worked' (Beckett, 2001). The understandings workers gained from developing relationships with clients also form part of learning that takes place, and in a study of frontline staff in mental health and learning disability services, this learning was significant for workers when negotiating the conflicts (often with more senior staff) that emerged in their working practice (Kubiak and Sandberg, 2011).

Therefore, when investigating learning to care it is essential to do so in a way that allows cultural norms, practices and relationships to be explored because it appears that who and how a care

worker interacts within the workplace may be more influential than what is formally taught and regulated, because any guidance on expert practice will be filtered through such cultural lenses. Crucially, relationships with residents as well as colleagues could have a significant impact and this is unexplored. Whilst harder to conceptualise and highly contextual, such cultural socialisation and interactions are not uncontrollable, but awareness is necessary in order to affect such control.

Performing the job

Within acquisition-type learning and intertwined with socialisation is learning achieved by simply doing the job. Billett (2014a) describes this as 'mimesis'; occurring through observation, listening and imitation and prompted simply by 'being there'. It is more than simple copying, however, as it involves assimilation of an embodied and sensory experience that can be hard to articulate (Chan, 2015). To carry out practice in the workplace requires more than simple reproduction of tasks and requires a worker to master the organisational processes which shape how practice can be carried out, and to respond to atypical events (Boud and Middleton, 2003). In a study of workplace learning by nurses, doing the job was central to how and what nurses learned because there was a distinction between 'nursing' and 'being a nurse doing the job' with the latter being a broader experience incorporating coping skills (Berings, Poell and Gelissen, 2008). Pool *at al.* (2015) identified that nurses' continuing professional development across all ages and experience was most often triggered by their daily work, and especially encountering new tasks. Autonomy in decision-making and problem-solving is positively associated with this type of learning (Billett, 2015; Takase, Yamamoto and Sato, 2018). Trust and rapport with colleagues is essential for this learning to occur in a good-quality way, and this is something identified as being compromised for nurses in busy, understaffed environments (Newton *et al.*, 2015).

In a longitudinal study of three professions, the performance of work through assessing situations in-situ, deciding action or inaction, and monitoring self and situations were key features of how individuals developed perspectives on their work (Eraut, 2007). Reich *et al.* (2017) identified particular regular events in workdays in various professions that acted as 'sites of emerging learning'. These included handovers and site walks and occurred when social relationships interacted with the practical, requiring interpersonal negotiation and exploration of work. Critical or unusual events are of particular importance in triggering mimesis for experienced workers (Manuti *et al.*, 2015). All of these activities implicate people, situations and spaces in shaping learning. For Pave and Le Maistre (2006), engaging in the 'rough and tumble' of practice was key to learning by new social workers and the site in which formal learning was activated and put to the test.

Crucially for many work situations, and particularly relevant to those of care-giving, the experience of doing the work is not one of holistically completing a task from start to finish, but instead one of performing parts of a larger process during a particular period of time. Work is thus characterised by the need to interpret existing circumstances and successfully pass those circumstances onto others at the end of a work period, rather than by the reproduction of discrete skills and knowledge (Eraut, 2004). Recognising individual work as being a component of a whole is of particular significance when the 'whole' is actually a person's experience of life and care (Billett, 2014b). In doing care work, therefore, successful interpretation of what has come before and what will come after their own input is a fundamental feature of practice, perhaps even more so when those individuals receiving care may struggle to communicate such factors themselves. Moreover, in so doing, the care worker learns the affordances of the workplace in influencing outcomes and responds to both routine and atypical problems.

Reflection and feedback

Reflection as a means of learning best illustrates the extent to which a mechanism for learning can be variously positioned on the formal and acquisition-learning spectrum. Reflective practice forms part of many 'caring professions' curricula as a technique to be learned and applied to day-to-day practice, informally in-the-moment and in more structured ways (Schon, 1991; Moon, 2000; Gibbs, 2015). However, it also exists as an ongoing way in which an individual makes meaning from experience, particularly when there is disconnect between what is expected and what actually occurs. Change, uncertainty, non-routine or unpredictable work therefore produces more disjunction and thus more triggers for learning through reflection and problem-solving (Marsick *et al.*, 2009; Hetzner, Heid and Gruber, 2015; Takase *et al.*, 2015).

Reflection has been shown to be a frequent and diverse way in which people learn informally through their experiences within different workplaces and professions, although most studies focus on trainees or new practitioners (Berings, Poell and Gelissen, 2008; Fowler, 2008; Meirink *et al.*, 2009; Skaalvik, Normann and Henriksen, 2012). In a large survey across professions, internal and externalised reflection was positively associated with professional development (Haemer, Borges-Andrade and Cassiano, 2017). Kyndt *et al*. (2016) identify that the opportunities for reflection are significant routes of informal learning for nurses. In a study of social workers' use of reflection it was shown to be especially useful when complex decision-making, working with uncertainty and flexibility were required (Ryding, Sorbring and Wernersson, 2018).

Reflection is also interconnected with workplace opportunities for feedback (Kyndt, Vermeire and Cabus, 2016) with feedback often prompting reflection by a worker to make sense of a situation or guide future action (Sparr, Knipfer and Willems, 2017). Feedback is thus a significant way that the work environment and leader activity can shape and influence informal learning, and encourage transfer of knowledge from formal education and training (Yen, Trede and Patterson, 2016; Takase, Yamamoto and Sato, 2018). Feedback and learning from reflection are both significantly associated with self-reported competence for nurses, with feedback being particularly relevant for those with more experience (Takase *et al.*, 2015). Both are also identified as a necessary environmental characteristic in workplace learning for nurses (Takase, Yamamoto and Sato, 2018).

However, no research addresses the extent of reflective learning or its impact for care workers in dementia care-giving. This is of particular note, given the unpredictable nature of caring interactions and the added complications that changing cognition may bring. Furthermore, accounts of how the person in receipt of care may influence learning are limited and yet their influence is potentially significant. For example, a study of student nurses showed that reflection on experiences by students was prompted in three ways; by a teacher, by the student themselves, or by a more unpredictable event such as a comment or question from a patient (Fowler, 2008). Furthermore, there are a number of well-established ways to 'formalise' this informal aspect of learning through work such as journal writing, critical incident appraisal, 'stop and reflect' episodes and group debriefs (Hetzner, Heid and Gruber, 2015; Wilkinson, 2017). However, it is notably deficient in care work curricula and formalised practice in comparison with other caring professions. More importantly, it is persuasive to argue that a failure to identify and understand the opportunities for reflection in day-to-day practice within these settings means it cannot be used to best effect and could be a site of poor quality learning. In a study of paraprofessionals working in mental health, learning disability and health visiting, it was concluded that work practices failed to provide reflective spaces for such workers, despite characteristics of their work suggesting a need for such spaces (Kubiak and Sandberg, 2011). Reflective spaces have also been found to be essential in enabling health and care workers to receive recognition within the interdisciplinary nature of their work, and that this recognition was a pre-requisite for their learning from such interdisciplinary sources (Liveng, 2010).

Trial and error and negative knowledge

Problem-solving and feedback in both routine and atypical situations has already been implicated in other aspects of acquisition-type learning. An inevitable part of any learning through problem-

solving or responding to unpredictable events is the role played by trying different options, making mistakes and negative knowledge; knowledge about what does not work. Trial and error has been identified as positively associated with professional development across professions (Haemer, Borges-Andrade and Cassiano, 2017). Teunissen (2015) showed that healthcare professionals experience a range of different actions in their practice which they then employ in other situations to see if they do or do not work.

In a study of error-related knowledge by nurses, negative knowledge was shown to provide a good basis for decision-making and avoiding mistakes. It could relate to procedures (what not to do), conceptions (common misunderstandings), and personal deficits (limitations to competence) (Gartmeier, Gruber and Heid, 2010). However, learning this through formal processes such as critical incident procedures was selectively engaged in by nurses depending on the 'effort cost' associated with it (Gartmeier *et al.*, 2017). This type of learning can be affected by tendencies to cover up errors, strain of negative emotions and workers' perception of their working climate as safe and trusted. These aspects contribute to an organisations 'error culture' and the extent to which it is learning-oriented or blame-oriented (Leicher, Mulder and Bauer, 2013; Leicher and Mulder, 2016). Furthermore, the extent to which a worker and others will learn from an error is intertwined with the latitude organisations give for activities such as reflection and seeking advice, suggesting that "trainers, mentors and peers should foster such (learning) by openly addressing and discussing errors," (Rausch, Seifried and Harteis, 2017, p. 386)

Consideration of how care workers may learn through errors and negative knowledge is therefore important, not least because the subjective nature of person-centred care and rapidly changing needs of residents living with dementia are likely to present opportunities where workers will need to learn rapidly from what has not worked, rather than simply apply a predetermined model of good practice. However, approaches to regulation and care quality tend to focus on the elimination of errors, and as such may contradict the openness and reflection required to learn from mistakes.

Implicit learning and tacit knowledge

Implicit learning or tacit knowledge is often implicated in workplace learning, as a highly individualised resource brought to bear on work situations, often without conscious awareness. It is knowledge that is personal, difficult to articulate and highly subjective, variously described as 'know-how', 'common sense' or 'tricks of the trade' (Collis and Winnips, 2002). It relates to the interpersonal, emotional and cognitive frameworks through which people process their

experience (Marsick *et al.*, 2009). This type of knowledge is highly influential in learning and is formed from inevitably biased knowledge about people and situations and exhibited in routinised and habitual action (Eraut, 2000). In a study of social workers real-world practice, tacit knowledge was one way in which they made sense of the case-work they had to do, contributing to a process of 'muddling-through' (Avby, 2015). Implicit learning is based on what works for a person, and as Eraut (2004) highlights, is most often deployed when a person does not have time, willingness or ability to identify better strategies; common occurrences when a person is overworked or alienated. Moreover, the implicit beliefs that a person holds about certain knowledge itself (e.g. whether "care" is innate or can be learned) will affect the extent to which they will engage in knowledge-sharing activities in the workplace (Weinberg, 2015).

Hager (2000) argues that it is vitally important to further explore tacit knowledge within workplaces because it is a third key part of knowledge (together with expert and cultural knowledge) that workers use to make practical judgements in daily work in response to routine and atypical problems. This would highlight a key area where learning may occur and thus could be influenced. For example, in investigating a variety of work settings it was shown that where workplace relations encouraged autonomous decision-making by workers but also high levels of practical involvement by managers, tacit knowledge was shared throughout the workplace rather than held individually (Fuller *et al.*, 2007).

Implicit learning and tacit knowledge demonstrate that forms of learning other than applying technical/expert knowledge are significant in determining day-to-day action, perhaps particularly so in stressful and busy work settings such as care. Moreover, it also demonstrates that although harder to conceptualise, such forms of learning can still be influenced. However, such influence requires an understanding of how and when such knowledge may be formed and deployed within residential care for people living with dementia.

The above summary of the myriad ways in which acquisition-type learning can occur informally in the workplace demonstrates the complexity of learning to work. This does not dismiss formal education and training as means to influence work practice but instead illustrates that its influence is not as exclusive as the focus within current interventions would suggest. Moreover, informal learning is an inevitable consequence of doing work, occurring in the interaction between the individual and their context. Therefore, these opportunities risk being vehicles for poor practice, regardless of formalised training, unless they are acknowledged and incorporated into understandings of how care workers learn to care. Taken together, the literature on adult

learning, workplace learning and non-formal learning present a picture of learning work practice that is complex, ongoing and influenced by interactions between individuals and context. This picture exposes the narrow focus of much current research and recommendations for learning within care settings, particularly within the context of trying to achieve relationship-driven PCC.

The debates and evidence illustrated here suggest that in order to effectively understand and influence learning by care workers and ensure that learning leads to good care practice, a fuller understanding of how learning occurs, that is embedded within the contexts of workplace practice and care-giving, is required. Without an understanding of this, emerging from these contexts and rooted within the perspectives of those who live and work in such settings, there is a risk that efforts to facilitate learning to care will be, at best, ineffectual in their effects. Furthermore, the consideration of how to influence workplace learning towards good practices necessitates an exploration of how care practice is currently understood within dementia care, and crucially for this study, how such practice can best be investigated.

Chapter 3: Methodology

In the previous chapter I examined current knowledge relating to how care workers learn to care for people living with dementia. Sitting as it does at the intersection of workplace learning research, explorations into dementia care quality and investigations into what impacts care worker practice, this topic is one that is touched on by a number of fields, subjected to recommendations stemming from research but never addressed directly or holistically. I illustrated that our understandings of how workers learn to care for people living with dementia are currently lacking in a number of ways and that each of these limitations bring methodological implications for how this area should be examined.

Excavating the gap in this field of study not only identified the research question but also determined the ways in which that question could be appropriately explored and answered. This process of identifying an area of research interest, positioning it in relation to existing knowledge, and deciding upon an appropriate methodology inevitably expose my personal understandings of the purpose of research within the world that I seek to study. In choosing a research question and making methodological decisions, I decided what constituted acceptable and useful data and thus the form that an appropriate answer to the research question should take. Therefore, in this chapter I describe the theoretical debates and subsequent decision-making regarding methodology that drove this study, its design and progress. I address the following: my personal epistemological and ontological position; the specific type of ethnographic work presented here (a focussed, critical ethnography); ethnography and ethnographic techniques; and I end with a description of the role of reflexivity in ethnographic work.

3.1 Ontology and epistemology

Throughout, this study reveals my personal ontological and epistemological stance; my underlying understanding of the nature of this world and my beliefs about what constitutes useful knowledge in this field and thus how it can be appropriately accessed (Carspecken, 1996; Gergen, 2001; Lincoln and Guba, 2005; Rubin and Rubin, 2005). Drawing on my personal beliefs and experiences and the conclusions I drew from literature in this field, I have held the assumption that the world of 'learning to care' is one that cannot be conceived in the reductive way that

would be familiar to positivism and the scientific tradition that stems from that paradigm, in which universal truths about this world exist to be uncovered (Guba, 1990; Lincoln, 1990; Parker, 1998; Brunt, 2001; Gergen, 2001). This contention would require a view of a culture as a discrete, bounded, coherent and systematically functioning entity (Faubion, 2001). Indeed, this is the paradigm that appears to have dominated the literature in this field up to now leading, as I have argued in Chapter 2, to erroneous conclusions and consequences. Instead, I conceive the social world differently because, being made of human actors interacting in complex ways, it cannot be paralleled to the physical world (Brunt, 2001). From my perspective, the social world must be understood as one constituted of multiple interrelated 'realities' that exist simultaneously, each of which can be regarded to be 'true' in some sense (Rubin and Rubin, 2005). This is because they are constructed by the actors in that social world in interaction with each other, within differing and ever-changing cultural, political and historical contexts, and thus must be viewed in light of these factors (Faubion, 2001; Gergen, 2001; Hammersley and Atkinson, 2007; Cruz and Higginbottom, 2013). A 'culture' therefore cannot be viewed as a distinct and stand-alone entity, it must be seen with its context (Carspecken, 1996). This is a relativist and constructionist ontology (Guba, 1990; Lincoln, 1990; Spears, Ibanez and Iniguez, 1997; Burr, 1998; Parker, 1998; Gergen, 2001).

My ontological stance leads to a series of implications that affect my epistemological position. In order to access knowledge about the relativistic, complex and ever changing social world, I accept three key assumptions related to that knowledge. Firstly, that knowledge about that world can only ever be seen in partial and situated ways, because there is no objective way of accessing it; all understanding and concepts are socially produced (Spears, Ibanez and Iniguez, 1997). All action and thought are directed towards a reality that is not only located in a distinct context but also filtered through individual understandings and beliefs. One cannot separate events, people's perceptions of them, or the contexts in which they exist (Rock, 2001; Rubin and Rubin, 2005). Knowledge therefore is viewed as interpretive, and merely a way to represent people's (differing) experiences (Marcus, 1986; Rock, 2001). Knowledge is *constructed* between the knower and the known (Guba, 1990; Lincoln, 1990) and thus 'truth' or 'facts' that are of interest are the (contingent) meaning-making processes in a particular arena, how and why certain constructions emerge and change, and what consequences they have for the field of study (Marcus, 1986; Rainbow, 1986; Macdonald, 2001; Fetterman, 2010). This is social constructionist epistemology (Gergen, 2001; Lincoln and Guba, 2005).

A second key assumption of this perspective is that appropriate findings are not the set of objective, universal laws of behaviour objectively observed that result from a positivist study

(Lincoln, 1990; Spears, Ibanez and Iniguez, 1997; Brunt, 2001). Instead, findings are a contextualised account of actors in a particular setting that question taken-for-granted ideas and explicate the unique perceptions, meanings and actions that characterise that setting as it pertains to the field of study (Carspecken, 1996; Bloor, 2001). These are best investigated in naturalistic settings, as opposed to contrived or experimental environments (Lincoln, 1990; Spencer, 2001; Fetterman, 2010)

The final key assumption of this epistemological stance is that because knowledge in this social world is constructed and re-constructed by human beings in interaction, a researcher cannot, and thus should not, be separated from that construction. A social constructionist attends to their own values, beliefs, interactions and interpretations and how they contribute to the co-constructed account of the setting under study (Rubin and Rubin, 2005; Hammersley and Atkinson, 2007). Unlike positivist assertions, it is not possible for the researcher to remove themselves and their values from the exploration, because every action or inaction of the researcher is infused with those values and thus any account is interpreted and filtered by them (Lincoln, 1990). It is therefore essential and desirable to acknowledge and reflect upon the ways in which the researcher is an active participant in the emerging account (Lincoln, 1990; Bloor, 2001; Pollner and Emerson, 2001; Cruz and Higginbottom, 2013)

Social constructionism developed in opposition to the dominant paradigm of positivism because of the latter's inadequate representation of, and consequent implications for, study of the social world (Lincoln, 1990; Parker, 1998). However, constructionists continue to feel the need to defend themselves against positivist criticisms, in a way that positivist paradigms do not return. These criticisms hinge on two interrelated points: the nature of the knowledge produced by social constructionist accounts, and the usefulness of such knowledge. In the first instance, critical appraisals of social constructionism assert that it does not produce definitive answers and lends itself to (qualitative) methodologies that cannot achieve the standards of objectivity, replicability and generalisability that are the quality marks of positivist enquiry (Hammersley and Atkinson, 2007; Cruz and Higginbottom, 2013; Torrance, 2014). However, I would argue that this criticism, paradoxically, add weight to constructionists arguments. Positivist ideals of objectivity and gold-standard outcomes are themselves values, albeit ones not often held to scrutiny. To continue to assert their primacy, even to those who prescribe an alternative view of the world, shows how inescapable those values are for research and the researcher, and therefore their centrality to the ways in which knowledge and truth are created (Gergen, 2001). These standards and aims are circumscribed by certain assumptions, by both the researcher and those who use findings, as to what is useful, valid and knowable, and is as mediated by values as any other style of research

(Marcus, 1986). As Okely (1996) highlighted, this illuminates the impossibility of scientific objectivity, and for van Maanen (1988) these positivist criteria are over-rated. Therefore, if subjectivity is inevitable, how much more useful is an approach that acknowledges and attends to this rather than denies its presence? (Macdonald, 2001). Bloor (2001) provides a real-world example of the danger of unacknowledged subjectivity by contrasting the findings of randomised controlled trials and ethnographies into palliative care in hospices. Ethnographic approaches identified crucial aspects of patient experience that had been rendered invisible by the decision-making required when operationalising concepts in a trial.

Further to this, whilst the limited generalisability that accompanies many subjective accounts is problematic in terms of translating learning to the wider world, I would contend that this is inescapable because it is the nature of the world. It is complex and changing and a desire to reduce that complexity to simplicity is again a value base and one that has real-world impacts that themselves are not value free (Carspecken, 1996; Spears, Ibanez and Iniguez, 1997; Rubin and Rubin, 2005). I have demonstrated this within my field: desires and pressures to simplify the complex area of 'learning to care' has led to a focus on training and education as unquestioned concepts, which can be operationalised in a positivist manner, and produce findings that fulfil unquestioned positivist standards. In turn, this has had real-world consequences as findings are put into practice. From my perspective, it is far better to provide a partial picture that acknowledges its partiality than a partial picture that claims to be otherwise.

In the second instance, the critique of constructionism centres on the consequences of its relativist stance. By conceptualising the world as entirely relativist, it is accused of rendering examination of it pointless resulting in findings that provide no direction for action (Stainton Rogers and Stainton Rogers, 1997; Wortham and Gergen, 2001). Critical Realism attempted to avoid this assumed nihilism by conceding that understandings are partial and situated because of historical and social contexts but, ultimately, behind them sits a fixed reality which can be explored and changed, albeit through these partial pictures (Carspecken, 1996). However, this argument betrays the reductionist nature of much positivist and post-positivist thought: it renders a complex argument to its two extremes that characterise them in absolutist terms (Burr, 1998; Parker, 1998; Gergen, 2001). Instead, I would assert that simply because knowledge is partial, situated, fragmented and restricted does not mean that we cannot discover more about social realities, only that we cannot wholly know and represent them (Spears, Ibanez and Iniguez, 1997; Burr, 1998; Maso, 2001). Moreover, a relativistic understanding does not render action meaningless or impossible (Burr, 1998). As Willig (1998) argues, relativism actually means that we

can never not act – we either oppose or legitimise present circumstances– and as such the focus is on what is done with the understandings of the world that are co-created through research.

Gergen (2001) describes the benefit of a constructionists perspective best by stating that it "opens what can be a precious space for reflection, reconsideration and possible reconstruction," (Gergen, 2001, p. 10), something that can be invaluable when examining situations that are taken-for-granted. This highlights that one does not have to discover the 'truth' or uncover 'reality' in order to develop better understandings of the social world. Particularly if the nature of that truth is complex, contingent and ever-changing. Essentially, the defence of constructionism is that it is working to a different end than that pursued by positivism. It endeavours to disrupt and break apart current assumptions and thought where positivism aims to unify (Gergen, 2001).

At this point, it may be useful to restate my social constructionist ontology and epistemology as directly related to my study. In the field of learning to care, I assert that the care a worker provides is a product of their own and others' perceptions of what dementia care entails in a particular situation, within the context of their particular care home, residents, work relationships and personal experiences. Therefore, how this care is learned (the knowledge of this world that I seek), can only be explored through an investigation of these meaning-making activities and their contexts. Findings will be partial and situated, because this is the nature of that world. Another time or place may result in a different description. Moreover, because I am a social actor in the world, findings will also be reflective of my interpretations and own constructions. Another researcher may produce a different description. My role and impact must therefore be acknowledged and explicated throughout the study. By describing my own study, one begins to see how these ontological and epistemological stances have implications for the methodological choices involved in designing and undertaking this study.

Lincoln (1990) identifies five key methodological implications that follow from a social constructionist paradigm: it will predominantly be qualitative in nature; it must be able to capture realities in an holistic and naturalistic way; it should enable interrogation of meaning-making processes; it must incorporate the role of the researcher, and its design should emerge from the field rather than being pre-determined (1990, p. 78). It is these, combined with my review of existing methodologies used in workplace learning and care settings, that led to my adoption of an ethnographic methodology with the intention of understanding what and how learning occurs in care homes. I intended to answer the question *'how do care workers in care homes learn to care for people living with dementia?'* from the perspectives of those living and working in care homes and to produce an initial thick description of 'learning to care' within this setting.

Ethnography can be seen as a natural adjunct to a constructionist stance (Rock, 2001) and I assert that ethnography is consistent with the implications of a social constructionist paradigm in the following ways. Firstly, explaining complexity as opposed to reducing the world to simplified, numerical descriptions is the very essence of qualitative methodology (Rubin and Rubin, 2005; Cruz and Higginbottom, 2013), and ethnography sits firmly within a qualitative tradition (Hammersley and Atkinson, 2007). Secondly, the aim of ethnography is to represent the culture under study in a holistic way by immersing the researcher within the real life activities of the culture, allowing the exploration of interactions and meaning-making from emic perspectives, as presented through people's talk, behaviour and interaction (Macdonald, 2001; Whitehead, 2005; Fetterman, 2010; Pensoneau-Conway and Toyosaki, 2011; Reynolds, 2016). It is for this reason that ethnography is a commonly used approach to examining care settings (Gubrium, 2009; e.g. Kelly, 2013; Liou, 2014; Bailey *et al.*, 2015). Moreover, those investigating workplace learning also recommend the use of ethnographic-type methods and inductively developing ideas because of the infancy and complexity of the field (Barley and Kunda, 2001; Eraut, 2007; Hunter *et al.*, 2008; Sawchuk, 2008). Thirdly, ethnography firmly places the researcher as an instrument within the study (Lewis and Russell, 2011; Pensoneau-Conway and Toyosaki, 2011; Cruz and Higginbottom, 2013; McQueeney and Lavelle, 2015). Finally, ethnography is a highly flexible approach, in which types, locations and focus of data collection are determined by developments in the field and the emerging understandings of the researcher (Carspecken, 1996; Hammersley and Atkinson, 2007; Fetterman, 2010). Therefore, as I have demonstrated that ethnography is a methodology consistent with my ontological and epistemological stance, I will now explore the debates surrounding ethnography itself.

3.2 Ethnography

I have outlined the epistemological and ontological understandings that underpinned my choice of an ethnographic methodology. However, ethnography itself is far from a straightforward discipline. It is difficult to find clear, unambiguous descriptions of ethnographic principles and it is a field beset with debates and eclectic, multifaceted, ever-changing applications in practice (Spencer, 2001; Hammersley, 2006; Zaman, 2008; Walford, 2009; Rashid, Caine and Goez, 2015). I would argue that this eclecticism is so clearly woven into the evolution of ethnography and its response to the societies and research contexts on which it is focussed that it should be considered a central attribute of ethnography itself: An ethnographer and ethnography become

ethnographic as they navigate and justify the application of ethnographic principles in the particular world under study and articulate an ethnographic viewpoint of that world. To this end, I shall trace the evolution of ethnography from its original manifestations to the social world I focussed upon and the ways in which I applied it in this study.

Ethnography's ambiguity comes from its roots in anthropology and its subsequent co-option within other qualitative methodologies, meaning that it can be seen in use across a wide spectrum of situations and disciplines which often have contradictory intentions and foundations (Atkinson *et al.*, 2001; Walford, 2009). It is difficult, therefore, to trace a single, definitive answer to the question 'what is ethnography?' This opens ethnography, and particularly its modern-day usage, to criticism from diverse quarters and results in confusion between its methodological roots and its application as a set of techniques. In the first instance, the anthropological focus of early ethnographers' work was distinguished by the lengthy, continuous, immersive contact between the researcher and the researched in the field through full participant observation in the society under study (see for example, Malinowski 1922). Thus, it is these early descriptions that many identify as being the characteristic components of traditional or classical ethnography (Faubion, 2001; Hammersley, 2006; Hammersley and Atkinson, 2007; Walford, 2009). Therefore, to what extent can a work be considered ethnographic if it does not adhere to these original tenets? This question is significant particularly for the field I studied; many modern-day ethnographies in health and social care diverge from these characteristics in critical ways. For example, it is not uncommon to encounter ethnographies that use short-term engagement in the field, with researchers visiting intermittently and/or for much shorter periods of time (Bourbonnais and Ducharme, 2010; Campo and Chaudhury, 2011; Stephens, Cheston and Gleeson, 2012; Liou, 2014). Nor is it uncommon for ethnographies to use non-participant observation and prioritise other data collection techniques (Spiers *et al.*, 2014; Taylor, Sims and Haines, 2014; Bezemer *et al.*, 2016).

However, there are persuasive rationale for these sorts of divergence, accepted by many theorists, and that fit with the type of culture I studied. Primarily, changes over time in how an ethnographer engages with their 'culture', such as length and intensity of engagement, are associated with changes in the nature of that culture itself. Where ethnography used to be employed to study remote peoples and obscure cultures, it is now applied to fragmented societies, and the sub cultures of particular communities, activities and relationships, and with which the researcher may be intimately familiar (Atkinson *et al.*, 2001; Brunt, 2001; Macdonald, 2001; Hammersley, 2006; Walford, 2009; Rashid, Caine and Goez, 2015). It is reasonable that in response to fragmentation and diversification of the field, the ways in which an ethnographer

engages with that field would also fragment and diversify to respond to different interactions, norms and circumstances of that 'new' type of culture. This will require alterations in the length and approach to immersion in that culture and engagement with its sub cultures, in order to understand them fully. In fact, in many respects, these more modern adaptations of ethnography serve to illuminate some of the erroneous assumptions inherent to more traditional applications; namely that 'cultures' are less uniform and cohesive than was often portrayed, and less amenable to being 'understood' fully by the (colonial) outsider than was claimed (Atkinson *et al.*, 2001; Faubion, 2001; Macdonald, 2001). Furthermore, allied to these changes are transformations in the practical academic and ethical requirements of research. These, too, often demand moves away from traditional long-term immersion common to anthropological ethnography (Wellin and Fine, 2001; Hammersley and Atkinson, 2007; Walford, 2009; Lewis and Russell, 2011). As Smith (2001) highlights, the diversity of approaches seen within ethnographies is less to do with methodological disorder than a consequence of the real-life constraints on what researchers can do in the field.

Whilst I accept both these aspects of the explanation for the move away from conventional ethnographic approaches, they do illuminate an underlying belief which, in order to account for my own study, must be addressed. By accepting divergence from traditional techniques in response to differing situations and practical pressures, one also infers that it is the focus of the research and the approach of the researcher that is ethnographic, rather than the particular techniques employed. As Fetterman describes, "ethnography is what ethnographers do," (2010, p. 15); the person and their practice is paramount. Deegan (2001) highlights that it is the openness of ethnographers to environments, people and the data they provide that is definitive of the ethnographic process, rendering pre-specified criteria not only obsolete but counterproductive. An ethnographer describes local contexts by examining behaviours through a cultural lens. The resulting text is an ethnography (Fetterman, 2010). The emphasis here is on the *ethnographer*, not on the researcher to *'do ethnography'* (Thomas, 1993; Taylor, 2002). For Lewis and Russell, it is the 'why and how' of ethnography that trace back to its origins, even whilst the locations and participants have changed (2011, p. 412). This suggests that whilst there are common techniques and applications, it is the use of them by a researcher with an ethnographic approach, in the service of a particular type of inquiry that makes them ethnographic and it is this that distinguishes ethnographic work from the broader domain of qualitative social research (Atkinson *et al.*, 2001). Therefore, within this understanding, the ethnographic sensibility of the researcher is at the core of what determines an ethnographic approach and therefore needs to

be described. Without it, a modern ethnography is at risk of being merely a label rather than a meaningful concept (Walford, 2009).

The ethnographic sensibility is the researcher's mind-set and approach to the field of study, variously referred to as methodological orientation, perspective or commitment (Miller, 1997; Hammersley, 2006). This orientation informs the whole research process because it stems from the researcher themselves. This influences their choice of focus through design, data collection, analytic approach and writing the final work (Bryman, 2001; Macdonald, 2001; Troman *et al.*, 2006; Fetterman, 2010). Firstly, in terms of research focus, an ethnographer is interested in the processes, meanings and interactions that make up the cultural life of that particular setting. They aim to see and describe that life first hand, in all its complexity and with the insight of those who participate in that life, through studying how people behave and interact within that context. Regardless of the breadth of the chosen culture or sub-culture under study, an ethnographer approaches the setting with this holistic and emic perspective in mind (Brewer, 2000; Whitehead, 2005; Hammersley, 2006; Hammersley and Atkinson, 2007; Fetterman, 2010). For example, within care home settings, Bourbonnais and Ducharme (2010) engaged with people living with dementia, their care staff and family members to explore the negotiation of meaning in relation to screams. In another care home ethnographers explored the world of people living with dementia and their relationships to the physical world by spending time observing and talking to them and their carers (Stephens, Cheston and Gleeson, 2012).

Secondly, with regards to how data are identified and collected, an ethnographic sensibility for me is seen through what Lewis and Russell describe as "'an attitude towards being there," (2011, p. 400) rather than through a pre-specified length of time or specific data collection method. Often nebulously referred to as 'fieldwork' and allied to the desire to understand the culture in a holistic and emic way, an ethnographer seizes what opportunities they can to access the experiences that make up 'life' in the culture under study by participating in routines and interactions, developing relationships, exploring the environment and seeking out contrary events and key occurrences; the resulting data providing a rich description of the culture (Deegan, 2001; Whitehead, 2005; Troman *et al.*, 2006; Crang and Cook, 2007; Hammersley and Atkinson, 2007; Neyland, 2009; Fetterman, 2010; Lewis and Russell, 2011). Whilst there are a variety of specific techniques for doing this, and associated debates as to their ethnographic status, the overall aim is to answer the question 'what is going on here?' (Spradley, 1980). It is only once this can be answered that an ethnographer has finished being ethnographic in the field. In an ethnographic study of learning in a hospital unit, Hunter *et al*. (2008) identified a myriad of ways in which the researcher became embedded in the setting, such as observing across shift patterns,

within unofficial spaces and 'non-patient' spaces, and engaging in informal conversations as well as interviews. In order to study the experiences of nursing aides in relation to death and dying, Erikson (2017) spent three years observing in all spaces of the home and interviewing workers informally and formally within a nursing home.

Thirdly, an ethnographer's sensibility leads to an analytical mind-set throughout data collection, not simply once fieldwork is complete. Many theorists do not explicitly advocate an analytic framework or approach. However, discussions of iterative tactics are common, in which there is a constant interplay between empirical data and the researcher's ideas throughout the whole research process, gradually focussing down on occurrences that will add depth to understanding (Spradley, 1980; Whitehead, 2005; Troman *et al.*, 2006; Hammersley and Atkinson, 2007; Neyland, 2009; Fetterman, 2010). For example, in an ethnography exploring learning within hospital rounds, Kuper *at al*. (2010), highlight that by iteratively switching between collection and analysis the interview scripts could be adjusted to enable focus on emerging ideas. Powers (2001) undertook analysis and ethnographic data collection simultaneously whilst developing a taxonomy of everyday ethical issues in the care of nursing home residents with dementia, so that the interpretive taxonomy was grounded in reality.

An ethnographer's sensibility is finally revealed in their writing and communication of the ethnographic work. It is seen in the thick descriptions of the world under study, the explicit use of participants' own perspectives or voices and a clear, reflexive account of the researcher's own involvement and influence (Clifford and Marcus, 1986; Hammersley and Atkinson, 2007; Fetterman, 2010; McQueeney and Lavelle, 2015). For example, Lopez (2006) draws extensively on his own emotions when faced with residents' competing needs in his ethnography of culture change in long-term care settings. In a study of healthcare assistants' emotional labour, Bailey *et al.* (2015) use the phrases and comments made by healthcare assistants to illustrate their findings.

I have argued here that ethnography is determined as much by the approach and mind-set of the researcher as by adherence to a specific set of techniques. In this study, my ethnographic sensibilities were evident in each of the four ways described above: I approached the field with a desire to explore the world of learning to care for people living with dementia through the eyes of those directly involved and open to the varied perspectives and different ways that this may manifest. I then engaged in that field in a variety of ways, examining it from different perspectives, analysing the data and then returning to data collection to focus in on particular issues. Finally, in writing this thesis I acknowledge my role in co-constructing the world of care

worker learning through explicating my interpretations of the conversation and observations I made of the care home world.

One criticism of this foregrounding of person above technique would be that it results in work that obfuscates the boundaries between social science and those of performative or fictional accounts (Walford, 2009). If I am central to the process, what prevents the process and outcome being my experience rather than a participant-informed description of the world? I would argue that this conflation is not only at the extremes of the discipline, but also ignores the centrality of the ethnographic purpose to the ethnographic sensibility. In social research, the ethnographer is central to the process, and their interpretation and influence an important, explicit part of the work, but this does not prevent them from being systematic and analytical in their approach to discovery, and critical in their application of techniques. It is this that differentiates an ethnographer from a story-writer (Atkinson *et al.*, 2001; Bloor, 2001; Hammersley and Atkinson, 2007; Fetterman, 2010). This reiterates the significance of the ontological and epistemological stance of the researcher. If one is contending that ethnography is a tool to uncover the truth about the world and present it to others, then the techniques and one's adherence to them are most important. If a researcher diverges from these techniques, how can they claim to represent the world in a satisfactory manner? It is this positivist aspiration that early ethnographers and anthropologists were aiming for, and form the basis of many criticisms of modern day ethnographic accounts that diverge from traditional method (Atkinson *et al.*, 2001; Deegan, 2001; Macdonald, 2001; Walford, 2009). However, if one is taking the stance (as I am) that ethnography is well suited to explore the social world and illuminate its partial and constructed nature, then the researcher's approach becomes the most important aspect, because they themselves are the research tool as they, inevitably and inescapably, participate in the social world. It is only through this that the techniques of ethnography become important. These are the methods an ethnographer uses to view the world, and crucially, to systematically and rigorously critique that description and their own role in living and interpreting it. It is not that techniques do not matter, but that it is the how, why, when and to what end they are employed that determines their ethnographic status.

3.3 A focussed and critical ethnography

Before addressing the specific techniques used in ethnography it is important to address the type of ethnography employed in this study. As I have explained, this is an ethnographic study because

this methodology is designed to help explore typical patterns of interaction, thinking, feeling and meaning-making in communities (Malinowski, 1922; Taylor, 2002; Hammersley and Atkinson, 2007; Fetterman, 2010) and I consider learning to care as an inherently social phenomenon created by the relationships and interaction with and within the community. However, as outlined above, ethnography is a broad discipline and further decision-making is necessary to ensure the focus and subsequent methods are suited to the purpose of the study and the practical considerations of fieldwork.

Firstly, my study is a **focussed ethnography**. This approach is not a departure from ethnographic traditions, but more an adaptation of method to enable investigation not of unknown situations but of familiar phenomena taking place in disjointed, complex communities (Boyle, 1994; Muecke, 1994; Knoblauch, 2005; Cruz and Higginbottom, 2013; Rashid, Caine and Goez, 2015). This is appropriate for this study because both work learning communities and care home settings are 'known' through existing ethnographic works (See for example: Gubrium 1975; Stafford 2003; Boud and Middleton 2003) but their combination is unexplored. Focussed ethnographies are common in both nursing settings (Wall, 2013; Al Sayah *et al.*, 2014; Taylor, Sims and Haines, 2014) and workplace and learning research (Hodson, 2004; Spiers *et al.*, 2014; Wegener, 2014a; Erikson, 2017) demonstrating that others in these fields identify focussed ethnography as an appropriate choice in these circumstances.

Focussed ethnographies are characterised by a number of features which resonate with the purpose and performance of my study. Firstly, they involve short field-visits rather than long-term placements, replacing length of data collection with intensity (Knoblauch, 2005; Liou, 2014). For example, in a focussed ethnography of staff-client interactions, a researcher spent only one month in the adult day services she studied, but was immersed for 45 hours a week during this time (Liou, 2014). This compares with other, traditional ethnographies where engagement with study sites can last for 12 months or longer, with observations intermittent during that time (Bailey *et al.*, 2015; Erikson, 2017). Secondly, a focussed ethnography centres on a discrete organisation or sub-group and involves a limited number of participants who hold specific knowledge (Muecke, 1994; Higginbottom, 2011; Rashid, Caine and Goez, 2015; von Lehn and Hitzler, 2015). For example, Wall (2013) and Wegener (2014a) focussed on specific groups of employees (self-employed nurses and vocational training students respectively) in their focussed ethnographies of aspects of learning in health and social care settings. Finally, focussed ethnographies are context and problem-specific (Knoblauch, 2005; Higginbottom, 2011; Stephens, Cheston and Gleeson, 2012) rather than seeking to describe an entire phenomenon as more traditional ethnographies do (McCall, 2006). As such, a focussed ethnography may pre-

select the topic of enquiry and structure data collection accordingly (Muecke, 1994). For example, in a care home-based focussed ethnography researchers concentrated only on staff decision-making regarding resident mobility (Taylor, Sims and Haines, 2014). This is in comparison to broader initial focus such as Cain's (2012) study of care workers' identities in hospice care.

Criticisms of focussed ethnography often centre around its limited perspective of the phenomenon under study, caused by the prioritisation or exclusive use of only one data source (Hammersley, 2006; Cruz and Higginbottom, 2013), short term engagement in the field or narrow conception of the topic under study (Hammersley, 2006; Walford, 2009; Brockmann, 2011). For example, Spiers *et al.* (2014) and Al Sayah *et al.* (2014) use only interviews to explore aspects of learning with specific staff groups and Stephens *et al.* (2012) use only 30 hours of observation conducted over two months to explore the interactions of people living with dementia. However, I would argue that this critique is less a critique of focussed ethnography specifically than a critique of research that is un-reflexive in nature. As I have argued, the unique nature of culture mitigates against the specification of prescriptive models for 'doing' ethnography because it is for the researcher and her ethnographic sensibility, immersed in the field, to determine when and how that world is 'understood' sufficiently. Therefore, it is no more appropriate to identify a minimum timescale or manner for engagement than it is to specify a maximum, sufficient one. It is instead the responsibility of the researcher to determine those boundaries and, crucially, to critically reflect upon them and their impact. This is true regardless of data source or length of engagement. Using a single data source in a focussed ethnography certainly limits the perspective on a culture, and these consequences are important to explore and acknowledge, but it does not prevent that study being ethnographic in its approach and focus. The choice of focussed ethnography may be a pragmatic response to difficulties faced in access, ethical limitations, or time available (Rashid, Caine and Goez, 2015), but that does not mean it cannot produce significant ethnographic insights, when accompanied by robust reflexivity (Cruz and Higginbottom, 2013).

The second, and perhaps most significant, dimension of my study was that it was a **critical ethnography**. This means that, whilst methods and techniques are similar to traditional ethnographies, its purpose is political in that it is directed towards interrogating the culture, examining status-quo constraints on behaviour, creating impetus for change and asking what *could be* in a community, rather than simply describing what currently exists (Thomas, 1993; Gordon, Holland and Lahelma, 2001; Madison, 2005; Braun and Clarke, 2013; Rashid, Caine and Goez, 2015). By choosing a critical approach I am explicitly prioritising an aim to question the taken-for-granted assumptions, taking an active and non-neutral stance and prioritising the

relationship of participants to activity, rather than simply describing it (Thomas, 1993; Boyle, 1994; Pallet, 2012). The critical stance is necessary when motivations are ultimately to change the status quo, and improve something such as quality of life for people living with dementia (Nolan, Davies and Grant, 2001; Kincheloe and Mclaren, 2005; Black and Rabins, 2007). For example, a number of authors have used critical ethnography to examine aspects of the care experience in residential settings with the intent to challenge existing care practices (Bransford, 2006; Bland, 2007; Bambustic, 2011). Criticality is also useful when the aim is to highlight the perspectives of those who are not usually heard in the discourse, or to examine conflicting perspectives, particularly those that may challenge the status quo (Carspecken 1996; Black and Rabins 2007). Bourbonnais and Ducharme (2010) used critical ethnography to examine the meanings of screams in older people living with dementia as perceived by staff, family and the person themselves and their relationship to the organisation of nursing care. Deforge (2011) used critical ethnography to examine the constraints placed on care workers by organisational factors. Lending weight to my adoption of a critical stance, those in the field of adult learning and education endorse a critical approach (although not the explicit use of critical ethnography) precisely because opportunities for learning and development (and the institutions that provide them) are so closely implicated in structures of power and inequality in society (Carspecken, 1996; Brookfield, 2005). Moreover, when translating this into care work-related learning, its significance increases because this is a world characterised by power inequalities that can and do effect practice, whether due to the nature of care-giving dependency, or due to societal factors of low wages, understaffing, 'unskilled' and transitory nature of the care workforce (Lopez, 2006; Deforge *et al.*, 2011).

Challenges to critical ethnography centre on two aspects. In the first instance this is the extent to which a critical stance affects the objectivity of the researcher, introducing undue bias (Carspecken, 1996). However, the challenge to objectivity is one that is only of concern to research that claims objectivity from the outset. My ontological stance asserts that no-one can be objective, one either accepts the status quo or challenges it and both stances are value-laden, infused by the inequality that marks society and power relations (Thomas, 1993; Carspecken, 1996; Willig, 1998; Kincheloe and Mclaren, 2005; O'Reilly, 2009). Reflexivity, aimed at exposing and addressing the consequences of such bias and attending to the implications of power relations, therefore, becomes a central component of critical ethnography in order to replace unreachable objectivity with rigour and transparency (Boyle, 1994; Sherif, 2001). In the second instance critiques of criticality focus on the tension between critical approaches and fieldwork realities, highlighting that a researcher's stance may directly contradict the perspective of a

participant (Hammersley, 2006; Avishai, Gerber and Randles, 2012; McQueeney and Lavelle, 2015). However, again, it is reflexivity that enables a researcher to address where one's own stance toward 'progressive' aims such as empowering the disempowered clashes with participants' own views of their world and the 'voice' they wish or do not wish to express (McQueeney and Lavelle, 2015). Indeed, as Aviashi *et al.* (2012) highlight, the events which prompt a tension between the researcher's perspective and those of participants are highly instructive dilemmas on which to focus reflexivity.

I have chosen this double stance for my study because of my understandings of the current, dominant discourse regarding learning to care and its inadequacy, as discussed earlier. It is a **focussed ethnography** because I studied the care homes intermittently. In addition, my attention was on a specific topic (learning) related to a specific staff group (dementia care workers) within a specific environment (care homes). My concentration was therefore focussed on a particular issue within the much broader and multifaceted life of a care home. My study is a **critical ethnography** because I wished to explore what *could be* in relation to learning to care. I explicitly framed my study in opposition to the dominant discourse in care worker learning - that of formal education and training as a route to improve quality care – I deliberately set out to investigate beneath the surface and challenge assumptions that might contribute to current understandings and activities of the field, and to prioritise the perspectives of care workers and people living with dementia as often-unheard groups in this field.

3.4 Ethnographic techniques

Previously, within my discussions of ethnography generally and a focussed and critical approach, I have argued that it is the way the researcher approaches the field and employs the tools and techniques at her disposal that makes them ethnographic. I shall now discuss the most commonly used ethnographic techniques, the theoretical considerations that underpin their use and their practical application within my study.

3.4.1 Fieldwork

Fieldwork is an ubiquitous term, often appearing in the literature interchangeably with ethnography and participant observation (Faubion, 2001; Rock, 2001; Hammersley and Atkinson, 2007; Silverman, 2011). However, I believe it is important to address fieldwork as distinct from

methods of data collection whilst in the field. The term 'fieldwork' encompasses everything that occurs from the moment one begins to engage to the moment one finally ends that engagement. Addressing it explicitly highlights that, for an ethnographer, this engagement and reflections upon the experience are an essential part of data (Okely, 1996) and an experience that, when taken holistically, is more than the sum of its parts in the form of specific observations or interviews (Miller, 1997). It emphasises the importance ethnographers place on 'being there', in the presence of those one is studying, understanding the environment through all senses and by gaining first-hand practical knowledge of how life is played out in that setting (Pratt, 1986; Atkinson *et al.*, 2001; Faubion, 2001; Fetterman, 2010).

For example, the process of contacting an organisation, negotiating access and initial visits – long before formal data collection activities begin – are highly illustrative of the setting itself (Hammersley and Atkinson, 2007; Fetterman, 2010; Silverman, 2011). In gaining access to the field one has to negotiate with gatekeepers both informal and formal; those individuals who can control access to the setting and can set the tone and ease of your engagement throughout your time in the field (Smith, 2001; Silverman, 2011; Robinson, 2014). The negotiations, challenges, solutions and consequences of these engagements are therefore important data to capture. For example, Monaghan and Fisher (2015) recommend strategies such as 'self-delegitimising' (playing down expertise) to reduce any perception of threat when access is a challenge. In recounting her experiences of gatekeeping in a school study, Robinson (2014) highlights how access is often an ongoing issue, even when 'official' permission has been granted. For her, each occasion offered the opportunity to reflexively engage with the dilemma it presented to the research and researcher.

The manner in which fieldwork experiences are recorded is therefore also important. For ethnographers, the research journal or fieldwork diary is an important tool, although there is disagreement as to whether the descriptive and reflexive aspects of it should be completed together or separately (Carspecken, 1996; Emerson, Fretz and Shaw, 2001; Silverman, 2011). The research diary has two purposes. Firstly as a way to capture the descriptive circumstances and constraints of data collection, developing analyses of data and therefore countering flaws of memory and enabling an iterative approach in the field (Hammersley, 1998; Silverman, 2011), Secondly, and most importantly, as the place in which the ethnographer engages in a vital "written conversation with oneself," (Rock, 2001, p. 34). This is the reflexive aspect of fieldwork and the ethnographer uses their research diary to capture their subjective experience of being in the field; their thoughts, feelings and developing understandings of the interactions and roles (Pratt, 1986; Clarke, 2009; Robinson, 2014). Tracking one's own emotional reactions to the field is

essential as they may mirror participants' experiences, expose bias or provide important analytical leads (Lofland and Lofland, 1995). When combined, the descriptive and reflexive accounts enable the researcher to track their decision-making and assumptions and therefore account for how they may have influenced the field, data and their own interpretations of it (Lofland and Lofland, 1995; Emerson, Fretz and Shaw, 2001). Clarke (2009) emphasises how the transparency afforded by her research diary enabled her to demonstrate rigour as a novice researcher. Engin (2011) refers to the research diary as demonstrating the 'scaffold' of her findings because it traced thoughts and interpretations of data.

By way of example, the experience of access and gatekeeping within my study as captured in my research diary illustrates the role fieldwork generally played in influencing progress and thus findings. In both care homes I was essentially sponsored by the manager in the initial stages of the research. I could not have gained access to residents or staff without her approval and without active work on her behalf to introduce me to others in the setting. Thus I was, inevitably, positioned by others according to their perceptions of me, their manager and both our relationships with her. Whilst I worked hard to counter the effects of this sponsorship by developing relationships with others and spending time in the care home when those sponsors were not there (Hammersley and Atkinson, 2007; Fetterman, 2010), it would be naïve to assume that this sponsorship had no impact at all. Below I provide extracts from my research diary following my initial staff meetings in the home[6].

> *First staff meeting was relaxed and open. Staff contributed and gave opinions – were not just listening to the manager. Manager relaxed and open at these interjections, does not appear threatened at debate/suggestions from staff. What effect does this openness and negotiation of issues with the manager have on how care is learned? (we 'the carers' can determine what care is here? Therefore we are active in construction of what it is?)*
>
> ***Research Diary, Strauss Hill Court***

> *Meeting 1, 6 staff present, including activities coordinator. Manager also present. Other staff seemed quite tired/disengaged and a number would not make eye contact with me. But this may be because I am a stranger? Or because I am the manager's "thing"? A few smiles towards the end. I was not invited to stay for the rest of the meeting, made clear that I should head out as 'business' needed to be talked about.*
>
> ***Research Diary, Sunshine Lodge***

[6] All care home and participant names used in this thesis are pseudonyms to facilitate anonymity

By reflecting upon these experiences, I could see the influence they had throughout the research: In Strauss Hill Court, the tone of these meetings was set as relaxed, interactive and a seemingly routine occurrence. As such, my participation and presence appeared to be taken in stride by staff; a pattern which continued through consent processes and data collection, regardless of whether an individual was involved in the research. In Sunshine Lodge, I was introduced by the manager in meetings that occurred in the middle of a shift and during which a number of disciplinary issues were raised. I experienced these meetings as difficult and disruptive to staff, and I found it challenging to communicate directly with staff during them. Again, this was an atmosphere that repeated itself during the consent process and, to a lesser extent, throughout data collection as a whole. These experiences made me aware of how I and others were likely to have carried our perceptions forward. In both cases, I was associated with the manager and their models of interaction, by both myself and staff. Despite the challenges this presented, these situations are, in themselves, data. When considering the patterns of learning that occurred within each of the homes, I often found myself reflecting back to these first meetings and considering the implication on learning of being interactive with those who are senior, or being in a more passive role. The implications of positionality, the roles I played and was made to play in the field is further discussed in relation to observations below.

It is characteristic of ethnography to use multiple methods whilst in the field, combined with continual reflection on the fieldwork experience as a whole (Hammersley, 1998; Fetterman, 2010). It is important to note that, in ethnography these are not employed in a linear fashion but instead in an iterative manner, constantly going back and forth between field experiences, different collection methods, reflections and developing analyses (Boyle, 1994; Rock, 2001; Hammersley and Atkinson, 2007).

3.4.2 Observation

Ethnography is often assumed synonymous with participant observation (Faubion, 2001; Rock, 2001; Hammersley and Atkinson, 2007), in which the researcher is immersed and participating in the routines, mundane activities and interactions of the community under study, reflecting on what they have seen and heard whilst simultaneously living the contexts of participants' themselves (Crang and Cook, 2007; Hammersley and Atkinson, 2007; Fetterman, 2010). It is viewed as central to ethnography because of its superiority to other methods of data collection in allowing access to 'real life', direct experience and providing opportunity to compare people's actions and words (Tope *et al.*, 2005; Fetterman, 2010; Pfadenhauer and Grenz, 2015). However,

as with ethnography more generally, specific descriptions of 'doing' participant observation are rare because it is viewed more as a way of 'being' in the field that grounds the researcher in participants' realities (Hodson, 2004; Hammersley and Atkinson, 2007; Neyland, 2009; Silverman, 2011). There remain unresolved debates in the literature regarding the extent to which an ethnographer should participate or observe when doing 'participant observation', what 'participation' really means, and how long in the field 'participation' actually requires (Smith, 2001; Angrosino, 2005; Corbin-Dwyer and Buckle, 2009; Brockmann, 2011; Jansson and Nikolaidou, 2013). Indeed, the nature and persistence of this debate perhaps owes more to the ever-present shadow of positivist notions of reliability and validity, than it does to the uncertainty of ethnographers' themselves (Pollner and Emerson, 2001; Smith, 2001; Walford, 2009; Brockmann, 2011). In reviews of ethnographies focussed on work and workplaces, studies include those conducted through full and sustained immersion in work as paid employees and those involving less participation and fieldwork that is intermittent and disrupted (Smith, 2001; Tope *et al.*, 2005). They are all ethnographies; it is the status of their findings and the ethnographers' claim to represent the culture holistically that is open to debate.

I have found the notion of 'ethnographic sensibility' - as I described earlier - applicable in resolving this confusion because it highlights that it is the *approach* of the researcher rather than specific roles that determine their ethnographic status during observations. Miller (1997) highlights four key commitments of an ethnographer in the field: to be in the presence of the people being studied; to evaluate people in terms of actions as well as words; to be present long enough that it allows people to return to their daily lives; and to analyse holistically and in context. Others highlight the need to develop 'fluency' in the culture (Faubion, 2001), to acquire a sense of enigmatic everyday life (Malinowski, 1922), or to be involved in the social life of the community (Emerson, Fretz and Shaw, 2001; Jansson and Nikolaidou, 2013). Each of these is less about specific parameters of observation or participation and more about the approach of the researcher to her time in the field and analytical consideration of it. This would suggest that the role the ethnographer plays will change over time with her own and others' understandings and circumstances in the field. The sufficiency of any role adopted or decisions made are based on the ethnographers' reflexive understanding of the culture under study, rather than external, objective notions of adequacy or appropriateness. Therefore, ethnographers can and do use a range of different observation roles and techniques in the field, depending on what and why they are focussing on a particular area of cultural life (Whitehead, 2005). Discussion of observation roles is important in a constructionist study such as this because of their effect on the data achieved not because one is any more ethnographic than the other.

My role as ethnographer in observations evolved with the research, often beginning at the margins of the culture, experiencing it as a stranger before moving closer and developing familiarity and perhaps membership of the community (Morse, 1994; Rock, 2001; Hammersley and Atkinson, 2007; Pfadenhauer and Grenz, 2015). However, these roles are not solely choices made by the ethnographer, they are the product of her interactions within the culture itself and therefore become part of the data. There may be aspects of the culture and the researcher that determine the extent to which one can be an active member - participating in the core activities of community life – or a peripheral member, on the fringes of the community (Adler and Adler, 1987). As Morse (1994) highlights one can only intrude or participate as much as one is allowed to. For example, Jansson and Nikolaidou (2013) illustrate that their previous work and ethnic identities led to each developing and re-negotiating different roles when researching in a care setting, because of the way participants related to, positioned them and performed whilst each was observing. Positionality, performances and the impacts a researcher herself may have on what is observed are not possible to predict in advance, or eradicate from data (Allen, 2004). Therefore, it is this process and experience that itself becomes data. It is the circumstances of the performance a participant gives in light of how they position the researcher that is as important as whether the action is affected by the researcher (Simpson, 2006). A researcher merely needs to be aware of the fact that performances will be part of the data and explore them. Indeed, these incidents can provide insight that could not be gained in other ways through what Monahan and Fisher (2010) call 'normal misbehaviour'. Brockman (2011) highlights that her experiences of embarrassment and pressure to 'look busy' when observing apprentices on the shop floor, sensitised her to the possible experiences of new workers and the pressures to learn the work in certain ways.

There are many techniques that an ethnographer may use to manage relationships and roles in the field, such as emphasising similar personal characteristics or sharing personal experiences to blend in with participants (Brockmann, 2011) or impression management, such as using one's clothing or speech, to integrate into the community (Hammersley and Atkinson, 2007). However, it is wrong to conceptualise these as solely utilised to move from the fringes to the centre of cultural life, or from observer to participant. In fact, as Castellano (2007) highlights, strategies such as 'selective incompetence' – in which a researcher acts less able than they are in the field – are often employed to move a researcher to the periphery during fieldwork, particularly in familiar settings. To view observation roles as distinct states progressing from periphery to centre of a culture advances a view of culture that is inaccurately homogenous. What may make one blend-in in one circumstance may mark one as an outsider in another. It is the ongoing

negotiation of, rationale for, and challenges to different observation roles that, in themselves, demonstrate culture. When viewed in this light, the traditional concepts of 'insider' and 'outsider' roles in which the researcher does or does not possess intimate knowledge or membership of the group under study, represent a false dichotomy (Larabee, 2002; Corbin-Dwyer and Buckle, 2009; Green, 2014; Wegener, 2014b). Instead, Wegener (2014b) advocates that they should be viewed as sensitising concepts rather than descriptors, by which a researcher examines their manifestation to understand the culture and their interpretation of it. Pfadenhauer and Grenz (2015) use the term 'stranger-participant' to explain that even an already-existing member must adopt the curiosity and separateness of a stranger in order to retain the necessary analytical mind for research. The inevitably fluid nature of the observation role led Corbin-Dwyer and Buckle (2009) to conclude persuasively that, rather than aiming for insider or outsider status, researchers must embrace 'the space between.'

By way of example, comparison of my time in the two care homes demonstrated the ways in which the researcher, participants and culture co-created a fluid role throughout the research. In both care homes my purpose was the same and I was carrying out similar activities: those of a volunteer to the setting, sitting in communal areas, interacting with residents at their instigation and taking part in communal activities but not personal care. This could be characterised as a definitive 'role' such as observer-participant or peripheral member (Adler and Adler, 1987; Hammersley and Atkinson, 2007). However, because of my style of interaction with residents in Strauss Hill Court, that role made me an insider and opened opportunities for further participation, such as being asked to 'watch' over residents when there was no staff member in the room. Whereas, in Sunshine Lodge, my style of interacting ensured I was positioned as an outsider. A comparison of extracts from my research diary illustrated this;

> *I explained to a member of staff that I'd received an unexpected hug and kiss from resident K. The staff member commented, "Ah, welcome to Strauss Hill! You're in it now…" This clearly communicated that this was both a normal and positive aspect of care at here. It felt like I had passed an initiation.*
>
> **Research Diary extract, Strauss Hill Court**

I became aware very quickly that my interactions with residents positioned me as 'different' to many of the care staff… when I responded to a resident's question by seeking out an answer from a staff, I was told that others did not usually answer the resident in question. This made me feel like I'd broken a basic rule.

Research Diary extract, Sunshine Lodge

Observation tools to involve people living with dementia

Traditional ethnographic observations are generally unstructured with guidance only as to what should be recorded in observation notes, or what to focus on as the research progresses (Woolcot, 1988; Crang and Cook, 2007; Hammersley and Atkinson, 2007; Fetterman, 2010; Silverman, 2011). However, some more recent ethnographies of dementia care settings do supplement ethnographic observations with the use of specific observation tools or schedules. For example, Kelly (2013) used Dementia Care Mapping to explore bodywork in dementia care on a hospital ward and Campo and Chaudhury (2011) used environmental assessment tools to aid in exploring social interaction among residents in a dementia care unit.

For ethnographic purists, the use of a structured tool could be unnecessary and contradictory to the aims of an ethnography and thus its use in this study questionable. Ethnographic approaches are deliberately unstructured and open in their application so that it is the participants and culture under study that have primacy over and above any pre-existing understandings or preferences that the researcher herself may bring to the setting (Woolcot, 1988; Fetterman, 2010). However, I believe that this stance is one that should be challenged within the context of ethnographic research that wishes to include data relating to the perspective of people living with dementia. This stance does not take account of the challenges and impacts dementia can have on a person's ability to communicate and attract attention, particularly in the more advanced stages of the condition. In order to capture the perspective of individuals living with advanced dementia, a researcher should accept that their own usual skills and techniques may need to be adapted to ensure that the verbal and non-verbal expressions which form the basis of communication (and therefore offer a window to their perspective) can be properly captured and given appropriate credence in the data and study (Brooker, 1995; Hubbard, Downs and Tester, 2003; Nygard, 2006; Dewing, 2008; Brooker *et al.*, 2011b; van Baalen *et al.*, 2011).

Far from contradicting an ethnographic approach, I believe that methods or tools that are specifically tailored to the communication and needs of people living with dementia can enhance

immersion in the culture by enforcing a discipline that foregrounds the person living with advanced dementia's experiences rather than relying solely on the researcher's (fallible) skills of observation. Ethnographers stress the importance of emic validity, understanding meaning of known phenomena from the perspectives of those who live them (Whitehead, 2005; Hammersley, 2006). Therefore, it is important to consider the way in which my perspective as a researcher may need to be augmented to enable access to a perspective that may be so cognitively different from my own. A dementia-specific observation tool can therefore act as the equivalent of a translator for an anthropologist exploring a foreign culture. As with any 'translation' the limitations inherent to interpretation have to be acknowledged. Whilst a tool may aid in focussing the observer on areas that are known to make a difference for people living with advanced dementia, (something that could be missed in unstructured observations), at best the data are an interpretation of what could be experienced by a person and cannot be considered a direct representation of what a person is thinking or feeling in the moment (van Baalen *et al.*, 2011). This is particularly important where data may not be able to be verified with individuals themselves through conversation or interview due to verbal communication and cognitive disabilities. This only serves to demonstrate the importance of constant reflection in ethnographic studies, and reminds one of the significant responsibility when attempting to represent another's experience (Clifford and Marcus, 1986; Fetterman, 2010). The specific tool I used and the insight it gave me will be addressed in detail in the following chapter. However, to illustrate the way in which a structured tool helped enhance other observational data, I provide the following example from my study:

> *In my study, (structured observation tool) became a highly useful method of questioning some of the conclusions I was drawing about 'learning' in light of the experiences of people living with advanced dementia.*
>
> *In Strauss Hill Court I identified a 'norm of care' related to the way people were supported to move by staff. However, by using (structured observation tool) I was able to see that this was not always beneficial to some residents with advanced needs and this prompted me to explore how 'learning' this norm manifested itself in different circumstances.*
>
> **Research Diary extracts**

3.4.3 Interviews

Interviews are a mainstay of ethnographic research as they are the most explicit way in which participants' experiences, opinions and beliefs can be explored (Hammersley and Atkinson, 2007; Fetterman, 2010). In addition to using interviews to explore a person's thoughts and feelings, they are also useful in exploring inconsistencies that emerge from fieldwork and probing beneath the contradictory messages that behaviour and more formalised messages can produce (Crewe and Maruna, 2006). For example, Reed-Danahay (2001), Powers (2001), Bailey *et al*. (2015) and Nakrem (2015) all use interviews to compare with observation findings in care settings. Interviews can take a variety of forms including spontaneous dialogues, unstructured, open-ended interviews and structured interviews in which the researcher controls the agenda more fully towards pre-determined categories (Fontana and Frey, 2003; Tope *et al.*, 2005). In ethnographies, interviews tend towards the informal and less structured form, sometimes being better described as conversations (Hammersley, 1998; Sherman-Heyl, 2001; Fetterman, 2010). Sherman-Heyl (2001) argues that an ethnographic interview in particular is distingushed by the length and quality of the relationship between the interviewer and interviewee, enabling a much more indepth outcome.

Ethnographic interviews, however, cannot be treated uncritically for two crucial reasons. Firstly, interviews can only ever access conscious understandings of the interviewee and will always be mediated by the person's ability to verbally communicate, be understood, and the interpretative nature of language (Faubion, 2001). For the topic of learning this is particularly problematic as learning can occur unconsciously and thus not be in the person's awareness (Collis and Winnips, 2002; Rogers, 2003; Eraut, 2004; Gola, 2009; Marsick *et al.*, 2009) and is often linked with experiences of formal education. Eraut (2000, 2007) sought ways in which learning could be traced through interviews without explicitly referencing learning for this reason. Secondly, and most significantly, regardless of the topic under study, interviews never occur within a vacuum. Positioning and reactivity to the researcher and the circumstance of the interview is as present as it is within observations. The answers an interviewee may give are not only answers to the question, but also answers to the person asking the question and the context in which it is asked (Sherman-Heyl, 2001; Rubin and Rubin, 2005). Hammersley (1998, 2006) highlights that the audience for the interview, the stimuli for it, and the constraints it was conducted under are all realities that affect the content and thus limit its ability to directly reflect reality. This reactivity can be managed and, to a certain extent, reduced. In general, this can be done through 'impression management'- a key aspect of all ethnographic work - in which the ethnographer is mindful of how her speech, appearance and interaction may affect relationships and modulates

this to some degree (Hammersley and Atkinson, 2007; Fetterman, 2010). Specifically, the ways in which interviews are conducted - the space used and tone of questions - can be designed to set the tone as relaxed and focussed on the participant and their experiences rather than the researcher's agenda (Schwartzman, 1993). Furthermore, attempts to explicitly encourage interviewees to disagree and object to research questions and their premise are important in counteracting the effects of the power differential inherent to interviewing (Tanggaard, 2008). However, none of these options are perfect solutions, because one is not always in control of aspects of self or how others perceive them. For example, Jansson and Nikolaidou (2013) experienced different reactions and positioning by care staff in their ethnographic study due to their past roles and nationality.

The challenges of interview data may present an argument for avoiding sole reliance on such data, or at least being aware of the limitations of research based on a single source. Tope *et al.* (2005), in a review of qualitative research into work practices, highlight that observation and participant observation yield consistently more information when compared with interviews alone, particularly when examining behaviour, relationships and group dynamics. However, these limitations do not render interview data inadequate or unimportant. Consistent with my constructionist and ethnographic principles, the limitations and impact of reactivity is only adverse when its effect goes unacknowledged or obfuscated by attempts to remove its influence (Spears, Ibanez and Iniguez, 1997; Lincoln and Guba, 2005; Hammersley and Atkinson, 2007). No interview data are free of this effect and therefore consideration of these dynamics becomes part of the data: what a person chooses to say or not to say and how they choose to present themselves is as telling of a culture as how they might behave. Consideration of how the self and others are created in the 'performance' of an interview is itself data (Sherman-Heyl, 2001). Rubin and Rubin (2005) argue that, far from attempting to minimize their influence, a researcher can, by recognizing and reflecting on their own style, the relationship at the heart of the interview, and the 'humanness' of themselves and their interlocutors, develop a responsive and flexible interaction that maximizes the output from the interview.

As an example, in one care home in my study, I became aware during early fieldwork that two care workers had recently had a public disagreement regarding an aspect of care of people living with dementia which had not been resolved definitively. Both conducting and analyzing these workers' interviews therefore needed to be considered within this dynamic as they both sought to explain their points of view, and what did (and did not) influence their own practice. Moreover, the interviews themselves became part of this dynamic, with one participant seeking me out for an interview after seeing me interviewing the other. Indeed, it was a challenge when conducting

these interviews to avoid being drawn into the debate. These dynamics actually became a strength of my data once I was aware of them as I could explore the roles influential people, peer interactions and 'grey areas' of practice played in care workers' learning.

3.4.4 Material aspects of culture

The investigation of the material aspects of the culture, such as documents, artefacts, decoration, or objects, is an important data stream in ethnography although often neglected in literature, subsumed within discussion of symbols and texts that are part of fieldwork and field notes more generally (Carspecken, 1996; Hammersley, 1998; Fetterman, 2010; Silverman, 2011). Material aspects of the culture most commonly included within ethnographic accounts include written texts, documents and images that have been recorded separately from the research/researcher, such as organisational policies, diaries, group photographs or websites (Hammersley and Atkinson, 2007; Silverman, 2011). Material culture, though, should be considered much wider than this. Carspecken (1996) advocates the use of maps to contextualise field notes and Tilley (2001) refers to ethnographic material culture as any 'humanly produced artefact' including objects and use of space. It is not simply their existence, but the ways in which they are used, intended, rejected, talked about and the meanings given to them by members of the culture that are of significance for an ethnographer. It is their context-specific and meaning-making existence that matters (Hammersley, 1998; Hodder, 2003; Silverman, 2011). This is because "(the) meanings people give to things are part and parcel of the same processes by which they give meanings to their lives" (Tilley, 2001, p. 260). Resistance to considering the role of material culture may come from concerns regarding the status of artefacts to represent 'reality' and the interpretation of something that cannot 'disagree' in the way a participant may (Hodder, 2003). However, this is only a reason for restriction if one is not cognizant of the ethnographer's active role in interpreting and constructing the meaning given to material culture. Reflexivity again plays a crucial role here.

The access and consideration of material culture is important for a number of reasons. Firstly, it is communicative in that it sends a message about the culture and people who interact with it. This can be in a symbolic form (what it is intended or understood to represent) and/or in a more practical form through the way in which it is used or engaged with (Hodder, 2003). Secondly, examining this material culture can be particularly significant in helping to expose and investigate multiple and conflicting identities that can exist in any culture (Hodder, 2003; Hammersley and Atkinson, 2007). In fact, precisely because artefacts and documents are not always as attention-grabbing in the same way as speech or action, they can be especially insightful as to unconscious

and internal meanings people may bestow in a setting (Hodder, 2003). Thirdly, material culture is not simply a passive feature of the culture. It also has effects itself by encouraging or limiting certain behaviours. For example, the space available and arrangement of furniture can influence the level and type of interaction that takes place in an environment by sending messages about what is deemed appropriate and physically limiting what is possible (Tilley, 2001).

It is notable that few ethnographic accounts in care settings or examining learning explicitly address the role of material culture, or indeed, even mention that it was a specific aspect of data collection. However, when considering accounts, the role played by material culture can appear significant even if not specifically addressed as such by authors. For example, Deforge (2011) highlights the role that documentation and policies played in staff feeling afraid and unable to care in a care home, but this is subsumed within the author's focus on organisational interactions rather than examined in its own right. Hunter *et al.* (2008) illustrate that learning in a neo-natal unit often takes place at the 'crib-side' but do not appear to consider the role of the physical environment in facilitating or constraining that. Where aspects of material culture are addressed explicitly, it is because the focus of the study specifically demands it, such as in Stephens et al. (2012) study of relationships between people with dementia and objects in a care setting.

This perhaps merely highlights the myriad of ways in which an ethnographer can approach and depict a culture, and the way in which writing the ethnography is a constructive act in itself (Clifford and Marcus, 1986; Fetterman, 2010). However, for me, it ensured that the existence and use of material culture was considered alongside other data collection techniques, not subsumed within them. This appeared particularly important to me from the outset given the fact that the material culture in a care home (through space, equipment, objects, pictures etc.) fulfils the dual role of home and workplace and 'learning to care' occurs at the interface of 'being at home' (for residents) and 'being at work' for staff. This account, drawn from entries in my research diary for the second care home I visited, illustrated how considering material culture, in particular space, was instructive in understanding the care provided and learned in the home.

I was shown very early on and with pride, the dedicated 'dementia lounge' – a small lounge which contained 50s/60s themed items and annexed off the main lounge.

However, when tracking this through my time in the case study it was used and interacted by staff as a storage space for hoists and wheelchairs. This highlighted its double meaning and how these different meanings were attached to different roles in the home

Research Diary, Sunshine Lodge

3.4.5 Reflexivity

By examining the data collection techniques of fieldwork, observation, interviews and material culture I have illustrated the centrality of reflexivity in any ethnographic study. However, the centrality demands that I also examine it in its own right as a key technique used by ethnographers both in and out of the field. Through decision-making, presence and interaction, I am absolutely central to the research process and subsequent findings. Far from being a disinterested observer, seeking to eradicate influence on the research process, data and conclusions, an ethnographer embraces their involvement in all parts of the research. In part this is due to the constructionist position that acknowledges objectivity as an impossible goal remedied only by describing involvement and influence (Taylor, 2002; Lincoln and Guba, 2005; Hammersley and Atkinson, 2007; Cruz and Higginbottom, 2013; Mortari, 2015). Primarily though, for ethnographers, their influence and interactions are part and parcel of the culture under study (Clifford, 1986). Therefore, describing, questioning and reflecting on those interactions becomes essential, because relationships, interactions, and communication are the core of ethnographic data and therefore the researcher is implicated in them as much as participants themselves (Pollner and Emerson, 2001; Jansson and Nikolaidou, 2013). As Crang and Cook describe, "research on social relations is made out of social relations," (2007 pp9). Accounting for these social relations is achieved though reflexivity.

Mortari (2015) describes reflexivity as a "turning back on the self," in which the researcher moves beyond describing findings to account for how those findings developed (2015, p. 2). It is a process by which the researcher, researched and their respective stories are differentiated, so that the researcher's influence can be seen and interrogated in different aspects of the research

(Sherman-Heyl, 2001; Clarke, 2009; Green, 2014). This can take different forms. Firstly, reflexivity most often appears as an awareness of self and personal characteristics and their practical impact on relations in the field (Okely, 1996; Corbin and Strauss, 2008; Braun and Clarke, 2013; Darawsheh, 2014; Mortari, 2015). For example Nakrem (2015) and McColgan (2005) both discuss their own experiences and thoughts whilst conducting ethnographies in care settings. Whilst this aspect is important, it is often criticised for being the most basic interpretation of what reflexivity requires (Spears, Ibanez and Iniguez, 1997; Sherman-Heyl, 2001). A second and more thorough approach to reflexivity is to extend this self-awareness into a critical interrogation of the research process, aimed at discovering and probing the researcher's often unconscious assumptions and their influence over decision-making, field relations and findings (Braun and Clarke, 2013; Mortari, 2015). For example, Jansson and Nikolaidou (2013) and Bambustic (2011) both discuss the ways in which their role influenced both the process and outcome of their research in care settings. This is particularly important in focussed and critical ethnographies given the respective familiarity and intention of such studies (Boyle, 1994; Lather, 2001). If one is intending to be critical regarding the culture, one must also be critical of one's role in it and, crucially, the power relations inherent in interpretative research methods (Spears, Ibanez and Iniguez, 1997; Sherman-Heyl, 2001). Indeed, Avishai *et al.* (2012) highlight that identifying where the researcher's value base and subsequent agenda conflicted with those of participants sensitised the researchers to significant aspects of the field that would have otherwise gone unnoticed.

Despite its obvious importance, it is notable how little reflexivity of either kind is contained in many published accounts of ethnographic work. Reed-Danahay (2001), Bailey *et al.* (2015) and Taylor *et al.* (2014) are examples of ethnographic studies in care settings that contain little description, let alone critical appraisal, of the researcher's role. This would suggest that the significance of reflexivity for ethnography is misunderstood, if not amongst ethnographers themselves, then by those who publish their research. Nonetheless, reflexivity is the primary way in which an ethnographer demonstrates the rigour of her research and thus its presence serves to nullify criticism of relativism by embracing authorship and its impact (Potter, 1998). By critically engaging with thoughts, feelings, encounters and assumptions occurring during the research process, a researcher can deconstruct from where conclusions have emerged and articulate the ways in which the researcher, the world and their interaction have constructed the findings as presented (Macbeth, 2001). Rigour is thus shown through transparency of self and decision-making and critical engagement with its consequences, displayed in a reflexively-produced audit trail of the whole research process (Finlay, 2002; Corbin and Strauss, 2008; Darawsheh, 2014). Whilst debates abound, specific descriptions of how reflexivity should be achieved and

demonstrated are limited (Green, 2014). However, three key aspects exist. Firstly, reflexivity belongs across all aspects of the research process from choice of research question, through ethical considerations, to writing. Thus any method must embrace this all-encompassing nature (Clifford and Marcus, 1986; Bloor, 2001; Finlay, 2002; Hammersley and Atkinson, 2007; Mortari, 2015). Secondly, it is to be applied and logged throughout the process as well as reconsidered in final analyses, through the use of journal or diary (Robinson, 2014). Finally, specific reflexive triggers or turning points should be used to illustrate its influence throughout the final account (Darawsheh, 2014; Robinson, 2014).

To this end I have demonstrated throughout this chapter how my own theoretical stance and understandings have influenced the choices made with regards to methodology, and how specific theoretical aspects of techniques manifest in this and others' studies. I shall now embrace reflexivity more fully by describing the specific methods and practical decision-making in my ethnography and the consequences it had for my experience, the participants and, ultimately, the findings.

Chapter 4: Methods

In the previous chapter I explained the theoretical foundations of my study, illustrating how personal ontological and epistemological positions influenced the research question, methodological choices and design. In this chapter, I describe the practical process of this research, the decision-making at key points, its rationale and impact. Within a qualitative and ethnographic study it is vitally important to explicate the process of conducting the research in detail as it is a hallmark of quality (Dreher, 1994; Muecke, 1994; Mays and Pope, 2000; Corbin and Strauss, 2008; Yardley, 2008; Tracy, 2010; Rashid, Caine and Goez, 2015). For Rashid *et al.* (2015) a thick description of research processes enables contextual evaluation of data and thus is essential in demonstrating rigour in focussed ethnographies. Rigour, along with credibility and transparency are evaluative concepts more suited to the intent of qualitative research than the positivist concepts of validity and reliability (Leininger, 1994; Smith, 2001; Corbin and Strauss, 2008; Yardley, 2008; Tracy, 2010; Braun and Clarke, 2013) but serve an analogous purpose in enabling the reader to judge the appropriateness of a researcher's conclusions and the likely transferability of findings beyond the specific study (Bryman, 2001; Lincoln and Guba, 2005; Braun and Clarke, 2013; Miles, Huberman and Saldana, 2014; Zulfikar, 2014).

In addition to this thick description it is also essential that my reflexive engagement is evidenced as my own influence becomes part of the data collected and interpretations made (Muecke, 1994; Mays and Pope, 2000; Walford, 2009; Cruz and Higginbottom, 2013; Rashid, Caine and Goez, 2015). For Nakrem's ethnography of care home organisations, reflexivity provided the foundation for others to "reconstruct the logic of inquiry," (Nakrem, 2015, p. 4). To this end, I have reflexively addressed the following features of my study: Recruitment and selection of care home sites and participants; data collection processes; data saturation; data analysis; and ethical considerations.

4.1 Recruitment and selection

Recruitment and selection of participants occurred at several levels: the care homes, the residents, and the staff. At each stage, decisions were made that influenced the final communities under study (see Figure 2).

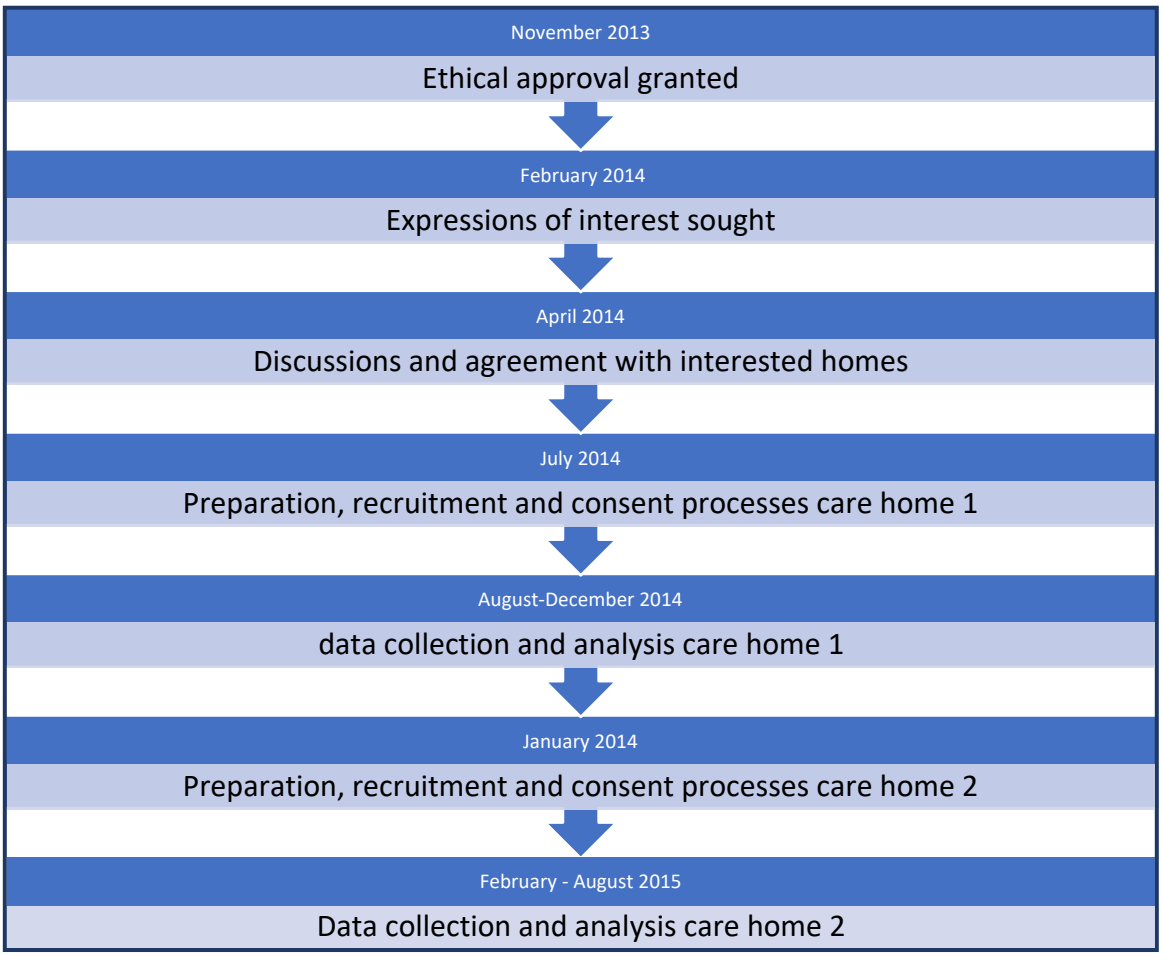

Figure 2: Timeline of selection and data collection in my study

4.1.1 Selection of care homes

In my initial research proposal I intended to select three care homes as sequential study sites. In order to recruit these, I identified possible care homes within 20km of my address, through a comprehensive database (Elderly Accommodation Counsel, 2013). Care homes that did not include dementia as a catered need or were not registered with the Care Quality Commission (CQC) were excluded as they did not fit the parameters of my study. I sent a letter to the registered manager of each home explaining the study and inviting participation (Appendix 2). Four care homes expressed interest and I visited the registered manager to discuss, sharing an information sheet and consent form (Appendix 3). At this stage, my own decision-making influenced the process in deciding which homes would participate and when. This highlights that practical considerations often delineate much research decision-making: being local and willing/able to participate could perhaps be seen as my primary selection criteria. In ethnographic research it is not unusual for sites to be purposively selected from within convenient options for their ability to illustrate pertinent features (Guest, Bunce and Johnson, 2006; Walford, 2009;

Spiers *et al.*, 2014). Thus, given that the first two homes willing to commit to the research contrasted in key ways, they were both selected to take part. In actuality, due to the volume of data collected and the first two homes' comparative value, I later decided that a third care home was not needed. This is discussed later with regard to 'data saturation'. Pen portraits of the two care homes Strauss Hill Court and Sunshine Lodge are provided following this chapter.

Whilst my ethnographic approach meant that this small, convenience selection was not a problem – there was no intention to sample representatively – this decision likely had consequences for my study. Firstly, a manager will have a rationale for opening their doors to a researcher. There is no guarantee that this reasoning would be neutral in impact on other areas of their work, such as dementia care and its relative importance in the home. In turn, these have potential implications for staff learning and thus my study. Secondly, the choice to select two contrasting care homes meant that early on I decided which dimensions of care home operation were important to me and the topic. Table 1 below shows these dimensions. Had I chosen different dimensions of comparison then different care homes thus different data and findings may have emerged.

Table 1: Key dimensions of chosen care homes

Dimension	Strauss Hill Court	Sunshine Lodge
Registration	Care only	Care with Nursing
Dementia status	Specialist	Non dementia specialist
Size of owning organisation	Large (more than 20 homes)	Small (5 homes or less)
Type of owning organisation	Not for profit	For profit

Finally, my decision to research each site sequentially, treating each care home as a distinct unit, betrays an underlying belief that the care home is the appropriate level at which to focus. This reveals something about my stance on learning and how it might occur. Had I a more individualistic and less social understanding of learning then I may well have chosen to treat care workers as the unit of analysis rather than anchoring their data to their workplace. Through this choice I assume that care home context is potentially more important in determining learning than the individual themselves; something which is consequential for my findings. For example, within the two care homes, the shift patterns of care staff differed in ways that appeared to affect their learning. In Strauss Hill Court, staff had variable and changing shift patterns, meaning that they worked at different times, with different residents and different colleagues. In Sunshine

Lodge, shifts were fixed, resulting in two distinct staff teams who had more predictability to their work, and contact with residents and each other. Had I chosen a design that resulted in data separated from these contexts, it is possible that the potential influence of the shift pattern on staff learning would not have been considered, especially as staff did not seem consciously aware of the affordances or restrictions such shift patterns provided. This lends weight to my methodological argument in Chapter 3 that it is impossible for any researcher to be entirely independent of what they study. How I framed the research question, and designed exploration of it, revealed my implicit thoughts and values; the role of an organisation to influence and prescribe individual behaviour has long been an area of interest of mine, stemming from my experiences as a care worker.

4.1.2 Selection of care home resident participants

Once initial access had been granted through the manager, I undertook internal selection processes with residents living with dementia in the home. The criteria for resident participation were akin to that prescribed in the PIECE-dem process (Brooker *et al.*, 2011b; Brooker *et al.*, 2013; Latham *et al.*, 2015) as follows: a resident must be living with dementia and experience one or more of the following;

- Be cared for in bed
- High levels of falls/accidents
- High dependency regarding communication
- High levels of challenging behaviour
- Very mobile or agitated
- Sight and/or hearing loss.

These ensured that my study focussed on those residents and care needs that most commonly presented dementia care challenges to workers (Benbow, 2008; Killett *et al.*, 2016), and prevented the need for a separate recruitment process for PIECE-dem and ethnographic observations. Residents who experienced paranoia, acute mental or physical health issues or who had previously asserted non-participation in research were excluded to prevent risk of harm (Brooker *et al.*, 2011). This recruitment process was prescribed by the Social Care Research Ethics Committee (SCREC - approval granted 18/11/13). This ensured that the process was compliant with the Mental Capacity Act (2005) in its involvement of people who may lack capacity. Resident information sheets, consent forms and consultee declaration forms mandated by SCREC are provided as Appendix 4 and 5. Appendix 6 shows the recruitment, capacity and consent process

as followed in the study in detail. Twelve residents participated at Strauss Hill Court and eight at Sunshine Lodge.

For all residents, consent (as comfort with my presence) was re-checked at the start of all observation periods through my re-introduction and ongoing observation of non-verbal behaviour. This ongoing approach to assent in which indications of discomfort or negative statements are taken as possible withdrawal of assent/consent is increasingly evident in studies involving those who may lack capacity (Dewing, 2002, 2007, 2008; Nakrem, 2015; Killett *et al.*, 2016). During fieldwork this led to a constant interplay between resident and research activities, with the latter frequently changed to accommodate residents' reactions. Whilst this is ethical research practice, it is important to acknowledge that by actively avoiding those residents who did not want to be involved I will have only experienced a partial impression of care home and resident life. The lives of residents who were not involved may have presented different challenges and opportunities to the research and thus affected findings

4.1.3 Selection of care home staff participants

Staff participants were selected last as only those who were likely to have contact with participating residents were involved. Awareness meetings were held with information sheets and consent forms provided (Appendix 7) before staff were invited to take part. Staff participation criteria were as follows:

- Had contact with the resident participants
- Were engaged in a care worker role or had substantial contact with residents or care workers who were participating
- Wanted to participate

The role of care worker for this study was identified by the following criteria:

- A role primarily concerned with providing direct care to residents **and,**
- A role requiring 'non-specialist' expertise (where specialist expertise is denoted by formal qualifications on which a role is contingent, such as a nurse or registered manager).

Whilst the majority of staff participants were in care worker roles, some senior staff, domestic staff and nursing staff also provided consent and were involved in observations and interviews where it was likely to enhance the insight gained. In addition, some staff who were initially reluctant agreed to participate once they got to know me and saw others were participating. In practice, 20 staff consented at Strauss Hill Court and 13 at Sunshine Lodge.

Data collection activities were organised to ensure the least possible contact with those staff who did not want to be involved, as well as accounting for residents' preference. It was not unusual in both care homes to find my visits crossed over with staff members who had not consented, despite planning. In these circumstances I individually approached the member of staff and explained that I was observing others only and asked them if this was okay. Judging both the verbal and non-verbal feedback I then made a decision whether to continue or to excuse myself as observation was not possible without impinging on non-consenting staff. Data collection activities were regularly halted or altered to avoid non-consenting staff. This care staff self-selection presented another influence on the findings. In both care homes, there were staff who were not involved and this influenced what events could be researched; certain shifts, occasions or areas of the home could not be accessed entirely.

This may have impacted data collected and factors related to learning. For example, in Sunshine Lodge, the care team comprised four distinct teams; two dayshifts and two nightshifts who worked fixed patterns of 12-hour shifts. Only dayshift 'A' provided sufficient consents to make observation possible and this meant I did not spend time with dayshift B or either of the nightshifts. This contrasted with Strauss Hill Court where consenting staff enabled me to observe shifts at all times of day and night. When a certain staff member, team or area could not be observed, it meant I could not access insights into learning that they may have been able to provide. Therefore, I had to ask myself what I was not seeing, what may be influencing learning that I could not access, and why I may not be able to access certain people, times, and places. These questions provided invaluable insight for the study. The following note from my fieldwork diary illustrates such an occasion. This interaction occurred towards the end of my research, when I was a familiar presence. I encountered a member of staff who had not consented. This staff member gave me permission to use these notes in my research.

> *"I checked in with (non-consenting staff member) to see if it was okay if I spent time with A (other staff member) and if I would be in her way. She replied to me that it was absolutely fine, that she was happy to chat to me too. I reminded her that she had said no to taking part. She explained that she had said no only because she didn't want to be observed doing care following a 'horrible' experience with her NVQ assessor. Being observed made her nervous and then she would do it wrong. She continued to chat to me throughout the shift."*
>
> **Research Diary, Strauss Hill Court**

Given that observing practice is an oft-used method of quality assurance, this incident made me question what might be learned by staff when these situations are experienced negatively. Most importantly it highlighted to me that there could be important, diverging perspectives that my study missed because they were allied to people or situations who did not want to be involved.

4.2 Data collection processes

I spent 6 months engaged with Strauss Hill Court and 8 with Sunshine Lodge. Data collection was over a longer period in Sunshine Lodge due to my employment commitments. During fieldwork I visited the homes intermittently, approximately one or two days a week. Visits varied in length and focus to capture different aspects of life in the home, adapt to practicalities, and to fit with other commitments, resulting in the data types/volume shown in Table 2.

Next, I have detailed the practical application of data collection techniques as part of the iterative process in each home. This is essential because such practicalities have a huge impact on data produced: It is not possible to record everything and thus data reflects where my attention was drawn and what I remembered. Data collection is therefore not a neutral recording of events, but instead an interpretive act (Emerson, Fretz and Shaw, 2001; Taylor, 2002; Hammersley and Atkinson, 2007; Fetterman, 2010).

Table 2: Data type and volume by care home in this study

Data type	Strauss Hill Court	Sunshine Lodge
Hours of observation (excluding PIECE-dem observations)	20 (all hours of day; incl. night shift)	25 (all hours of 8-8 shift, one shift team)
Hours of PIECE-dem observation	13 (2 residents, whole waking day)	5 (2 residents, active parts of the day)
Number of interviews (standalone)	10 (12 hours) (2 managers; 2 lead care; 6 care assistants)	5 (5 hours) (2 managers; 1 nurse; 1 activity worker; 1 care assistant)
Number of in-situ interviews (ethnographic, usually less than 5 mins each)	52 (inc. care assistants, lead care, activity workers)	39 (inc. care assistants, senior carer, activity workers)

4.2.1 Ethnographic observation

My default method of data collection was ethnographic observation, and I returned to it often when plans for interviews or focussed observations went awry. The role I occupied varied but observations generally involved me sitting in public areas of the home or walking between areas, occasionally making notes in a research diary. I took part in activities and conversations during this time if I judged that it might enhance my insight, or help maintain my 'unobtrusiveness' in the home. The choice to visibly record notes likely affected the data I collected as it will have made people more aware of my presence. However, this was an ethical consideration; an attempt to flag my researcher-status for residents living with dementia in an environment where I often looked and acted like their staff or visitors. This is discussed further in 'ethical considerations'.

I typed my handwritten in-situ notes as soon as possible after the event, together with my reflective and analytic thoughts. The purpose was to enable me, long after the visit itself, to understand the care home as a whole, the events I referred to, and the content of conversations. In structuring notes I used several layers of description:

- The location of the observation (unit, area, room, time, date etc.);
- The physical space of the observation (who, what and where, the 'feel' of the environment)
- The interactions between others
- The interactions of myself with others in that setting,
- My reflections on what I was seeing and hearing
- My self-reflection on what I was feeling and its impact

(Emerson, Fretz and Shaw, 2001; Whitehead, 2005; Crang and Cook, 2007; Zaman, 2008; Clarke, 2009; Engin, 2011)

In addition, I included two specific questions to ensure that my reflections engaged with my study's central purpose: 'what is being learned here?' and 'what does this suggest about how that is learned?' This was particularly helpful in iteratively reviewing what I was seeing and therefore what I needed to explore further.

In terms of what I observed, I began by seeking a variety of events and people to avoid making assumptions. This developed into efforts to observe 'strangeness' (such as what happened following an unusual event), or focussing on 'familiarity' (such as probing or taking part in something that had become routine) (Neyland, 2009). This contrast is common in ethnographic studies as a way to ensure both breadth and depth (Carspecken, 1996; Hammersley and Atkinson,

2007; Miles, Huberman and Saldana, 2014). The transition to more focussed events occurred after I considered I had a reasonable grasp on the 'rules of care here'. These were ways of caring that I considered (based on my observations and discussions) to be viewed as 'normal'. I then took these and explored them in both strange and familiar situations in order to explore why and in what circumstances they were created or changed. For example, one rule of care I noted in Strauss Hill Court was freedom of movement for residents throughout the home. The chance to explore this rule in 'strangeness' occurred when residents were moved to a communal area to allow maintenance work to be completed, limiting the possibility of freedom of movement. Again, in Sunshine Lodge, I noted the prevalence of certain language to communicate what needed to be done for residents. I therefore chose to explore this very familiar event by using the language myself with staff and probing whether I had the right understanding.

4.2.2 PIECE-dem observations

The PIECE-dem (Person, Interaction, Environment care experience in dementia) observational tool is a framework for observing the care experiences of people living with advanced dementia and complex needs (Brooker *et al.*, 2011b; Brooker *et al.*, 2013; Killett *et al.*, 2016). It is designed to ensure a focus on a single individual at a time, with minute-by-minute recording of observations for a set period. It is a qualitative tool that relies on subjective notes, but guides the researcher to focus on the person's interactions, and engagement or disengagement with the environment. This is based on the recognition that these aspects affect a person's well-being and that those with advanced dementia are most reliant on staff to make best use of these opportunities (Brooker *et al.*, 2011b). This is an approach that I have used before in previous research and so am familiar with the data and perspective it can offer (Killett *et al.*, 2016).

I have advocated my use of a structured tool within ethnography in chapter 3. Using PIECE-dem forced me to focus on individual experiences when they would likely have been lost in the commotion of the typical care home. For example, in Strauss Hill Court I captured a number of very small bodily movements, exhibited by a resident with advanced dementia, that suggested engaging with a doll positively impacted her well-being, through a relaxed body posture and a smile replacing a frown. Simultaneous to this, many other events were occurring in the lounge where she sat, which I likely would have been drawn towards had I been observing without PIECE-dem.

My initial intention was to use PIECE-dem as described in the V3 manual (Brooker *et al.*, 2013; Latham *et al.*, 2015) at the beginning of each case study so that my first impression of care was

from the perspective of those living with advanced dementia. In addition, the involvement of a second researcher (as required in PIECE-dem) would have provided a sounding board for myself as the research progressed. However, for two practical reasons this did not occur. Firstly, I found that in order to build positive relationships with staff (essential from the outset) the more open ethnographic approach provided me with more flexibility than PIECE-dem, particularly given that I visited the home intermittently. To be introduced to me and the study in the intense, structured way required by PIECE-dem would have reinforced barriers that exist as a stranger entering a closed environment. Instead, flexibility - taking part in any opportunity that presented itself - facilitated my immersion in the care home faster and more effectively. In addition, the second researcher was not available to observe with me at a time that suited both of us and the care home and it became impossible to organise this without substantial delay. As a result, I decided to delay the use of PIECE-dem in the first home and conduct it with one researcher, using a supervisor as an external source of reflection.

I therefore used PIECE-dem as a device to check tentative conclusions emerging from observations and interviews later on in Strauss Hill Court and found it well suited to creating 'strangeness' or exploring 'familiarity' (Neyland, 2009). I found this ordering helped me to more thoroughly explore the tensions between individuals' needs and those of the whole community, because I had a perspective on the holistic community before I sought to focus on specific individuals' experience. This is significant for this study as care work occurs at the nexus of these potentially contradictory pressures. Argyle (2012) highlights that a challenge to person-centred care and some observational tools can be their focus on individual needs to the exclusion of relationships and interconnections that are fundamental to such communal situations.

The circumstances of Strauss Hill Court therefore inadvertently led to the development of an observation sequence that enhanced my data collection which I replicated at Sunshine Lodge. Overall, PIECE-dem became a highly useful method for questioning conclusions I was drawing about learning to care in light of the experiences of people living with advanced dementia. As such, it was one way in which I was able to 'member-check' my conclusions, albeit in a highly interpretive way due to the challenges of verbal interaction (Carspecken, 1996; Sherman-Heyl, 2001; Braun and Clarke, 2013; Miles, Huberman and Saldana, 2014).

4.2.3 Material artefacts

Material artefacts - documents, policies, notices, decoration and objects that formed part of the care home - were also included as data in my study. These were collected throughout my time in

the field, either when I noticed them or when they were referenced by others. As part of ethnographic observations, I often took tours of the home explicitly exploring the physical environment and its artefacts, or spent time reading records. These items were either physically copied, anonymised and stored or described within my research diary.

4.2.4 Interviews

Interviews provided substantial data for my study and included conversations with senior staff, nurses, activity worker and care workers, as shown in Table 2. All participants were informed about the opportunity for interviews early, although in both homes only the manager and deputy undertook interviews at the beginning, with care assistants taking part towards the end. This was a product of practical circumstances and intentional planning. Firstly, as the focus of my study was care assistants, senior staff were interviewed primarily to 'set the scene' of the home. Secondly, volunteers from more junior roles in the home were more forthcoming once they knew me better. Thirdly, I wanted to use interviews with care workers not only to explore their experiences but also to 'member-check' my interpretations of what occurred in the home to ensure that they resonated with participants' understandings (Carspecken, 1996; Sherman-Heyl, 2001; Hammersley and Atkinson, 2007; Braun and Clarke, 2013; Koelsch, 2013). This necessitated observational data, analysis and reflection prior to conducting the interviews.

I selected possible interview participants with an intent similar to that of my observations; to broaden and deepen my understandings by seeking out those who would help me to explore and challenge my evolving thoughts about the home and learning to care (Sherman-Heyl, 2001; Fontana and Frey, 2003; Hammersley and Atkinson, 2007; Fetterman, 2010). I asked potential participants if they would like to participate and provided an information sheet and consent form (Appendix 8). I arranged a time and place convenient for them, with some taking place within shifts and others in their own time. All but one interview took place in the workplace. Recruitment was highly instructive as to the different circumstances in the two homes and became part of the data itself. In Strauss Hill Court I was inundated with offers of interviews, and staff were able to find time and accommodated by colleagues to talk to me. However, in Sunshine Lodge recruiting care assistant participants was extremely difficult because I had struggled to form relationships with staff due to their 'busyness' throughout shift. The one interview that did occur with a care assistant occurred during shift, but afterwards I observed several interactions with his colleagues that referenced his earlier 'time off' (to talk to me). This contrast led me to consider what this may mean for learning: could the structure of work and organisation of roles influence learning in similar ways to its influence over taking time to talk and reflect on that work

and role? This is not to ignore that these differing circumstances were likely influenced by my relationships with staff, but there may have been other factors at play.

Whilst the imbalance of interview data from Sunshine Lodge was a source of frustration, the experience reconfirmed the holistic nature of ethnographic data and the huge advantages ethnographic sensibilities can have when investigating real-world cultures. The challenges, barriers and limitations of fieldwork are data for an ethnographer (Simpson, 2006). These frustrations helped me to reflect overall on how hard getting to know staff had been, and how excluded I was in 'learning to care' in Sunshine Lodge simply because I was able to sit and talk to residents whereas care workers were not. This fitted strongly with a rhetoric of care work as 'never-ending', highlighted the contrast with other roles in the home, and provided significant insight into what and how learning may occur for care staff.

In preparation for interviews I developed a broad interview schedule for senior staff and care assistant/other roles (Appendix 9). This schedule was not to standardise conversations but to remind myself of key topics and ways to usefully probe for further information (Sherman-Heyl, 2001; Madison, 2005; Rubin and Rubin, 2005; Hammersley and Atkinson, 2007; Fetterman, 2010). In addition, as shown in Figure 3 and Figure 4 below, I used 'prompt sheets' developed during my time in each care home as follows:

1) List of statements that illustrated what (I thought) 'care' was at the home
2) Key vignettes of situations I had observed that could be discussed with participants to explore learning (Wareing, 2010).

Both prompts served two purposes. Firstly, they enabled discussion of learning without explicitly mentioning learning, as discussed in chapter 3 (Boud and Middleton, 2003; Eraut, 2004, 2007) . Secondly they provided an opportunity to check my interpretations with care staff and identify if my interpretations contradicted their experiences.

Each interview was audio recorded and transcribed verbatim (without disfluencies) by me, with only identifiable details changed to ensure anonymization. Where possible this was done before the next interview, although in both homes there was transcription remaining at the end of fieldwork.

Possible 'Rules' of Care at CS1: From observing care I have noticed the following patterns and general rules to the way that care is given here.

Generally, staff give step by step instructions to a resident when supporting them to move, take medication, eat etc.	Generally, when about to do something with a resident, they're warned first and then staff try several times before it gets done.	Generally residents have freedom to move around the home, or their units; they're rarely asked to sit down or go somewhere else	For some residents, chances to encourage them to eat are seized on whenever possible
Staff encourage and cajole residents to carry out certain tasks (move, eat, personal care etc.), but usually only up to a point	Generally there is quite a laid back and relaxed approach to getting stuff done throughout the day	There are some staff who are known to 'succeed' with certain residents and they are often asked to help with that resident	Generally, if people are confused or worried about something, honesty & explanation is used in response.
M is visited regularly by staff, but they do not respond to shouts/calls etc.	It is generally assumed that J understands what is being said to her	Some residents do not join in activities	Hugs, kisses and physical contact are seen a lot throughout the day

- Would you say that is a usual way things are done here? (if not what/when/why?)
- How do you know to do it like that?
- Are there times it wouldn't be done like that? (when/why, how do you decide?)
- Has it changed over time (whole home or particular residents)?
- How do you know if it's worked? What do you do if it doesn't work?
- Can you remember the first time you dealt with that type of situation? What happened?
- Are there people who don't do it like that? (why don't they?)
- How do you know that's the right way to do it? How would you know if it was the wrong way to do it?

Figure 3: Interview prompts used in Strauss Hill Court based on 'rules of care' observed in practice.

Care Vignettes:

F asking where her husband is, upset that he hasn't visited her today

A resident without dementia is upset that two other residents with dementia are sat in the wrong chair at breakfast time

J is sitting down and doesn't seem to want to move, but the lounge is being cleared for the builders

- How would you respond to this sort of situation?
- Why?
- How do you know that that's the way to deal with it?
- Would it ever be dealt with differently?
- Can you remember the first time you responded to a similar situation?
- What if you saw someone else dealing with it differently (good or less good way?)
- Is there anyone you'd go to (or anywhere) for advice in those sorts of situations? (why them?)

Figure 4: Interview Prompt used in Strauss Hill Court based on care vignettes observed in practice.

4.3 Data: when is enough, enough?

Whilst practical considerations and circumstances influenced my choice of care homes and participants these were not the only factors. An ethnographic approach can be open-ended until parameters are placed on it (Knoblauch, 2005; Marcus and Okely, 2007) particularly within such a dynamic setting as a care home; there is always a different shift, another day or new people with which to engage. However, I did impose parameters and these related to the purpose of the study and my evolving understanding of it. I wished to answer the question *'how do care workers in care homes learn to care for people living with dementia?'* Therefore, decisions made about whether to continue or stop seeking care homes, recruiting participants or collecting data related to their usefulness in answering that question. I used three interrelated concepts to guide my decision-making.

Firstly, at several points a researcher has to decide who and what should be included as part of the study, aiming to focus on those people, events and settings that are involved with 'living' the research question. This is **sampling** and in an ethnography it is the quality of insight provided that matters most in decision-making, rather than quantity or representativeness (Crang and Cook, 2007; Bourbonnais and Ducharme, 2010). This type of qualitative sampling can occur across time, people and contexts (Hammersley and Atkinson, 2007) and aims to progressively focus data collection down on to emerging themes within an iterative research process (Bowen, 2008; Corbin and Strauss, 2008; Silverman, 2011) by exploring similarity, conflicting accounts and unheard voices (Carspecken, 1996; Sherman-Heyl, 2001; Hammersley and Atkinson, 2007; Miles, Huberman and Saldana, 2014). In my study this influenced care home and within-home participant selection. Essentially, when deciding whether a care home, participant or particular event was used I asked myself the question: ***is this person or circumstance involved in 'learning to care' and if so, is it able to teach me something about it which may enhance my knowledge?*** For example, when presented with two care homes I had to decide whether to use them or seek alternatives and/or additional homes. Strauss Hill Court was a residential home that described itself as dementia specialist and Sunshine Lodge a nursing home that did not. Therefore, when asking my sampling question, both potentially offered something very different and this swayed my decision to use them both. In addition, both yielded good quality data, meaning that another home would not necessarily enhance my understanding of the phenomena further. This is not to say that a larger study and more data would not be useful, but in the context of a time-limited study that sought to develop initial understandings, I had seen and heard enough to be able to

explicate sufficient thematic findings and judge their applicability to the wider world (Hammersley, 1992).

This question also served me well in selecting participants and events within case studies. I was actively identifying those people who could potentially provide a different insight into the research problem. For residents, this meant seeking out those who had contrasting care needs or demands of staff because this may lead to different learning opportunities for care workers. For example, in Sunshine Lodge I ensured my observations involved a resident who spent all her time in her bedroom as I felt this was likely to yield different needs than those residents in communal areas. Again, with staff, I sought out those who could provide different viewpoints on how care workers learned. This meant I sought interviews with those who appeared to do things differently. For example, in Strauss Hill Court I approached a member of staff who only worked in one particular unit of the home because she was the only staff member who worked in this restricted way.

Secondly, the concept of **adequacy** is closely allied to sampling and concerns when a study can be considered to have sufficiently addressed the research problem, particularly from the perspective of the wider research context. This means there is sufficient breadth and depth of data to address and probe the different perspectives that currently exist on the problem (Crang and Cook, 2007; Bowen, 2008). This meant understanding both the care home and learning contexts and resulted in asking the following question of any tentative conclusion I drew: ***what might someone else say is going on here and do I have enough information to agree or disagree*****?** In relation to the care home context, my decisions regarding care homes and participants sought to reflect the known critical differences in the field. For example, common poles across which arguments regarding care quality occur is that of nursing/residential homes, large/small providers and for-profit/not-for-profit providers (Killett *et al.*, 2016). The two care homes represented opposite poles in these regards, which made it possible for me to consider such issues as whether having registered nurses might influence the learning of care staff. In resident selection I was guided to represent the range of needs and issues dementia can presents to a care environment, such as differing diagnoses, presenting behaviour and co-morbidities. This was because it is conceivable that learning of care may be different depending on the different presenting needs and existing knowledge of a condition. Again, with staff I sought out a range of age, past experience, and length of service when possible.

Finally, achieving **saturation** is a common assertion in qualitative research and cited as a hallmark of quality, although its practical explanation is ill-defined (Dreher, 1994; Leininger, 1994; Guest,

Bunce and Johnson, 2006). Whilst its roots are in grounded theory (Glaser and Strauss, 1999) for wider qualitative research it is the process by which a researcher knows when to stop collecting data, identified as when no new concepts emerge, accounts and incidents echo established themes, and patterns repeat (Guest, Bunce and Johnson, 2006; Crang and Cook, 2007; Bowen, 2008; Corbin and Strauss, 2008; Fetterman, 2010; Silverman, 2011). This manifested as the question ***'what else am I likely to learn here?'*** In regard to each care home, I achieved saturation when I was able to predict what would occur during an observation. With residents I knew I had observed enough when no 'new' types of incidents, needs or events presented themselves. In observing and talking to staff, I achieved saturation when the stories and interactions I saw began to repeat themselves. An iterative approach to data collection and analysis was essential to recognise saturation because, had I not been actively examining the data whilst in the field, it would have taken longer to recognise patterns. This is not to say that saturation is easy to define or recognise. Indeed, many argue that it is impossible to achieve (Dreher, 1994; Sandelowski, 1994; Patton, 2002). There was always the desire to get one more observation or interview, and always the worry that something new might happen as soon as I closed the door. Indeed, from an interpretive and constructionist perspective one could argue that saturation is an illusion as each unique person brings their own understandings to bear on the situation and creates a new reality. However, for me, sufficient saturation had occurred in both care homes when I felt I could act like a care worker in the setting without guidance. Essentially, saturation was reached when I felt I had 'learned to care' in that home and in their way.

4.4 Data analysis: iterative, inductive and thematic

This study was a focussed ethnography aiming to critically explore the ways in which care workers learn to care for people living with dementia. Therefore, any analytic tools needed to aid the following issues: a focus on learning; consideration of context; moving beyond description; and developing understandings from within the data itself. The analytic approach I used was therefore iterative, inductive and thematic, with the overall process shown in Figure 5.

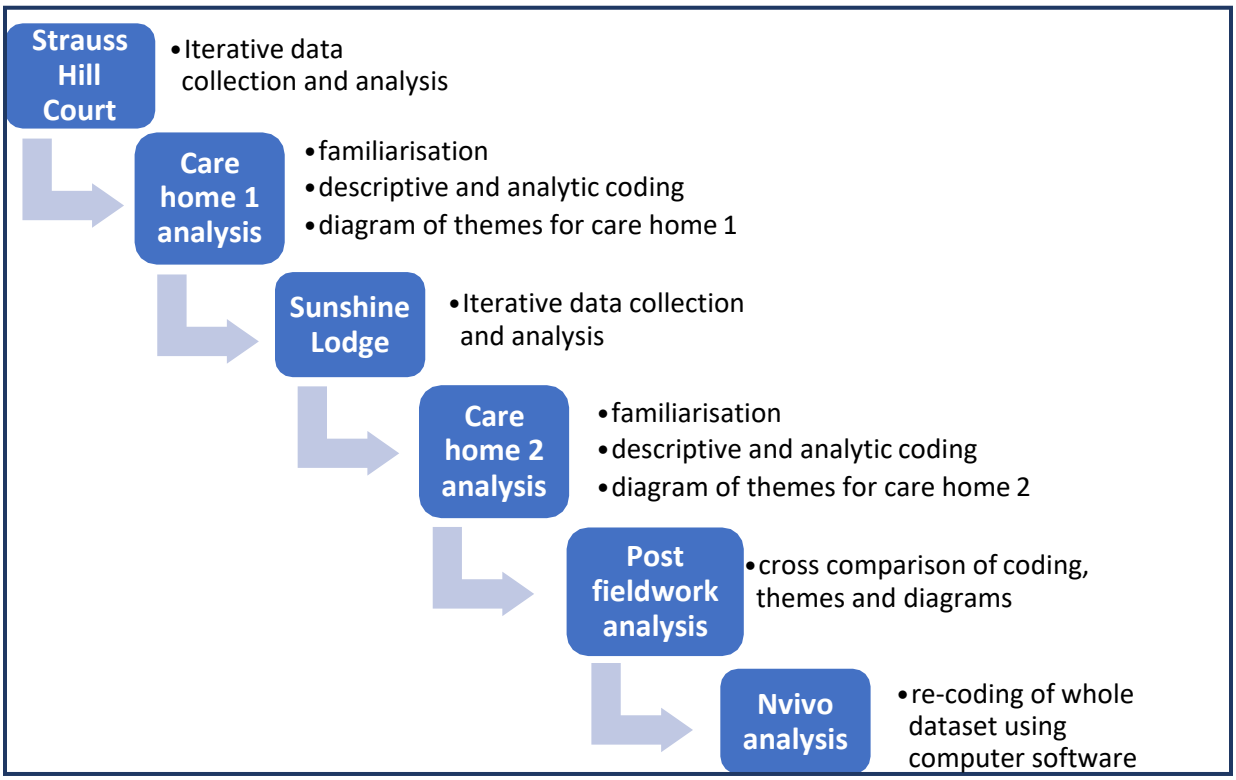

Figure 5: The process of analysis across the whole study

I used an **iterative** approach to data collection and analysis and so, whilst there was a distinct period of analysis at the end of each study site, there was also a constant back-and-forth between data collection, fieldwork and analytic thinking (Fereday and Muir-Cochrane, 2006; Hammersley and Atkinson, 2007; Bourbonnais and Ducharme, 2010). This approach aided in funnelling data towards understanding and is characteristic of ethnography (Hammersley and Atkinson, 2007; Adams, Robert and Maben, 2012). To this end, from my very first visit I was forming and reformulating my thoughts and impressions of the care home, care practice and learning by staff as I asked questions of what I was seeing, hearing and thinking. Rock (2001) describes this as 'dialogic interrogation' of data. Developing understanding fed back into data collection in such ways as interview questions, choice of observation or people with which to talk. For example, an early research note in Strauss Hill Court highlighted the following issue which led me to focus on a particular resident and staff's perceptions of her in later observations and interviews:

What is staff's understanding of (resident) J's communication and level of understanding? Their interaction appears to show that they think she can understand spoken words. How do they know this, how does this become an aspect of 'care for J'?

Observation, Strauss Hill Court

Due to my dissatisfaction with the methods, assumptions and conclusions drawn by existing research into the area of learning to care I chose to analyse data inductively. **Inductive** approaches look for understanding from within the data itself, as opposed to applying an external framework (such as theory) for interpretation (Thorne, 2000; Ryan and Bernard, 2003b, 2003a; Braun and Clarke, 2013). Inductivity does not exclude the possibility that something already known could explain what occurs, but asserts that applying an existing theory without first exploring the field from the insider-perspective can inadvertently miss and actively exclude aspects of the field that are central to understanding it. This study aimed to provide this alternative perspective and prioritise 'bottom-up' ways of viewing the setting. However, as Hamersley and Atkinson (2007) highlight, whilst the orientation might be inductive, analytic ideas are rarely devoid of external influences such as the researcher's own common sense, stereotypes and existing knowledge. I used my research diary throughout to keep track of my analytic thoughts and their origin. I also prioritised techniques that help to examine data in different ways and challenge any preconceived ideas. These techniques, borrowed from a variety of thematic analyses included: prioritising indigenous categories, looking for missing data, and focussing on the 'unremarkable' (van Maanen, 1979; Ryan and Bernard, 2003b; Silverman, 2011; Miles, Huberman and Saldana, 2014). For example, this note from an observation shows something 'unremarkable' occurring which I had not questioned previously and it led me to re-examine data from both care homes looking for examples of this shorthand.

They use the short hand of 'do' a lot here. "I'm going to do J"; "Are you doing P"? What does this actually mean to them – I know, but how do I know this? It's meaning changes depending on what task is happening. What impact does this have for learning – you learn the shorthand - a non-literal explanation. Was this as prevalent in (1st home)? Why haven't I picked it up?

Observation, Sunshine Lodge

Thematic analysis is a commonly used approach within care home ethnographies, and those involving people living with dementia (Thorne, 2000; Powers, 2001; Holthe, Thorsen and Josephsson, 2007; Bourbonnais and Ducharme, 2010; Doyle and Robinstein, 2013; Taylor, Sims and Haines, 2014). It is a good fit for ethnographic, inductive approaches as it aims to explore concepts and patterns within the data that help to describe the phenomena under study, whilst maintaining context of data and integrating meaning applied to the phenomena by participants (Fereday and Muir-Cochrane, 2006; Ayres, 2008; Corbin and Strauss, 2008; Braun and Clarke, 2013; Vaismoradi, Turunen and Bondas, 2013). There is no clear, universally accepted way to conduct thematic analysis, despite its frequent use within qualitative and ethnographic studies (Braun and Clarke, 2013; Vaismoradi, Turunen and Bondas, 2013). However, there are some broadly similar features to many accounts of thematic analysis and it is these that I used to develop my approach.

Thematic analysis segments, categorises, summarises and then reconstructs data in a way that captures significant concepts and connections between them, resulting in a presentation of researcher's interpretation of the data in a way that helps readers to view the phenomena anew (Powers, 2001; Ayres, 2008; Corbin and Strauss, 2008; Braun and Clarke, 2013; Vaismoradi, Turunen and Bondas, 2013). The analysis resulted in the following terminology and structure within my study:

- A **theme** is a higher order concept and overarching descriptor of what is going on in the data. It cuts across the data set, existing in different types of data, actors and circumstances. It is a central organising idea.
- A **subtheme** is a lower order concept that helps to describe a theme further by explaining the properties, dimensions and contingencies of its existence within the dataset
- An **element** sits under these subthemes and belongs to individuals or individual data; further explaining when and how a particular facet of the theme and sub-theme occurs and the circumstances that may enhance or limit its expression.

(Corbin and Strauss, 2008; Braun and Clarke, 2013; Vaismoradi, Turunen and Bondas, 2013)

This structure was achieved through a sequential process shown in Figure 5, initially undertaken by hand and later using NVivo computer software. A detailed account of this analytic process is included as Appendix 11.

4.5 Ethical considerations

As stated earlier, ethics approval was granted SCREC in November 2013, REC reference 13/IEC08/0036 (Appendix 10). This was only the start of ethical considerations for this project. In fact, for many, the formalised process is ill-fitting for ethnographies as it fails to accommodate their fluidity and complexity (Walford, 2009; Lewis and Russell, 2011; Rashid, Caine and Goez, 2015). This is not to say that formal ethics approval is unimportant but that the everyday dilemmas which arise when one is an active agent embedded in a setting are rarely resolved by the paper-trail of formal processes. Therefore, as an ethnographer, I needed to consider my everyday ethical practice, long after approval had been granted. Ethical practice – as who I am and what behaviour I adopt at crucial points - therefore become part of the study itself (Dennis, 2009; Robinson, 2014). Ethical dilemmas are data, captured and explored through my research diary and reflexivity (Vanderstaay, 2005; Clarke, 2009; Robinson, 2014; Mortari, 2015). My ethical practice related to informed consent, privacy, harm, and exploitation, as central considerations for ethnography, is addressed below (Hammersley and Atkinson, 2007).

4.5.1 Informed consent

Informed consent is always complicated within ethnography. This is because these studies evolve (requiring consent to also evolve) and often involve an intertwining of researcher, participant and setting in a way which questions whether a participant can ever be truly 'informed' as to what may occur and result (Lipson, 1994; Rubin and Rubin, 2005; Hammersley and Atkinson, 2007; Sherratt, Soteriou and Evans, 2007; Mitchell and Irvine, 2008; Braun and Clarke, 2013). These issues are magnified in institutional settings where one encounters power differentials, vulnerable groups and undertake a researcher role that may seem similar to that of practitioners (Lawton, 2001; Tinney, 2008; Lefstien, 2010; Watts, 2011). Therefore, everyday ethical practice is required to ensure that consent is continually addressed, on top of any initial formal process. In my study in particular, the presence of people living with dementia and my presence in a person's home and/or workplace, where participants are dependent on the setting in some manner, meant that I needed to maximise participants' ability to express their wishes throughout if I were to be an ethical researcher.

I achieved this by adopting behaviour that regularly reminded people I was a researcher, such as keeping my notebook visible, reintroducing myself and asking people how they felt with my presence. This behaviour then provided me with opportunities to consider verbal and non-verbal communication from participants, and react accordingly, removing myself if I felt consent was unclear. This approach served for both staff and residents, but it was most significant in relation to residents living with dementia as it was not unusual to be confused with staff by residents, even following formal introductions. By showing that I was 'different' in these regular ways I provided an opportunity for residents to react to that difference, and thus gave myself the opportunity to interpret that as unhappiness with my presence at that moment. Encouraging this ongoing interaction is a central component of person-centred researching with people living with dementia by facilitating their control through ongoing assent (Dewing, 2002, 2007). Whilst this approach certainly affected what I observed it also created interesting opportunities. In this diary extract below I detail one such exchange that occurred when I had been sitting making notes whilst residents living with dementia were finishing lunch.

> *Resident M is chatting with staff member V. I then hear her say "I'm looking at that one over there (points at me) what's she scribbling down do you think?" V laughs and I smile and get up to sit next to M at the table. I explain that I'm watching what life is like here and V interjects "she's watching me to see if I'm doing it right!" M smiles and replies 'ah, well then, I'll have to tell her some stories!' V and M then have a relaxed and humorous exchange about all the things V has done 'wrong' so far today. There are smiles all round and it really seems to tap into M's sarcastic and lively side. Later I chat to V about her relationship with M and how she knows how to interact with her and how it compares to what she does with other residents.*
>
> **Research Diary, Strauss Hill Court**

Not only did this exchange provide staff and residents with the opportunity to express feelings about my presence, it also opened the door to an informative discussion about how a care worker learns to communicate with different residents.

4.5.2 Privacy and confidentiality

Maintaining participants' privacy and confidentiality is fundamental to formal ethics processes and everyday practice. Whilst superficially straightforward this can be complex in practice,

particularly within institutional settings. This is because these concepts are already challenged by the nature of care needs and behaviours that blur the boundaries between public and private spaces (Hammersley and Atkinson, 2007; Tinney, 2008). Whilst I observed only in public places as per the PIECE-dem manual in order to protect resident privacy during personal care activities (Brooker *et al.*, 2011b; Latham *et al.*, 2015) in reality private activities and spaces were often treated as public by staff, necessitating action by me to ensure I did not take advantage of this. For example, in Sunshine Lodge when using PIECE-dem I planned to focus on a gentleman living with dementia who was laid in bed in the afternoon by staff. However, the positioning of the bed meant that he could see me watching from the corridor as he attempted to remove his incontinence protection. As I could not be sure that he could distinguish me from a member of staff, I felt that this was an invasion of his privacy even though this was caused more by the institution (staff routinely left him in bed with the door open) than my research. I therefore chose to use less intensive observation – passing his door occasionally - so that I could see when and how his needs were met without subjecting him to such intense gaze. Having a sufficiently flexible approach to ensure maintenance of high ethics standards without compromising the study is important for any researcher (Watts, 2011).

In addition to adapting my behaviour during fieldwork there were a number of techniques I used to preserve privacy and confidentiality in the field and in writing this thesis. Firstly, I was mindful to use shorthand and pseudonyms when taking notes in the field, so that if someone read my notes it would be difficult to identify individuals (Watts, 2011; Braun and Clarke, 2013). Secondly, pseudonyms for individuals and homes have been used throughout this thesis as a recommended way to avoid identification (Hammersley and Atkinson, 2007; Braun and Clarke, 2013). Nonetheless absolute guarantee of anonymity is problematic as individuals are likely to be able to identify themselves (Murphy and Dingwall, 2001). I have therefore aimed to show respect to participants and settings in my writing. Finally, in preparing the data sets, I removed instances that were highly personal if I was uncertain that the individual had been mindful of how identifiable that data was. For example, in Strauss Hill Lodge, an interviewee spoke at length of her grief. I chose not to transcribe this portion of the interview as, when listening back I could hear that the interview had veered off topic, and she may have been responding more to me as an ally rather than a researcher.

4.5.3 Avoiding harm

An overriding principle in all research is to avoid doing harm to participants and settings. However, in practice ‘harm’ is complex to define and thus hard to predict and mitigate (Tinney,

2008; Dennis, 2009; Braun and Clarke, 2013). This is particularly so in ethnography where fieldwork is unpredictable and risks associated less with the behaviour of the researcher and more with consequences of the research (Lipson, 1994; Murphy and Dingwall, 2001; Vanderstaay, 2005). Whilst my formal ethical process committed me to following the safeguarding policy of the setting, I knew from experience that the majority of dilemmas faced would not be resolved through this. I therefore adopted ethical practice in response to risk of harm in the ways detailed below, informed by my own experience of care work, care home research and discussions with my supervisors.

Firstly, I occasionally had to decide whether to intervene in situations in the care home that put residents at risk of harm. Where an obvious risk of serious physical harm to a resident occurred that I felt confident to prevent (such as stopping a resident sitting on an unstable table) I chose to intervene, as resident well-being was more important than my research. However, most often the likely harm was less clear and the dilemma not between preventing harm and influence but about balancing the longer term consequences for the setting and the research. These issues are commonplace for ethnographers and are solved not through pre-determined guidelines but reflection on the nuance of any situation (Vanderstaay, 2005; Tinney, 2008; Dennis, 2009). For example, I encountered one such situation as described below;

> *Exchange between senior staff member V and resident as she stands in doorway. V says 'I need to get though, which way are you going?' resident says, 'come on then'. V explains that she can't fit though. The resident's voice becomes increasingly irritable and anxious throughout the exchange, not seeming to understand that there is no space for V to fit through the door. I wonder whether her spatial awareness is affected by her dementia, given difficulties with moving I've seen before. The back and forth continues with increasing irritation on both sides… I don't feel it is that helpful for the resident or solving the situation. I wonder what understanding (staff) have about causes of behaviours/difficulties etc. or how you could escort the resident through the door to avoid the problem.*
>
> **Observation, Strauss Hill Court**

This extract shows that I was aware of potential (emotional) harm occurring to the resident (and others, as the tension in the area was palpable during this exchange). However, I chose not to intervene and as a result captured a very useful vignette for my study. Ethically I must therefore consider whether I acted appropriately when it was within my power to change the situation. I

chose this course of action because of the possible long-term consequences of any intervention: creating resentment or tension between myself, staff members and resident. I estimated that not intervening and using the incident to develop understanding might be more beneficial in the long term (by helping staff reflect) than intervening in the moment. Tinney (2008) prioritised avoiding long term negative impact on the social environment and relationships during her study in a care home, and my thinking followed similar lines. However, it is important to note that such a 'situational' ethical stance – in which ethical principles are judged according to the situation – would be criticised by those of a more absolutist view (Hammersley and Atkinson, 2007).

Secondly, I had to make a decision concerning my interactions with staff and residents. Mirroring the behaviour of those you are researching is a common, successful ethnographic technique for gaining access and being accepted in the setting (Taylor, 2002; Hammersley and Atkinson, 2007; Jansson and Nikolaidou, 2013). However, I also considered role-modelling person-centred practice in my day-to-day interactions as ethically important in promoting personhood, well-being and equality for people living with dementia during research (Dewing, 2007). With this stance I was promoting an ethical principle of beneficence, beyond simply 'doing no harm' (Murphy and Dingwall, 2001; Tinney, 2008; Dennis, 2009). In Strauss Hill Court it was possible to achieve both these targets, but in Sunshine Lodge they came into conflict; the ways in which I interacted with residents (engaging in conversation, validating their realities) often set me apart from care staff and thus undoubtedly affected my research opportunities. I chose this course of action not only because my personal values demanded it, but also because role-modelling person-centred practice, particularly when perceived by participants as an 'expert', has the chance of improving the lives of people living with dementia in the long-term (Dewing, 2007; Lefstien, 2010).

4.5.4 Avoiding exploitation

Considering exploitation is important to because of the inherent power imbalance between researcher and researched, magnified when research settings embody those power relations as well (Lipson, 1994; Murphy and Dingwall, 2001; Hammersley and Atkinson, 2007). The very act of research implies that I can represent another which is by no means a neutral or powerless statement. It is therefore imperative that a researcher is aware of the power she holds in conducting and writing research and reflexively works against exploitation of those she studies. Maximising opportunities for informed consent, protecting privacy and avoiding harm all supported this aim, but in addition I was mindful of two further issues - reciprocity and representation – throughout the research and writing.

Reciprocity required that I considered the balance between what participants shared with me and what I shared with participants, both in terms of our 'selves' (time, personal history etc.) and opinions (Mitchell and Irvine, 2008; Fetterman, 2010; Lefstien, 2010). This obligation was fulfilled through my adoption of a 'reciprocal communicative stance', in which a back-and-forth style conversation, rather than one-sided dialogue took place (Lefstien, 2010). This necessitated me sharing my experiences, thoughts and ideas with participants and enabling them to counter and reshape them. This approach occurred in individual conversations and at the end of fieldwork where I offered to provide comprehensive feedback to the home, and invited each participant to contact me if they would like to receive updates on the project. However, neither care home took the opportunity to take feedback any further than a discussion with the manager, and no participants expressed an interest in being updated further. Whilst there may be practical factors at play, this suggests that reciprocity may be of more concern to me than participants. Secondly, considering representation meant that I needed to reflexively challenge the ways in which I presented others in vignettes, stories and findings, being careful not to distort participants' depictions or drown out others' voices with my own. To this end, I have aimed to highlight the interpretive role I have played in producing this thesis and to differentiate between participants' experiences and my reconstruction of that into findings (Murphy and Dingwall, 2001; Braun and Clarke, 2013).

In this chapter, I have built on my theoretical position as laid out in chapter 3 to provide a thick description of the real-world application of my study's method. This is intended to allow readers to understand the processes, decision-making and interpretive points in the study that will, inevitably have influenced the data available to me and thus the findings produced. This means that the findings and conclusions presented in the following chapters can be judged within this well-explained context. This is a hallmark of quality in ethnographic and qualitative research studies (Dreher, 1994; Muecke, 1994; Mays and Pope, 2000; Corbin and Strauss, 2008; Yardley, 2008; Tracy, 2010; Rashid, Caine and Goez, 2015)

Chapter 4b: Participating Care Homes

4b.i Description of the care homes

Strauss Hill Court

Strauss Hill is a 30+ bed care home in Worcestershire. It is registered for care only and described as dementia-specialist. It is owned by a large, national, not-for-profit provider. The home is divided into 4 different 'suites'. Each suite is home to 9 residents, with en-suite bedrooms, bathroom, toilet, lounge/dining and kitchen area. Residents had free access throughout the whole building, with no doors limiting movement between different units or the home's communal areas (large activities room, reception area and conservatory). The front door (leading to a carpark and residential streets) was not locked, although was at times alarmed. Suite 4 is the 'specialist dementia suite', and residents here have higher needs than others in relation to their dementia. These residents also have higher levels of physical need, often requiring 2 care workers to support with movement and personal care. Some residents in other suites are living with dementia as well, with half of the total population living with dementia, (although not all had a diagnosis).

On an average weekday the home is staffed by 5 care assistants, (1 on each suite with 2 working on Suite 4), and a Lead Carer, although this is sometimes lower in the afternoon. Staff would often work in the same one or two units, although several were seen to work across all suites. Staff were allocated to the suites by the Lead Carer on a shift-by-shift basis. The manager, deputy, a single activity worker, domestic, kitchen and reception staff were also present at various times during the day. At night the home is staffed by a Lead Carer and 2 care assistants. Staff work a variety of shifts broadly fitting a 07.00-14.30; 14.00-21.30; and 21.00-07.30 pattern. Overall there is a staff team of about 30, with recruitment taking place during the research. At the time of the research the home had achieved a CQC assessment of 'fully compliant' and had achieved the local authority's dementia standard.

Sunshine Lodge

Sunshine Lodge is a 30+ bed care home in Worcestershire. It is registered to provide care with nursing and the home describes their specialism as 'end of life care'. It is owned by a small, for-profit provider. The home is not dementia specialist. Residents with dementia are admitted but dementia is not their primary need. Approximately 12 residents were living with dementia at the time of the research. The home had achieved the local authority dementia standard in the last year. 50 % of the beds in the home are funded for people at the end of life, meaning that it is anticipated they will live no longer than 12 weeks. For this reason there is a regular turnover of residents, although a number have been at the home for several years. The home was registered as fully compliant with CQC at the start of the research. An inspection occurred during the research and the home achieved a 'good' rating, (CQC inspection criteria changed between recruitment and data collection). The home operates on two floors. It has a large reception area with nurses' station and reception desk. It has one dining room, one main lounge, as well as a smaller, 'quiet lounge' and an ante-room of the main lounge described as the 'reminiscence lounge'. This small area looks like a 1960s room with wall paper, old posters and a teas-made.

A large number of residents spend days in their room, with a (generally) predictable group of residents using communal areas. The home is surrounded by a large, open green area and car park. Access to this is through the main front doors, usually left open. It is not a secure garden and leads immediately onto a busy road. It was unusual to see the outside area used. There were no internal doors and so there was a potential for free movement throughout the home by residents. However the majority of residents required significant support to move about the home.

On an average weekday the home is staffed by 6 care workers who worked across the whole home, although in practice paired up and covered specific room numbers. Care workers worked 12 hour (8-8) shifts and were divided into two set teams. Each shift had a senior carer. In addition, there are also 2 registered nurses on in a morning and 1 in the afternoon. The activities coordinator worked 3 days a week and during the research the home was recruiting another. Domestic staff also work each day (including weekends) and a variety of students on placement from nursing and health and social care courses. These students tend to shadow/support nursing staff rather than care staff. Overall, there is a staff team of approximately 30.

4b.ii Comparison: living and working in the care homes

Strauss Hill Court

Staff involved in observations seemed motivated and engaged and often spoke about 'loving' their work. Many staff had been with the home for a long time and had actively sought promotion or increased hours. Staff appeared to get on and function well as a team, although interviews demonstrated some in-team divisions which had not been evident in observations.

There was talk of 'resident-led care' and a sense of freedom and flexibility for residents. However staff were often busy completing tasks and 'on their feet' constantly, making interactions and activity with residents beyond these tasks unusual. However, even though staff were engaged with tasks they interacted with residents when opportunity arose and this was in a very relaxed, friendly and affectionate manner. Residents were known about and interacted with as individuals with separate needs, wants, personalities and backgrounds, although there was some evidence of labelling, particularly when a person exhibited behaviour that was a challenge for staff to work with.

Sunshine Lodge

Staff in general seemed constantly busy. This fitted with a strong rhetoric of care work as "never-ending, on your feet, don't stop". In contrast, nurses spent a large proportion of time sitting and working on paperwork. This was observed and spoken about regularly by care staff. Care at Sunshine Lodge was functional and task-oriented although tasks were completed thoroughly. It appeared as if care staff simply carried out the routine as expected and instructed. Within routines there was evidence of change (for example, what time a person was dressed) however the overall routine of the day was obvious and predictable. Activities added variety to life in the home.

Staff were hard to get to know, although relaxed a little in time. Some staff showed very caring attitudes with residents within the remit of their tasks. There was an obvious separation between different roles in the home. Nursing or care staff did not undertake actions of other roles, even when there was a need. Often the tasks of each role did not fit seamlessly from a resident's point of view. For example, residents often arrived late for activity sessions. There was a strong rhetoric from senior staff that suggested low expectations of care staff, often connected to the 12 hour shift pattern and 'busyness' of the role. It was reported that staff did not want this shift pattern changed. There was a strong value of quality in nursing practice and a particular pride in end of life care.

4b.iii Comparison: researching in the care homes

Strauss Hill Court

Researching at Strauss Hill was generally a pleasure, and I felt welcomed most of the time, free to move about the home and over time became 'part of the furniture'. Routines and patterns to days could be seen and predicted but they were not rigid. Staff shift patterns changed often, making it hard to easily predict who would be on duty. Residents moved freely and often interacted spontaneously with me. Staff were friendly with me, each other and residents, and once I had settled in, some would ask me questions about myself and the research. My time at Strauss Hill took place across a 6 month period from late July to late November 2015. During this time the home was undergoing renovation work which did lead to some disruptions and changes to usual daily life. Staff acknowledged that it had maybe made them less flexible and more focussed on routines.

Sunshine Lodge

Researching at Sunshine Lodge was a challenge, although easier over time. The activities coordinator welcomed me and was often my main point of contact and involvement. The manager and lead care/deputy were also interested and welcoming. Staff were not unwelcoming, but were often hard to find and engage with, primarily because they were always busy and rarely in communal areas except to transfer residents. It was hard to converse with staff beyond grabbed occasions in the corridor and only one full interview was completed. This was with a newer member of staff who was very engaged. I often felt that I should not stop staff to talk as they were constantly on the go. Staff often seemed to lack confidence. Towards the end of the research, some would smile and joke good-naturedly with me with jokes often based on how they were always busy and I was always sitting down.

Routines and patterns to the days were predictable, although the timings were flexible, and residents who could exercise choice were able to within the routines, (e.g. whether to go to lounge/stay in room). Staff shift patterns were predictable. I only observed one of the shift groups in action, as most staff from the other shift did not want to participate. The manager predicted which staff team would say yes/no. It was rare to see care staff engage with residents outside of care tasks, and so it was often very obvious when I was doing so. The activities coordinator engaged a lot. Overall, researching at Sunshine ***Lodge was sometimes quite repetitive****, except on the days when an activity took place. I often found myself touring the home and seeing no one.*

Chapter 5: Findings – the process and themes of learning to care

In this chapter I will present the findings from my study, explaining the process of learning to care for people living with dementia in the two care homes in my study. Following data analysis, three interrelated and complex themes emerged as being significant to the learning experienced by care workers in the care homes I visited. As discussed in the previous chapters, I classified learning whenever an action or experience was repeated or drawn on by a worker in their practice or where such actions and experiences were shared with others and applied to future practice. Taken together, the three themes and their interactions describe the *process* - as a series of activities that interact to produce an outcome[7] - of learning to care

Significantly, the same three themes described learning as it occurred in both care homes, but that resultant process often produced different care practices in each home. It is the relationships between the three themes, their sub-themes and elements that appeared significant to these differentiated outcomes. The interactions of the themes as a process are described in these findings as occurring across three conceptual levels, linking singular day-to-day learning experiences with the wider culture of the care home environment, and thus accounting for the different types of practice learned in each home. The diagram overleaf depicts the three themes and this three-level interaction Figure 6.

At the micro level, a singular theme (1) emerged as being the dominant explanation for how learning occurred within day-to-day practice, demonstrating the mechanisms through which care workers applied, refined, reinforced or rejected their learning. At the meso-level, three contributory components to Theme One (1a, 1b and 1c) represented the skills and information care workers brought to bear on this everyday activity, explaining where and when these skills and information were learned by care workers. At the macro level, two further themes (2 and 3) show the way in which care workers learn to incorporate the 'cultural knowledge' of their care home; knowledge that is influenced and delineated by structural decision-making regarding work type and work teams in the care home.

Throughout this chapter I will use indicative examples from the practice I observed, engaged in or discussed within the two care home sites to illustrate the learning process in action. First, I will address Theme One, its subthemes and concepts as the primary explanation of the micro-level

[7] Definition paraphrased from that given at www.dictionary.com

interactions and circumstances that resulted in learning. Second, I will address the meso-level by explaining the three components of Theme One and how they are utilised by care workers in the learning process. Thirdly, I will turn attention to Themes Two and Three as macro-level influences on learning. Finally, I will describe the overall process of learning, and how the interaction across micro, meso and macro levels accounts for different outcomes in practice for the two care homes despite the similar learning process[8].

[8] Note: the numbering in this chapter deliberately does not follow the pattern in the thesis thus far. This is to enable the themes to be consistently identified as themes 1-3.

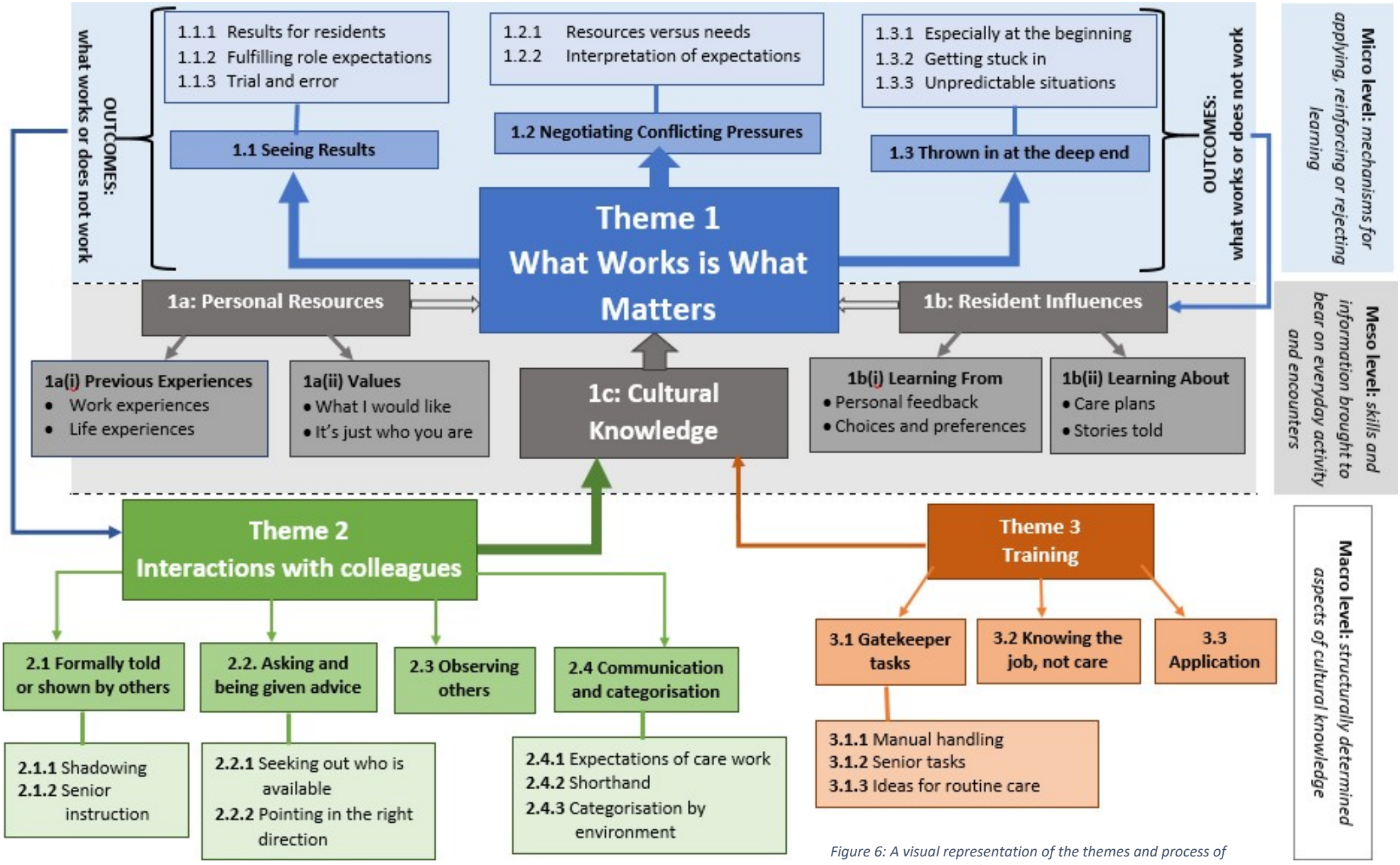

Figure 6: A visual representation of the themes and process of learning to care

1. Theme One: What works is what matters

The most frequently occurring and most influential theme that emerged from both care homes was Theme One: *'what works is what matters'*. As Figure 6 shows, Theme One accounts for the micro-level mechanisms of learning; the situations encountered and acted upon by individuals on a day-to-day and moment-to-moment basis. This is learning that occurred through a care worker doing something and seeing that it achieved a successful outcome to the particular circumstance. It was an active process of responding to a situation and/or carrying out parts of their role. If a successful outcome was achieved through this process, the practice was likely to be repeated by the individual care worker in similar situations and passed onto others.

> *"Unknowingly maybe they use these things to (care for the residents) … We do explain why we have these things but I think probably…they just. It works, it's working… If it doesn't work, it doesn't work and we try something new"*[9]
>
> ***Interview with Manager - Strauss Hill Court***

Whilst strongly present across different data types and in both homes, this form of learning resulted in different practices being enacted by the care workers. This was because what was determined as a successful outcome (what 'worked') was dependent on a number of different factors. These factors are the source of the sub-themes of 'what works is what matters' and are described below and summarised visually in Figure 7. It is in these sub-themes that differences in learning emphasis occurs between situations and, most significantly, between the two care homes. It is important to note that, whilst they are described separately below it was not uncommon for several sub-themes to be interacting at one time to create learning and this is discussed at the end of the chapter.

[9] In all quotes I have transcribed the words and phrasing used by the participant verbatim, unless it hampered understanding. Where alteration or addition was needed to aid understanding then this is signified by the use of (parentheses)

Figure 7: A visual representation of sub-themes and elements of Theme One 'what works is what matters'

1.1 Seeing results

The most common area of 'what works is what matters' related to the subtheme **'seeing results'**. When workers interacted with residents as part of their role, they would learn what worked based on seeing the result. When a particular practice achieved a satisfactory result (or failed to) this would be learned and applied in the future. The elements of: **results for residents**; **fulfilling expectations**; and **trial and error** outline the different ways in which a 'successful' result was determined by a worker. The relative importance of each of these elements was influenced by the workplace and nature of the work tasks and it is here that the significant differences could be seen between the homes.

1.1.1 Results for residents

A successful result for a resident occurred when an action taken by a worker achieved what it was intended to (such as initiating personal care, movement, eating, or conversation) whilst simultaneously achieving behavioural-emotional outcomes from the resident. This related primarily to avoiding negative responses and secondarily to promoting positive responses. This element was the most common type of learning in Strauss Hill Court.

For example, I noticed that staff responses to residents who asked questions about family members varied depending on the resident in question. I therefore explored with staff how they knew what to do for each person. Avoiding negative responses for the resident was their primary concern, as this care worker explained;

"I mean, there are a couple on [unit 4] that you can either go along with or tell them the truth which depends on that person. If you know that they are going to completely break down, don't tell no lies but just go along with it. Whereas with Felicity, very much tell her straight out because…she can take the truth. ***(I: What's the reaction you're looking for that makes you think you've done the right thing?)*** *Just to keep them settled, I think. Regardless of what you say [another resident] seems happy with what you've said, whereas potentially you could lie to Felicity and it would make the situation worse."*

Interview with Verity - Care Worker, Strauss Hill Court

In the observation extract below an experienced care worker, Anna, interacted with resident, Julia - a lady who walked almost constantly pushing baby dolls in a pram, had limited speech and with whom staff often struggled to undertake personal care - showing again the primacy of avoiding negative reactions. The back-and-forth illustrated here was common in staff interactions with Julia around personal care.

MOS A[10] says 'I'll just see if I have any luck with Julia'. Approaches and asks if she'll come with her. Tries to encourage, asks about 'help change the babies nappies', 'you're the best at it'. Gentle cajoling and encouragement. Tries for 5 minutes, then leans in close and whispers 'can I change your pad, Julia?' MOS A tries a few more times, holding her hand and saying 'come on then'. Julia shakes her head, says 'no no no' and looks displeased (frown). She slaps A's hand away and A says 'That's a no!' to the room.

(5 minutes later) A comes over to Julia and tries again, 'come with me'. 'No' - Julia smiles and giggles a little. MOS A says with an amused tone 'you're giggling now, are you playing me up?' Julia smiles again. A tries one more time and Julia slaps her hand away. MOS A shrugs and walks away saying 'well you can't say I didn't try.'

Observation (210914) Strauss Hill Court

As illustrated, avoiding negative responses from residents dominated what was seen as a successful result and thus learned. However, the promotion of positive responses was also evidenced as indicating a successful result and thus likely to contribute to a particular

[10]To aid reading, if data referenced both staff and resident, I have used the resident's full pseudonym and identify members of staff by the initial of their pseudonym, e.g. MOS B ('member of staff B')

approach being learned by care workers. Positive responses tended to be a more general aim compared with the more resident-specific avoidance of negative responses. For example, care worker Ruth had only been working at Strauss Hill Court for a month but she illustrated this factor in response to my question *"Can you think of a time you've learned something really important about care for people living with dementia"?*

"The smile. When you get somebody who is really moody, bad tempered…and then you get that smile, or the cuddle, that is the best day in the world. You go home thinking I've done something. You might not get it for another month, but that… is so important. Just a smile"

Interview with Ruth - Care Worker, Strauss Hill Court

Furthermore, this factor explained the use of expressive physical touch at Strauss Hill Court; a common feature of care that stood out throughout my time there and which, when I experienced a hug and kiss from a resident, led staff to say this was a sign I belonged in the care home. Care worker Cath explained the impact and thought behind her and others' actions,

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"Some of these (residents) that you give them a hug and they're like (big smile, sigh, relaxes) 'what was that for? It was lovely.' To them it's massive but to us it's just a hug. It's just a hug but to someone who's not had it for a long time and misses that… (it's a) connection thing…People like their alone time and their space, (but)… They like the cuddles, feeling contact with other people. You don't have to do anything, there's nothing that you have to do (but) if you want to, give them a hug!"

Interview with Cath – Care worker, Strauss Hill Court

Nonetheless, whilst both avoiding negative responses and promoting positive responses existed as mechanisms for learning through seeing results for residents, it was apparent that avoiding negative reactions had primacy in influencing practice. This was shown through situations, such as the one described below, where certain practices occurred frequently because they achieved the required outcome without provoking negative responses, even

when the practice itself was less-than-optimal. My observation notes described an interaction with a resident (Marion) that was indicative of many interactions when supporting her to walk.

Marion is stopped in the doorway and a queue is forming behind her. MOS P is walking with her, hand on frame. Marion's frame keeps veering off, staff comment several times that the wheel is like a shopping trolley. MOS P instructs Marion several times to 'look where you are going' as her head is looking down at her feet. This doesn't seem to change Marion's behaviour. Several times MOS A (behind) says 'Marion, step into your frame'. This makes no difference either. Eventually Marion reacts saying 'who is that shouting behind me?' It is not nasty, Marion is not upset by it and she is laughing. This has me thinking that [these instructions] are not terribly helpful to the task at hand.

Observation Notes (130914) Strauss Hill Court

Seeing results for residents was an important element in determining care practice at Strauss Hill Court precisely because of the inevitable differences between residents exacerbated further by their dementia. As no one solution or practice could suit everyone, learning occurred through a mechanism that allowed for this flexibility in identifying what was the 'right' thing to do. As this senior care worker explained when discussing how she knew the right overall approach to adopt when she is on shift;

"The more calm you are and the less you show them that you're bothered, the more calm…huffing and puffing stood there with hands on hips…it doesn't work. So you have to judge the moment on the moment and go with it…It's no good thinking well that person's a certain way… You can't say that about somebody living with a dementia because it changes from day-to-day, hour-to-hour. So that's the difference; the people who haven't got a dementia you know their personalities, what will upset them…but even they can change their mind… You just have to be calm, ***(I*: how have you found that out?)** *Just by working with them…you learn from that person and dealing with that person and then you get a couple more in and they're a little different and you learn to deal with that, so everybody is so different that there's no hard and fast rules for it,"*

Interview with Mary - Senior Care Worker, Strauss Hill Court

1.1.2 *Fulfilling expectations*

Whilst **seeing results for residents** was a significant element in the subtheme of learning by seeing results**,** common at Strauss Hill Court, it only occurred sporadically at Sunshine Lodge. The major element of learning by seeing results here instead concerned **fulfilling expectations.** In this element, a successful outcome was determined by the extent to which the practice achieved its intended aim (such as initiating personal care) whilst simultaneously achieving an outcome for the worker themselves. The behaviour and emotional response of a resident was less influential unless it was directly associated with a 'result' for the worker in fulfilling expectations of their role. At Sunshine Lodge 'fulfilling expectations' went beyond specific tasks of care work to include the boundaries of different roles within the home. It was rare to see care practice that did not fulfil this 'extra' function. For example, the following observation was typical of care work routine at Sunshine Lodge with regard to its (dis)connection with other aspects of home life. In the example below I observed a short church service organised by the activity co-ordinator and led by a local church leader;

Elaine arrives about 5 minutes into the session (in the middle of prayers). She is wheeled in a large blue reclining chair by MOS J. I get the impression she was deliberately brought into the session (as she orients quickly and joins in with the 'Amens' and prayers). If it was deliberate, why wasn't she ready for the start?

Violet is brought down by MOS D a few minutes after Elaine. As they share a room and MOS D and J have been paired up this morning this would mean they've been done together, wouldn't that mean that Elaine could have been brought down earlier? MOS D says to MOS J 'Where shall we put Violet?' whilst stood in the middle of prayers. Short conversation, the session leader asks for '5 more minutes'. Violet is then wheeled to sit in the adjacent lounge. MOS D and J talk to each other which can be heard in the session. This is a sign of disconnect between care work and other activities in the home

Observation, (150715), Sunshine Lodge

This practice was a successful 'result' for staff (and thus 'worked') because they had fulfilled the expectations of their role: to wash and dress Elaine and Violet and bring them downstairs before leaving them in the communal area. Expectations of care work at Sunshine Lodge were disconnected from activity or social aspects of resident's lives (these were the

responsibilities of other roles) and was consistently described as hard work, in which workers were constantly busy and 'on their feet', as evidenced below;

"I can assure you that my staff are never sitting down doing nothing. They are all working really hard but it is impossible in a nursing home environment to provide one-to-one care."

Manager's response to visitors' survey pinned to noticeboard, Sunshine Lodge

Chatted to [nurse]. She said it was busy and non-stop. Said it was easier for nurses than 'the girls' (care workers) as they just don't get to sit down. This was borne out to be true. Staff moving constantly. I rarely saw them unless 'delivering' a resident. Manager repeated this saying they 'don't sit down, work so hard'.

Reflective Diary, Sunshine Lodge

The contrast between how care workers and activity coordinator described their typical days (and thus roles) emphasised this point;

"We sort out between ourselves who is getting up and then just work through…we get them done, personal care, washing, make sure them all oral hygiene, make sure their rooms are tidy and…bring them downstairs or run the breakfast upstairs."

Interview with Dennis - Care Worker, Sunshine Lodge.

"I check on the moods of everybody to start with and already I've just picked up…there's a lot of stress with the new one. I tried to calm that down. I've given her a teddy… She got really picked up with seeing the dog so I put the dog on my lap and she was petting (it). I (have) put that in the care plan."

Interview with Yvonne – Activity Coordinator, Sunshine Lodge

This aspect of learning practice was also not solely a product of a never-ending task load, because, when workload potentially allowed a more flexible approach, workers rarely altered their pattern, as this observation (following a period of time when staff had spent half an hour sitting and chatting together) illustrates;

Resident, Nicky, is sitting in the lounge watching TV, one of the nurses has been sat with her. MOS J comes in and the nurse tells her Nicky likes Emmerdale. MOS J replies 'she's going to bed'. The nurse replies 'oh okay then, but put it on in her room, she likes it,'

Observation (170517) Sunshine Lodge

This is not to say that seeing results for residents did not matter at all at Sunshine Lodge, only that the primary influencer of learning a practice was a worker seeing results in terms of meeting expectations. Results for residents mattered only through the filter of these expectations. Dennis, a new care worker at Sunshine Lodge gave an example of when his practice considered resident outcomes within the margins of expectations;

"If someone's a bit upset, like Betty this morning, she was very agitated, she's very clingy…very scared. So I thought it best to leave her in her chair to minimise that – because she doesn't like the hoist – so leave in the lounge,"

Interview with Dennis – Care Worker, Sunshine Lodge

Betty's emotional needs were considered, but only in so far as the expectations of getting her washed, dressed, and bought downstairs had been met.

Whilst the contrast between learning at Sunshine Lodge and Strauss Hill Court was strong in this element, it did not mean that fulfilling role expectations was not influential at Strauss Hill Court, only that its influence occurred through the filter of 'seeing results for residents'. This was because the care worker role (and thus expectations of it) was broader and more flexible at Strauss Hill Court. Care workers undertook more than physical tasks of care with

their residents and care was spoken about as 'resident-led' in formal descriptions of the home and in day-to-day discussions.

1.1.3 Trial and error

The final element of subtheme **seeing results** was learning that occurred through trial and error. Within this element learning occurred when a worker tried out different things as part of their work and learned through both success and failure. This element of learning occurred in both care homes, although through the filter of the other elements (1.1.1 and 1.1.2). It was more prevalent at Strauss Hill Court, perhaps unsurprisingly given the flexibility of practice inherent in seeing results for residents as a method of learning.

The extract below shows this element in action with regard to finding ways to occupy residents during the day;

Chatted with MOS V about how she knows what to do to entertain residents. She says sometimes she'll try a quiz, or a word search but this is not always successful. She says it can be as simple as 'throwing a ball, playing catch'. They had balloons here last week and had a fantastic time. She said 'there's no list or anything, you 'just try and see whatever works'.

Another MOS, A, comes in and joins the conversation, agreeing. She gets the juggling balls out of the packet and says to (resident) Julia 'you're in a good mood today.' She throws the ball to Julia and she catches it and then throws it back. Julia is very engaged with this. Then MOS A moves to throw it to Keith saying 'catch it' but Keith replies 'No!' MOS A moves back to do it with Julia.

Observation (210914) Strauss Hill Court

At Sunshine Lodge, trial and error was most likely to occur when trying to fulfil role expectations in relation to a resident's care. In this extract below the deputy manager described how the care team had worked out that it was best to sit a resident, Neil, in the quieter lounge during the day as it reduced his calling out and distress;

"Basically (by) trial and error. Because before… (his daughter) is finding it so difficult to accept that Dad is getting worse and it is basically trial and error…and see if there's a link. Usually it's something, 'oh they're not sleeping

well,' or 'being aggressive in the lounge'…it's usually started with something negative,"

Interview with Deputy Manager, Sunshine Lodge

Within the central theme of **what works is what matters,** the care homes showed that learning occurred through **seeing results** in three distinct ways: **results for residents; fulfilling role expectations;** and **trial and error**. Whilst all were present in both homes, their relative influence was created by the circumstances of the care worker's role resulting in a wider, more flexible route for learning in Strauss Hill Court than Sunshine Lodge. Ultimately this led to practice which, from my perspective, promoted higher well-being for residents as judged by positive expressions from residents and greater anticipation of needs.

1.2 Negotiating conflicting pressures

Another common feature of learning through **'what works is what matters'** related to the subtheme **negotiating conflicting pressures.** A fundamental part of care work in both care homes involved encountering situations in which workers were pulled in opposing directions. These situations were frequent and occurred at the intersection of care worker knowledge ('what I am supposed to do'), care worker reality ('what I can practically do') and care worker values ('what I want to do'). Inherent in negotiating these conflicting pressures was an acceptance that it is not possible to resolve the issue equally and that a decision must be made as to how to achieve an outcome that is acceptable in that unresolvable context. Negotiating conflicting pressures evidenced two key elements: **resources versus need**; and **interpretation of expectations**. Both these occurred in each of the care homes although with a different emphasis.

1.2.1 Resources versus needs

Within this element, workers weighed up the task of meeting residents' wants and needs with the resources available to them. Resources included time, staff and facilities. A particular compromise solution would be learned by a worker if it led to the worker seeing results (either in terms of residents or fulfilling role expectations) as discussed in 1.1. Below, my

observation notes recorded a discussion during handover illustrating a conflict related to facilities:

> *Workers discuss the action to take in a difficult situation. A resident needs a particular type of hoist, but it's not available in the home. There is no right answer here but the carers have to find it. They say 'do what you can' and 'write it down' and then 'the organisation is responsible'.*
>
> ***Reflective Diary, Strauss Hill Court***

The following observation demonstrated a common conflict between care staff availability and resident need at Sunshine Lodge.

> *Nurse comes into the lounge with medication. A resident calls out 'I need some help to the toilet'. Nurses says 'alright love, I'll let them know'. She leaves (appearing to search for them) and then says 'I can't find who's on the floor, I think they've taken Neil'. I find myself feeling anxious, wondering if the resident will be helped.*
>
> ***Observation, (150715), Sunshine Lodge***

Resources versus needs was a conflict that played out in both homes. However, in Strauss Hill Court it appeared less prevalent and, when it did occur, resulted in better outcomes for residents than at Sunshine Lodge. This appeared to be because the organisation of work and routines at Strauss Hill Court was more flexible and thus provided less situations in which needs conflicted with resources, and provided more options to staff in resolution. By contrast, Sunshine Lodge's strict boundaries between roles meant I never observed nurses undertaking personal care, even when there was a need as illustrated in the observation above. This can be compared with the following description of a typical day at Strauss Hill Court in which the manager discusses a flexibility to roles and routine that was observed in action many times.

"It just completely depends, it's resident-led I suppose. So if they weren't ready to have their lunch at 1.00 then the staff member won't come and get (the hot trolley), or if they're ready early….The other night I was here and normally tea comes at about 5 and they were all at the table and they were hungry so the staff came and got it at about 10 to 5,"

Interview with Manager, Strauss Hill Court

The contrast between the resolution of conflicting pressures in Strauss Hill and Sunshine Lodge also re-emphasises the respective importance of fulfilling expectations and seeing results for residents as aspects of workers' learning. The examples below contrast a response to the exact same issue which arose in both homes: how to engage residents when activity-specific workers were not present.

"(After lunch care workers) put everybody back to bed then there will be (activities) going on…if (activity co-ordinator) is here; or (if not) if we've got enough staff we'll allocate (one of them) to…do quizzes or reminiscence or play music."

Interview with Manager – Sunshine Lodge

Staff do not seem stressed even though they are one MOS down, exchanges are still meaningful (not task-focussed). Later on when chatting to MOS V about what activities when they are short staffed she says 'you can still interact with them can't you?' There seems to be a rule here 'even when we can't do everything, just being with people is meaningful/important'.

Observation (210914) Strauss Hill Court

At Sunshine Lodge the expectation was that activities happened if enough staff were on duty. At Strauss Hill Court activities happened as best they could regardless of staffing because results for residents were primary.

1.2.2 Interpretation of expectations

In this element, the conflicting pressure occurs between alternative interpretations of particular expectations in the home. There were two main concepts evidenced here: **dependence versus independence** and **best interests versus resistance**. The latter was a significant feature in both care homes, with the former primarily present in Strauss Hill Court, perhaps because the nursing status of residents in Sunshine Lodge made independence a relatively moot issue.

Dependence versus independence was a regular discussion amongst staff at Strauss Hill Court, where situations and resolutions revolved around whether a worker's job was to promote a person's independence or respond to their dependence. It was most obvious in relation to Keith, a resident living with dementia, who used a wheelchair and received full support with personal care. At mealtimes staff responded in different ways to Keith, with some actively feeding him and others leaving Keith to do this himself, which he did, albeit slowly with smaller amounts and with some reluctance. Staff often debated with each other about which course of action to take, the rationale behind Keith's reluctance and the purpose of their care. Care worker, Gail, described this complexity in her interview;

"You have to, they're still allowed their independence. This is independent living to their limits. Like Keith is a prime example, let's have something to eat, 'No', but you really have to 'No'. Do you want to sit at the, 'No'. So you've got to say, K, I'll give you five minutes and I'll come back and you can come back and give him a little bit of food and he'll eat it straight away. Do you want any more? 'No' but then you put another in his mouth and he'll be like 'Mmmm...'

He's a stubborn old goat and he knows he's stubborn…it's his independence to say no…Work for it! You want me to eat? Work for it! ...He just wants to be fed and pampered. But not everybody, I will feed him if I think he's going to eat a plate of food with me sat there then I will feed him, but we're not allowed, I (do) you can tell me off if you want, but he's got food in him and that's all good. But a lot of them will go 'no, no, no, don't feed him'… You'll see with some of them, they'll leave the plate in front of them for half an hour,"

Interview with Gail – Care Worker, Strauss Hill Court

This diary extract showed my reflections on this issue;

There's a rhetoric that 'you shouldn't feed Keith because we're independent living' and (dominant?) view that Keith is choosing not to because he's lazy, rather than he can't. Decision for staff is therefore whether to feed him or not? My feeling is that Keith's behaviour is a function of his dementia rather than a choice and so the 'solution' might be somewhere in between.

Reflective Diary, Strauss Hill Court

In practice, it appeared that each member of staff learned their own response based on what they saw as the best outcome for Keith; to eat lots or to do things for himself. This might suggest that this dilemma continued to appear because staff could not (yet) learn from 'seeing results from residents' as they did in other situations. There was not consensus as to what a 'result' for Keith was in this context.

The conflict of **best interests versus resistance** occurred on a daily basis in both homes and particularly related to people living with dementia and aspects of personal care or safety. Care worker Dennis explained the ongoing nature of this dilemma for dementia care:

"If he doesn't want (something) he'll try and bite us you know…because it's hard to explain to him. Obviously he needs changing but in his eyes he doesn't want to. So that's a very hard one because you know he's got to have it done and then he's sort of fighting against you. Sometimes we leave him for a little bit, calm him down, but you don't want to leave him too long. Especially if he's soiled in his pad. Then it comes that you're looking after the resident a bit more, because obviously the health side overweighs them getting slightly upset. So you have to find the balance, you know."

Interview with Dennis – Care Worker, Sunshine Lodge

Staff learned through this negotiation to reflect on the interests and wants of the residents, coming to a conclusion that was often a subtle balance between the two. Again, learning by seeing results appeared to come into play here, with carers at Sunshine Lodge more often choosing an option of fulfilling role expectations (prioritising getting a task completed) and those at Strauss Hill Court showing a more nuanced balance involving results for residents and trial and error, as senior care worker Mary, explained;

"Again, its trial and error, you just try it. If it works, it works. You've just got to persevere to get them to eat and drink and let them change them because it's in their best interests and that's what we're here for…We're here to look after and to give them the best care we can and the only way you do that is by thinking of them and what is right for them,".

Interview with Mary – Senior Care Worker, Strauss Hill Court

As part of the theme of **what works is what matters,** the care homes showed that learning occurred through **negotiating conflicting pressures** in two ways: **resources versus needs;** and **interpretation of expectations**. Whilst both were present in both care homes, the subtleties of their presence varied. Moreover, at times, negotiating conflicting pressures also illuminated the previous learning mechanism of **seeing results,** demonstrating that learning is often a complex and interactive process.

1.3 Thrown in at the deep end

The final subtheme of learning through **'what works is what matters'** is the concept of being **thrown in at the deep end**; a phrase I heard several times in both care homes during my study. Workers were placed in unfamiliar situations for which they felt unprepared. These were seen as being an inevitable and inescapable part of the job, related to the nature of care work and dementia care. When experiencing a situation like this, a worker learned through their success or failure and developed a more sophisticated response for the next time a similar situation occurred. Being **'thrown in at the deep end'** evidenced three key elements: **especially at the beginning**; **getting stuck in**; and **unpredictable situations.** The three elements were evidenced in both care homes, but they were more frequent at Strauss Hill Court. This was again related to the broader and more flexible role of the care worker there, which provided more opportunities for experiences that had not been encountered before.

1.3.1 Especially at the beginning

Workers highlighted that this element of learning occurred most often in the first few weeks or shifts in a care home, whether they were experienced in care work or not and regardless of

the effort put into formal preparation such as training or shadowing other staff. This care worker reflected on her first few days at Strauss Hill Court and in particular responding to residents' requests or confused talk;

> *"You get the general gist of it and then it was a case of 'you're on your own'…But it was scary... But then you get used to (it)…I was just like 'arrrrgggh, I don't know what to say'. To begin with I may have gone along with it but then you get to the point where you realise that you can be honest and don't be scared to be honest. Because sometimes it's, when people talk to you and you're thinking I don't know…I will just say 'I'm going to be honest'."*
>
> **Interview with Verity – Care Worker, Strauss Hill Court**

1.3.2 Getting stuck in

Care workers identified that being willing and able to 'get stuck in' was a key component of the job and often a significant way of learning, with no substitute. Julia, a resident of Strauss Hill Court, had repetitive, perseverated speech that was initially hard for me to interpret. Early in the research I noted that staff interacted with her as if they understood her and she them, leading me to explore staff's learning of this. I asked Gail how she knew this, and to describe the first time she encountered Julia;

> *"She does though! Because when you ask her to do things, it is there somewhere. It just doesn't come out verbally… so like in her brain the bit that does all the understanding what you're saying (is) perfect… If you say to her 'right, Julia would you like some dinner?' she'll go 'dinnerdinnerdinnerdinonononononononono' so it's there for one moment. (When I first met her) they literally just did this, "here's Julia!" and I was like, I don't know what to do with her…I realised that if you walk down the corridor and go 'alright Julia!' and she smiles at you, makes noises at you, (and they) somehow make sense. It's weird but you just do it,".*
>
> ***Interview with Gail – Care Worker, Strauss Hill Court.***

I observed the following example of **'getting stuck in'** at Sunshine Lodge with a new member of staff and it led me to reflect on how different reactions to such events can affect a person's learning. This will be discussed further in Theme Two, 'interactions with colleagues'.

MOS S is in the lounge with a very mobile resident. She finds a frame and gives it to him, talking to him. MOS S then goes and tries to find another MOS. MOS J says 'he's got to sit down' MOS Y says to her to 'get a wheelchair behind him'. S does. Chat with S, no one showed her what to do, that's the first time it happened. She seemed quite shaken. I say that she seemed to find a sensible response. I find myself wondering what different things would be learned from MOS J's and MOS Y's response.

Observation (170715) Sunshine Lodge.

1.3.3 Unpredictable situations

Being thrown in at the deep end was shown to be an important way of learning because unpredictable situations were a frequent and inescapable occurrence in dementia care work. In the following extract a care worker described a resident's fall which occurred when she was on her own supporting another resident and required equipment with which she was not familiar.

"Now I'll know for next time, that's the (correct hoist). So it's good in a way, I'd rather not have been shown that way but I suppose anytime they have an accident you learn something new off anybody…I've got no problem with somebody going 'you're going to do that differently?' Absolutely if you've got a better way,"

Interview with Gail – Care Worker, Strauss Hill Court

The three elements of 'being thrown in at the deep end' were all experienced by me as I attempted to learn what it was to be in the two care homes, interact with the residents and alongside the staff. Activities as simple as sitting in a lounge or making a cup of coffee could quickly become unpredictable situations in which I had the choice to 'get stuck in'. When I did, it was sometimes successful and often not but when I next encountered the resident or

circumstance I felt more confident, drawing on the previous occasion. The learning curve was steep at the beginning but by the end of my time in a home I felt more able to respond.

Interaction and contingencies in Theme One

As highlighted in the introduction to this theme, these subthemes and their concepts did not occur in isolation, instead interacting with each other and with the wider context to influence the ways workers learned. For example, a worker may be presented with an **unusual situation** that requires them to **negotiate a conflicting pressure** as part of their work. They may then seek to resolve that pressure using **trial and error**, aiming to **see results** of reducing negative behaviours. Each factor interacts with the others as the worker draws on previous learning to resolve the current situation. The resolution then becomes learning that can be drawn on again.

In examining 'what works is what matters' in depth I have shown how the theme manifested in the learning of care workers in both care homes. This was the most dominant theme in both homes and across different data types. However, this discussion has also highlighted variations in expressions of a subtheme and their elements, with a more complex expression of Theme One at Strauss Hill Court. These variations hint at structural factors within the care home, operating at the macro-level, that subtly change the outcomes of learning and thus influence the practice that may occur as a result. This suggests that it is not that different practices are learned in different ways, but that the same learning routes result in different practice because of the environments in which they occur. This is the effect of the care home's culture in action. Therefore, from early on in my study, I began to highlight these structural factors and it is worth summarising the pertinent issues for Theme One, prior to their discussion later in this chapter.

Firstly, the relative breadth and flexibility of the care worker role between Strauss Hill and Sunshine Lodge altered the practice that was learned via this theme. In Strauss Hill a broader focus allowed a wider range of possibilities in learning. The highly constricted nature of the role prevented such possibilities in Sunshine Lodge. Relatedly, the rhetoric and understandings throughout the home as to the purpose of the care worker role reflected and reinforced this flexibility or constriction. Secondly, the subthemes and elements appeared particularly prevalent in caring for people living with dementia. Whilst both homes had residents living with dementia, only Strauss Hill Court focussed on this as part of their identity. Sunshine Lodge, by contrast, focussed on end-of-life care, with dementia often viewed more as a secondary condition to residents' nursing needs. Therefore, it stands to reason that workers in a home foregrounding

dementia may show more learning through mechanisms accentuated by dementia care than workers for whom dementia is less significant.

As these interactions and contingencies show, whilst Theme One primarily explains the micro-level mechanisms through which learning occurs in day-to-day practice, it also crosses into the meso-level when considering the resources workers to drawn upon when engaged in '*what works is what matters*' learning. Figure 6 visually illustrates this interconnection and it is to this meso-level and its influence on learning that I now turn.

The meso-level components of Theme One

In this study, the meso-level represents an intermediate space between an individual's day-to-day learning (micro-level) and, the cultural and structural (macro-level) influences on the resources (skills, knowledge and experiences) that a worker may have available within those day-to-day learning situations. As Figure 6 shows there are three sources of skills, knowledge and experiences that workers in the care homes employed: Personal Resources (1a), Resident Influences (1b) and Cultural Knowledge (1c). These are in themselves ways of learning, but their effect is filtered through the lens of 'what works is what matters' and thus are secondary (though no less significant) components to Theme One.

1a) Personal Resources

Component 1a of Theme One relates to the ways in which workers' **personal resources** were brought to bear within their learning. Its presence in the data across both homes was the least apparent of the three components and it was primarily raised in interviews and conversations rather than observed in practice. In addition, reference to these types of influences on learning tended to be in relation to general practice instead of specific incidences. Nonetheless, it was a feature consistently raised across both care homes and thus important to acknowledge and describe.

This type of learning occurred through the worker applying aspects of themselves to the work that they did and the learning situations they encountered through *'what works is what matters'.* Its influence is therefore primarily indirect, as workers used personal resources to review, reflect and decide on a particular practice that arose through Theme One. The outcomes of this interplay, whether in-the-moment or after-the-fact, determined whether an action was drawn upon in the future or shared with others.

"I don't know if they're born carers, but they are born to care."

Interview with Manager, Sunshine Lodge

There are two sub-components to Component 1a: **Previous Experiences** and **Personal Values,** (see Figure 8 below) and these will be discussed in turn. Personal Resources, situated as they are with the individual, were often viewed by workers and senior staff as an external learning source rather than one internal to the workplace. However, as my data showed, because their influence is primarily through '*what works is what matters'*, a theme that is influenced by structural factors (such as role boundaries), this assumption is not accurate. The personal resources a worker brings to bear on learning to care may be less directly controllable, but the opportunities in which they can be used are shaped by factors that can be directly manipulated. As will be seen, whilst the presence of this component within *'what works is what matters'* was similar across both Strauss Hill Court and Sunshine Lodge, its indirect effect of this theme resulted in different practices on the ground.

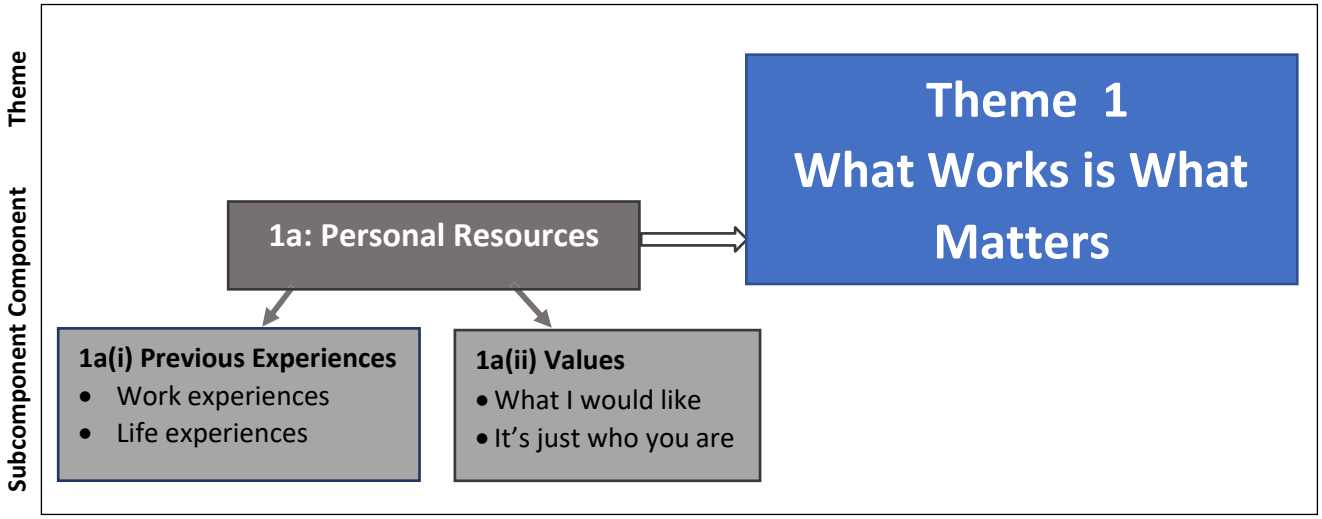

Figure 8: A visual representation of Component 1a 'Personal Resources'

1a (i) Previous experiences

The first subcomponent of **Personal Resources** was the use of **Previous Experiences.** Here learning was influenced by the workers' application of previous experiences within situations they faced at work. This was both specific (where workers had dealt with a similar situation before), or more general (when workers had learned a particular way 'to be' in their work). The elements of this subcomponent illuminate the type of experience drawn upon: **work experience** and **life experience**

- Work experience

Care workers utilised their previous work experiences in learning how to carry out their present job in three different ways. Firstly, when faced with an unusual or challenging

situation, workers would draw on previous work experiences of similar events if they had experienced them. These events did not have to be identical, instead experiences were 'mined' by the individual and applied to the current situation through the mechanisms of Theme One 'what works is what matters'. Here, care worker Cath explains how her previous work experience in domiciliary care had helped her to interpret residents' moods.

I've done this for 12 years on the road, you get to know the look of someone's face, the way their hands are acting, either they've had a good night or a bad night. You have to adjust to everything you see. I mean, we have one lady here, as soon as you see her teeth drop you know that she's going to become…aggressive. So you have to, by experience, know (what to do)…It is learning. You can be told 100 times the right way, wrong way…but you'll learn yourself when you do the wrong thing,"

Interview with Cath – Care Worker, Strauss Hill Court

Dennis explained how his previous care experiences influenced his response to residents who did not remember that someone had died, a common situation in both homes;

Me? I go along with them… (if you don't) they go through that grief period again and I've seen it. They go through the crying and the emotions of, because to them it's new…I think that's the best approach from what I've seen and what I done myself. Because I've seen when they're told that it's not true and I can see them getting agitated,"

Interview with Dennis – Care Worker, Sunshine Lodge

Secondly, previous work experiences also influenced workers more broadly in learning their general approach to their roles. I reflected with Dennis that he had settled in to his role at Sunshine Lodge very quickly describing him as an 'old hand already', he explained why this was the case;

A lot of people are saying that! Obviously, because of all the experience I've had before: care's care. But it's getting (it) person-centred, so it's learning the

residents… You know one person is treated different to another. So once you've learned that it makes the job a lot easier and you can do, go anywhere …That's the bit that takes the time, learning their individual needs…That's why I like working in different sections so I learn everybody and then obviously if you need to go anywhere you can move everywhere. Some people like staying in one place but I'd rather learn everybody."

Interview with Dennis – Care Worker, Sunshine Lodge.

This is particularly notable because Dennis was one of the few care workers who worked across the two different shift teams at Sunshine Lodge suggesting that he had, perhaps unintentionally, defied the norm there; enhancing his learning as a result. I observed Dennis to be one of the more 'person-centred' carers at Sunshine Lodge when he interacted with residents.

Previous experiences also influenced workers' general approach by drawing contrasts between different work experiences to influence their attitude to current work. Gail had a varied work history and Strauss Hill Court was her first experience of caring for people living with dementia;

Gail says she loves her job. She moved from a busy city to this area and she used to work with drug addicts and (people with) schizophrenia and in comparison she said 'this lot (the residents) are a joy'. (I reflect) does previous experience influence what messages you absorb about this role?

Reflective Diary, Strauss Hill Court

Moreover, Dennis illuminated this issue by describing his previous experiences of very poor and challenging dementia care, perhaps explaining why he did not seem to be overly concerned by the less person-centred aspects of care at Sunshine Lodge; in contrast to his previous experiences Sunshine Lodge was an improvement.

I've worked in a dementia home. I worked in a 63 bed unit and that was er, challenging in the least. Challenging and interesting! Especially with four people, nights as well. I was a team leader there, I had to do all the

medication. Two staff didn't speak English and 63 residents. They all had dementia and you had one person getting up 20 times to be put to bed…there's a point of safety in my book…you can't give your full care (to) all 63 people. You can't do it…It's impossible,"

Interview with Dennis – Care Worker, Sunshine Lodge.

The third way that previous work experiences influenced learning was through role models. Not all workers identified these, but for a few they were significant in influencing their approach to practice.

I was obviously taught to greet the resident, explain to them what was happening, and the nurse that taught me initially on the job she was very kind, lovely, person…and she taught me high standards and obviously a great deal of respect for those people I care for, however difficult it was…she taught me to strive for the very best and to the highest standards that I could within those difficult circumstances…I could see where she was coming from and I always try very hard to put myself in somebody else's position and I think that sometimes other staff think that I'm perhaps overly fussy or I'm taking a little bit too much time or perhaps that I'm too particular,"

Interview with Janet – Care Worker, Strauss Hill Court

Janet appeared to be quite separated from the care team at Strauss Hill Court for precisely the reasons she identified, so this influence for Janet was perhaps significant enough to outweigh the influence of her colleagues. In addition, Janet herself explicitly linked her desire not to talk over residents to her preference to care by herself on Unit 4. This was a practice that was unique to Janet.

- Life experience

Workers' life experiences were also shown to influence their learning in similar ways to work experiences. These experiences provided either direct knowledge of dementia and caring or more general personal and family events. These experiences often motivated workers into care work and also how they approached their day-to-day work.

"My Nan bought me up and I wanted to do it because I think they're fascinating, residents, old people. It's just they've got so many things to say, so many things they've done. I always think…'now if that was my mum and dad'. I'd still want their independence as much as they can you know so…it comes with experience"

Interview with Della – Senior Care Worker, Strauss Hill Court

Life experience of caring for elderly relatives, children and grandchildren were mentioned by many of the older care workers as significant to their approaches in general and specific situations. Ruth explained how she brought personal experience in to help her learn how to respond to the anxiety and distress-driven behaviour that residents living with dementia could exhibit;

"You learn what to do and what not to do very quickly. I mean I've got two grandchildren with ADHD so you learn straight away what buttons to press and not press. It's dealing with old people but it's the same thing"

Interview with Ruth – Care Worker, Strauss Hill Court

For some, the significance of life experiences meant that age was an important factor in care workers learning to do the job well. However, age was not always a distinction relevant to quality of care, rather one relevant to style of care practice. This suggests that age and age-related life experiences may be a factor influencing a worker's interactions with colleagues as much as it directly influenced care, and this will be addressed further as part of Theme Two. For example, care worker Cath was one of the youngest in the team at Strauss Hill Court, but was observed to provide care that was frequently person-centred. She described how a serious accident she had a few years' before influenced her approach to care:

"I had a brain injury, which I don't mind talking about…because I can empathise…you can see them (residents) the frustration because of what they couldn't do and I had the same. Initially, after my accident I couldn't walk (had to) get my brain working again because it wouldn't tell me to walk. I had a zimmer frame and everything! … Being put in a situation where I had to rely on

my Mum to get me dressed, get me food, get me washed … because I couldn't do it myself… To be put in a situation where I had to rely on someone makes you appreciate how much life means to you and how much independence we take for granted."

Interview with Cath – Care Worker, Strauss Hill Court.

1a (ii) Personal values

Previous work and life experience also contributed to the second subcomponent; personal values. Here, learning occurred through a worker applying their personal values to the circumstances and decision-making they engaged with in their care homes. In doing this, workers essentially appeared to filter possible responses and actions through their own values and this steered them towards options with which they felt most comfortable. Personal values showed up in different ways that form the two elements of this subcomponent: **What I would like**; and **It's just who you are.** The first element was sporadically apparent in the data in both homes, with the second appearing the more consistently.

- *What I would like*

In considering their practice and decision-making some care workers explained that they chose particular practices or responses because it was how they themselves would like to be treated in similar circumstances.

"I always try and put myself in that person's position and treat somebody how I'd like to be treated,"

Interview with Janet – Care Worker, Strauss Hill Court

This ability to imagine oneself into a particular situation was something Dennis felt influenced his approach to challenging behaviours or reactions from residents;

"I'd always say, put yourself in that person's shoes. You know, you imagine being sat in that chair, not being able to go to the toilet and you know you

want to go to the toilet, or you know you want to get a drink and they can't get up and get a drink. So you can understand if some people get very agitated and they will take it out on you because you're the nearest person."

Interview with Dennis – Care Worker, Sunshine Lodge

'What I would like' appeared most commonly in connection with practices that were viewed as being the difference between completing the task of care and *caring* for the person. The extra flourishes that made that care particularly meaningful for the resident and the worker:

I just think if that was me, or my little girl, what would I want doing? ... The same things for me, I want to give them a kiss good night because if they pass away they've had a kiss good night. They can (die) in their sleep now if they want to now, because they've been hugged, they've had their kiss, somebody's told them they love them….but some of (workers) are very 'good night', door shut, job's done….But that's the thing: job is done. Not care work, their job is done,"

Interview with Gail – Care Worker, Strauss Hill Court.

These types of considerations were highlighted by senior staff in both homes as being a particularly valued characteristic and something the manager would look out for in recruitment.

"I think they have to be an empathetic person, they have to be able to think how would I feel if it were me…How would I like to be treated, how would I like them to be treated? I think it is that kind of person really,"

Interview with Manager, Sunshine Lodge

Interestingly, several experienced workers in Strauss Hill Court discussed a downside to this sort of approach from the worker's point of view,

> *"Sometimes you just have to be willing to go that extra bit…and I think a lot of times you leave yourself open as well. Because…you know if anything ever, when, because obviously its inevitable (she'll die)…I mean Julia, I love her to pieces and you know, I'll be devastated. I suppose because I've allowed myself to get that close to her I've left myself open to heartache if you like,"*
>
> ***Interview with Anna – Care Worker, Strauss Hill Court.***

Further to this it was not unusual to hear a great deal of ambivalence on this point in general talk amongst care workers at Strauss Hill Court. There was no evidence of mixed messages from management at Strauss Hill Court, in fact emotional closeness was encouraged, but nonetheless such ambivalence existed. As Janet explained:

> *"Obviously you are, well recommended is not the right word, from a professional point of view you shouldn't really get close to people. However when you work in the way I do, and I feel that you should, sometimes it's something that comes naturally and it can't be avoided. Being detached I don't think is necessarily a good thing."*
>
> ***Interview with Janet – Care Worker, Strauss Hill Court***

Within the two care homes I was unable to trace the source of this 'you shouldn't get too close' message because I didn't recognise its significance until after my time at Strauss Hill Court had finished. In addition, I was not able to develop close enough relationships with workers in Sunshine Lodge to explore this emotion-laden issue. Nonetheless, this aspect resonated strongly with me, from my own time as a care worker and from countless conversations with care workers in care homes in my career. This suggests that ambivalence related to this issue may be significant and that learning to manage that ambivalence may be an important part of learning to care, particularly if aiming to encourage person-centred practices that foster emotional connection rather than detachment.

- It's just who you are

The final element of **personal resources** concerned aspects of care practice that were manifestations of who the care worker was as a person, rather than practice, skills or knowledge that had been learned. It is important to note that the distinction between learned behaviour and a person's 'inherent' nature is not one that can be taken for granted. However, for the purposes of my study, the distinction was a very clear one in my participants' expressions and thus I chose to accept this in analysing and writing my findings.

'It's just who you are' occurred when a person applied aspects of their personality or innate knowledge such as 'common sense' to the role. In these situations, a practice is not learned in the conventional sense but instead comes about because a worker is being and listening to themselves. Crucially, this element was viewed, at least on face value, as being immutable; it could not be taught or changed.

"I think a huge amount depends on that person, being the right person to do the job…I think it comes down to compassion…I think a lot of it can be common sense, being sensitive to people's needs…you've either got it or (not),"

Interview with Yvonne – Activities Co-ordinator, Sunshine Lodge

"I think you have to have a natural care about you to be a good carer…You've got to have a caring nature about you. You have to care and give a monkey's about what they want and how they feel,"

Interview with Cath – Care Worker, Strauss Hill Court

Through examining **'it's just who you are'** further, a number of characteristics were cited across both homes as being central to the right kind of person: compassion, honesty, patience, respect, empathy and, a willingness to learn,

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"They have to be that all-round person, they have to be willing to learn, they have to be willing to learn from other people as well, regardless of age or experience you know? Just because I have a masters…doesn't mean I'm going to be good at dementia care…Some people who have never done dementia care before, or any type of care before come in and they've just got that way about them,"

Interview with Manager, Strauss Hill Court

It is interesting that 'a willingness to learn' appears as a characteristic that makes someone a 'natural' care worker, illustrating that the relationship between assumed-immutable characteristics and learning is not straightforward. Indeed, conversations about this factor were often contradictory, highlighting that other factors come into play as well;

> *"I think it's all down to the individual…letting people in I suppose, rather than just coming to work, doing their job* ***… (I: Is there a way you can teach people to be that way?)*** *I don't think you can. I don't think it's something you can learn (but) I think there are probably people in the middle as well. I don't know whether it comes with time as well. I mean, I've seen people come into doing this, they haven't done it before and when they first start you think 'god'. I think over time, it's a learning process. I think people do change over time,"* ***(I: What do you think it is that influences that change, whether it's to the good or bad?)*** *I think it's to do with the whole sort of home, with watching and learning…and whether you take it on board,"*
>
> ***Interview with Anna – Care Worker, Strauss Hill Court.***

Here it seems that factors associated with the work and workplace may be influential in the interface between 'innate' and 'learned' aspects, influencing how workers change practice over time and questioning the assumed unchangeable nature of personal resources.

Interaction and contingencies of component 1(a)

The component of personal resources was less complex than the other components of Theme One and appeared to influence learning and subsequent practice indirectly through Theme One. This allowed for issues of workplace and work organisation to affect the way in which personal resources impacted practice, despite its seeming fixed identity within an individual.

A care worker's **previous experiences** in **work** and in **life** were significant to learning because they provided options and examples of both general approaches and specific practices which could be applied when considering **what works is what matters** in situations encountered in their current

work. For example, if a previous **role model** was significant to a care worker, this may contribute to their approach to **negotiating conflicting pressures**, when **resources and needs** of residents conflicted. If a worker had previously **seen results** through using **trial and error** with a resident with dementia then this may shape a worker's practice with similar residents in the future and be incorporated into their **personal work experiences** over their long term. Furthermore, a care worker's **personal values** not only stem from and influence their **work experiences**, but also provide a standpoint from which success through **what works is what matters** can be determined. In turn, the popular belief that good care practice is at least in part determined by '**it's just who you are'** will interact with how **role expectations** are interpreted.

Therefore, whilst these personal resources are internal to the individual and often viewed as unalterable, they can still be affected by structural factors in the workplace because the influence of personal resources is via Theme One and in conjunction with component 1b (resident influences) and 1c (cultural knowledge). Workers in both homes brought their personal resources to bear; resources that were no more different between the two homes than between individual workers in the same home. However, broadly similar manifestations of personal resources in the two care homes resulted in different practices being learned and carried out on the ground. This suggests that similar workers placed in different circumstances can be expected to learn different care practices.

1b) Resident Influences

The second component of Theme One is **resident influences**. It is a body of skills and knowledge the care worker applies to the process of learning through what works is what matters. Resident influences is a learning process in its own right, as discussed below, but its impact on care outcomes was indirect through Theme One. In this component, learning occurred whenever a worker adopted a particular practice because of their relationship, interactions or knowledge of an individual resident. Such a practice was repeated, drawn on or shared if it was seen to be successful in achieving a desired outcome as 'what works'.

"That's the best way to learn in this particular job. I think that's the best way because you see how people react and interact with residents…because different residents react differently to different things and people,"

This aspect of learning was again present in both care homes, but its indirect effect meant that it resulted in different care practice in either home. This is because it's impact was filtered through the 'what works is what matters' process of each home. Resident influences were therefore more noticeable in Strauss Hill Court because learning via Theme One encouraged more focus on residents. Sunshine Lodge's experience of Theme One provided fewer resident-oriented opportunities through which this component could have an effect.

Resident influences had two distinct subcomponents: **learning from** and **learning about**, (see Figure 9). As previously, whilst the subcomponents are discussed separately, they often interacted to affect the practice learned.

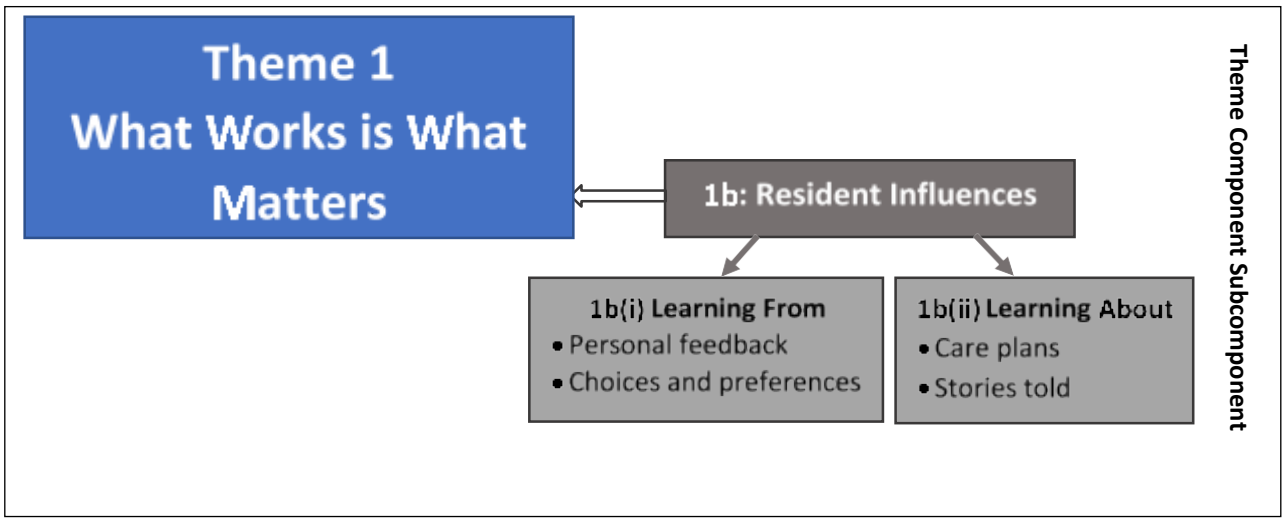

Figure 9: A visual representation of Component 1b 'Resident Influences'

1b (i) Learning From

The first subcomponent of resident influences is **'learning from'.** In this subcomponent, learning occurred through interactions with individual residents. An action that was seen to elicit a response that enhanced the worker-resident relationship (from the perspective of the worker) was more likely to be utilised repeatedly by the worker with that resident, shared with other workers and applied across the resident group.

There is obvious overlap here with the particular subtheme **'seeing results - for residents'** of Theme One. However, this subcomponent is worthy of distinct consideration because it concerns the underlying relationship between the worker and resident, rather than the interface between the worker, resident and the tasks of care. In subcomponent 'learning from' actions that created connection had a meaning for workers beyond their ability to facilitate a specific goal or outcome in relation to resident care. In essence, **learning from residents** provided information about the longer-term resident-worker relationship which the worker could draw on (alongside other resources) within the more immediate consideration of **seeing results for residents**.

The subcomponent's individual elements of **personal feedback** and **choices and preferences** describe the different ways this subcomponent played out in both care homes. Again, the relative importance of these elements differed between the two care homes because their impact was filtered through the what works is what matters process, and subsequently mediated by the structural boundaries of that theme within each home.

- Personal feedback

Personal feedback related to the responses residents gave to interactions with the worker. Responses that the worker experienced as enhancing their relationship with the resident (whether through explicit verbal or physical feedback or a feeling of connection) were more likely to be integrated into the worker's actions in the future. Actions that resulted in resident feedback suggesting a worsening of the relationship was subsequently avoided or altered. In the example below, senior care worker, Mary received an unusually coherent response from resident, Julia. In a later interview, Mary reflected on this and about how it had reaffirmed her approach when coaxing Julia to take medication which she often refused;

MOS M comes over and kneels in front of Julia with medication pots. 'Julia, can I give you a little something to help your mouth so it's not sore?' Julia hold up her hand and turns her face away. 'Just a little, to help your mouth?' MOS takes the spoon towards Julia's mouth. Her mouth is firmly shut. MOS takes the spoon away. 'Just a little to help your mouth?'

Julia chatters and then opens her mouth as the MOS slowly moves the spoon towards it. Closed mouth around the spoon and MOS says 'there you go'. Removes the spoon and Julia swallows. MOS says 'and another'. Slowly takes spoon to Julia's mouth and process is repeated. 'One more?'

Process is repeated again with other medication. Julia wrinkles her nose and swallows. MOS says 'there you go, does that feel better?' Julia replies with 'chachacha'. MOS gets up and says 'thank you very much' as she moves away. Julia says (clear as a bell) 'and thank you too'. MOS does a double take, smiles and then says 'You're very welcome'.

PIECE-Dem observation- Julia, Strauss Hill Court

Within this element, many carers provided examples of small, in-passing moments with residents, where they expressed affection and gratitude to workers and these appeared to be particularly meaningful and significant. Of particular note was an example given by care worker Janet. Janet's role was unusual at Strauss Hill Court because she worked on her own in unit 4, where usually two members of staff were allocated. In explaining this she emphasised that working on her own enabled her to connect more with residents, rather than being distracted by another worker. She was observed to have helped Keith out of bed in an afternoon when previous staff had failed to do so all day. Janet explained her relationship with Keith through the following example:

Janet explains that she knows she does the right thing by Keith because once, when she was kneeling in front of him and said, in passing, 'oh, I do love you Keith', he replied 'I know you do.' This meant a huge amount to Jo because of how difficult Keith finds it to communicate.

Reflective Diary, Strauss Hill Court

Far fewer examples of these type of interactions were observed at Sunshine Lodge. This element only appeared to manifest when resident responses suggested a possible medical concern, such as infections. This led me to reflect that it may have been the medical focus of a nursing home at play;

Had a conversation with MOS J telling me where the other MOS was. She is in with Giles. Reports that he has been unwell for a few days and 'we don't know what's wrong'. He's been having hallucinations, saying that his wife has been in a car crash and getting very distressed with staff. They think his 'salts may be out of balance'. J showed great concern for Giles in this discussion.

Observation (120515), Sunshine Lodge

It is important to note that for many residents at Sunshine Lodge it was impossible to observe the majority of their care as it occurred in their bedroom with the door shut. Therefore, I may have missed many occasions when care workers experienced this type of connection and thus could not explore it further with them.

Another contrast between the two homes with regard to this subtheme could be seen in the influence of negative feedback from residents and signs that an action had diminished the worker/resident relationship. The examples below show how in Strauss Hill Court it was common for workers to take personal responsibility for negative feedback, resolving to change future action. In contrast, Sunshine Lodge this type of response did not appear to be used by the worker to reflect on their contribution to the relationship.

"One day I stood in the way of the door and got a right slap (from Julia). Let's put it this way, I'm stood between you and the door, what are you going to do? I can't blame Julia for that, it's my fault for standing between her and the door."

Interview with Gail – Care Worker, Strauss Hill Court

Following a tense/angry interaction between MOS T and Jack when he is transferred to dining room, Jack is being supported to eat by MOS T. Pudding has been placed on the table for the other resident. I hear (I cannot see staff or resident's faces) 'don't touch it, Jack, it's not yours' several times. Pause. Then I hear MOS T says angrily 'He spat it all over me!' stands up, turns to other MOS in room and says 'Yes! He just spit it all right at me, I'm going to wash my hands'. MOS T storms out of the room.

Observation (070515), Sunshine Lodge

The presence of learning by reflecting on negative feedback from residents in Strauss Hill Court may have contributed to the general quality of care and flexibility in approaches that I observed there. Learning from all types of feedback, both positive and negative, may have offered a wider range of information available for workers to employ within the 'what works

is what matters' process and thus helped to reinforce the prevalence of seeing results for residents at Strauss Hill Court, as compared with the prevalence of 'fulfilling role expectations' at Sunshine Lodge. However, it is important to note that in both homes there were staff members who flouted these usual responses to negative feedback from residents, so this element may be one related more to individual staff than norms of behaviour in the respective teams.

- Choices and preferences

In the second element of subcomponent **'learning from'**, learning occurred when workers had to find out and enact residents' choices and preferences, often whilst balancing them with others' needs or communal living. If successful through the mechanism of 'what works is what matters', a worker adjusted their own responses in the future, and suggested them to others. Care worker Anna demonstrated this in relation to breakfast time in Unit 4, and particularly for Julia who often would not sit down to eat;

"It's just basic things like at breakfast time, who has their crusts cut off their toast and who has jam and marmalade….Like with Julia…she'll go through phases. I recently discovered that she'll eat porridge which I didn't know because everybody gave her cornflakes…I gave her a bowl of porridge, plenty of sweetener, jam and…two bowls! Not saying she will next time but you know, (try it). I know that you can't give Julia a hot drink because as soon as you give it to her she'll just put it down because it's too hot, so you (make it differently) and if it's just warm she'll drink it."

Interview with Anna - Care Worker, Strauss Hill Court

Although less frequently seen at Sunshine Lodge, opportunities to find out about a resident's life history were important aspects of this type of learning, as care worker Dennis explained;

I think [resident] was a preacher, because he asked me for a couple of babies the other day, and I thought okay, what's he want the babies for? I found out after that he was a preacher and he was on about marrying people, things like 'I want to marry you' and they took it as 'I want to marry you' but he meant I want to marry you as a preacher,"

Interview with Dennis – Care worker, Sunshine Lodge

In addition, as with personal feedback, this aspect appeared to play out in Sunshine Lodge with particular reference to medical concerns such as nutrition and hydration, as this example shows;

"Because you put a drink of orange squash for instance in front of Florence, she won't drink. Then she'll get a urine infection and it's just because she doesn't like orange squash. You give her a drink of water and she'll constantly drink. It's things like that that you've constantly got to be aware of likes and dislikes. Something like that, it's a silly little (thing) but it can make a difference,"

Interview with deputy, Sunshine Lodge

The importance of knowing choices and preferences of residents was impressed upon me several times in both homes, usually when my lack of knowledge caused problems, as the following extract demonstrates;

I hang around and make tea… a resident walks in and expresses annoyance at Felicity sitting in the wrong chair. I get an extra chair for her to sit down…The discussion starts to get a little heated. 'Why can't you just move?' 'I can sit where I like'. Another resident in the end gets up and moves, mumbling 'I can sit where I like'. Felicity says several times (to another resident), 'she should be put down'…I wonder what would be different if the staff were here. This is usually avoided by some of the staff routine, headed off at the pass by thinking ahead?

Observation (210914), Strauss Hill Court

As has been shown, both elements of the subcomponent 1a (learning from and learning about) existed in both homes albeit with different emphases. Nevertheless, it is important to note that in both homes, when a resident was unable to provide feedback to staff (at least in a way they recognised), this subcomponent could not be brought to bear within the Theme

One learning process. This could result in learning care practices that were less-than-optimal for resident care, because a practice could 'work' without reference to staff knowledge based on residents' input. These two examples illustrate this issue in each home.

"During a dance activity, I had the impression that Paula was aware of what was going on but trying to ignore it rather than being asleep. I didn't see any attempts to engage with Paula and yet they chose to do the activity around her. MOS said that Paula 'never joins in anything'.

This example was played out repeatedly with regards to Paula, and I saw few attempts to connect with her. She has flat affect and rarely seems to 'react' to anything,"

Observation (270814), Strauss Hill Court

"So, as you can see, what (care staff) tend to do is leave those that are happy or not really aware of whether they're in bed or not they will leave those till last,"

(Reflection): This was borne out in observations of resident, Emma, who spent most days in bed in her room, alone. She would call out and sing, and on one occasion when I turned her radio on she grabbed my arm and said 'you gave my ears'.

Interview with Manager, Sunshine Lodge

This is of particular significance when considering the care of people with a progressive condition such as dementia and suggests that a focus on relationship and communication in advanced dementia may be necessary to take full advantage of this aspect of learning.

1b (ii) Learning about

The second subcomponent of **resident influences** is **'learning about'.** This occurred when a worker learnt information about a resident from a source other than direct interaction and then applied that in practice with the resident. This subcomponent was less influential than 'learning from', particularly at Strauss Hill Court, primarily because of their emphasis via Theme One, on 'seeing results for residents'. This ensured that direct encounters - 'learning from' - was valued more than the secondary information of 'learning about'. The component **Learning About** consisted of two elements: **care plans** and **stories told.**

- Care plans

Both care homes had extensive care plans in place for all residents which were detailed, contained past and present life history, and were updated regularly. They were intended to link to the daily care of the resident and daily records were kept by staff as part of them, making them 'active' documents. Senior staff in both homes emphasised their importance to care workers' learning about residents, how to care for them and, more generally, the ethos of care at the home;

"The 'My Life' document, for the carers is for them to understand that before they came here, they were a 'normal' person with a 'normal' life, a family, had a high-powered job or was a dustman, it really doesn't matter that's who they were. Not this thing you see in the bed."

Interview with deputy, Sunshine Lodge

"There's a whole section in the care plan…so our lady who pushes her dolls there's information around her…because obviously it's quite relevant to her she gets quite possessive about you touching her dolls and it's important for you to know about that because otherwise you might get clocked.,"

Interview with deputy, Strauss Hill Court

However, it is notable that in discussing learning with care workers, care plans did not feature as prominently in their considerations of how they learned to care for people, being mentioned only in passing, if at all. At Strauss Hill Court in particular, there was a sense that care plans did not always represent reality, as these two staff discussed;

Ruth: *"We can read through the care plan, we can read what it says on there but that might not be the person…You've got to look at them they're not like that at all."*

Jackie: *Yeah, What you get on paper, you get them in a different setting, you think somebody else has come in."*

Interview with Ruth and Jackie – Care Workers, Strauss Hill Court

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In addition, at Strauss Hill Court I identified discrepancies between the care plan and practice for Julia, whose records I examined in detail:

> *Of particular note is Julia's (care plan) for personal care as it notes that two staff can distress her and therefore 1 MOS should provide it when possible. Everything I have been told (and some of what I've seen) is that she requires and gets two MOS and yes, it does distress her.*
>
> ***Reflective Diary, Strauss Hill Lodge***

This may suggest that, for Strauss Hill Court at least, care plans could be a factor in learning, but overridden by other resources within the 'what works is what matters' process. At Sunshine Lodge this discrepancy did not appear, although this could simply be because I was not able to discuss specifics of care directly with as many care staff as at Strauss Hill Court. Indeed, the care worker I interviewed at Sunshine Lodge explicitly raised his use of care plans, particularly as a new member of staff and because of the 'non-active' time that the Care Certificate induction provided;

> *"(induction delay) gave me a chance to read some of the care plans…So I get a basis of what they was like and what their stories is like, try and get a bit of knowledge on them before…(did that make a difference to your care?) Yeah, because you've got something to talk about. You know, I knew that Rebecca was the lifeguard…cause I'd read that in her thing and she'd worked there for 50 years…so we started talking about that and having a laugh."*
>
> ***Interview with Dennis – Care Worker, Sunshine Lodge***

The relative importance of utilising care plans within each home when learning via Theme One may be a partial explanation of the less flexible care practice I observed at Sunshine Lodge. After all, care plans do, inevitably provide a static view of care required (as opposed to responding to a resident's reaction for example), and if this is enacted precisely it will result in very similar care from one day to the next.

- Stories told

The final way in which 'learning from' influenced the learning of care workers was through the stories told about residents. In this element a worker would listen to stories told and utilise that knowledge when carrying out care and learning through the 'what works is what matters process' of Theme One; particularly so if the story contradicted the worker's own experience. These stories appeared most relevant when they came from someone who knew the resident well. This included both residents' families and staff who had worked with them for a long time, regardless of seniority in the home. In Strauss Hill Court the stories told were frequent, often recounting snippets of an interaction or something that had been said or seen;

"It's interacting with the families as well, because they can tell you an awful lot about the person that they used to know. Because a lot of people, we find that when they come in, like we've got a certain lady who had never been confrontational, never been confrontational in her life, so its finding things out like what she used to do, what she worked as, what she did, you know, did she like knitting, things like that that she used to do and try to introduce things like that…you watch, listen and learn,"

Interview with Jackie – Care Worker, Strauss Hill Court

At Sunshine Lodge, it was the activity worker who was able to recount stories of residents, because her role enabled her to interact in a more social capacity with residents. She made efforts to share these stories with care workers, although the disjunction between the care and activity roles made this challenging. For example, the 'social records' for residents were almost exclusively completed by the activity worker and she shared a number of these stories with me. However, I never heard these stories being recounted or referenced in care worker's interactions with those residents on subsequent days. Compare these two entries for the same day from Jack's daily records;

Much better today. We sat and looked at his photo album, stirred lots of recognition. We had a voice concert after that and J was totally animate with the mandolin concert. He was singing along to lots of tunes was excellent.

Social Event Record for Jack, Sunshine Lodge

Washed, dressed and put in reclining chair. Shave and bed changed

Daily Care Record for Jack, Sunshine Lodge

The disconnect between the social and physical aspects of life at Sunshine Lodge may well have prevented learning occurring for care workers through those stories told, at least in terms of presenting challenges to their own perceptions and experiences with a given resident.

Interactions and contingencies of component 1(b)

As with the component 1a, each of the subcomponents of Resident Influences interact with each other to influence what practice is learned by care workers. For example, a care worker may experience **personal feedback** from a resident in interaction with them which highlights a previously unknown **preference** or way of enabling **choice.** In turn this may be documented into a **care plan** and shared with others as an influential **story.**

Resident Influences occurred more frequently in the data than for component 1a, particularly within Strauss Hill Court. More significantly, because the impact of Resident Influences is mediated by workers' utilisation of it within the 'what works is what matters' learning process, it resulted in different care practices being learned in each home. Learning through **what works** by **seeing results for residents**, (as was prevalent at Strauss Hill Court), could be affected by the **personal feedback** a care worker interpreted as enhancing or detracting from their relationship with the resident. Alternatively, if **what works** by **seeing results for fulfilling expectations** dominates (as it did at Sunshine Lodge), then learning could be affected by what is documented in a **care plan**.

Furthermore, because of this mediating role of Theme One, structural circumstances in the two care homes affected the opportunities to develop and use the resource of Resident Influences. In particular, the boundaries to the role of 'care worker' inhibited or encouraged the development of relationship between worker and resident. The more flexible boundaries at Strauss Hill Court accounted for the more significant influence of this theme there when compared with Sunshine Lodge. Only the element of care plans (arguably the least relationship-focussed aspect of the theme) appeared more influential at Sunshine Lodge. Crucially, it would appear that when the

operation of Theme One in a care home favours **seeing results for residents** over those elements more concerned with role expectations. Resident Influences are not only utilised more frequently but also *reinforced* as an important resource for learning. As Figure 10 shows below, this creates somewhat of a cycle in which the resource of Resident Influences is utilised in Theme One learning and the outcomes of Theme One learning increase the usefulness of the Resident Influences resource.

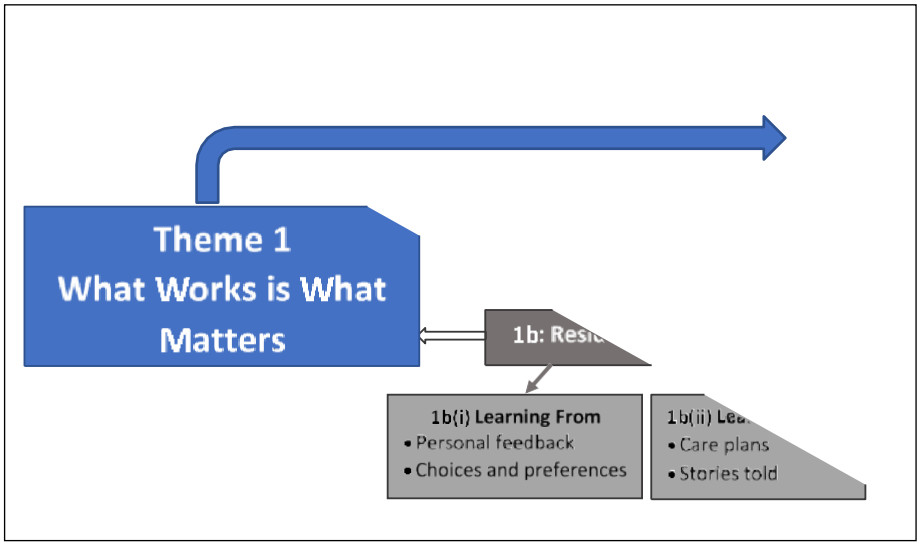

Figure 10: The reinforcing relationship between Theme One and Component 1b 'Resident Influences'

Within this study's data there did not appear to be a similar reinforcing cycle between the outcomes of Theme One learning and Component 1a (Personal Resources). This may be because Personal Resources were considered by participants as external to the workplace (and as such disconnected from in-work feedback) or simply because this feedback takes longer to have effect or went unnoticed by myself. This may be worthy of further study.

There is a third component to Theme One – (1c) Cultural Knowledge – which was a more influential component within the 'what works is what matters' learning process than either Personal Resources (1a) or Resident Influences (1b). As Figure 6 showed this component actually acts as a vehicle for the influence of macro-level factors on how learning to care occurs, and as such is worthy of specific focus.

Themes Two and Three: from meso to macro-level influence

Cultural Knowledge, like components 1a and 1b, is another resource that a care worker draws upon when engaged in learning to care through the 'what works is what matters' process. However, it differs from the other components because of its level of significance to the outcomes of 'learning to care'. As Figure 11 shows, Cultural Knowledge encapsulates the learning from two additional themes, both of which carry with them strong macro-level influence as they are structurally determined by the organisation of work tasks, roles and teams in the care home. These are conceptualised at the macro-level because these structural determinants are, for the most part, outside of the control of an individual worker or group of workers. They are primarily the result of organisational and leadership decision-making and as such an individual worker is subject to them with only limited scope to affect.

The themes embedded within Cultural Knowledge therefore act as the route through which a care home's specific organisational culture shapes the learning that can take place and its subsequent impact on practice. Theme Two describes the learning that occurs via interactions with colleagues and it was the second most frequent theme identified in the data across both homes. Theme Three is the least influential of the three themes and represents influences on worker's learning from formalised training.

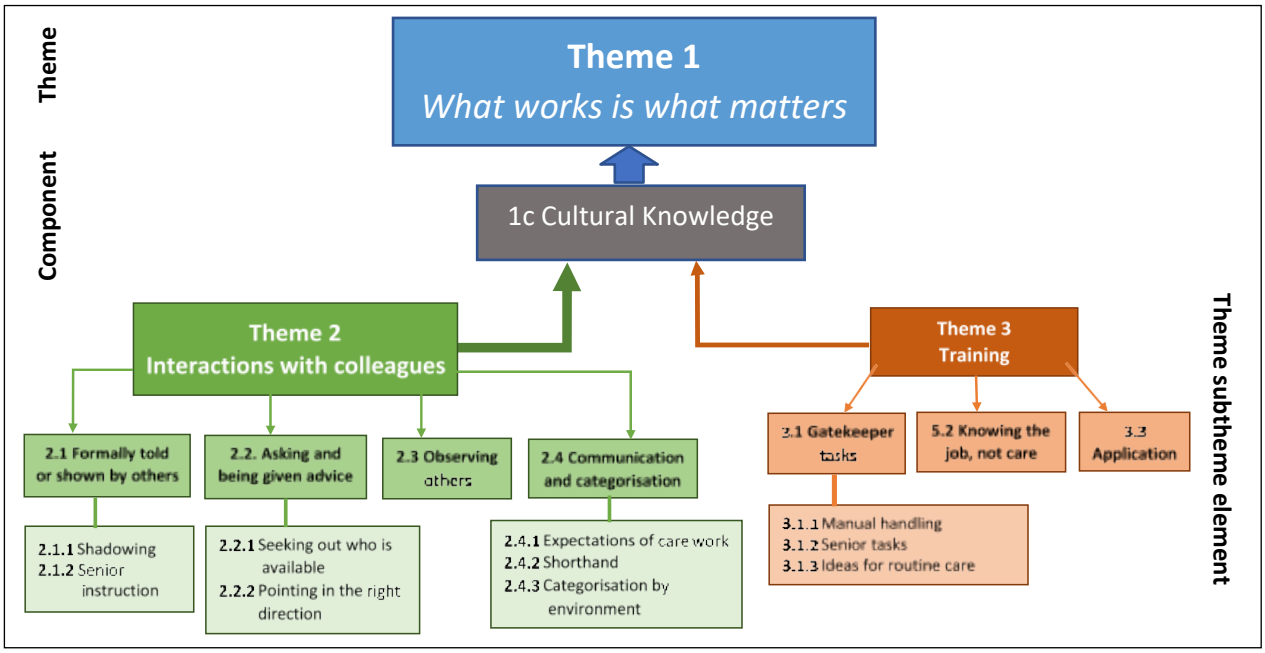

Figure 11: A visual representation of Theme Two and Theme Three's relationship with Theme One

2. Theme Two: Interactions with colleagues

The second theme was prevalent in both care homes and evident across all data types, although with less prominence than Theme One and with different levels of complexity in the two homes. **Interactions with colleagues** is learning that occurred through relationships, contacts and communication with colleagues of all levels. These interactions could be deliberately planned and formalised activities in the home, as well as informal and sometimes unintentional interactions.

> ***(Do the staff feed off each other?)*** *I think so, very much. I think it's really nice actually because we've got some new starters, so some new blood in the team and new ideas coming in and I think that's brilliant. I think it's getting out of the habit of 'well we've always done it like this,' you know?*
>
> ***Interview with Deputy, Sunshine Lodge***

Whether a particular practice was learned or not depended on both the type of interaction, its circumstances and existing relationships and these factors are the source of the four subthemes of **interactions with colleagues: formally shown and told**; **Asking and being given advice**; **observing others**; and **communication and categorisation** (See Figure 12). It is within these subthemes and their interaction within the 'what works is what matters' process that the impact of the individual care home and its organisation have influence and thus can result in different practices being learned, despite similar learning processes. As with Theme One, whilst the subthemes are discussed separately, they often interacted to influence learning.

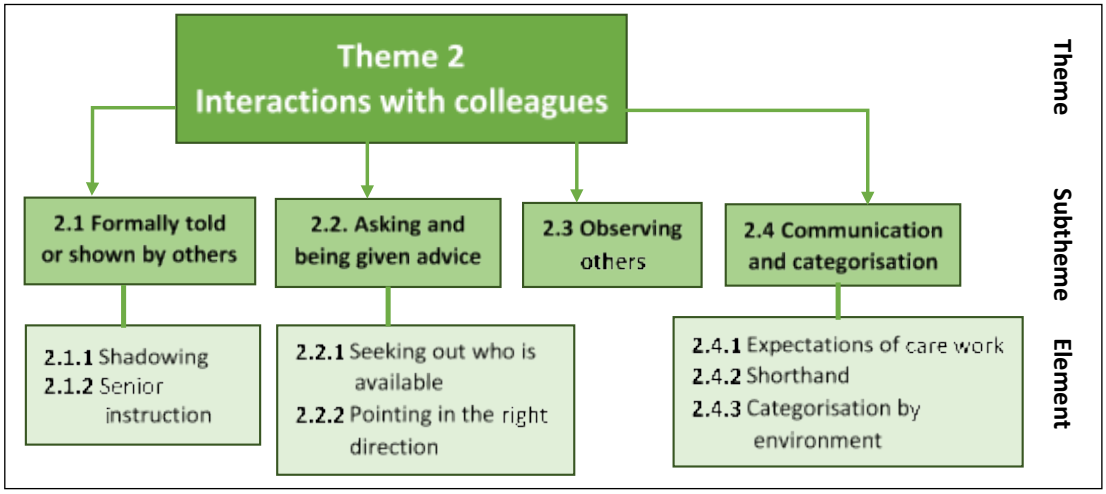

Figure 12: A visual representation of sub-themes and elements of Theme Two 'interactions with colleagues'

2.1 Formally told and shown

The most obvious subtheme where **interactions with colleagues** influenced learning was by activities in the workplace in which workers are **formally told or shown by others.** This is an area of consciously acknowledged learning where managers and senior staff explicitly anticipated and encouraged learning to take place. However, despite this recognition, it was seen to be a flawed process, heavily affected by resource factors in both homes. Moreover, in each home this aspect of learning resulted in different outcomes, primarily due to the organisation of teams and workloads in each home. The process of being **formally told and shown** existed in two distinct forms in both homes: **shadowing** and **senior instruction**.

2.1.1 Shadowing

Shadowing took place in the first few days and weeks of starting work in the home when a care worker followed another more experienced worker during activities of care. It involved observing, talking and doing alongside the more experienced worker. It was highly influential for staff in both homes, and recognised as such by all. What was seen and practised here was likely to be replicated when shadowing ceased, although it could then be modified by other forms of learning, in particular learning through **'what works is what matters'**. Shadowing was mandated practice as part of procedure in both homes, with paperwork designed to support the process;

The form lists items with spaces for ticking when completed and making comments. Day 2: "Commence Shadow Shift with most experienced member of the team"; Day 3 -17: lists tasks of care (e.g. washing, dressing, bathing, skin care) and aspects that need to be shown and demonstrated, then the phrase 'Must be competent alone"

Induction Form (Carer), Strauss Hill Court

Week 2: shadow shifts: understanding role; work in a person-centred way; privacy and dignity. Week 3: possible shadow shifts at discretion of manager: duty of care, equality and diversity, nutrition and fluids.

Induction Folder (Carer), Sunshine Lodge

These processes were seen in action and explained by care staff and senior care staff in both homes. Ruth, a relatively new care worker, explained what happened when she first started;

"I did a shadow shift on (unit 4) and that was great, because doing a shadow shift you are working with somebody who had been here for 3 years so they were able to show who, what tasks, what times, when somebody will have something to eat or drink, I have a notebook and I write it down,".

Interview with Ruth – Care Worker, Strauss Hill Court

It was acknowledged that, because of the significance of shadowing, it was important to carefully select who led the shadowing role even if practicalities sometimes limited options;

"I'll pick the best one that I've got on. There's very few that I wouldn't…(they're) generally the more old fashioned carers, that I don't want them picking up habits and ways…I want someone lively, maybe someone who I know will be doing something fun…(it's) the luck of the draw as to who you pair people with. There's a couple who I'd love to do it full time because they're just wonderful, but of course they're not always here…It makes or breaks whether they want to work here,".

Interview with Deputy Manager, Strauss Hill Court

This factor had a significant impact on practice learned at Sunshine Lodge, because of the structure of the work force. Their care team was divided into two distinct teams who worked a set shift pattern, meaning that they routinely worked with the same team members. In addition, the boundaries between different roles were rigid. This had its effect on the shadowing period for new staff as the extracts below demonstrate.

"They would normally go with the team leader. They are the most experienced. My guys, because they're in two teams they will work within that team and learn from their peers as they go along,".

Interview with Manager, Sunshine Lodge

(I: When somebody is new, what involvement do the nurses have?) *"To be honest, you don't really…We don't tend to have a lot to do with (them),".*

Interview with Ailsa – Nurse, Sunshine Lodge

Shadowing at Sunshine Lodge appeared to establish very early on the separation between the two care teams and the boundaries between care and other roles, and contributed towards the more habitual and less flexible ways of working that characterised the care I saw. When learning through shadowing, care workers here had less opportunities to see different types of practice in action when compared with the opportunities presented at Strauss Hill Court.

Moreover, in Strauss Hill Court it became clear that the learning from shadowing was intended to be broader, extending to communicating the ethos of the home's approach to care, not just routine tasks. The deputy manager explained:

"The best way we do it here, when somebody starts they have shadow shifts for two reasons. Firstly so that people can pick up on how we do things and that it's okay to be relaxed, because the first thing that (new) people (ask) is 'what time are meals, drinks' and it doesn't happen like that, (here),".

Interview with Deputy Manager, Strauss Hill Court

This is not to say that ethos was not learned through shadowing at Sunshine Lodge, only that this was explicitly considered in Strauss Hill's organisation of shadowing and thus more intentional in its outcome. Indeed, the manager of Strauss Hill Court had expanded the process of supervision for new starters to explicitly address this. Below is an extract from the supervision paperwork used to review shadow shifts with new staff:

"We have discussed the ethos of the home and this is that staff need to be residents' friends before their carers. The importance of 'being with' people is crucial to making person-centred care work. Engagement through all aspects of care is imperative and 'getting to know people' is part of everyday life and adopted by all."

New Staff Supervision Prompts, Strauss Hill Court

Furthermore, this explicit focus, together with the influence of team structure on shadowing, may help explain why the practice I observed at Strauss Hill Court was more person-centred than that which I saw at Sunshine Lodge. After all, a worker can only shadow the practice that is carried out.

Shadowing as a form of learning was affected by the need in both homes to get new workers into action as quickly as possible and this was seen to impact its effectiveness.

> *"Normally by the time new starters start, we're so desperate to get them on the ground and off…In an ideal world they would have 2 weeks pure shadowing where they are … an extra person, they're not counted on the rota, but the business of it is…it's not always possible, even if you over recruit,".*
>
> ***Interview with Manager, Strauss Hill Court.***

However, my time at Sunshine Lodge coincided with the transition to the Care Certificate (an industry-wide standardised induction programme, that mandates what care staff have to achieve before being non-supernumerary staff members), and this illustrated that time spent shadowing was not as significant as the quality of that shadowing. As this reflection captured;

> *"I really wonder what they're learning here through this 'following' someone as required by care certificate rather than more focussed tasks. Could this time not be used better? I wonder whether it teaches a task focus because we follow to watch the tasks."*
>
> ***Reflective Diary, Sunshine Lodge***

2.1.2 Senior Instruction

The second aspect of subtheme **'formally told and shown'** was not focussed on a specific time period like shadowing. Instead, **senior instruction** influenced learning each and every

day. Learning occurred when senior members of staff gave instruction to care workers about residents and care tasks. It happened in two distinct ways: through handover and through responses to observed events. What was shared in these ways was likely to be enacted, although with modifications based on **what works is what matters.** The breadth of these opportunities, like shadowing, were influenced by the people present and the opportunities for discussion to reach understanding.

Regular and formalised handovers between shift changes occurred in both homes, although in different ways. At Strauss Hill Court, handovers occurred at each shift change (three times a day) with care staff, seniors and sometimes manager involved.

Senior carer takes the lead, says who is working in each unit and goes through each resident in turn; giving summary of last day and night for each. Other staff interject with either their experience or a question/opinion…A consensus seems to be reached in these meetings about the problem/issue, what the cause might be and what response should be.

Observation (240914), Strauss Hill Court

However, at Sunshine Lodge handovers occurred twice a day (at shift change) between nurse, manager and care team leader only, whose responsibility was to filter it down to the care team.

If someone is going out for (an appointment), if we want someone up if we want someone left in bed then it would all be on the 'grab sheet.' The senior team leader takes the report with us and then she will assimilate that information to the carers."

Interview with Manager, Sunshine Lodge

This was supplemented by written notices displayed in the staff room such as this;

"Note for Night Staff: 6/7/15 – [resident T] to be washed and dressed on a Wed and Fri mornings and [resident K] on all other mornings not [resident P].

Noticeboard, written on back of a ripped envelope, Staff Room, Sunshine Lodge

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This approach appeared to provide less opportunity for active involvement of care staff; they were expected to simply do what they were told. This perhaps reinforced the routinised practice and narrow learning opportunities that were common at Sunshine Lodge. Nonetheless, the more flexible and involving approach of Strauss Hill Court did not always result in desired practice as the following reflection showed. This exchange was observed between staff following a discussion at handover about the 'mealtime experience' (an aim to promote independence and normality at meal times, reducing the institutional-feel);

Interesting discussion between staff (at lunch time): 'we need to put vegetables on the table and serve from there'. Example of learning 'what' but not 'how'. This is a clear message of what (manager) raised (at handover) but when they enacted this it was not in a 'mealtime experience' way – staff were still perfunctory, just with vegetables on table instead of the trolley. The instruction was enacted, experience was not.

Reflective Diary, Strauss Hill Court

A second way that senior instruction occurred in both homes was by responding to observed events. Although, again, a subtle difference can be seen between the two homes;

"Being present on the floor is quite something for us, because [manager] and I generally go down a couple of times a day and so if there's a tea trolley out…we'll kind of question why they're doing it that way…Trying to make people think for themselves really and making sure that they know that it is okay to do what the residents do. I would much rather a bed not be made all day that people be sat in a circle doing nothing,"

Interview with Deputy, Strauss Hill Lodge

"Little things like I feel that somebody's perhaps not being spoken to as they should be. I notice that somebody's just walked into a room and perhaps not knocked on the door. (Aprons/gloves) not being worn when they should be. It's just little things that sometimes people don't, people forget…It's trying to keep

*the standards up to a certain level. I think it's more effective than giving someone a ******ing basically,"*

Interview with Deputy, Sunshine Lodge

The focus of responding to events shown in these quotes and in practice appeared to be broader in Strauss Hill Lodge, addressing direct outcomes for residents as opposed to compliance with specific practices. Moreover, responding to events was something that was echoed throughout the senior team at Strauss Hill, but only highlighted by the Deputy Manager at Sunshine Lodge who had a specific focus on managing the care team. This reflected and reinforced the difference in role for care workers at each home.

2.2 Asking and giving advice

Another area in which **interactions with colleagues** influenced learning is through **asking and being given advice**. A worker learned through situations in which they either sought out the input of others who had more experience or another worker gave them advice unsolicited. These interactions were informal but were observed in practice frequently and referenced by staff in discussion. However, whilst they occurred in both homes, the range and frequency of these interactions was much broader in Strauss Hill Court than Sunshine Lodge and resulted in a wider range of practice being learned. This was primarily because of the flexibility of the staff team and their tasks at Strauss Hill. At Sunshine Lodge care workers only interacted with a set team of the same care workers around the same sorts of task every-day, (often paired together and working with the same group of residents) limiting the opportunities in this area.

There are two distinct elements to asking and being given advice which occurred in both homes: **Seeking out who is available** and **pointing them in the right direction.**

2.2.1 Seeking out who is available

When a worker encountered a situation they had not encountered before, or in which they were uncertain, they sought advice from others available at the time and then applied the advice, repeating it if was seen to work to solve the situation. Demonstrated experience,

rather than seniority, of the other worker was the most significant factor in deciding who would be approached in these situations, as these care workers explained;

"You're always learning off people… …If I've been on [unit 1] and something's happened or there has been a situation that I'm not used to and it didn't go particularly well…Then I would go to [MOS who usually works in the unit] because she's here five days a week, so she knows them inside and out… I was doing the lunchtime menu and Iris…I couldn't understand what she was trying to say. I came and got [MOS] and said 'can you do me a favour? I don't know what she wants'. [MOS] came up and said 'sausages'."

Interview with Anna – Care Worker, Strauss Hill Court

They knew (him) so I asked one of others. If you don't know, one of the others, she's been here for 20 years and she knows quite a lot of them,"

Interview with Dennis - Care Worker, Sunshine Lodge

This was an influence on learning that the manager in Strauss Hill Court explicitly recognised and had sought to build on;

"One of our care assistants…she is brilliant at doing carer-led activities…I sat her down and…asked her to create like a file for each [unit] based on activities that carers can lead… (and) people may be more willing to listen to (her) because they know she's done it, they know that she's got a reputation for doing really good activities…so that's worked well,".

Interview with Manager, Strauss Hill Court

At Sunshine Lodge, these sorts of interactions were with a much smaller group of carers around the same, repeated range of tasks, meaning that a much narrower range of practice was learned. In fact, senior staff and care workers themselves commented on the differences between the two teams;

Discussed the difference between staff teams, whether they were ever mixed up. Not interchanged…It's clear that each team does have a very clear 'personality'. This 'shift' (the one I am observing) is less organised/efficient than the other. People get matched to the 'team they would suit'; 'you can usually tell',

Reflective Diary, Sunshine Lodge.

Moreover, as highlighted earlier, not only was the care team at Sunshine Lodge small and static, but the crossover between their tasks and that of other roles in the home was very limited, meaning that the breadth of learning through this route was inevitably limited.

2.2.2 Pointing them in the right direction

The second element of learning through asking and being given advice was when someone else steered a worker in the right direction. This was not in direct response to a question but instead when the worker giving the advice thought it necessary, usually to correct practice carried out by another.

Exchange between MOS A and MOS V when MOS A took a mug away from a resident... MOS V said 'would it be better to let her finish? There's only a mouthful,' MOS A replied 'Yeah!' returns the cup to the resident and says jokingly, 'I've been told off!' (I reflect) that it seems okay to challenge and suggest at this home.

Observation (051014), Strauss Hill Court

"I explain all those things to them as I'm working because obviously you get it from working with people and if you can pass on knowledge and experience that makes for better carers and company…Sharing experiences and knowledge that's the way to do it,"

Interview with Dennis – Care Worker, Sunshine Lodge

The effectiveness of 'pointing in the right direction' to influence learning appeared to lay with the communication style and personal relationship between the two people, as this care worker explained using contrasting examples;

I don't respond to barking orders and I'm still going to do it if it works for them. It's like I was told, [resident]'s a dancer, she loves to dance so me and (her) we dance, and groove and we giggle and she absolutely loves it….but we had a meeting one day and it was like 'you shouldn't do that' so I was like (makes 'waving away' gesture) 'I'll do it anyway…

…so depending on who you work with they'll do it a certain way and you think, 'oh I like that'… (if) you're trying to pull (resident's) skirt up from the bottom…and somebody just went 'just stick it over her head, Gail,' and I was like 'Oh, that works for me, works for you', so now I'm like over the head, job's done,"

Interview with Gail – Care Worker, Strauss Hill Lodge

This was also a type of interaction that I experienced as I became more immersed in life at Strauss Hill Court and was left to 'keep an eye' on the lounge in unit 4, leading me to reflect on how I was learning there;

Very interesting exchange when I asked if [new resident] was able to move independently. Verity said to me 'it's not very nice is it, to have to keep asking them to sit down? (Suggesting that I should allow her to move). 'But if you don't feel comfortable with it, just do what you think is best'. There is something very nurturing and instructive about it whilst at the same time empowering of me.

Reflective Diary, Strauss Hill Court.

2.3 Observing others

The third way in which **interactions with colleagues** influenced care workers' learning was through **observing others** as they interacted with residents and undertook the activities of the role. This was distinct from 'being shown' as it was unofficial and occurred frequently with the worker choosing who to learn from based on whether the practice met the parameters of 'what works' and their opinion on the worker they were observing. Whilst this

aspect of learning existed in both homes, it resulted in a much broader range of opportunities and practice outcomes in Strauss Hill Court primarily because of the narrow range of tasks that care workers engaged in at Sunshine Lodge.

Observing others was shown to influence learning on a regular basis in both homes and was mentioned by staff as a form of their learning. It occurred in both routine ways and in unusual situations.

Florence is asking everyone that passes for 'soup' (is she anticipating tea time?) Every member of staff, including the newer ones respond 'soup's not yet' before moving on. This seems to be learned a response, picked up from over-hearing it.

Observation (170715), Sunshine Lodge

Observation of dance session, led by external facilitator: MOS P sat on the arm of the chair (separate from activity) but then joined in and helped with Bella's movements, this increased when the drumsticks were used and MOS P was given some too… (I reflect, how do these unusual interactions affect the staff who take part?)

Observation (270814), Strauss Hill Court

Senior staff recognised the importance of observing others, trying to capture it in their own practice and in what this reinforced for staff;

I observe the Deputy start to dance around the (lounge), demonstrating to the resident. She uses me as a partner and takes instructions from the residents. I chat to her later and she says 'making a fool of yourself is important' and that 'if the staff see me do it then they'll do it, not all of them but that's what you get,"

Observation (070515) Sunshine Lodge

"It's also little things, not massive things like (taking a resident out for the day)…Things like making someone a cup of coffee meaning you have to leave work 5 minutes later because they ask for a cup of coffee and not just saying 'actually another person's coming on in a minute'. And I think if people see that then hopefully they learn,"

Interview with Manager, Strauss Hill Court

Observing others also appeared to transmit learning about the ethos of the home as well as specific practices, reinforcing some of the features of the approach to care and care work mentioned previously. For Strauss Hill Court this was a generally relaxed approach to care, often being led by residents' needs. This reflection below indicates that this was modelled during staff meetings;

[Resident] attended the meeting as well because she was around prior to it starting and appeared to want to come in. A chair was pulled up next to the manager and she was involved in discussions when she interjected,"

Reflective Diary, Strauss Hill Court

At Sunshine Lodge, however, such learning from observing others appeared to reinforce the separation between the different roles in the home.

"The carers don't like to see the (nurses) once they've done their drug round, sitting up there. I think the carers work so hard and…you can see there's (resentment). Couldn't the (nurses) take the time to go sit with the residents?"

Interview with Activities Coordinator, Sunshine Lodge

Again, as with asking and being given advice, the worker's relationship and opinion of those they observed and their practice influenced whether they would learn through observing and copying practice, or actually learn by doing the opposite. Here, care worker Gail describes her contrasting influence on members of staff;

"I get disapproving looks every time I (dance) to which I did it even more because some of the carers going 'are you supposed to be doing that?' I said 'yes I am'…I'm going to do it this way, because if they're smiling there's nothing in the rules that says do not dance and play with residents…Some

people are just so, set in their ways…I'm hoping that some of the other carers will take note…Verity for instance I went 'hell yeah, girl, well done.' Because I think she's realised you can…She was so stuck working with people who were square that now somebody has gone in and gone 'let's party' she's gone, 'Oh, I can do that!'."

Interview with Gail – Care Worker, Strauss Hill Court

2.4 Communication and categorisation

The final subtheme of **interactions with colleagues** related the types of **communication and categorisation** that occurred in the homes, resulting in learning certain messages that played out in practice via Theme One. These could include overall descriptions of care in the home or individual exchanges about specific tasks. There were three elements to communication and categorisation that played out in both homes: **Expectations of care work**; **shorthand**; and **categorisation by environment.** Unsurprisingly, the two homes showed marked differences in what care practice was learned through this route. The contrasts related again to the structure of work practice and roles in the homes.

2.4.1 Expectations of care work

This element overlaps with that of 'seeing results - fulfilling role expectations' within Theme One and shows a strong point of interaction between Theme One and Two. Expectations of care work related to any communication that contributed to workers learning the anticipated tasks and boundaries of their role. This communication occurred in three main ways. Firstly, written communication played a role in sending messages about expectations of care workers and then reinforcing them in practice. The manager at Strauss Hill Court reflected on changes to record keeping which had reinforced expectations of resident-led and relaxed care despite slow learning and adaptation by staff;

"I think some of the kind of traditional care assistants found it difficult not to put in the daily record of the residents that they've had their bowels open, and they had personal care…They found it really difficult that I've asked them to (change) Did they have a conversation on the way to the activities room? That's more the sort of detail that we want… just a short paragraph on what each resident has done this morning…Some people say it's fluffy but that's what we want to try and encourage,"

Interview with Manager, Strauss Hill Court

This 'fluffy' focus was evidenced in daily records and care practice at Strauss Hill Court suggesting that these expectations were indeed being learned. This contrasted strongly with the task-focus of care work at Sunshine Lodge, often disconnected from the social aspects of residents' lives. The carers' care plan kept in each resident's room caused me to reflect:

A4 page at the front of the care plan folder lists 6 "main duties for named carers". 1) Ensure resident's toiletries are well stocked; 2) Ensure resident's toiletries are named; 3) Ensure wardrobe and drawers are kept tidy; 4) Ensure ensuites are kept tidy; 5) report maintenance issues; 6) spend time each shift with your resident and log in care plan. (Reflection) What message does this send that spending time is the 6th action not the 1st. The first 5 are very task-focussed and unlikely to add anything to residents' well-being but may add something to home's functioning.

Carers Care Plan, Sunshine Lodge

A second way that such expectations were communicated and learned was through the explicit talk of senior staff in the homes. Below examples are given of frequent concepts/phrases used by management in relation to care work that reinforced the contrasting styles of care learned by workers in the two homes;

Attended staff meeting. Manager states that 'because we've always done it' is not a good enough reason to continue a routine. The caveat of 'unless the resident wants it' is used as an exception to a lot of the changes discussed.

Reflective Diary, Strauss Hill Court

Seemed to be low expectations of care staff, slightly higher of team leaders. (Manager) linked it to low wages and 8-8 shifts ('how can you expect them to…?') So why does this home continue with that? ... Manager repeated how hard they work and always busy ('don't sit down', 'work so hard'). This seems to be what 'doing care work well' is here.

Reflective Diary, Sunshine Lodge

In particular, the low expectations of care work beyond physical tasks was starkly apparent at Sunshine Lodge and explicitly linked to learning and changing practice by the manager;

"It's a really hard job that they do. They do 12-hour shifts, it's a hard, hard job. If you're only paid (minimum) why would you want to do more than that? … I can't expect them to be jumping up and down to learn about something. They would enjoy sitting down having afternoon tea with cucumber sandwiches and having a conversation. That is not what it's like... Gone are the days of that kind of thing. We are as busy, if not busier than any acute ward,".

Interview with Manager, Sunshine Lodge

Finally, management talk was echoed in conversation heard from all staff in the homes and this provides the final way that expectations were communicated at both care homes and influenced the learning of practice on the ground. I was subjected and influenced by this in my interactions during observations as these examples show;

I asked staff if I could make a cup of tea, MOS said yes and said I could make everyone else one too! (Sending an expectation that we all muck in here – residents are the focus). I asked resident if he would like a cup of tea and how he would like it. He didn't respond so I asked if he would prefer something else, maybe a coffee. MOS A said in the background 'water, juice, milk, coffee' – indicating to me that anything goes… This interjection clearly taught me the 'correct' approach to drinks here: Everyone gets offered as and when, there are not fixed times, there is always a range on offer.

Observation (270814), Strauss Hill Court

Had a conversation with MOS J as I sat in the lounge observing. I said I was tired. MOS J relaxed, laughs with me, asks if I want to swap, saying she would 'sit around taking notes' whilst I ran around. Being busy is definitely the order of the day here and I feel very self-conscious that I am not.

Observation (120515), Sunshine Lodge

Expectations of care work were communicated throughout the home on a daily basis by the language used to describe the role and its associated tasks. Whilst its influence on learning is not clear-cut, (it can be seen as both a product of care work and an architect of it), it is hard to refute the unintentional impact these expectations might have on the decision-making and actions taken as part of the role, especially when I experienced these first hand.

2.4.2 Shorthand

Relating to the ways that workers communicate with each other, **shorthand** occurred whenever a task or resident behaviour was communicated about in a non-literal, non-descriptive way. It influenced learning because, in order to understand this type of communication, the worker has to intuit what the shorthand referred to using previous experiences and understanding. It formed a powerful and influential way in which learning was transferred throughout the team because it communicates meaning and values as well as instruction. My reflections on the following examples demonstrate this;

Comment from MOS about the new resident – she is: 'another Julia'. By this she means she is a challenge regarding personal care and they anticipate difficulties and having to work through them. Classification of tasks that are difficult by using another resident's name seems to communicate what is expected and permitted. (Especially when) they also say 'we have to use the hug' as a way of communicating the low level restraint used to provide Julia with personal care. There is an awful lot being communicated in just these two phrases, opens up for misunderstanding?

Reflective Diary, Strauss Hill Court

MOS D chats with MOS J in the corridor. "Me and G when we're finished we'll ***do*** *these two, who can you* ***do****, [resident]?" They're dividing up work here:* ***'Do', 'Doing', 'Done'*** *are used as shorthand for 'whatever that person usually gets/needs'. What message does this shorthand give about care? Care is tasks, we do to rather than support someone. Care is routine enough that 'doing' is the same each time and thus can be communicated in this way.*

Observation (290715), Sunshine Lodge

Shorthand appeared to be particularly influential because it merged the resident with the task, perhaps to the point of obscuring the person. Moreover, it was particularly powerful because of how mundane and embedded in everyday talk it was. Indeed, its power was such that I did not question it until late in my time at the second care home when I noticed that I was engaging in this unconscious translation and had to retrace it back through data to examine what was occurring.

Shorthand occurred in both homes but was much more common in Sunshine Lodge. At Strauss Hill Court, descriptive and literal explanations were used regularly alongside shorthand, meaning that what was represented by the shorthand was often made explicit at later points. Whereas in Sunshine Lodge, shorthand was rarely supplemented and was also used regularly to communicate about residents' behaviour as well as staff work;

MOS returns from hospital and comes into the lounge. MOS J explains where another MOS is, uses the phrase 'Neil is in a state', What does 'in a state' mean? It's used as if it frequently happens?

Observation (150715), Sunshine Lodge

The commonality of shorthand again was both a product and a cause of the routinised nature of care at Sunshine Lodge because it did not allow clarification or discussion of what care work actually involved, instead substituting a phrase and relying on an individual's knowledge of what that phrase meant; this knowledge was inevitably tied to previous uses and thus practice perpetuated was based on tasks rather than the individual.

2.4.3 Categorisation by environment

The final element of this subtheme was **categorisation of the environment** and it related to the way the environment sent messages about what was appropriate in certain spaces and thus influenced the work that was performed there and thus subsequent learning through what works is what matters process. This categorisation occurred through the ways the environment was spoken about and used and these two interacted to enhance or reduce the impact of categorisation on practice.

In Strauss Hill Court there were four units, each of which catered to a different group of residents with different needs. All four units included people living with dementia, but unit 4 was described as for people with 'more advanced dementia'. Staff talk and practice reflected a progression of work difficulty through the units;

"She's on the dementia unit, the really bad unit... (difficulty of work is) dependent on how far up the units you work"

Interview with Gail – Care Worker, Strauss Hill Court

However, what was notable was that unit 4 did not just contain those residents with more advanced dementia, but also those who required more physical support, in many cases unrelated to their dementia need. Therefore, in Strauss Hill Court advancing dementia was learned to be 'heavier work' with the unit being staffed with two care workers, primarily because several residents required two people for moving and handling.

Nonetheless, this aspect of learning was counteracted by other uses of the environment at Strauss Hill, preventing the 'heavy' dementia unit becoming a silo of practice functioning differently than elsewhere in the home. Because the majority of staff worked across all the units at different times, and because mobile residents were encouraged to use the whole home (including units that were not their 'own') perceptions of one unit being harder, or substantially different were frequently challenged by experience. In addition, all areas of the home were designed to be 'dementia specialist' by providing opportunities for stimulation and reminiscence throughout, including corridors and alcoves. This mitigated against any one area (and thus work in that area) being seen and experienced as substantially different.

By contrast, Sunshine Lodge did not present itself as dementia specialist home, instead the home had a single area that appeared to be designed with dementia in mind;

There is a dedicated 'reminiscence lounge' (the manager was very pleased to show me this area). It is decorated in a 60s/70s style, contains a teas-made, rationing books, books, CDs, old style posters etc. It is an ante-room to the main lounge and therefore a thoroughfare. Also contains a storage space for hoists. There is also a separate quiet lounge, decorated with cinema posters.

During the course of the research I only saw the reminiscence lounge used to store equipment and walk through, or for seating when there were not enough seats in the main lounge. The quiet lounge was barely used, occasionally had one resident sitting in it alone.

Artefact - Physical environment, Sunshine Lodge

The environment here categorised dementia needs as something 'different' and separate from the rest of the home. Moreover, and more influentially, staff's use of that environment communicated that the 'dementia space' was nothing more than a storage space, with all residents who were not in their bedrooms being seated in the large communal lounge together, regardless of need. These factors suggest that dementia care was not viewed in the home (at least by those working on the ground) as requiring anything different than 'usual care'.

Interactions and contingencies in Theme Two

As with Theme One, the subthemes and elements of Theme Two did not operate independently of one another, instead they interacted as they influenced learning by care workers, reinforcing or contradicting one another. For example, a worker may know how to a respond to a particular situation based on their experiences of **being shown or told**, but their **shadowing** experience may also have influenced who they approach for **advice** or who they hold in esteem to **observe** when a situation changed. Moreover, the **communication and categorisation** that takes place in the home may send different or counter messages about what is appropriate practice. The worker, experiencing all of those factors may come to a different 'learned practice' depending on the situation.

Moreover, Theme Two, whilst enacted primarily through the 'what works is what matter' process of Theme One, was nonetheless significant in determining how learning occurred in both care homes. Notably, very different types of practice could be learned through very similar mechanisms, suggesting, as with Theme One, that the 'how' of learning does not dictate the 'what' that is learned. In particular Theme Two, acts as the primary vehicle for the macro-level influence of the care home culture on learning because structural decisions about job roles, work tasks and team makeup affect when and with whom interactions occur. In Sunshine Lodge, the

picture of Theme Two in action was far less complex than Strauss Hill Court, and produced practice that did not vary substantially across time and situations. The rigid boundaries between different roles in the care home and the static shift pattern of the care team itself meant that there were simply less opportunities to learn through via interaction with colleagues, because there were in effect fewer colleagues and thus more repeated patterns of learning through what works is what matters. Furthermore, Theme Two and particularly subtheme 2.4 (Communication and categorisation) demonstrated some conditions that appeared to be unintentional in their impact on learning and that were not explicitly recognised or discussed by participants to the study. These unintentional routes and the factors that affect their outcomes are important to articulate precisely because their influence may be less obvious to the casual observer.

Of particular note with regard to this theme, is that the data suggested a feedback cycle between the outcomes of 'what works is what matters' and the resource of learning from Interaction with Colleagues. This is shown in Figure 13 below and demonstrates that learning from Theme Two is a major contributor to the resource of Cultural Knowledge that is drawn upon by workers within Theme One learning. In turn, the outcomes of Theme One learning influence the interactions with colleagues that a worker experiences (e.g. what is formally told or who they choose to observe ask for advice) and thus feed back into the resource of Cultural Knowledge available to be mined. This self-reinforcing loop may well explain the complexity experienced when attempting to change care practice; unless this reinforcement is addressed any efforts will be undermined.

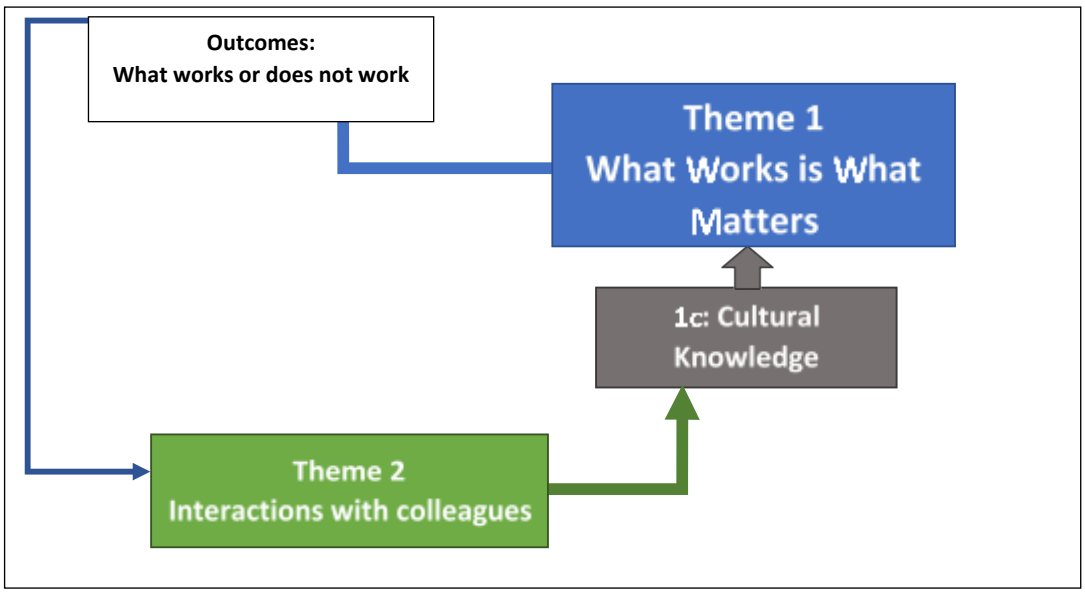

Figure 13: Feedback between Theme One and Theme Two, 'interactions with colleagues'

It is also notable that within this data there was no comparable feedback cycle between Theme One outcomes and Theme Three (Training, perhaps contributing to its lesser influence overall.

3. Theme Three: Training

The final theme describing how care workers learn to care concerns training. It is the last of the themes because it was not as prevalent in the data in either home compared with other themes. Training, with the exception of some specific tasks of care, was most often seen descriptively in documentary and interview data rather than identified as a dynamic factor in relation to observed practice. Learning occurs in this theme by a worker taking knowledge or skills they have gained through training and applying them to practice, filtered through Theme One's 'what works is what matters' process. As with Theme Two, training's influence is as a component of cultural knowledge that workers draw on within the 'what works is what matters' process of Theme One. It acts as a route through which structural decision-making (who has what training, when and why) beyond the control of individual workers, influenced care practice outcomes.

"I stood near somebody who was trained a lot more than me, because I've never done it and she just expected me to know what to do. I said 'what would you like (me to do?) and she went, 'oh well, obviously you need to be trained more'."

Interview with Gail – Care Worker, Strauss Hill Court

As Figure 6 visually depicted earlier in this chapter, its effect is noticeably less than that of Theme Two and as such the cultural knowledge of the care home was only moderately shaped by formalised training. Theme Three's subthemes **gatekeeper tasks**; **knowing the job not care**; and **application** help to articulate the particular aspects of culture transmitted through training, (see Figure 14).

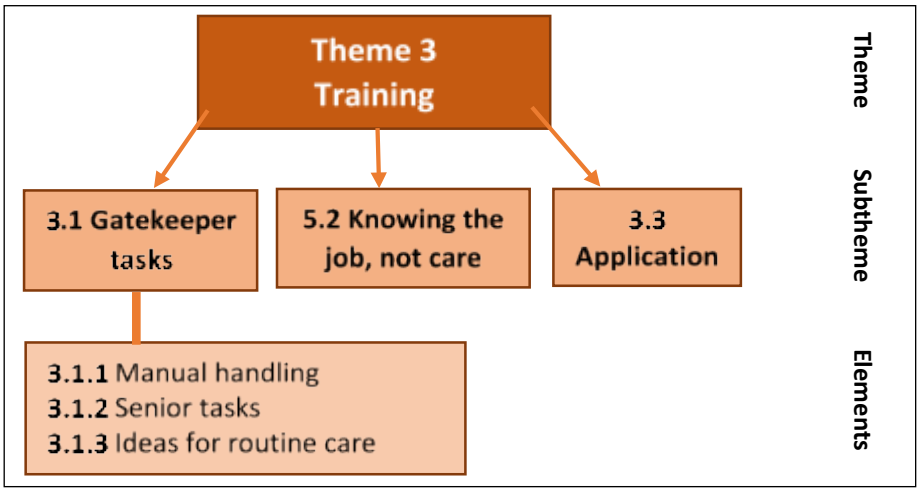

Figure 14: A visual representation of sub-themes and elements of Theme Three 'training'

Both care homes had training for staff that was mandatory (determined by the Common Induction Standards/Care Certificate and broadly similar in both homes) and optional. The training documented as received by an established member of care staff was broadly similar in both homes. However, there were some key differences. In Strauss Hill Court, there was a wide range of training on offer from internal e-learning, face-to-face training in-house and externally, with staff opting-in or being prompted to attend by management. In Sunshine Lodge the range of training was less broad, but it was mostly delivered in-house by the deputy manager and nurses, with staff being allocated to attend short sessions whilst on shift. Both homes had dementia training, although this was (mandatory) e-learning and (optional) external sessions in Strauss Hill Court and (mandatory) in-house sessions in Sunshine Lodge. If examined superficially, it would be easy to align the different training available to staff with the differences in person-centred care for people living with dementia I saw in practice. However, when exploring the data, the relationship was not that straightforward.

3.1 Gatekeeper tasks

The most prominent and influential subtheme of training was gatekeeper tasks. In both care homes there were specific tasks that required training, without which you could not act as a care worker. As such, these tasks served as gatekeepers to acting and being seen by other workers as a care worker, (and thus participating fully in the Theme One learning process). Three elements emerged within this subtheme, helping to show the ways in which training

around gatekeeper tasks were experienced by care workers: **manual handling**, **senior tasks**, and **ideas for routine care**

3.1.1 Manual handling

The most significant gatekeeper task was supporting residents to stand, sit, walk and move about the home through 'manual handling'/'moving and handling'[11]. Practical, mandatory training was supplied for all staff in both homes, and they were unable to undertake any moving and handling tasks with residents until this training had been received. I first identified the influence of this because it presented a barrier to me working alongside the care workers in both the homes, as this extract shows;

It's busy this morning and I'm fielding a lot of requests from residents. Yvette asked if I could help transfer someone to a wheelchair (to go to the toilet) had I had my 'manual handling' yet? I explained that I didn't and she said she would go and find someone who could help.'

Reflective Diary, Sunshine Lodge

The importance of this training was also evidenced in both homes when existing staff had to undertake extra tasks because others on shift were yet to receive the training, resulting in complaints and resentment.

However, despite determining who could be a care worker and who could not, the influence of training was not always straightforward even after it had been received because it was not always applied in practice;

Several times I hear instruction 'take him backwards'. Meaning pull the wheelchair backwards with no footplates on it, even though residents' heels bump on the ground. They do know this is not appropriate practice as in other observations I have seen MOS Lesley point out that someone's heels are dragging.

Observation, (070515), Sunshine Lodge.

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[11] These two terms were used interchangeably in both homes, despite 'manual handling' being a term that is no longer in guidance/training use.

This example shows that some of the time in Sunshine Lodge, learning through training was trumped by 'what works is what matters' (in terms of completing a task), at least when the option of contradicting training advice 'worked' from the staff's member's perspective. When it was directly challenged by another staff member it was not an option that 'worked' anymore and so training guidance was followed. This highlights that the effect of training on practice is dependent on that being reinforced by other mechanisms of learning. Dennis reflected on this when we talked about how he differentiates good and poor practice;

"As a new carer it's hard, but you should automatically know from the manual handling training because they tell you two people, with hoist, standings, you know? (deputy) is with you at the start so she knows if you're manual handling correctly or not but if I work with somebody who's an old carer I gently remind them, you know there is a slide sheet there, things like that,"

Interview with Dennis – Care Worker, Sunshine Lodge

There were fewer examples of contradiction of training in manual handling practice at Strauss Hill Court. Indeed, there was a very distinct pattern to how workers approached residents when helping them to stand, which the manager explained was linked to training;

"Yes, with that (pattern) I would hope that in training within moving and handling…the process of how to even help someone get up from a chair…just a hand on the back, just constant reassurance, warning people what you're doing, telling them through the process. Straight away you're looking for that warning someone what you're going to do, encouraging someone to do what they can themselves, reassuring them as the process goes on and warning them what the next step is…In the training that would be reiterated"

Interview with manager, Strauss Hill Court.

However, there were occasions of contradiction and these appeared to relate to times when the worker felt that the training had not provided them with relevant information; information that 'worked' within the situations they faced. As Gail explained,

"Well, you do get trained on the moving and handling, which I think is an absolute joke. Not because of the training, I agree we need the training, but the level of the training is, we went in for a couple of hours with a slippy mat with people who can walk and talk already themselves… You don't get trained to pick them off the floor. You don't get trained how to talk to them like when they're scared and on the floor"

Interview with Gail – Care Worker, Strauss Hill Court.

Therefore, training's influence on practice was dependent on other factors that occurred in the workplace that have been highlighted by other themes. It had to be seen to 'work' and be reinforced by colleague interactions, in the situations care workers faced in their daily work with residents.

5.1.2 Senior tasks

The second element of **gatekeeper tasks** related to **senior tasks** and only occurred in Strauss Hill Court. Senior tasks differentiated care workers from senior care workers; those members of the care team who led shifts and often allocated work amongst the care team on a daily basis. These senior tasks included areas such as medication, first aid and care planning and required training to be completed before someone could undertake a senior role by themselves. This factor was only present in Strauss Hill Court because Sunshine Lodge was a nursing home, meaning that these tasks were undertaken by nurses, who were absent at Strauss Hill. There was no specific training for senior care workers/shift leaders at Sunshine Lodge.

The deputy manager of Strauss Hill Court described what would be done if a member of care staff was identified as having potential to be a senior, outlining an approach meaning that staff often had more than the minimum training required for whichever role they were undertaking;

Yeah, you can tell within three or four weeks who would make a really good senior and so we try and make sure that they're trained on the different elements of task first so that they can kind of then be ready for jumping in when needed, like medication is one of the things."

Interview with Deputy, Strauss Hill Court

Care worker Gail confirmed this approach, with Mary a senior care worker describing the positive effect it had on the home's practice;

"I've been here only 7 or 8 months so not long, but I'm just about to get on my med-training done. You know the tablets and they want me to be a team leader,"

Interview with Gail, Care Worker, Strauss Hill Court

"Obviously it's good to have like the knowledge I think, more carers should be meds trained because … I think it would give everybody a better understanding of what medication they have and why they have it. Even when it comes to like pain relief, because obviously if you're doing lead care then if it's (a resident) who won't sort of say that they need pain relief then you turn to the carer and say, have they been in pain?...It's the carer that knows because it's the carer that's the one who is with them all the time."

Interview with Mary – Senior Care worker, Strauss Hill Court

The relevance of this element in one home but not the other points towards the way in which structural factors, such as the division of work, affected the opportunities for learning available. In Strauss Hill Court there was a wider range of tasks required of the care workers, and decision-making by management to encourage training beyond the minimum required for a role. This appeared to affect the potential influence of training, especially when combined with other learning such as interacting with colleagues. This demonstrates that training had an influence on the learning of care staff but in a complex way through the mechanisms of Theme One and Two.

5.1.3 Ideas for routine tasks

The final element of subtheme **gatekeeper tasks** related to other types of training that occurred in the homes. In this element, the training was not directly about a gatekeeper task but was instead more general, prompting staff to consider and enact **'ideas for routine tasks'**

that they may have picked up from training. This element appeared in both homes but had a much broader influence in Strauss Hill Court, because there was both a wider range of training available and a more varied array of tasks that constituted routine care in this home.

The focus of such training included varied topics such as; sensory awareness, dignity, hydration, continence, care after death, falls prevention, activities and dementia. These sorts of training were optional and from training records appeared to be offered and taken up more frequently in Strauss Hill Court. The difference in availability and uptake related to structural factors in each home. Strauss Hill Court was part of a large care provider organisation who organised training and made homes aware of training available in their local areas, providing a range of options. Sunshine Lodge was part of a much smaller organisation and provided most of their training in-house, which meant less flexibility on top of the already rigid shift structure that operated there.

The influence of these sorts of training opportunities was through care workers becoming aware of new knowledge, either in the content of the course or from other participants. Below, care worker Cath explained an area of her practice that had changed as a result of training;

"When I went on care plan training, just because I didn't realise the importance and the legality. It wasn't until I heard about situations where it like goes to coroner's court… I try to be much more precise (in writing daily records)… and the importance of everything has to be linked in. Like if (resident) gets upset or wound-up and has a lorazepam the care plan can't say 'x has been fine all day'.

Interview with Cath - Care Worker, Strauss Hill Court

Training also changed others' perceptions of care staff abilities, particularly at Sunshine Lodge. However, it was notable that despite this difference in perception I did not observe an impact on the ground either through hands-on practice or care worker's involvement in nurse-led aspects of care.

I mean the NVQs and that are very good. They're very good for learning you know ***(I: do you notice a difference when somebody has done that kind of thing?)*** *yeah, I do. Because you know they've got more knowledge of it and*

that can relate to what you're saying, understand what you're saying more so,"

Interview with nurse, Sunshine Lodge

The extent to which training could influence practice often depended on more than an individual worker themselves, meaning that the home and how work was organised mediated the impact of training. The manager of Strauss Hill Court described clearly how her response to staff's ideas following training was very important in facilitating transfer of training into practice;

"Listening to them as well, so when they've been on training. So for example, someone came to me with a massive list of things and said 'oh it's probably all rubbish' so I said, let's have a look and if it's a good idea you're the one who is working there every-day, let's try it…I remember one of the younger girls she came after she'd been on the (external dementia training)…we just had plain clear glasses and she said to someone with dementia or eyesight problems, especially if its got water in it, it won't look significant, so she said to me how about maybe getting different coloured glasses…and we did it, got it, we bought the glasses and now they're in use down there"

Interview with Manager, Strauss Hill Court

In both homes, the ability to transfer ideas into practice was recognised as being heavily dependent on decision-making and organisation of work in the home and it was here that the differences between the two homes is apparent. Below you can see the contrast between the impact dementia training undertaken by the two deputy managers was able to have in their respective homes;

"I actually went on a dementia (course) and (participant from another home) had what they called a golden hour, an idea about a golden hour (dedicated activities for residents) I thought it was such a brilliant idea, but we cannot always give an hour bang on. We just don't work like that,"

Interview with Deputy, Sunshine Lodge

"They're mixed up with people from other homes and a lot of the ideas that we have have come from different homes. I met a lady on a dementia (course) and her night staff wore pyjamas and said that it solved a particular problem. So I thought, well we have that problem we'll give it a go and it was allowed and it's worked really nicely."

Interview with Deputy, Strauss Hill Court.

Thus, we can see that as with previous themes, the flexibility of the care worker role and the organisation of work in the home affected the impact that training around gatekeeper tasks had, through both the training that was on offer and how such training could be transferred into practice.

5.2 Knowing the job not care

The second subtheme of **training** was **'knowing the job not care'.** Here, there were aspects of training experienced by care workers that they identified as being relevant to doing the job of care worker, but not to the act of caring itself. Training was therefore important in relation to being allowed to be a care worker, but not necessarily connected to the factors that made someone good at caring. The data that existed in relation to this subtheme were relatively sparse compared with other subthemes and so was insufficient to produce individual elements. However, this concept was still referenced in both homes, although far less consistently than aspects of training related to gatekeeper tasks.

When discussing training it appeared in both homes to be viewed by both workers and management as something disconnected from the day-to-day and therefore something to get past in order to focus on hands-on caring. It was often connected, particularly in relation to mandatory training to the need to communicate factual knowledge and legal aspects of the caring role. The manager at Strauss Hill Court reflected on the performance of a new member of staff;

"Yeah, she's just hit the ground running. Obviously she's had to do the training that everyone has to do: the [e-learning modules], the moving and handling. She's been sent on a couple of courses, but nothing that's different to anyone else and she's just got that way with residents... It's nothing to do with the training she's had. She's an intelligent person, so I would imagine 'click, click, click' training done. Not really read or anything, just done, like probably most

people do…Obviously she can train on different types of dementia and different heath conditions…She can learn about hypertension, she can learn about frontal-temporal dementia…and it will increase her knowledge…but the way she cares for them it's not got anything to do with training"

Interview with Manager, Strauss Hill Court.

I, too, completed the e-learning modules required of staff in my first few days visiting Strauss Hill Court and reflected after the fact;

The overall impression I get through doing this is that [e-learning] is about the stuff we have to get out of the way so that we can get down to the real work.

Reflective Diary, e-learning notes, Strauss Hill Court.

This separation between the purpose of training and the reality of the caring role was not isolated to online training. Sunshine Lodge did not use e-learning, instead training courses were run in-house or accessed outside of the organisation. The introduction of the Care Certificate had resulted in new workers undertaking a process of induction in which the first two weeks consisted of classroom-based training alongside observing (not contributing to) care in the home. Dennis and Tash were both new workers experiencing this Care Certificate induction and I discussed their experiences with them:

They comment that it is "frustrating" to have to sit and watch 'there's lots of just standing around'. I ask about how you learn this job and Dennis responds immediately 'hands-on'. 'You can learn about 20% from policies and things but it has to be hands on because everyone is different'. You learn from interacting and learning their triggers. It has to be hands on because it's about people and relationships with them.

Reflective Diary, Sunshine Lodge

Indeed, one of the reasons I was able to discuss this issue with Dennis and Tash was because they were significantly more available than regular care staff at Sunshine Lodge, precisely because other staff were constantly engaged in 'hands-on' tasks with residents.

5.3 Application

The final subtheme of **training** concerned its **application**; the way in which training was used within the care home. Again, as with subtheme 'knowing the job not care' (5.2) the data for this subtheme was sparse compared with that related to gatekeeper tasks and so it did not present separate elements. In addition, it was a subtheme that became apparent in the contrast between the two homes as Strauss Hill Court and Sunshine Lodge used training in subtly different ways. Whilst evidence was relatively sparse, this comparison provided an interesting dimension to the potential influence of training on learning practice in the two homes.

Strauss Hill Court showed a more thoughtful approach to training by considering the indirect ways it could be used to influence practice. For example, the deputy manager spoke of the challenges they had encountered in trying to encourage a more person-centred approach to care in the home;

> *"Inevitably you generally inherit staff…they can be quite old-fashioned in the way that they do things and trying to get away from that is very tricky. So quite often when we do training courses we'll be quite careful about who we'll put them in with. We'll put them in with new ideas,"*
>
> ***Interview with Deputy, Strauss Hill Court.***

This demonstrates a more sophisticated application of training that did not appear to have been considered at Sunshine Lodge, particularly as the in-house training was held during shift, meaning that the same staff who worked together also trained together. This contrast was echoed in the ways that knowledge gained from training was reinforced with staff. Below are extracts from the supervision notes for new staff at Strauss Hill Court and the induction folder for Sunshine Lodge which were consistent with accounts of senior staff for how training was organised;

***Supervision and support record**: Review the following mandatory training: infection control, DOLS, MCA, Safeguarding.*

"We have met today as a new member of staff to discuss induction so far, what has been learnt and further training needs identified."

Supervision records, Strauss Hill Court

First day/week induction checklist:

1) Tour of home, uniform, terms of employment, hours of work, sickness absence, dress code, health and safety at work etc.

2) Policy and Procedure list: MOS and the Deputy sign the policies listed to confirm they have been read

3) Description of manual handling training requirements and copy of manual handling training certificate

4) Care Certificate Training Records

Induction Folder, Dennis – Sunshine Lodge

Within these documents, management at Strauss Hill Court appeared to recognise the need to reinforce training with staff rather than simply record that it was completed, as occurred at Sunshine Lodge. This suggested that the usefulness of training was recognised in Strauss Hill Court as being dependent on other factors in the home and thus, at least some attempts were being made to account for this.

Interactions and contingencies of Theme Three

Training, as the final theme of learning to care, was the least prevalent and complex in the data from both homes, especially beyond **gatekeeper tasks**. It was not that it was irrelevant, but that its influence on practice was often subsumed within the learning processes of Theme One and Theme Two. **Training** influenced the options and activities applied through **what works is what matters** and apparent within **interactions with colleagues**.

As with Theme Two, training is a vehicle for cultural knowledge to be brought to bear on the day to day processes of 'what works is what matters'. This is because it is infused with the consequence of structural decision-making about work types, role boundaries and team composition and thus imports those into the day-to-day milieu, and determines what information can be applied by whom in this in-action learning process. Thus, broadly similar mandatory training in both homes resulted in different care approaches in practice. The additional tasks and flexibility to work and work team in Strauss Hill Court, combined with their subtly more reflective approach to training, may have explained some aspects of the different style of care observed. However, training was by no means the most definitive influence on this and this contrasted strongly with the amount of consideration and effort dedicated to organising and resourcing training in both homes. This will be discussed in the next chapter.

Learning to care becomes learning to care *here*

I have described each of my three themes separately, demonstrating the interactions within their subthemes and the ways in which contingencies of the care home context influenced the outcomes of learning in the homes. I have shown that the same learning processes occurred in both care homes, but they resulted in different care practice. This is accounted for by the ways in which culturally-influenced meso and macro-level factors are drawn into the micro-level learning process of Theme One's '**What works is what matters'**. Meso-level factors enable individual workers to utilise information, skills and knowledge shaped by their **Personal Resources** and **Resident Influences** as they participate in their 'what works is what matters' learning process. However, the utility of these resources is based on their ability to help a care worker to practice care that 'works' on the ground. Macro-level factors (such as the organisation of work tasks, team composition and role boundaries) are imported into the learning process as **Cultural Knowledge**; a resource determined by the highly influential **Interactions with Colleagues** and the less consequential **Training**. Again however, their utility is determined by the extent to which they provide successful solutions to daily work through the 'what works is what matters' process.

As Figure 6 showed, when all the themes are viewed together their constant interaction is evident. Both meso-level and macro-level factors receive constant feedback from the micro-level process: successful or unsuccessful outcomes to 'what works is what matters' are integrated into learning occurring through **Resident Influences**, and (most significantly) through **Interactions with Colleagues**. These in turn are channelled back into the micro-level learning process, thus

creating a cyclical and self-reinforcing process in which culturally-differentiated outcomes result from similar processes. For a worker in a care home, the process of learning to care therefore inevitably becomes a process of learning to care *here*, and thus these findings help to shed light on why care home culture can be such an influential and intractable issue when aiming to improve care practice and outcomes for people living with dementia. Care workers are not only engaged in a daily process of learning to care, but that process is also infused with culturally-specific and self-reinforcing features.

In the following pages I will use an in-depth example from Strauss Hill Court to illustrate the whole learning process and the three themes in action. This will set the scene for discussion of how these findings can be used to improve practice and influence learning towards good quality outcomes for people living with dementia, which is the focus of the next chapter.

In Strauss Hill Court, I was observing on a day when essential maintenance work needed to be done in one unit, meaning that residents could not access their usual lounge, dining area and bedrooms for safety reasons. I was particularly interested to see how this may affect staff's practice with resident, Julia, as she usually used this area as part of her walking/pram-pushing circuit. This therefore presented staff with a very unusual and potentially challenging situation; one I (wrongly) anticipated might involve restrictive, physical responses that would make me uncomfortable. The observation below started following an hour of attempts by different staff to encourage Julia to move and whilst workmen waited to start.

MOS G bends down in front of Julia and says 'good morning lovely, you coming down for breakfast?' 'Yes' 'shall we take the pram?' starts to wheel pram slightly. 'Come on then'. Julia says 'No' loudly. Back and forth again. Gentle encouragement. 'You have to come, Julia, I can't leave you!' 'I'm getting that face today?' More suggestions/comments, standing up holding hand out.

Says to self 'I'll turn the TV off that might help', turns TV off then sits next to Julia and chats. They discuss the workmen, explaining what they are here to do. Then points to the workmen outside and says 'shall we go and see?' 'Let's go down and look' 'shall we take the pram'? Julia replies to all of these with a 'No'.

MOS M comes in and joins the exchange, says to MOS G 'she's got that look'. Says how lovely the weather is outside etc. MOS M 'shall we take the babies for a walk? Shall we take the babies for a picnic?' Julia says something angrily and MOS M says 'I know. Some of us can be mean.' More back and forth with

Julia as they stand some distance back smiling, open body language making various suggestions and encouragements. Gentle but insistent.

MOS M leaves and comes back a few minutes later, says 'We've got to go Julia, look at the men – they're getting ready'. Julia says 'No' arms folded. MOS G says to MOS M 'I've tried everything: babies, cakes, carrots, everything'. MOS M opens the lounge garden door and says 'shall we go and have a look, we could pinch that man's bottom!' MOS G comes closer and says 'Julia, I need to clean your chair," Julia says No again. MOS M says 'I'll leave you to it, because two of us may be stressing her."

Julia's tone is getting angrier and she slaps the offered hands away. MOS G walks away and comes back a few minutes later. Says 'I know, Julia, but I have to stay here annoying you until you move' (gentle tone). More back and forth. 'We have to go, Julia'. 'Why?' 'The working men are coming' Julia says something and MOS G says 'when? Now, we've got to go, take the babies down with us, we've got to keep the babies safe in their room'. Julia makes a softer noise. G says 'yeah got to keep them safe'. (MOS's tone of voice says she thinks this may be working).

'Come on then.' Julia moves slightly and G helps Julia to stand up, stepping swiftly behind her so she cannot sit back down. (G makes a 'yes!' gesture at me). Julia reaches for the pram and walks towards the activities room with G, passing the workmen on the way. She encourages Julia all the way, Julia's facial expression is cross and she chatters in a grumbling tone all the way. She approaches the other room and is greeted happily by other staff 'hello!' Julia's facial expression remains cross/annoyed. 'Come in here and have a cup of tea', 'No!' starts to turn the pram around, staff let her do it and she starts to walk back towards the unit. One goes to check the barrier has been put up.

Observation, (230914), Strauss Hill Court

I later discussed this situation with staff members Gail, Mary and more generally with others, talking about how they knew what to do and not do. Their responses helped to illustrate how all three themes and their subthemes may have influenced the practice in this situation and how a single piece of applied knowledge may have come from multiple sources and via different themes.

Theme One: What works is what matters

Firstly, **seeing results (1.1),** particularly in terms of avoiding exacerbating Julia's negative responses, was a primary guide. Gail explained that a worker should try *"the nice happy stuff first, before you go to the other stuff* (the 'keep babies safe' option),*"* because that might distress her, or make her angry, so you "progress from the nice happy options and then you go to the other stuff". Secondly, **trial and error (1.1.3)** was an inherent part of the options worked through with Julia, with G using *"anything and everything"* including knowledge of Julia's interests (babies), attempts at distraction and gently wiggling her fingers on Julia's back to encourage her to move from the chair.

Thirdly, this situation required that staff **negotiate conflicting pressures (1.2)** of Julia's need for freedom of movement and the unavoidable requirement that the unit be vacated. Even though they had to restrict Julia's freedom of movement, they used **seeing results for residents (1.1.1)** as the marker for how far/what options they would try, whilst also acknowledging the need to **fulfil role expectations (1.1.2)** on them to enable the maintenance work to go ahead. Finally, staff were inevitably **thrown in at the deep end (1.3)** in such an unpredictable situation once there were no other options but to find a way for Julia to move. Gail (and others) learned through this situation what worked for both Julia and herself in fulfilling this part of her role and these strategies were seen being used with Julia throughout my time at the home.

Component 1(a): Personal Resources

Gail hinted towards using her personal resources in the learning process when she reflected on this interaction. When explaining why she used her hand to wiggle behind Julia's back and stepped immediately behind her once she stood, Gail drew on **previous experiences (1a.i)** particularly from her previous **work** (with a different client group) because she knew it was helpful to make someone less physically comfortable where they were and necessary to make the most of an opportunity once it arose, (by making sure Julia could not sit down again). Furthermore, Gail's **personal values (1a.ii)** were consulted as well, because she explained that she herself 'would do anything' to keep her daughter safe and that's how she knew that might be an option to try with Julia.

Component 1(b): Resident Influences

This incident also demonstrated the ways in which resident influences were integrated into Gail and Mary's learning through their care of Julia. There were a number of examples where both showed their **learning from (1b i)** Julia herself. Mary commented that Julia had 'that look'; an expression that staff knew represented Julia's stubborn refusal to do what they were asking, because of their **personal feedback** from her on previous occasions. Both Gail and Mary used Julia's 'babies' in many of their interactions, knowing Julia's **choices and preferences** for reacting to the world with and through them. Their **learning about (1b.ii)** Julia from **care plans** and the **stories told** by others would also have provided information that was brought to bear: the fact that Julia liked orange food and sweet snacks ('I've tried carrots, cake, everything!') and that having two people interacting with her at once may have worsened the situation by 'stressing her out'.

Component 1c: Cultural Knowledge

Theme Two: Interactions with colleagues

With regard to Theme Two, Gail and Mary's interactions with each other in the moment and with others in the hour leading up to this incident informed their practice in a number of ways. Firstly, both Mary and Gail left Julia for brief periods of time before returning in the hope that it may change Julia's responses. This was a common feature of care for people living with dementia here and something that was **formally shown and told**, **(2.1)** to staff on a regular basis, especially when situations were challenging and residents distressed. When Mary first joined Gail, **asking and giving advice (2.2)** is enacted, (I've tried everything!') although without much success.

Gail also used **observing others (2.3)** as she watched Mary's attempts (using some aspects – such as invoking the workmen - in her later attempts) and, in her general approach to Julia, adopted practice observed from others in assuming that Julia understood what was being said and what she herself wanted. Finally, **communication and categorisation (2.4)**, also played its part in setting up and resolving this incident. The **environment (2.4.3)** of unit four was recognised as being the 'hardest' unit and as such this work had been delayed repeatedly because of problems moving the residents out for the day. Moreover, extra staff had been employed for this day, to ease the anticipated challenges of moving and caring for Julia and others. **Expectations of care work (2.4.1),**

especially concerning the avoidance of restraint and primacy of 'resident-led' care helped to reinforce the need for Gail and others to find a solution in which Julia had as much control and freedom as possible

Theme Three: Training

Finally, training was not explicitly referenced by staff when discussing this incident, perhaps reflecting that training appeared to be viewed as primarily focussed on **knowing the job, not care (3.2).** However, a potential impact of training could be traced here, without staff consciously recognising that it had such an impact. For example, common training for many staff members regarding **gatekeeper tasks (3.1)** such as **manual handling** and **ideas for routine care** in dementia training may have influenced staff's practice and thus had an indirect effect here through Theme One and Theme Two. In particular, the consistent habit of always warning a resident first, explaining what was happening and avoiding physical restrictions whenever possible was a reliable feature of care at Strauss Hill Court that was played out even in this unusual situation. This practice is consistent with that taught to staff via manual handling training, and reinforced in supervision and shadowing. This could suggest that the **application (3.3)** of training, by embedding it in practice beyond the course itself contributed to the options explored (and not explored) throughout this incident.

Throughout this chapter I have described three themes and components of learning to care, and how the process of learning manifested within both of the care homes. All three themes and components appeared in both care homes, and the relative influence of each was similar across the homes. However, similar mechanisms of learning produced different practice outcomes in each home because the interactions of themes and components occurred across the micro, meso and macro-levels. This resulted in a process in which learning from personal resources, resident influences and, most significantly, cultural knowledge is incorporated into the day-to-day learning process of care workers within the central theme of 'what works is what matters'. This causes a process of learning to care to become a process of learning to care here; within the particular cultural milieu of a care home.

Describing the themes and process of learning to care is not where my study ends, however. I embarked upon a *critical* ethnography, aiming to not only describe how learning to care takes place but also consider how the current state of affairs could be changed to influence the quality of care, particularly in light of a unique study that prioritised care workers' own perceptions and experiences embedded in the cultural context of everyday working life in a care home. Therefore, in the following chapter I will examine how my model of learning to care contributes to understandings in this field and discuss how it could be utilised to improve available learning opportunities and achieve better quality outcomes for people living with dementia and those who care for them.

Chapter 6: Discussion

In the previous chapter I described the three themes of learning to care that emerged from my ethnographic engagement with two care homes. This showed a complex, multi-level picture of how learning to care for people living with dementia takes place within a care home in which different processes interact with each other, with the relationships and opportunities workers experience day-to-day and with the cultural milieu of the specific care home. This thematic process is original and thus it is important to explore how existing understandings of person-centred care for people living with dementia, improving practice and quality, and learning in the workplace integrate with this new representation of learning to care.

Moreover, as addressed within my methodology I adopted a critical ethnographic approach because of dissatisfaction with existing characterisations of learning to care and thus a desire to explore how this field could be conceived differently and shaped more successfully towards improving care for people living with dementia in care homes. It is this critical re-visioning that is the focus of this chapter. Therefore, I will now address the significant intersections between my thematic 'learning to care' process and the existing literature, highlighting the aspects that hold relevance for achieving person-centred care for *people living with dementia* in particular, and the consequences these aspects have for how learning to care should be better conceived and organised.

6.1 The significance of care home culture for learning to care

The pervasive effect of organisational culture on care for people living with dementia has long been intimated (Kitwood, 1997) and more recently explored theoretically (Brooker, 2003; Brooker and Latham, 2016; Woods, 2019) and empirically (Zimmerman *et al.*, 2005; Kirkevold and Engedal, 2008; Caspar *et al.*, 2013; Killett *et al.*, 2016). It is known to be particularly influential and intractable because it helps provides effective solutions to the problems workers face day-to-day in the performance of their work and thus can be self-reinforcing (Killett *et al.*, 2016; Schein, 2017). By describing the specific mechanisms through which care workers learn, the learning to care process not only affirms the importance of organisational culture but, most importantly,

demonstrates for the first time precisely *how* organisational culture is drawn upon within the learning process; the problems to which it provides workable solutions. With this understanding comes an ability to shape that influence towards improving care practice for people living with dementia. Three aspects of the process bear particular attention when considering the impact of organisational culture: At the micro level, the sub-themes of the 'what works is what matters' process (**seeing results** 1.1, **negotiating conflicting pressures** 1.2, **thrown in at the deep end** 1.3); At the meso-level, the ways in which **resident influences** (1b) integrate into that process; and at the macro-level, the influence **training** (3) has on determining the cultural knowledge absorbed into the day-to-day learning.

6.1.1 Micro-level influence of culture

Firstly, for the day-to-day learning process of 'what works is what matters' (Theme One) aspects of organisational culture such as structural decision-making about the configuration of work tasks, composition of work teams and prevailing perceptions as to what constitutes success ('what works') shape the circumstances workers encounter within the three sub-themes, and thus influence learned practice in the following ways: (1) setting the boundaries of acceptable **results** (whether these relate primarily to resident well-being or fulfilling expectations of role); (2) determining the nature of **conflicting pressures** that need to be negotiated in work; and (3) shaping the milieu into which workers are **'thrown'.** This helps to explain the success of multifactorial educational interventions in improving care outcomes compared with simpler efforts; the additional elements serve to reconfigure these structural factors in the care home, at least for the length of the research or intervention. In these circumstances, the educational element of an intervention is more likely to be reinforced, rather than contradicted, by the far more influential process of learning through 'what works is what matters'. Therefore, as is increasingly acknowledged in intervention design and study, this cultural x-factor should be considered an integral aspect of the intervention itself (Fossey *et al.*, 2006; Colón-Emeric *et al.*, 2016; Lawrence *et al.*, 2016; Bauer *et al.*, 2018). In particular, raising awareness of, and explicitly addressing necessary changes to the manifestation of the three sub-themes within intervention design will improve effectiveness and longevity, because the internal care home-specific learning process will be consciously aligned with the intervention's goals.

Moreover, these learning mechanisms may go some way to addressing why organisational characteristics (such as communication or access to resources) appear to matter more to achieving PCC than human variables such as knowledge or attitudes (Cioffi *et al.*, 2007; Caspar *et al.*, 2013; Gilster, Boltz and Dalessandro, 2018; Laybourne *et al.*, 2019). Essentially, I would

suggest that these organisational characteristics influence the structural decision-making that takes place, supporting person-centred parameters for the 'what works is what matters' learning process in the care home.

Furthermore, there is coherence between the structural facets of 'what works is what matters' and its sub-themes and prominent concepts within workplace learning literature, empirically illustrating these within the care home setting for the first time. For example, Billett's (2006) assertion that a workplace creates its own curriculum for workers by structuring what experiences are available to them is demonstrated in my study: 'curricula' for workers in Strauss Hill Court and Sunshine Lodge differed (in part) because structural factors delineated who they worked with, on what tasks, and towards what end, creating a specific and unique set of conditions for determining 'what works' in each home. Put simply, structural factors resulted in a curriculum entitled '*reduce negative emotions for residents'* at Strauss Hill Court and '*keep busy'* at Sunshine Lodge.

Theme One also concurs with the concept of expansive/restrictive approaches to learning within organisations, in which expansive approaches offer a wider range of experiences, opportunities and collegial interactions (Evans *et al.*, 2006; Fuller *et al.*, 2007). This study has shown the specific manifestation of 'expansiveness' within a dementia care home. Strauss Hill Court evidenced greater expansiveness than Sunshine Lodge because staff engaged with a wider range of colleagues across a broader range of tasks. However, it is important to note that these characteristics were not instituted by the homes because of any conscious learning-based decision-making. They were instead the result of unique practical and historical decision-making within each home, enacted with little apparent reflection on impact, particularly with regards to learning. Being able to articulate the day-to-day features of expansive learning environments within care homes and dementia care will therefore hopefully enable these to be activated more consciously towards person-centred care practice.

6.1.2 Meso-level influence of culture

In the second instance, component 1b (resident influences) is another area where care home culture exerts influence over the mechanisms of day-to-day learning by care workers. This aspect is of particular importance because it is relevant specifically to PCC for *people living with dementia*, given the centrality of interpreting resident experience to that goal. Through 'resident influences' structural decision-making about work tasks and teams determines the extent to which learning **from** (1bi) and **about** (1bii) residents can be applied within the 'what works is

what matters' process: when workers have the opportunity to engage with residents, receive **feedback** and enact **choices and preferences** (1bi), or apply knowledge gained from **care plans** or **stories** (1bii). Strauss Hill Court evidenced a far more flexible and variable set of circumstances for engaging with residents because the interpretation and organisation of care work included responsibilities related to social, emotional and occupational needs as well as physical care. This resulted in a crossover between care worker and other roles in the home. Moreover, the shift patterns in the home meant that care workers encountered residents across the whole of their 24-hour experience, and variable allocation of staff to units and mobility of residents throughout the whole home meant that care workers regularly encountered every resident in the home. Contrastingly, the fixed shift pattern and rigid boundaries to roles at Sunshine Lodge combined with the day-to-day allocation of workers to the same group of 'room numbers' and the immobility of many residents resulted in narrow and unchanging encounters with residents. These different circumstances ultimately created substantially fewer learning opportunities at Sunshine Lodge, meaning that practice was less likely to be challenged or changed by encountering something different. The workplace learning literature would explain the inhibited range of practice at Sunshine Lodge as a result of this lack of opportunity (Rogers, 2003; Marsick *et al.*, 2009; Illeris, 2011; Pool *et al.*, 2015; Takase *et al.*, 2015; Teunissen, 2015). Sunshine Lodge's structural factors essentially rendered it a restrictive learning environment in respect of resident contact with Strauss Hill Court as more expansive (Evans *et al.*, 2006).

However, the relative variation of contact with residents does not by itself explain the difference in *quality* of care practice; repetitive learning opportunities that affirm good practice are possible. The quality issue is accounted for by the nature of person-centredness specifically for dementia care which is, as I argued in chapter 2.1, at its core a complex and subjective notion which requires moment-to-moment adaptation to the person and circumstances. Learning PCC for people living with dementia therefore requires learning that necessary adaptation. My findings illuminate the necessity for flexibility and variety in learning opportunities with residents (created by structural factors) if one is to learn to care through resident influences. Moreover, these findings suggest that these resident influences on learning can be influenced towards improving practice by considering the range of residents encountered and the range of circumstances they are encountered in. This is not simply about increasing frequency of encounters; after all, knowledge of the person and trusting relationships are cornerstones of person-centred dementia care as well, both of which are potentially diluted by focussing only on frequency. Instead, it is about increasing quality rather than quantity. A care worker will learn more and thus be better able to adapt (a core feature of PCC in dementia) if they have the chance to experience a person

in varied circumstances and through a variety of individuals' experiences. For example, how different might practice have been at Sunshine Lodge if care workers' supernumerary shifts (a requirement when they first started their role) had been spent observing and engaging with residents across their day rather than observing a single member of staff engaged in care tasks?

6.1.3 Macro-level influence of culture

The third way that care home culture asserts itself into the learning process is through the formal training that workers receive (Theme Three). However, it is notable that this influence is not a direct one, as is often assumed. Instead, its impact is indirect because it is filtered through the 'what works is what matters' process as part of the **cultural knowledge** (1c) component that care workers utilise as they look to **see results** (1.1), **negotiate conflicting pressures** (1.2), or respond to being **thrown in the deep end** (1.3). This filtering not only helps explains why training does not always have its intended impact, but crucially it highlights how structural decision-making about availability and application of training may, unintentionally contradict the goal of PCC for people living with dementia. In both care homes, training in **gatekeeper tasks** (3.1) of care was mandatory, thus creating a barrier (and often points of stress) between care workers and non-care workers in the case of **manual handling** (3.1.1) and senior and junior care workers in the case of **medication** administration (3.1.2). Prioritising this type of training essentially ensured that it was a significant aspect of care workers' thinking when engaged in the sub-theme learning processes of 'what works is what matters'. Correspondingly, non-gatekeeper training (and those excluded from the care worker role by a lack of same) asserted less influence.

Whilst the consequences of poor practice in these areas makes their promotion understandable, it is important to consider the implication of prioritising only these aspects, especially given the associated sub-theme (3.2) in which training was considered to be focussed on '**knowing about the job, not care**'. It is here that the starkest contrast with the PCC literature exists. None of the key characteristics theoretically or empirically identified as necessary for PCC for people living with dementia within chapter 2.1 align with these physical tasks. For certain, undertaking these aspects of care safely is necessary to achieve well-being, but it is a very different, interpersonal and 'softer' skill-set which has been implicated as important to person-centred dementia care. Why, if the aim is to achieve person-centred care for people living with dementia, are physical tasks the gateway to 'becoming worker' or 'becoming senior worker' as opposed to dementia-specific abilities such as communication skills and behaviour interpretation, or broader interpersonal proficiencies such as critical reflection, forming relationships with residents or influencing colleagues?

The indirect effect of training illustrated within these findings suggests that, without careful consideration, organisational decision-making about training can re-affirm an over-simplified conceptualisation of learning to care *within the day-to-day learning experiences of care workers themselves*, regardless of the care home's explicit cultural aspirations. This unintentionally reinforces a prevailing view of care work with people living with dementia as task-based, low-skilled and something that anyone can do. It may contribute to the commonplace adage that caring well is "not rocket science". My study would suggest that learning to care is much more complex than this perception infers. This is not a case for increasing mandatory training but one to better articulate and facilitate the complex knowledge and skills, interpersonal abilities and ongoing learning required to care well for people living with dementia in care homes.

In discussing the three aspects of the learning to care process in which the culture of the care home has effect on the outcomes of day-to-day learning, it is possible to see exactly where in the process person-centred outcomes for people living with dementia could more directly influenced and why culture is such an intractable issue when attempting to change practice. However, there is a significant aspect of care home culture that is yet to be discussed: the role of colleagues. My study showed that interactions between colleagues play a highly significant role in shaping the learning of care workers and, crucially, an important vehicle for transmitting the cultural values and practices of the care home. It is to this that I shall now turn.

6.2 The significance of communities of practice to learning dementia care

Theme Two - interactions with colleagues – formed a crucial part of the learning to care process because it was the primary contributor to the cultural knowledge (1c) employed by workers within 'what works is what matters'. Whilst its path of influence was indirect, this does not reduce its significance in shaping the resulting care practice, particularly because the outcomes of learning (what works or does not work) are fed-back into future interactions with colleagues. This creates a self-reinforcing cycle in which past learning of practice influences the cultural knowledge that is drawn on in future learning of practice. This cycle helps to explain further the enduring and persistent influence of the care home's culture on learned practice. Again, my study illuminates for the first time the specific mechanisms by which interactions with colleagues, shape learning and transmit culture. The subthemes of **formally being shown and told** (2.1);

asking and being given advice (2.2); **Observing others** (2.3); and **Communication and categorisation** (2.4) demonstrate how the macro-level, determined by structural decision-making in the care home, comes to influence the micro-level day-to-day incidents of learning. This understanding helps to improve ability to influence the care practice outcomes that result. The following four issues are of particular significance for improving care quality and outcomes for people living with dementia specifically and thus deserve further discussion: the composition of the care home community of practice; the role of residents; the importance of interpersonal skills; and the function of role-modelling.

6.2.1 Composition of the care home community of practice

Firstly, of most obvious significance is Lave and Wenger's (1991) theory of learning through participation within a community of practice (COP). In applying the '**what works is what matters'** process in the context of **'interactions with colleagues'** care worker learning demonstrates the following defining features of a COP within the care home setting:

- Meaning (as 'what works') is socially negotiated within the care home in the process of doing work
- Internalisation of knowledge by individuals is less significant to practice than the care home context within which a worker participates because of this social negotiation
- Opportunity and organisation of relationships in the care home are therefore significant to shaping the learning that takes place.

(Lave and Wenger, 1991)

Essentially, Theme Two and its sub-themes articulate the composition of the care home COP, showing the varied way it can manifest and the likely consequences for learning of practice by its members. This is a new contribution to our current understandings of both learning within care homes and COP theory for three reasons: Firstly, the COP concept has not been applied to care home or dementia care settings thus far, and so this study provides a first indication of its relevance to this field. Secondly, this study focusses mostly on the experiences of established workers as opposed to those coming into the workforce for the first time. This extends the evidence of COP beyond new entrants, addressing a common criticism (Fuller *et al.*, 2005). Finally, and most significantly, critics of COP theory argue that it does not explain the specific processes of learning that occur within the COP and fails to consider the effect of organisational factors

(Illeris, 2003; Thomas, 2017). This study precisely addresses this issue by demonstrating the ways in which the COP creates the cultural knowledge that workers apply to their day-to-day learning through Theme One and thus the implication for everyday care practice. For example, the composition of staff groups (variety of colleagues and situations in which they were encountered) differed between the care homes resulting in a highly circumscribed COP in Sunshine Lodge compared with Strauss Hill Court, despite a wider range of staff of potential members (e.g. nurses). These unique circumstances thus resulted in learning of different practices because it is the COP which, at least in part, frames the determination of '**what works**'. Furthermore, the organisation of work tasks (the homes' relative flexibility in areas of responsibility and boundaries between roles) also served to determine the constitution of the care home COP, (broad in Strauss Hill Court and narrow at Sunshine Lodge) and thus influencing the learning that occurred.

Moreover, because these cultural influences determine the composition of the COP from which a worker draws as they learn to care, it has a particular relevance within care homes and care practice for *people living with dementia*. The COP serves to either emphasise or minimise the inter-subjectivity associated with work in both homes. Billett (2014b) describes inter-subjectivity as the shared knowledge, procedures and dispositions necessary for successful achievement of co-working. This becomes particularly important within workplaces where individual workers contribute only a part of the whole such as a care worker contributes to the holistic resident experience (Billett, 2014b; Kuipers, Ehrlich and Brownie, 2014). Additionally, for dementia care this notion of inter-subjectivity has particular resonance because it aligns closely with achieving the indispensable relational co-production of PCC as discussed in chapter 2.1 (Kitwood, 1997; Sabat, 2019).

In Sunshine Lodge, the creation of two distinct shift teams made a narrow COP which was then exacerbated by the rigid boundaries to roles within the home. Workers at Sunshine Lodge could only engage in learning via **interactions with colleagues** in a limited and repetitive way because there was only a small circle of colleagues who could **formally tell them**, (2.1), whom they could **ask advice** from or **observe** (2.2 and 2.3) and whose **communication and categorisation** (2.4) they were surrounded by. At Sunshine Lodge, a nurse, the activities coordinator and care workers from the 'other' shift were not (regular) member of this COP and their responsibilities did not crossover. Therefore, what resulted was, not only a restricted COP in number and role, but also in terms of tasks and likely encounters, thus limiting the inter-subjectivity which could be learned. By contrast, at Strauss Hill Court, the people who contributed to **formally telling**, who were available to **ask** or **observe**, and in whose **communication and categorisation** a worker was immersed, varied daily and the responsibilities of care workers ensured contact and overlap with

non-care roles as well. Thus, inter-subjectivity was a core aspect of the learning that occurred for care workers there.

This suggests that the level of inter-subjectivity engendered by the COP may be associated with facilitating PCC by ensuring the different parts of the whole care experience are understood by individual workers. This is not to paint a simplistic causal relationship between COP variety and quality of care practice learned from it. Instead it serves to highlight the importance of considering the care home COP when trying to affect workers' learning and, most significantly, the need to examine that COP and its promotion of inter-subjectivity from the perspective of workers' day-to-day engagement. The relationship between COP scope and learning arising from it is essentially one of *potential*. On the surface, Sunshine Lodge had a far broader COP and more obvious promise for inter-subjectivity than Strauss Hill Court because the home had a higher staff-resident ratio and nurses within the workforce. However, in practice, the potential learning of new or different practice was limited by the lack of inter-subjectivity facilitated by the COP.

Another aspect of the care home COP's role in learning is highlighted by the way the individual worker interacted with it. Within two subthemes of 'interactions with colleagues' workers actively chose who to engage with from within the COP. In **'asking or being given advice'** (2.2) a worker chose who to consult, listen to or whether to provide guidance to someone else. When **'observing others'** (2.3) a worker again chose who to pay attention to and who to ignore. This suggests that, for at least some situations, a worker constructs their own chosen-COP from whom they will learn, rather than being influenced by the COP as a whole. Illeris (2003) critiqued COP theory for subsuming the individual workers' agency within the COP process, and it would seem that my study has explained a way in which individuals are active agents within such a group process. Significantly for this study, the basis of this chosen-COP was not necessarily one rooted in PCC but in several factors including existing relationships with colleagues, the interpersonal approach of a colleague and the worker's interpretation of the colleague's success or otherwise in tasks of care. For example, in Strauss Hill Court colleagues' age and experience were important for some, meaning that someone who was of a similar age and/or with more experience would be brought in to a chosen-COP more easily than someone younger (or older) and less experienced. For others, their own interpretation of 'good care' mattered, with those who valued informality in care approach bringing colleagues with a similar view into their COP and excluding others. More general relationship patterns of personality and interaction history also played their part.

This highlights that considerations of PCC are only one of many factors influencing workers' decisions when creating a chosen-COP grouping. This demonstrates a complex dynamic between

the individual and the social, acknowledged within social psychology, in which neither one is predominant, but instead co-determine what learning occurs (Bandura, 2018). This serves as a reminder that social learning theory generally, and the COP concept specifically, should not be separated from its broader (historical and socio-cultural) backdrop nor its interpersonal-level dynamics (Billett, 1998; Illeris, 2003; Billett, Fenwick and Somerville, 2006). This is not to say a particular composition of COP is directly related to PCC. Instead it is to say that the makeup and shifting nature of a COP must be recognised in any attempt to influence the learning that occurs within it. This means that, to a certain extent, conceptualising the care home COP has to take place at the individual home level (and sometimes the individual worker level) because each care home will have a different COP depending on the external context and internal interpersonal dynamics.

6.2.2 Role of residents

Exploring the staff composition of the care home COP leads to the second area of consideration; the role that residents play within the learning process. Within this study, Resident influences (1b) emerged as another component workers utilise within the what works is what matters process. Whilst not as significant to practice outcomes as interactions with colleagues, the centrality of relationships to person-centred dementia care suggests a potential route of learning that could be further maximised (Kitwood, 1997; Brooker and Latham, 2016; Sabat, 2019). Relationship with residents – as something more meaningful than merely contact – was relevant particularly to learning from **personal feedback** (1bi) and learning about the **stories told** (1bii). It is distinctive because it positions good care practice as cumulative across time rather than a single transaction and it positions the resident as an active agent in care workers' learning rather than a passive receptor of care. This lends itself to the complex and subjective interpretation of good dementia care discussed in chapter 2.1 and explains why simplistic training interventions can fail to achieve PCC as discussed in chapter 2.2.

Strauss Hill Court evidenced **learning from** resident influences significantly more than Sunshine Lodge because the contacts with residents were more varied and the outcome of relationship (**seeing results for residents** 1.1.1) was important to how good practice was conceived. Essentially, resident feedback was a key trigger of learning in Strauss Hill Court but less so in Sunshine Lodge. This links with workplace learning literature that positions receiving and facilitating feedback as important components of learning at work (Evans *et al.*, 2006; Doornbos, Simons and Denessen, 2008; Skaalvik, Normann and Henriksen, 2012; Kyndt, Vermeire and Cabus, 2016). Therefore, this study expands that knowledge to include the role of recipients of care in

providing necessary in-the-moment feedback and, most significantly for dementia care, workers' abilities to interpret it. It also charges those who wish to influence learning to care towards PCC to maximise the opportunities afforded for this resident feedback to be exchanged, interpreted and responded to. Furthermore, this aspect of care worker learning appears to highlight Billett's (2014b) notion of 'inter-subjectivity' again, this time extending it to include care recipients. As I argued in chapter 2, dementia care is a fundamentally social activity in both execution, experience and learning. Therefore, this inter-subjectivity, in which workers and residents co-create care, needs to be recognised and maximised in order to fully integrate and take advantage of learning to care through resident influences.

Moreover, learning through **resident influences** also illuminates an additional sub-element to component 1a '**choices and preferences**' (1bi) that is important to consider: the communal nature of care home living. In this sub-theme workers learn how to balance individual's preferences within the needs of the group. This is a significant dimension to consider because it challenges two concepts prevalent within care home and PCC rhetoric. Firstly, the notion of a care home as analogous to a person's 'own home' is contested by the evidence from this study; no-one's individual home requires the balancing of preferences with the needs of multiple other people whom they have not chosen to live with. Given that learning to care requires workers to learn how to negotiate communal living on behalf of residents (particularly those whose dementia makes it challenging to advocate for themselves), I would argue that failing to recognise this feature leaves care workers unsupported in discovering person-centred solutions to the issue. Secondly, this aspect of learning to care also highlights a potential difficulty for achieving PCC: that supporting individual lives through PCC will inevitably result in conflicts with others' individualised needs (Brooker and Latham, 2016). Neither of these challenges are unsurmountable when enacting PCC, but I suggest that the findings from this study demonstrate the need to be realistic about the communal and unusual nature of care home living and for PCC advocates to explicitly recognise the relational nature of PCC in communal settings. Literature and movements embedded in relationship-centred care are therefore important to embrace and may be particularly effective for some homes because they more explicitly address this contradiction (Bridges *et al.*, 2006; Nolan *et al.*, 2006).

6.2.3 Importance of interpersonal skills

Thirdly, as already hinted at with regards to COP, inter-subjectivity and resident relationships, the learning to care process highlights the importance of interpersonal dynamics and skills (between individuals or across the COP as a whole) particularly within the sub themes of Theme Two and

Component 1b. The extent and quality of learning from **shadowing or senior instruction** (2.1), approaching others to **give or receive advice** (2.2), **observing** others' practice (2.3), **communication and categorisation** (2.4) and learning from residents **personal feedback** (1bi) is to a large extent influenced by the interpersonal skills of workers as they engage in and with these mechanisms. In both Strauss Hill Court and Sunshine Lodge the skills of individuals to critique, advise and explain the work and rationale to others was referenced as necessary for learning to occur. The significance of these skills in both homes was also emphasised particularly when learning experiences were compromised during '**shadowing**' (formal observation of another's practice during induction) with both homes highlighting systemic staffing issues which compromised the effective application of shadowing.

However, Strauss Hill Court appeared to pay significantly more attention to interpersonal issues in three ways which contributed to the PCC observed in comparison with Sunshine Lodge. Firstly, senior staff demonstrated efforts to 'grow' these skills through promoting (formally and informally) individuals who demonstrated them in practice. Secondly, there were daily handovers at shift changeover, led by a senior member of staff in which all were encouraged to participate and discuss relevant care issues for residents, often resulting in an agreed course of action. Thirdly, in general, the senior staff of this service modelled these sorts of skills in interaction with staff at other times, with staff meetings being a forum for debate and joint decision-making. By contrast, Sunshine Lodge's daily handovers did not include care workers, with the team leader being tasked simply to pass on instructions handed down from nurses. This more directive approach was also seen in general staff meetings, in which staff made very few contributions.

The findings from this study concur with the importance person-centred dementia care literature places on interpersonal skills for delivering PCC (Kitwood, 1997; Kadri *et al.*, 2018; Sabat, 2019), and thus the significance of well-being and self-knowledge of staff (Kadri *et al.*, 2018; Cheston, 2019; Keady and Elvish, 2019). However, existing literature does not explicitly relate these interpersonal skills to learning processes. This study presents evidence that how staff relate to one another and residents is a highly important component of facilitating the learning of PCC and thus a necessary consideration. Indeed, I would argue that some of the challenges evidenced in empirical studies to implement PCC could relate to the failure to address these facets directly. The 'lack of fidelity to intervention' often cited as explanation for compromised implementation may well indicate specific interpersonal issues such as poor communication and team work functioning (Boumans, Berkhout and Landeweerd, 2005; Fossey *et al.*, 2006; Chenoweth *et al.*, 2009; Argyle, 2012; Sjögren *et al.*, 2013; Surr, 2018). Furthermore, measures as part of more complex interventions such as increased group supervision (Clare *et al.*, 2013; Rokstad *et al.*,

2017) feedback (Noguchi, Kawano and Yamanaka, 2013) expert practitioners (Fossey *et al.*, 2006; Brooker, Woolley and Lee, 2007; Ballard *et al.*, 2018) and leadership support (Chenoweth *et al.*, 2015) likely improve these interpersonal characteristics and thus influence learning, contributing tacitly to their success.

Workplace learning literature recognises these skills as significant to learning, emphasising the importance of such things as trust and rapport, positive relationships, team working (Newton *et al.*, 2015; Leicher and Mulder, 2016; Mornata and Cassar, 2018), daily opportunities for emergent learning (Collin and Valleala, 2005; Reich, Rooney and Hopwood, 2017), and communication skills (Fejes and Nicholl, 2011) as essential elements of learning from others at work. This literature also articulates the organisational challenges to such features such as pace of work and insufficient resources (Evans *et al.*, 2006; Bound and Lin, 2013). I would argue that my study emphasises that it is important to clearly articulate and address these interpersonal skills if wishing to influence learning towards PCC. Moreover, these have to be displayed every day within opportunities for team involvement in decision-making about care matters. This is particularly relevant in dementia care as resident experience is a consequence not of individual action but of the whole team. This challenges the conception of learning as aimed towards expert practice, replacing it with one of learning to function effectively as a team (Newton *et al.*, 2015; Leicher and Mulder, 2016). Without such skills engaged between staff each day, any efforts to explain, promote and resource PCC could well be compromised at the first learning hurdle; when that effort has to be communicated from one person to the next.

6.2.4 Function of role-modelling

The final feature relevant to the functioning of the community of practice is the role observation and role-modelling play in learning to care. This occurred both formally through **shadowing** (2.1.2), and informally through **observing others** (2.2). The influence on learning played out in broadly similar ways in both care homes and both homes also experienced significant resource constraints on **shadowing** as a formal process. There are two interconnected concepts worth exploring here: role-modelling and mimesis. Firstly, role-modelling is seen as a particularly powerful way of learning because it links together an action or behaviour with its associated attitudes, values and (crucially) outcomes, providing the learner with an aspirational model to achieve or avoid (Bandura, 2018). In my study, this mode of learning was explicitly recognised by individuals and management through formalised **shadowing** and the agency of individuals in deciding who to mirror informally in their workplace. Furthermore, Strauss Hill Court showed

more consideration of the impact of role-modelling, by taking steps to foreground workers who were good role models for PCC notwithstanding resource constraints.

However, I would argue that overall, role-modelling as a route to learning was conceptualised insufficiently within the care homes, something explicitly encouraged by a focus on shadowing within induction standards and the Care Certificate as the route for formal learning in the initial stages of work (Skills for Care, 2010, 2019; Health Education England; Skills for Care; Skills for Health, 2014). It is not that this focus is incorrect, but that it does not simultaneously address the complexity of other learning mechanisms in the care home. This absence may well create an over-concentration on this one route, neglecting the influence of other learning processes (such as **what works is what matters**) and failing to recognise the triadic nature of learning behaviour that Bandura articulated. This triad invokes inter-personal and environmental factors alongside individual agency as determinants of learning behaviour (Bandura, 2006). Indeed, this over-focus on individual agency is replicated in interventions to improve PCC that focus only on changing one aspect of this triadic model (individual workers' skills and knowledge) as discussed in chapter 2.2.

Therefore, role-models are significant within learning to care but they are not sufficient unless accompanied by focus on the other processes occurring, such as the reflection involved in **seeing results** discussed earlier. Billett's (2014a) notion of 'mimesis' - a process of continual observation, listening and imitation that is prompted by simply being in the workplace - is a useful addition here as it emphasises not only the constant potential for role-modelling influence but also the intangible nature of much that is picked up whilst engaged in the embodied experience of doing work (Billett, 2014a; Chan, 2015). Therefore, in order to make best use of learning by role-modelling and ensure its influence towards PCC, I would suggest that the alternate, informal learning processes need to be explained and utilised alongside role-modelling.

6.3 The dominance of informal learning for dementia care

Both Theme One, its three components and Theme Two show that learning to care in the care home took place primarily through processes that are not specifically focussed on or designed for learning. Therefore, if one wishes to influence the practice that is learned, awareness of and focus on these non-formal mechanisms is vital. This lends weight to my argument throughout this thesis that the narrow focus on education and training (formal learning) to improve practice is unwarranted. Indeed, workplace learning research has long identified the powerful effect of non-

formal mechanisms precisely because they are embedded in day-to-day practice, and as such validated by their practical usefulness for workers (Rogers, 2003; Marsick *et al.*, 2009; Billett, 2014a). The three sub-themes of '**what works is what matters**' demonstrate routes of learning that occur when workers are engaged in the practice of 'doing work', rather than 'doing learning': **Seeing results** (1.1) of the actions they take; **negotiating conflicting pressures** (1.2) to an acceptable solution, and responding to the unpredictability of being **thrown in the deep end** (1.3). Moreover, **Resident Influences** (1b) on learning through utilising **personal feedback** or **choices and preferences** (1bi) and **Interactions with colleagues** (Theme 2) both highlight the hard-to-articulate and subtle activities of engaging in relationship with another person which is best described as incidental learning; learning that occurs when a person is exclusively focussed on a task (Rogers, 2003; Marsick *et al.*, 2009). In addition, a care worker's use of **personal resources** (1a) mining **previous experiences** (1ai) or **values** (1bii) to apply in their daily work implicates the role of tacit knowledge use through implicit learning. Manuti (2015) argues for empirical studies to better describe learning events occurring along the spectrum of learning types outside of formal learning. I propose that this study answers that call by detailing the varied informal learning evident within the learning to care process. These are: socialisation and performance; trial and error; problem-solving; reflection; effects of language; tacit knowledge in implicit learning; and formalising informality.

6.3.1 Socialisation and performance

Firstly, socialisation and performance learning is implicated by the sub-theme of **seeing results** which accounted for the most frequent learning seen across both homes. Socialisation occurs whilst workers engage in the mundane activity and interactions of their day-to-day work and it determines the way workers understand their purpose and situations which arise (Rogers, 2003; Eraut, 2004; Marsick *et al.*, 2009). By performing the job, workers master organisational processes as well as the technical actions required (Boud and Middleton, 2003; Eraut, 2007; Billett, 2014a). Within **seeing results**, 'doing work' involves an active process of responding to a situation and judging the outcome. In so doing, workers draw on their workplace-specific cultural knowledge of what counts as success: avoiding negative responses from residents at Strauss Hill Court and fulfilling expectations of the role at Sunshine Lodge. The success or failure of a worker's actions in this regard then becomes part of the cultural knowledge for that worker and others in the team. It is this socialisation through performance that accounts for the different care actions that occurred and were perpetuated in each home. A significant change in care practice was prompted by a change in the situation faced or a change in the cultural definition of success. For

example, because the required 'result' at Strauss Hill Court was based upon '**results for residents'** this led to relatively frequent changes in situations faced by workers, resulting in more variation and flexibility in care practice. In contrast at Sunshine Lodge the cultural definition of success related to the relatively stable concept of '**fulfilling role expectations'**, producing a more repetitive range of practice.

Furthermore, '**seeing results'** also highlights a care home-specific property of socialisation through performance which is important to consider if wishing to influence such learning towards person-centred care (PCC). Residents are contributors to this cultural climate in which workers are socialised. This is something that makes care homes distinct from many workplaces that have thus far been empirically investigated (Eraut, 2004; Billett, 2014b). Therefore, resident experience can be a significant factor in influencing learning if other aspects of that climate permit it. Strauss Hill Court provided subjectively more PCC because resident responses were a central feature through which care practice was learned. In Sunshine Lodge, however, resident responses were far more limited in their influence because '**fulfilling role expectations'** (relating to tasks of the role rather than well-being) dominated.

Establishing or maintaining this foregrounding of resident perspective is by no means a simple task, particularly as dementia progressively compromises the ease with which residents express their well-being and ill-being, thus requiring more sophisticated interpretation by staff. However, understanding this mechanism of influence is important because assessing how well residents with dementia are truly integrated into this '**seeing results**' process in a care home is a starting point for influencing learning towards PCC. This is beyond tokenistic attempts to represent residents in recruitment or training, but about their (highly varied) interactions and behaviours being central to activity in the home and the abilities of staff to interpret and respond. It may seem redundant to say that PCC is achieved by placing the resident at the centre of home life. However, I would assert that '**seeing results**' provides insight into precisely how they need to be integrated in order to truly affect care outcomes via this influential route of learning. This is not as simple as a care home focussing on PCC, but about a very practical understanding of what is important for each resident. Strauss Hill Court achieved a level of PCC with a focus on reducing negative emotions. What would have been achieved had their focus been on a wider understanding of well-being?

6.3.2 Trial and error

In the second instance, the sub-theme of '**seeing results'** explicitly draws out **trial and error** (1.1.3) as a way to learn dementia care but it is also implicated within the other sub-themes; trial

and error forms part of '**negotiating conflicting pressures'** (1.2) and being '**thrown in at the deep end'** (1.3). This is not surprising as it is a common and useful form of learning (Gartmeier, Gruber and Heid, 2010; Teunissen, 2015; Haemer, Borges-Andrade and Cassiano, 2017). However, it appears to take on a particular importance in my study because the unpredictable nature of dementia makes trial and error a frequent occurrence and learning from both positive and negative outcomes significant and necessary. It also occurred more frequently within Strauss Hill Court where care practices were more flexible, suggesting that trial and error may be a significant component of achieving PCC. This would concur with my argument in chapter 2.1 regarding the subjectivity of PCC and the flexibility and complexity required for its practical implementation.

The seemingly inevitable connection between the unpredictability of dementia and learning from trial and error therefore necessitates that this learning be acknowledged when it occurs and facilitated towards good care outcomes. Without this explicit focus and effort there is a risk that either trial and error is discouraged when it is necessary or the learning that arises inhibits good care. For example, care practice at Strauss Hill Court often showed variety in engagement with residents and staff openly discussed 'trying' a different approach on many occasions; with unsuccessful outcomes greeted by fellow staff with the same good humour as successes. However, at Sunshine Lodge the activity co-ordinator spoke about negative responses to suggesting something new and unsupportive interactions with care staff. These care staff showed little propensity for trying something new within everyday care practice, unless it was encouraged by senior members of staff. This led to only a limited range of responses observed for residents living with dementia and a predictability to care which did not always achieve well-being.

Existing workplace learning literature emphasises the need for a workplace climate that is open, safe and not blame-oriented (Leicher, Mulder and Bauer, 2013; Leicher and Mulder, 2016; Rausch, Seifried and Harteis, 2017) to enable individual and organisational learning from mistakes. However, I would suggest that the concept of trial and error evidenced in my study extends that conceptualised in the literature because it shows trial and error learning as an essential way of working, as opposed to a by-product of mistakes aimed at preventing future errors. Trial and error learning in this study sees negative knowledge (what not to do) as equally important as positive knowledge. Discovering what not to do for a resident shaped care practice as much as what was liked or successful. This type of trial and error learning certainly requires a blame-free climate but it also requires team interactions and norms of practice that explicitly encourage experimentation and accept that 'getting it wrong' is not only okay but also expected. This was the case at Strauss Hill Court but not at Sunshine Lodge.

6.3.3 Problem-solving

The third example of informal learning present within the learning to care process is problem-solving. Problem-solving is generally subsumed within socialisation/performance in workplace-learning literature (Eraut, 2007; Billett, 2015; Takase, Yamamoto and Sato, 2018). However, within the 'what works it what matters' process it appears to hold distinct characteristics justifying a dedicated focus. Two of the three sub-themes are predicated on problem-solving: '**Thrown in at the deep end**' (1.3) arises from evidence that unpredictability (and solving problems it presents) is a fundamental and inevitable part of dementia care. Additionally, '**negotiating conflicting pressures**' (1.2) is, at its core, about solving the dilemmas that are an everyday part of dementia care and care home practice.

Workplace learning literature highlights that change, uncertainty or unpredictable work all present critical 'disjunctions' for workers, placing expectations and reality at odds and requiring problem-solving (Marsick *et al.*, 2009; Hetzner, Heid and Gruber, 2015; Takase *et al.*, 2015). My study would suggest that these disjunctions are actually the core of care work itself, rather than an occasional or unusual event. This links back to my discussion of the subjectivity and complexity of concepts at the heart of PCC, and the challenges this presents for implementation as addressed in chapter 2.1: If PCC were a straightforward notion to understand and apply in practice it is unlikely that learning to care would evidence problem-solving as frequently, because the solution for a resident would be obvious. Thus, accepting this ubiquity and understanding the nature of the disjunctions faced each day is central to effectively supporting workers to learn to care and influencing that learning towards achieving PCC. Furthermore, characterising care work as an active 'problem-solving' type of work in this way moves away from the competency approach common in care work and discussed in chapter 2.3.

Moreover, this would suggest an explanation for the failure or muted impact of many training-only interventions, as discussed in chapter 2.2. Training alone, by its very nature, seeks to 'simplify' PCC work into discrete elements that can be passed from one person to another and then applied. This is juxtaposed with the apparent nature of care work itself and thus can have only limited effect. However, interventions that do more than training may also influence the nature of problem-solving in the home (as opposed to only the knowledge or skills brought to bear by a staff member) and thus be more impactful. For example, an intervention that (alongside training) places an expert within a home (Fossey *et al.*, 2006; Lawrence *et al.*, 2016) or reconfigures the work roles of staff or external professionals (Brooker *et al.*, 2011a; Brooker *et al.*, 2015) could be altering the disjunctions encountered as part of care work and thus the learning that takes place.

These issues point towards the ways in which problem-solving learning can be affected towards good care outcomes and prevented from contributing to learning poor practice. Firstly, it is important to identify the nature of conflicting pressures faced by care workers so that their source can be pinpointed and addressed. For example, in Strauss Hill Court a conflicting pressure arose when a residents' freedom of movement clashed with the need for renovation work in her usual space. This was able to be resolved by staff in a person-centred way in part because the conflict had been anticipated and its nature altered through additional staff on duty and flexibility to usual routines. Without such anticipation and action, the solutions available would not have been able to be as person-centred.

The nature of some of these conflicting pressures are described within the literature as 'dilemmas' of care work (Hertogh *et al.*, 2004; Manthorpe *et al.*, 2010; Kartalova-O'Doherty *et al.*, 2014). However, based on this study, dilemmas would appear to be highly contextual and thus in order to affect learning appropriately it would be necessary to explore the conflicting pressures specific to each care home. For example, Strauss Hill Court evidenced a conflict regarding expectations of independence that was not present at Sunshine Lodge in part because of the higher dependency of its resident group. Specifically identifying the dilemmas relevant in a particular care home will enable more focussed support for workers to resolve these conflicting pressures in person-centred ways. Moreover, it would also illuminate whether these conflicting pressures are contributed to by the structural factors discussed previously or by resource limitations, (such as poor staffing or lack of equipment). I would suggest that the presence of problem-solving learning through **negotiating conflicting pressures** may be particularly prevalent in poorly-resourced work environments because this increases the likelihood of a mismatch between expectations and capacity. In such environments, the extent to which PCC can be achieved solely by focussing on staff learning (of any kind) is limited.

The second way in which problem-solving can be influenced towards PCC would be to work towards making the '**deep end**' (1.3) shallower: supporting staff and whole staff teams to identify dilemmas inherent to achieving PCC for each individual and critically examine the solutions (past, present and future) on offer. Essentially, this is about explicitly acknowledging the complexity of work in dementia care and facilitating the critical thinking skills and team resources required to do it well. Whilst elements of this might be achievable through training, I would argue that this study suggests a more effective route might be to develop on-the-ground strategies and skilled facilitators of critical reflection such as illustrated by the action-research exploring 'mental-health huddles' (Wagner *et al.*, 2014).

6.3.4 Reflection

All of the sub-themes of Theme One and its components of **personal resources** (1a) and **resident influences** (1b) implicate reflection as a significant component of learning to care. Indeed, the other forms of informal learning discussed thus far are also reflective processes at heart. They are all means of reflection-in-action arising from the worker's processing in the midst of a situation (Schon, 1991). My study therefore elaborates on the specific factors that come into play within dementia care work, depending on the circumstances of the worker, resident and care home in any given situation. It is not surprising that reflection should occupy such a prominent space within care workers' ways of learning; it is identified as being a significant form of learning in other 'caring', people-focussed professions such as nursing and social work (Kyndt, Vermeire and Cabus, 2016; Ryding, Sorbring and Wernersson, 2018; Takase, Yamamoto and Sato, 2018). However, what is noteworthy is the predominance of informal reflection-in-action as opposed to the – arguably more sophisticated – examples of reflection-on-action; considering situations after the fact, addressing feelings, actions and outcomes in a potentially more systematic way (Schon, 1991; Moon, 2000; Gibbs, 2015). Learning through reflection within my data was very much subsumed within other more action-oriented events, with very few explicit references made to it in practice.

This predominance is a result of the unpredictability and complexity inherent to achieving PCC for people living with dementia that I outlined in chapter 2.1. It may also mirror the absence of formalised reflective practice education within care work curricula in comparison to the pre-qualifying curricula of caring professions[12] such as nursing and social work. This indicates a way in which learning by care workers can be influenced towards PCC practice. This could be achieved by explicating the circumstances of reflection that does take place (as I have done here) and creating more opportunities within daily work to bring such reflection under explicit attention. Here, the existing literature indicates the environmental factors which maximise the benefits from reflective practice: creating temporal spaces for reflection (Liveng, 2010; Kubiak and Sandberg, 2011); providing opportunities for feedback (Fowler, 2008; Takase *et al.*, 2015; Kyndt, Vermeire and Cabus, 2016; Sparr, Knipfer and Willems, 2017; Takase, Yamamoto and Sato, 2018); utilising regular opportunities such as handover (Reich, Rooney and Hopwood, 2017); and supporting

[12] Again, I am uncomfortable with the distinction often made between 'professionals' and care workers because of the implicit value and skill inferences. Nonetheless, it is an accurate word to differentiate between roles that require specific pre-requisite skills, knowledge and qualifications and those, such as care work, which do not.

more formalised activities such as critical incident groups or debriefing facilitated by skilled individuals (Hetzner, Heid and Gruber, 2015).

These measures illustrate the interconnection between informality and formality in learning, showing that informality is not synonymous with uncontrollability. The reflection-in-action informal mechanism can be 'formalised' (and thus influenced) through the environment and approach taken. Moreover, I would argue that, whilst it is not explicitly referred to in multi-factorial training interventions, the attention on reflection that I suggest here may well be achieved as a by-product of intervention elements implemented such as improved staff supervision and in-house experts (Clare *et al.*, 2013; Brooker *et al.*, 2015; Lawrence *et al.*, 2016; Ballard *et al.*, 2018). This suggests that the success of such interventions may be attributable in part to their unintentional impact on care worker informal reflective learning via '**what works is what matters'** and thus this needs to be incorporated into future design of interventions.

Furthermore, and most significantly for person-centred dementia care, the role of resident influences on care worker learning offers an opportunity to consider the ways in which residents are involved or represented within reflective processes. This would suggest that improving skills and methods through which resident reactions, well-being and ill-being are identified, interpreted and communicated to all interested parties (regardless of the impact of their dementia) is a pre-requisite to effectively engaging resident perspectives in these processes. This is a developing area of theory and practice within PCC as awareness of the variety of communication abilities and importance of directly involving people living with dementia grows (Brooker *et al.*, 2011a; Sabat, 2019; Surr, 2019). Additionally, this acting on this opportunity will require consideration of the impact of this enhanced resident involvement on the '**negotiation of conflicting pressures'** inherent to learning through '**what works is what matters'**. Increasing resident input could result in learning of care practice that is supported by resident outcomes but that contradicts other perspectives, such as conceptualisations of risk.

6.3.5 Effects of language

The final types of non-formal learning appearing with learning to care processes fall into the category of unconscious learning; learning that occurs not only without intent, but also without awareness (Rogers, 2003; Marsick *et al.*, 2009; Illeris, 2011). Talk by care workers or about care work is implicated throughout the whole process of learning to care because language is a basic tool used to navigate each of the themes. However, the role language plays within Theme Two's subtheme **communication and categorisation** (2.4), emerged as particularly significant. Here, literal aspects of care work were learned simultaneously with encoded meanings and categories.

Indeed, there appeared to be an unquestioned conflation of person and task within the shorthand used to instruct and explain work tasks and to describe the environment. Essentially this language became a vehicle through which the **cultural knowledge** (1c) was imported into the day-to-day learning process of 'what works is what matters'. Because of this, whilst the subtheme was evident in both care homes it resulted in different care practices because workers interpreted these encoded meanings through the cultural lens of their own care home. This was observed more commonly at Sunshine Lodge and this was perhaps because the influence of this language was understood explicitly by senior staff at Strauss Hill Court in relation to written communication. This suggests a possible connection between the use of such **shorthand** and **categorisation** and less person-centred practice. Moreover, this indicates that language may be an unappreciated and untapped resource for influencing learning that occurs within the care home.

Surprisingly, given widespread constructionist roots, workplace learning literature does not often explicitly address the ways in which language choice influences learning although it is an inescapable aspect of most formal and informal learning events. However, a few studies are noteworthy particularly in relation to my findings. Collin (2008) identified that workers' categorisation of tasks implicitly communicated values and beliefs about those tasks. Beckett (2001) highlighted that in a dementia care unit staff communicated about resident behaviour in a way the both described and transmitted the relative value of responding to it. The use of **shorthand** and **categorisation** essentially implicates 'tacit knowledge' where a worker draws on 'common sense' or taken-for-granted knowledge to interpret the meaning of this language (Eraut, 2000; Hager, 2000; Marsick *et al.*, 2009). This concept has been investigated within workplace learning studies and identified as a potential route for poor or insufficient learning, at least when it is not explicitly addressed (Eraut, 2000; Avby, 2015; Weinberg, 2015). Taken together with my findings these would strongly suggest that certain communication strategies influence learning practice and this is particularly significant when taken together with theoretical conceptualisations of PCC that stress the importance of language used to describe people living with dementia and its role in societal change (Power, 2010; Brooker and Latham, 2016; Oliver and Guss, 2019; Surr, 2019). I would therefore argue that my study urges interventions focussed on improving PCC to extend the considerations of language beyond how people living with dementia are described to encompass the way in which their needs, day-to-day tasks of care and the environment are communicated. Again, this is not to prescribe specific words or models that will create PCC, but to emphasise the need for reflection on the meanings transmitted within commonly used phrases or descriptions and how they may play out uniquely in each care home.

6.3.6 Use of tacit knowledge through implicit learning

Both sub-themes of **Personal Resources** (1a) show that worker applies highly individualised knowledge to the emerging situations of 'what works is what matters' learning process. Through **previous experiences** (1ai) a worker learns by drawing on knowledge or skills they possess from similar past occasions. Through **values** (1bii) a worker learns by applying their own perspectives to situations. These all implicate tacit knowledge. This type learning is challenging to articulate because it is highly subjective and relates to the emotional and relational frameworks through which a person interprets the world (Collis and Winnips, 2002; Marsick *et al.*, 2009). Crucially, Eraut (2000) highlights that such 'common sense' knowledge is often taken-for-granted and used habitually by a person because it 'works' for them. In particular, it is drawn on when a worker does not have the time, ability or desire to try out alternative strategies. These situations often occur within busy or under-resourced professions (Eraut, 2004; Avby, 2015) and so its relevance to care work is significant.

This study's findings help to illuminate the ways in which tacit knowledge is drawn upon within learning and it elucidates where such knowledge comes from (previous work, work role models, and personal experience). It highlights the specific language in use to signify its application: '**what I would like**' and '**it's just who you are**'. This is significant because it identifies the 'what' and 'how' of implicit learning within learning to care; a vital step in order to influence it towards PCC. It would be tempting, especially in light of the PCC literature, to conclude that the role of tacit knowledge in learning to care indicates that there are certain 'types' of people and experience that are preferential pre-requisites for care workers. For example, Kitwood (1997) himself identified a level of 'moral development' required for care workers and others have elaborated this to highlight significant issues around recognising personhood (Kadri *et al.*, 2018), mental health (Keady and Elvish, 2019) and implication of attachment experiences (Cheston, 2019). However, I would suggest that whilst issues of recruitment and training are important, and the associated consequences of a societally undervalued, unsupported and transitory workforce must not be ignored, the findings presented here would suggest that tacit knowledge is not immutable. Therefore, opportunities to use, challenge or reframe it are available and important to consider. To ignore these possibilities in favour of exclusive focus on worker characteristics (through recruitment, qualifications and training) ignores the inherent interaction between individual and context that is at the heart of doing work and learning to work (Billett and Somerville, 2004; Somerville, 2006).

Hager (2000) argues that it is possible (and crucial) to influence such implicit learning through making explicit the times tacit knowledge is drawn upon. Empirical research has identified

strategies that achieve this, such as high level of day-to-day involvement of managers and explicitly recognising and maximising occasions when a workers' private experiences overlapped with their work (Evans *et al.*, 2006; Fuller *et al.*, 2007; Ahlgren and Tett, 2010). Significantly for this study, the indirect way in which personal resources have effect via the 'what works is what matters process' suggests several key mechanisms through which it can and should be affected towards PCC including reflection, role-modelling, and considering the consequences of structural decision-making such as composition of work teams and tasks as discussed previously. The role reflection plays in exposing and utilising tacit knowledge is worthy of further note because those reflective opportunities will need to coincide with the occasions when tacit knowledge is employed. In so doing, the tacit knowledge used can be brought into conscious awareness, critically examined and shared if desirable or challenged and modified if necessary. Without such explicit processing there is a risk that workers' tacit knowledge remains unquestioned and rooted in the unknown of individual's experience.

For example, at Strauss Hill Court, I identified a significant piece of tacit knowledge: 'you shouldn't get too close' which workers used (and expressed ambivalence about) when considering '**what I would like**' (1aii) as a way to learn to work with people living with dementia. For a manager or mentor such a phrase should prompt a reflective event to uncover where that knowledge originated, how it impacts practice and thus what needs to be affirmed or changed to achieve PCC practice. 'I shouldn't get too close' may stem from previous employment experience, the guidance of a role-model, the person's identity as a 'professional', or from the emotional cost to workers of investing in residents. If it inhibits PCC, creates challenges for workers, or disagreements with a course of action this can then be addressed by re-framing the old knowledge or ameliorating the emotional cost. This cannot happen until the tacit knowledge is identified and addressed through reflective activity. This reflective process is by no means an easy one to facilitate or experience, and as such the time, resources and skills it takes to enable it should not be underestimated. However, I would argue that my findings suggest it is necessary if advancing PCC for people living with dementia in care homes is desired.

6.3.7 Formalising informality in learning to care

In highlighting the myriad methods of informal learning within the learning to care process, the resulting complex picture can seem unwieldy. However, it is also important to note the ways in which more formal efforts to shape learning co-exist with informality and thus could be capitalised on. Whilst Theme Three (training) is an exclusively formalised aspect of the learning process, Theme Two (interactions with colleagues) includes both formal and informal aspects.

Moreover, these themes form the cultural knowledge (1b) brought to bear within Theme One's day-to-day learning, thus importing those co-existing formal and informal influences. This simultaneous informality and formality is something affirmed within workplace learning literature (Malcom, Hodkinson and Colley, 2003; Eraut, 2007; Marsick *et al.*, 2009; Billett, 2014b; Manuti *et al.*, 2015; Kyndt, Vermeire and Cabus, 2016; Clardy, 2018). This study therefore adds to this body of work by articulating specific ways in which this dynamic relationship exists and can be influenced within care homes.

With regards to interactions with colleagues, three out of four subthemes related to informal processes of learning, with only the first being formalised. However, the formality of being **instructed by senior staff** (2.1.2) and of **shadowing** (2.1.1) occurred at crucial points: the beginning of a worker's role and at regular points throughout the day. This enabled, in both care homes, formalised opportunities to be utilised to influence outcomes of informal opportunities, showing their interconnection and, crucially, affecting the content of the cultural knowledge workers imported. In particular, Strauss Hill Court used formalised occasions such as handover or written instructions to affirm the desired COP, facilitate productive interpersonal relationships, role-model appropriate practice and utilise appropriate language. In doing so, this ensured that these factors were a constant mediator of informal mechanisms and their effects. As these embodied some aspects of PCC, it was PCC that was present as a mediator. For example, inviting team discussion of care issues opens up the range of people from whom a worker can choose to **observe** (2.3) or **seek advice** (2.2) from and identifies those who appear to be doing it 'right' in this care home. Without such efforts, as Sunshine Lodge illustrated, formality was less able to influence the outcomes of informal mechanisms. For example, by excluding care workers from handover, this formal mechanism re-constituted a COP for care workers that was limited and inflexible, failed to encourage interpersonal skills across the different teams or role-model certain practice and failed to demonstrate alternative uses of language in the home.

Further to this issue, whilst Training (3) was the least influential of the themes, it was not insignificant. Its influence on practice was an indirect one, as it was drawn on (or not drawn on) within the informal learning of 'what works is what matters'. Therefore, if training is to maximise its influence, its connection through these informal processes needs to be recognised and acted upon. The sub-themes of training illustrate that this was only partially achieved in the two care homes in this study, with training often being viewed as disconnected from the reality of **care** (3.2),or influencing only certain specific **gatekeeping tasks** of practice (3.1) or in only marginal ways. Strauss Hill Court showed a more sophisticated **application** of training (3.3) by 'activating' it through supervision or eliciting suggestions from training attendees. However, this did not

maximise what could have been achieved had learning to care been better understood. This study would demand a re-visioning of training and its interaction with informality in order to maximally influence PCC.

This state of affairs is unremarkable within the workplace learning literature in which the social dimension of learning is acknowledged: The social nature of both work and learning mean that any training will be filtered through the prevailing COP and the associated structural and organisational factors (Lave and Wenger, 1991; Evans *et al.*, 2006; Lave, 2009; Jarvis, 2010; Billett, 2014a). Moreover, this body of work also identifies specific features of workplaces and work that aid transfer of more formal education efforts into practice, such as reflective opportunities (Marsick *et al.*, 2009; Manuti *et al.*, 2015), feedback (Yen, Trede and Patterson, 2016), problem-solving (Eraut, 2004; Collin and Valleala, 2005) and an orientation towards development as opposed to competency (Evans *et al.*, 2006). These reflect the non-formal ways of learning to care highlighted previously

Nonetheless, the disjunction between training and real-life learning demonstrated in this study brings into stark relief the continued focus on formalised training within the care home sector. As I highlighted in chapter 2.3, formalised training dominates the current regulatory and good practice frameworks and fails to sufficiently articulate the ways in which learning occurs and mediates the impacts of training (Health Education England; Skills for Care; Skills for Health, 2014; Skills for Care, 2016, 2019; Care Quality Commission, 2017; Skills for Health, Health Education England and Skills for Care, 2018). Perhaps the disjunction here is caused by a conflation of what can be specified, simplified and measured with what is influential. Moreover, this conflation may have been appropriate in order to transform the unregulated sector of the 20th Century into one standardised and regulated, and to skill a workforce in relatively non-complex care giving. However, care within residential care settings has become significantly more complex over past decades because of the increased dependency, co-morbidities and most significantly the dementia profile of its resident population. I would suggest that this study is a starting point for explicating the complex picture of learning in care homes within this very different context and the shift of focus required to maximise influence towards advancing PCC.

This argument is reinforced by the experiences of implementing PCC and training interventions as discussed in chapter 2.2. Training in PCC and other subjects often showed only qualified impact, with success increasing as interventions became more complex and involved aspects other than training. I would suggest that this is because those training-only interventions affected only one aspect of learning (individual staff knowledge) and neglected the mediating impacts of the

workplace and more impactful informal learning; often blaming them indirectly for the lack of impact in the short or long term (Aylward *et al.*, 2003; Stolee *et al.*, 2005; Lyne *et al.*, 2006; Chenoweth *et al.*, 2018). The multifactorial interventions introduced training but also affected other factors in the workplace, inadvertently activating the processes of learning to care through expert practitioners, dedicated time for implementation and reflective opportunities (Fossey *et al.*, 2006; Brooker and Woolley, 2007; Lawrence *et al.*, 2016). Furthermore, recent reviews of effective dementia training suggest that the most impactful training includes (amongst others) activities that: encourage application to work situations; engage learners in practice-based problem solving; and tailor training to the setting and job role (Irving *et al.*, 2017; Surr and Gates, 2017; Surr *et al.*, 2019). My study would suggest that the reason these aspects are significant for training effectiveness is that they tap into the learning that is actually occurring informally whilst doing work through processes such as reflection and problem-solving.

Again, this is not to dismiss training and its influence altogether but instead to articulate the complexity of what occurs at the care home level. This serves to show how interventions, training and the relevant regulations and frameworks can be better influenced towards PCC. Firstly, training should not be viewed as the only or most significant way to transform practice. Instead, to transform practice, all aspects of 'learning to care' need to be explicated, understood and worked upon. Frameworks for induction or developing skills should therefore include guidance about the nature of learning to care alongside specific recommendations or requirements. Secondly, any training considered necessary should be designed and delivered with 'learning to care' in mind, explicitly identifying how the training can be used to improve outcomes from the what works is what matters process. Finally, training may well have a role in skilling those working in and with care homes in the ways in which learning occurs and how it can be facilitated appropriately such as through reflection, problem-solving and making tacit knowledge explicit.

Finally, the role of **care plans** (1bii) as formal mechanism of learning provides a cautionary tale for assuming the influence of formal processes over informal ones. Care plans were identified as a component of resident influences on learning care practice, but this was primarily by the staff who wrote them rather than all those delivering care. Generally, day-to-day influences were more influential in determining care practice learned than care plans. This was particularly true in Strauss Hill Court where care plans (as a temporal snapshot of care) were unavoidably out of date compared with learning through 'what works is what matters.' This is significant because these findings may suggest that the more adaptive and flexible care practice is (a requirement of truly PCC), the less useful care plans become, at least in relation to learning daily practice. This is not an argument against care plans or care planning processes, but instead illuminates that care plans

should not be given too much weight by those wanting to influence *learning* in particular. This is a potential contradiction with the weight given to them by regulation and PCC guidance (Care Quality Commission, 2015, 2017; Brooker and Latham, 2016). It may be more fruitful to view care plans as delineating the boundaries of appropriate care for a person and consider how they can be activated within daily learning processes. For example, in Sunshine Lodge a care plan identified the importance of one resident having access to his bible. However, it took someone listening to the gentleman (1b), asking a colleague (2.2) and watching his reaction to being given it (1.1) for that to be learned as appropriate care practice. The question is therefore not 'is it in the care plan?' but rather 'how is that care plan information made available at the time it is needed?'

By examining each of the themes and components of the process of learning to care, I have identified how this new model fits with current conceptualisations of workplace learning and PCC for people living with dementia. I have highlighted that it underscores the significance of structural factors, meaning that organisational decision-making and culture have a strong influence on learning that occurs, suggesting that this may account for culture's pervasive effect. Many parts of the process also implicate non-formal mechanisms of learning, the composition of the care home COP and a social understanding of learning that is well known within the workplace learning literature but stands at odds with current rhetoric regarding training and improving practice within the care sector. This study therefore adds to that body of knowledge and explicates its workings within the care home workplace, demonstrating that the complex and subjective nature of achieving PCC for people living with dementia inevitably implicates such a relational and non-formal model that allows daily adaptation of what and how care should be.

Furthermore, I have identified particular informal processes present within learning to care that are ripe to be shaped towards desired PCC. These included reflection, feedback, problem-solving, trial and error, tacit knowledge and socialisation and performance, all of which take place within an evolving community of practice of which residents (can) form a significant part. Crucially for a critical ethnography, I have moved beyond this description to articulate how each of these could be managed towards improving PCC, arguing for a re-visioning of how the care home sector conceptualises and acts upon learning to care for people living with dementia.

Chapter 7: Conclusions

In the previous chapter I brought together the findings from my study with existing understandings of dementia care, learning to care and workplace learning, suggesting ways in which learning to care should be better conceptualised and thus influenced towards improved quality of care for people living with dementia. In this final chapter I address the implications of the study for the practical, theoretical, methodological and policy facets of dementia care and care worker learning. These implications include both the direct contributions of this study's findings and the lessons to be incorporated in future research and practice. Following this, I discuss the limitations of the study, ensuring that its contributions and recommendations can be viewed critically and within an appropriate context. Finally, I discuss my future plans to develop this work.

7.1 Practical implications of this study – a System of Learning to Care

The primary focus of the previous chapter was to articulate the contributions my study makes to understanding learning to care for people living with dementia in care homes and consider the ways in which this field could be transformed. Building on this, recommendations can be made to develop a new Learning to Care System for people living with dementia in care homes. These are of relevance to: care home organisations wishing to make the best out of their workforce and improve care practice for people living with dementia; those concerned with delivering training, learning and development within this field; and those developing and implementing interventions designed to improve dementia care. These practice recommendations fall into five categories: cultural aspects and decision-making; staff composition of the community of practice; resident role in the community of practice; influencing informal mechanisms; and the revised role of training. Each category is detailed below with the key practical considerations and questions to prompt transformation towards a new Learning to Care System.

7.1.1 Cultural aspects and structural decision-making

The Learning to Care System recognises that learning to care takes place across micro, meso and macro levels. This is how (often unintended) cultural messages are shaped and incorporated into

day-to-day learning and thus influence care practice for people living with dementia. Therefore, creating the Learning to Care System requires actors to:

- Address definitions of 'success' in the care home overall: what is seen as a 'good result'? Does it relate to resident well-being or to achievement of certain tasks or expectations?
- Analyse how the organisation of work tasks and teams impact on what can be learned. Are opportunities to learn through performing work providing the broadest range of personnel and work types and promoting PCC?
- Identify the conflicting pressures care workers feel they have to negotiate. Can these be reduced or influenced towards PCC outcomes?
- Maximise varied experiences with residents across time and activity type. Are residents being encountered in different situations, times of day and with different intent?
- Enact the features of expansive learning environments (Evans *et al.*, 2006; Fuller *et al.*, 2007) within the day-to-day functioning of the specific care home as well as the wider organisation. How much does the day-to-day functioning of the care home facilitate discussion, reflection, consultation etc?

7.1.2 The composition of the community of practice – organisation of staff

The Learning to Care System is fundamentally embedded within a care home community of practice (Lave and Wenger, 1991) and thus considering its make-up and function is essential to influencing learning towards good outcomes for people living with dementia. Therefore, creating the Learning to Care System requires actors to:

- Maximise the extent to which the COP enhances inter-subjectivity (Billett, 2014) - understanding different roles and experiences and how they fit together to shape resident experience - across care staff and others involved in home life such as nursing staff, activities staff, management, residents and visitors. Do care workers get to see the whole resident experience and understand how different roles contribute?
- Recognise the crucial role that senior instruction and shadowing can play in guiding towards PCC. Can more opportunities for instruction, feedback and reflection be created in day-to-day interactions?
- Take a wider view of role-modelling. It is not only something significant in induction. What are the features of PCC that you want to see every day? How can you use organisation of staff teams/work tasks to maximise these examples?

- Be aware that care workers individually construct parts of their COP. Does the decision-making about work tasks and teams help expose individuals to those who demonstrate PCC?
- Address the interpersonal skills of staff: team building, communication, encouraging critical reflection, giving constructive feedback. What characteristics are being rewarded with influence and promotion?

7.1.3 The composition of the community of practice – role of residents

Within the Learning to Care System, the role of residents is significant to person-centred **dementia care** particularly, because it is achieved through a subjective and evolving process of relationship with residents. This makes residents themselves members of the community of practice, although their influence is facilitated or restricted by the functioning of care home Therefore, creating the Learning to Care System requires actors to:

- Remember that residents can form part of the care home COP. Assess the ways in which organisation of work teams and tasks may maximise or inhibit the range of resident contact staff have. Do care workers get to experience residents in a variety of situations?
- Facilitate resident representation in feedback and reflective activities. How are outcomes for the resident articulated? How frequently are experiences of residents discussed, agreed and reviewed?
- Identify methods for better observing and interpreting resident well-being and ill-being. Do staff have these skills for all residents (particularly those with advanced dementia)? How and when are these interpretations used and discussed?
- Explicitly explore the challenges communal living poses for achieving PCC and support staff to negotiate them. When do staff encounter conflicts between different residents needs and desires? How do they currently go about resolving them?

7.1.4 Influencing informal learning mechanisms

The Learning to Care System inevitably entails a significant amount of informal learning experiences and these must be actively recognised and influenced towards PCC. The flexibility and adaptability inherent to achieving person-centred **dementia care** specifically centres these informal aspects. Therefore, creating the Learning to Care system requires actors to:

Recognise informality as predominant

- Understand the informality of day-to-day learning for care staff and consider it as the most significant influence on learning and development (above training). Can senior staff and organisational decision-makers articulate these day-to-day mechanisms and pinpoint their impact on care practice?
- Do not overestimate the influence of care plans or training to shape practice. How can the most pertinent information from care plans or training be activated when needed in day-to-day activities?

Examine problem-solving and trial and error

- Identify the conflicting pressures negotiated by staff each day. Resolve those that are caused by structural factors such as organisation of work and work teams. When staff decide between different needs/pressures are they able to choose a person-centred solution? If not, what needs to be in place to facilitate this?
- Assess the approach to trial and error in the home and articulate its central role to dementia care. Is experimentation encouraged? How is negative knowledge (what not to do) from experimentation viewed and shared?
- Make the deep end shallower: make explicit the problem-solving and dilemmas that occur each day and encourage critical reflection of past, present and future solutions. How are these situations brought to light and reflected upon on a daily basis?

Maximise reflection and feedback

- Maximise reflective opportunities in the home. Create in-work opportunities for reflection: temporal spaces, routine events, opportunities for feedback and skilled facilitators. What can be done every day to encourage reflection on tasks, problems and resident experiences? What systems are in place to identify and respond to critical incidents?
- Consider skilling certain individuals in the team with reflective practice, critical thinking and facilitation skills. Who in the home shows these abilities already? How can their influence be formalised in either day-to-day interactions or after specific situations?
- Explicitly articulate the individual resident's experience into feedback and discussion amongst staff. Is care work articulated according to completing tasks or resident outcomes?
- Assess how well resident interaction and behaviour are integrated into the way the home views and rewards success. How is 'success articulated/rewarded day-to-day? How skilled are staff at interpreting resident well-being and ill-being?

Consider language use

- Consider the language used to talk about care work in day-to-day interactions between staff? Address any shorthand that may transmit unintentional meanings rather than literally describe. If a new staff member heard staff-to-staff interactions would they know what was communicated, or do they have to 'decode' the message?

Expose tacit knowledge

- Identify situations occurring in the home where appropriate action is considered to be 'common sense' or 'taken for granted'. Explore these further; what is meant by 'common sense'?
- When stand-out examples of good or poor practice occur, take time to reflect with individuals or teams as to why they occurred. What opportunities exist to identify and draw out the tacit knowledge used by staff?

7.1.5 The revised role of training and formalised learning efforts

Within the Learning to Care System, training has a primarily indirect influence on care outcomes. Application of training and other formalised efforts to define and influence practice must consider and adapt to this indirect interaction in order to maximise their effectiveness. Therefore, creating the Learning to Care System requires actors to:

- Consider the connection between training and informal mechanisms of learning. What are the intended outcomes of formalised instruction, shadowing or training? When and how are these being undermined or reinforced in practice?
- Activate learning from training through regular reflective activities embedded within the informal processes of learning: trial and error, socialisation, language, problem solving etc. How do we reinforce the key intentions of training within these day-to-day processes?
- Facilitate informal learning within the workplace to align with desired 'standards' (whether set out in training or more generally). How can we identify and skill up staff to work as role-models, coaches or to lead reflection?
- Commission and plan training on the basis that it must address and work within the themes of learning to care. What are the expected outcomes of this training and how should it manifest in Theme One or Theme Two activities?
- Consider the gatekeeper tasks within training (the training that determine when a person can officially 'be' a worker in the care home). Ensure these include dementia-specific skills such as communication and interpreting behaviour and inter-personal skills such as

critical reflection and constructive criticism. What skills differentiate your care workers from others in the home? Do these mirror key features of PCC for people living with dementia or more task-oriented, mandatory skills?

- Push beyond what minimum standards or frameworks require. How can you recognise and accredit the reflective practice, interpersonal and dementia-specific skills you wish staff to develop?

7.2 Theoretical implications of this study

I believe this study, notwithstanding its limitations, has contributed to the theoretical field in three key ways. Firstly, in describing the specifics of learning by care workers, I have been able to explicate mechanisms of organisational culture's pervasive influence on quality of care and the outcomes of interventions. The structure of work and work teams within a workplace shape the scope of learning experiences that can occur for a worker and thus dictate the likely practice learned. Interventions often introduce elements that alter (often temporarily) these structural factors and thus alter the resultant learning. Secondly, I have described the interactions between formalised efforts to influence practice and informal learning processes that occur with the care home, integrating the workplace learning literature and that focussed on dementia care quality. Thirdly, whilst relationships are integral to person-centred care theory (PCC), these findings demonstrate their importance to the learning of PCC. Relationships with residents and between staff circumscribe the boundaries to how learning takes place and thus what practice is learned.

These three contributions offer several lessons for future theoretical work and practical applications of such theory:

- I call for a better incorporation of care workers' perspectives into theoretical discussions related to PCC for people living with dementia care. Similar to the way representation of people living with dementia in such discussions has transformed in recent years, we should strive to include the authentic voice of care workers and move away from positioning them as subjects or a group adequately represented by others, such as service managers.
- I suggest that this study emphasises the complexity at the heart of an issue such as learning to care. Whilst reaching for theoretical and empirical simplicity is appealing, it does not necessarily serve reality well. Articulating complexity might be a better

foundation on which to build visions and interventions and thus the urge to recommend staff training as the primary response to theoretical developments needs to be resisted.

- The ever-present and unintentional effect of learning processes in the workplace needs to be integrated into interpretations of what may help or hinder interventions to have effect. This would serve to better articulate how and why interventions succeed or fail and move the body of knowledge further.

7.3 Methodological implications of this study

This study was built on a dissatisfaction with the dominant methodological approaches to exploring dementia care, care quality and I believe its findings reinforce my arguments in this regard. My findings have contributed to a conceptualisation of PCC for people living with dementia, care giving, care homes and learning as social worlds packed with context and complexity and with relationships at their heart. Furthermore, this study shows that the dominance of positivistic empirical studies in the field promote an overly simplistic characterisation that obfuscates what is actually occurring, leading to an unwarranted predominance of interventions that lend themselves to positivistic operationalisation such as standardised training programmes. Therefore, this study provides the following lessons for methodological consideration in the future:

- I suggest that there is a need to shift the prevailing perceptions of what constitutes useful knowledge within the context-specific and relational nature of care and care-giving. Methodological acknowledgement of this may be how understanding can be further advanced.
- More broadly, I suggest that the conceptualisation of the social world as a closed system akin to the physical world needs to be challenged. The current dominance of this results in repeated attempts to fit the square pegs of care-giving and learning into the round hole of positivistic methodology.

7.4 Policy and guidance implications of this study

Two overarching factors with implications for future policy and guidance emerge from the practical recommendations I made at the start of this chapter. Firstly, this study articulates clearly the way in which organisational decision-making (and its circumstances) affects and circumscribes

the learning of care practice by care workers. This challenges the predominance of individual worker-focussed interventions to alter practice and implicates systemic approaches to identifying and remedying practice issues, whether at the care home, provider-organisation, regulatory or governmental level. Further to this, the ubiquitous and enduring interaction between formalised efforts and informal mechanisms result in different practice dependent on the individual circumstances of the care home. These issues suggest the following lessons for future policy regarding learning to care:

- The care home needs to be recognised as a unique and 'living' entity requiring individualised attention: what works for one may not be suitable for another. Therefore, regulatory and practice development work may need to be adaptive to this distinctiveness and seek to work with informal learning structures, rather than focussing only on standardised knowledge transmission.
- Initiatives should counter a tendency to characterise care work skills (and thus the learning of them) in overly-simplified and competency-focussed ways. The more complex relational and emotional work inherent to how practice is learned reflects a growing understanding of the complex emotional work inherent to providing good dementia care. A natural desire to offer solutions should not inadvertently misrepresent what good practice entails nor how it is learned. Training interventions may be easy to formulate, justify and fund but this thesis argues that the field is in need of more innovative approaches.
- The importance of adequate resourcing for residential dementia care needs to be acknowledged. Many of the practice recommendations made in this thesis depend upon sufficient staffing, funding and support for care homes and dementia care. This is not to say that organisations and individuals cannot progress towards many of the recommendations I have suggested here, but ultimately, there is a limit to what can be achieved within a system that is chronically underfunded and undervalued.

7.5 Limitations of this study

Having discussed the significance of this study's findings it is important to also address its limitations in order to provide context for the recommendations made. In chapter 3 I addressed the methodological foundations of this study, asserting its qualitative and constructivist perspective. I will not repeat the positivistic challenges to this standpoint here except to say that,

inherent to the findings and recommendations of my study is an acceptance that the social world is constructed and as such drawing generalisations and translation of knowledge beyond that specific social world must be done with caution and awareness of the partial and situated nature of that knowledge (Lincoln, 1990; Carspecken, 1996; Spears, Ibanez and Iniguez, 1997; Brunt, 2001; Rubin and Rubin, 2005).

Nonetheless, the practice of my study illuminated several limitations. Any future exploration of learning to care should aim to address them and any application of findings should be mindful of them. Firstly, both of the care homes studied had a predominantly white, non-migrant and native English-speaking workforce and this was intensified in the individual staff who participated in the study. Whilst this is consistent with other care homes in the area, (reflecting the county more generally) it is not comparable to the residential care workforce as a whole in which non-white workers, minority groups, migrant workers and speakers of English as a second language can be over-represented compared with the general population (Bottery, Ward and Fenney, 2019). This ethnographic study did not aim for representative sampling nor straightforward generalisability. However, this discrepancy is important to note given that experiences of discrimination, migration and working in a second language are likely to impact on a worker's perspectives on care, experience of learning specifically and relationships within the workplace more generally. Moreover, it is notable that the characteristics of participants in these regards matched my own and thus I am mindful that I will not have been exposed to differing perspectives rooted in these alternate experiences and that my own cultural profile may have unintentionally affected the participants recruited.

Secondly, the two care homes that participated fortuitously contrasted strongly in certain dimensions. Had these homes been more similar or contrasted in different ways (such as size or workforce characteristics) it is likely that additional or divergent features of learning may have been illuminated. The picture drawn here and the conclusions stemming from it could thus have been different. Therefore, this model of learning could be advanced and challenged by future studies or, indeed, found to be wholly wrong. I am particularly mindful of this factor as my study's findings broadly mirror a picture that I intuitively thought may exist within learning to care before I began the research. This may simply reflect how well-rooted within care home learning my prior experiences have been, but I cannot ignore the role my own pre-conceptions and approach may have played in producing my findings despite my reflexivity.

Thirdly, I was only able to undertake one interview with a care worker in Sunshine Lodge. Whilst, this reflected something important about the world of that care home, and I did endeavour to

compensate through other data sources and my own reflexivity, it must still be acknowledged as a significant gap in the data. In particular, interviews were an important step in sharing my thoughts and interpretations with care staff and allowing them an opportunity to challenge and reshape them. Therefore, the conclusions I have drawn particularly for that home, may well be skewed unintentionally by my own experiences and those of more senior staff who were willing to be interviewed rather than those of care workers.

Fourthly, both care homes exhibited relatively low turnover of staff, again something that is at odds with social and residential care more generally (Bottery, Ward and Fenney, 2019). This is a feature that is likely to significantly impact learning and one recognised as a substantial challenge to raising the quality of care. Fifthly, as both care homes were drawn from the same local area this may have obscured locality-specific influences affecting learning and quality such as investment in dementia care, availability of training, performance of local services or challenges represented by urban areas or extreme rurality. Sixthly, I was not able to include any family members or visitors as participants to the study because of time constraints and my intermittent presence in the homes (meaning that I did not develop noteworthy relationships with visitors). This means that an important perspective is missing from the study, both in respect of learning by care workers and the quality of life and care of residents living with dementia. This absence is particularly significant because of the challenges the resident participants faced in directly expressing their own views. Finally, whilst I made attempts to share and discuss my findings once they were developed with the two care homes and participating staff, these attempts were not successful with meetings cancelled and key personnel no longer in post. This issue was exacerbated by the length of time between data collection and production of findings because of the part time nature of the study. This means that I was not able to expose myself and the study to the scrutiny and appraisal of those whose experiences and words I had interpreted.

7.6 Future directions

At the beginning of this chapter I detailed the practical steps required to incorporate the alternative conceptualisation offered by this study into a new System of Learning to Care. I have also articulated the broader implications of this study for the theoretical, methodological, and the policy/guidance arenas. I believe these provide a basis from which I can pursue further work in this area, through academic, practical and investigative routes.

Academically, I intend to publish a number of peer-reviewed articles sharing the methodological and empirical insights of my study. This is with the aim of disseminating findings but also to help shift the research agenda in the ways I have suggested previously. True to my practice-based roots I am also planning to integrate my findings, particularly the recommendations I made in this chapter, into the education and practice development work with which I am already engaged through my employment. This will ensure that the power to influence change that comes with new knowledge is in the hands of those best placed to effect such change in ways that are responsive to context. Prioritising this practice-based interaction with those delivering residential care for people living with dementia will also provide important opportunities for me to critically appraise my study's approach and findings on an ongoing basis and in light of varied real-world perspectives.

Finally, in a research capacity, I am interested in exploring the ways that my findings and suggestions can be successfully operationalised into practice. Working together with care provider organisations, care workers and people living with dementia, and being mindful of the limitations to this study, I plan to investigate different methods of influencing the learning process explicated here and assessing their impact on the quality of care practice and outcomes for people living with dementia. There are important questions that need answering for my study to have any significant and long-term impact and these are particularly important to address given the ethnographic and constructivist foundations of my study

- How representative are my findings of the learning processes experienced in other care homes and care settings?
- How feasible are the suggestions I have made for influencing learning to care?
- How receptive are care workers, care homes and care providers to them?
- What external and internal barriers need to be negotiated in order to operationalise my findings?
- Does reconceptualising learning to care result in improvements in the experiences of care workers and the quality of life for people living with dementia in care homes?

I believe that this next step will be the true appraisal of my study, beyond the rigours of doctoral assessment. Producing findings and recommendations as I have done in this thesis is one thing but integrating and putting them to the test on the frontline is quite another. After all, my motivations for undertaking this work were rooted in my own experiences of learning to care early in my career. Therefore, ultimately, the significance of this research study will be in the

extent to which it can aid care workers like myself to learn to care well for people living with dementia.

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Appendices[13]

Appendix 1: Construction of literature review

1. Overall aims of the contextual literature review

- **Establish current state of knowledge**: What do we currently know about learning by care workers for people with dementia working in residential care?
- **Establish contribution to knowledge:** What do we need to know about learning by care workers for people with dementia working in residential care? Why?
- **Justify methodological choices**: What is the best way to investigate what we need to know?

2. Justification for a contextual literature review:

Purpose of the literature review is to establish the state of knowledge in this field as it stands currently, rather than predetermine the concepts to be used in the study. With ethnography it is the setting that defines the concepts to be used, with findings emerging from the field. Therefore, the literature review is concerned with establishing the boundaries of the field.

3. Relevant Electronic databases

Peer-reviewed journals that cover: health and social care, education, organisational culture etc.

- Psyc info
- Psycjournals
- Medline
- CINAHL
- Academic Search Complete
- Ingenta Journals
- SWETWISE
- Emerald Management Journals
- Taylor and Francis Education Complete

4. Keywords and search strings

- Search strings below are the most complex used.
- Search terms were identified in abstracts, as key words often did not capture all relevant articles.

[13] Where appendices include SCREC approved documents they are included here as images. There are a variety of version numbers within these documents and some highlight passages as a result of SCREC requests for changes. The documents included here are those listed in the approval letter from SCREC (included as appendix 10) and used within the project.

- Depending on the sophistication of the database search engines, some simplifications were used.
- Searches were always limited to articles reporting research and those in the English language .
- Following identification of relevant articles, they were examined for commonly occurring citations that and not been identified (usually excluded by date range). These articles were incorporated.

4.a Learning to Care

(learn* **OR** educat* **OR** train*)

AND

("care staff" **OR** "carer" **OR** "care worker" **OR** "care assistant")

AND

(dementia **OR** "care home" **OR** "residential care" **OR** "nursing home" **OR** institution* **OR** "long term care")

NOT

(child* **OR** youth **OR** "family car*" **OR** "informal car*" OR "family caregiv*" OR "learning disabilit*")

Original search - November 2012

Searched (databases: Psyc info, Psych journals, medline, CINHAL, ASC & emerald management journals; Ingenta; Swetwise & Taylor and Francis) using search strings above.

Limited to peer-reviewed journal articles, English language, date range to 2005-2013, and yielded **825** removed duplicates yielded **320**. This list was then examined manually, looking at title and abstract, to produce a final pool of **92**.

Criteria for exclusion at this stage:

- Protocols for trials/research not yet conducted
- Studies not relevant to care homes or care workers (usually related to education of family carers)
- Niche issues in care home that were not specific to dementia care (such as 'bringing the vote to LTC facilities' or 'Art Gallery Access'). Articles were retained when they focussed on older people (not dementia –specific) but related to an aspect of physical or emotional care that could be relevant to person-centred care, (for example; spirituality, sexuality, dental health).

Additional Search - 2018 update

- Search terms for ESCBO host databases as above
- Date range Jan 2013-dec 2018
- Returned **489** articles; **276** once duplicates removed.
- Read through abstracts and titles and **57** in final selection

4.b Dementia care quality

(Dementia **AND** Quality)

AND

("care home" **OR** "nursing home" **OR** "long term care" OR "aged care")

Original Search - March 2013

Searched databases: Psyc info, Psych journals, medline, CINHAL, ASC & emerald management journals; Ingenta; Swetwise & Taylor and Francis) using search strings above.

Limited to peer-reviewed journal articles, English language, date range from 2000-2013, yielded **327** (with duplicated removed). Following manual search of titles and abstracts, this was narrowed to **47.**

Additional Search - 2018 update

- Escbo search using string above in abstracts
- Between 2013 and Dec 2018
- 967 first identified; refined by searching in title **99**, **47** when duplicates removed.
- **22** relevant

4.c Adult and Workplace Learning

Original Search - March 2013

Searched for **"workplace learning"** in title, abstract or keywords: using web of knowledge (Education; health sciences; social work; public work; vocational work). (Limited to post 2000). Returned **1,446** articles. Examined title and abstract for relevance and narrowed sample to **47** relevant articles.

Additional Search - 2018 update

- Searched web of science (new version of web of knowledge) again using same search term narrowed to last 5 years
- Returned 581, searched manually through titles and abstracts to return **58**
- Then read and resulted in: **39**

Appendix 2: Expression of interest care home letter

University of Worcester

Association for Dementia Studies

Association for Dementia Studies
email: dementia@worc.ac.uk
http://ihsc.worc.ac.uk/dementia

Learning to Care PhD Research Project - Expression of Interest

Dear

At the Association for Dementia Studies we are committed to identifying evidence-based practical ways that really help people living with dementia and the people who care for them. Our research with care homes is an important part of this. One of our Senior Lecturers, Isabelle Latham, is undertaking her PhD to explore the different ways in which care workers in care homes learn to care for people living with dementia.

This is a really important area to know more about as a great deal of emphasis is placed on formal classroom training or e-learning and yet we know that significant learning also takes place in other ways through day-to-day work. In order to explore this area Isabelle needs to identify a small number of care homes in which she can spend time observing everyday events and getting to know what living and working in a care home is like for residents and staff.

I am contacting you as a registered manager of a local care home that might be interested in hosting this research. I enclose an information sheet about the project. Obviously this is a big undertaking, but one that could be very rewarding. This is an opportunity to be part of developing understanding about what influences learning by care staff in care homes and this may help other care homes, staff and residents in the future.

If you may be interested, the next step would be to meet with Isabelle to talk through what it would involve for you and your care home. Isabelle is an experienced researcher and already has 15 years' experience of care homes as a care worker, a care home staff trainer and as a safeguarding adults specialist. All discussions would be exploratory at this stage and so an expression of interest does not mean that you are obliged to take part.

If you would like to discuss this further, please contact Isabelle by e-mail: i.latham@worc.ac.uk or Telephone: 01905 542326.

With best wishes

Dawn Brooker

Professor Dawn Brooker,
Director, Association for Dementia Studies

University of Worcester
Association for Dementia Studies

Isabelle Latham, PhD Student

Association for Dementia Studies
University of Worcester
Henwick Grove
Worcester, WR2 6AJ

i.latham@worc.ac.uk
01905 542326

"Learning to Care" Research Project Information Sheet

This care home is taking part in a research project. This leaflet provides you with some basic information about what the research involves and how it may affect you and your home. The research does not directly involve everyone who lives, works or visits the home. If you are likely to be directly involved then I will make sure you know this and provide you with additional information and a chance to tell me whether or not you are happy to be involved. However, even if you are not directly involved, it is important that you know what is taking place.

You should feel free to ask me or the manager of the home any questions you have about the research. My contact details are provided at the top of this page. A photograph of me is provided on posters displayed throughout the home so that you can recognise me when I visit the home.

What is the research study about? This study is exploring how care workers in care homes learn to do their work. I want to find out about the different ways that care workers learn to care for people living with dementia in care homes by talking to care workers and watching how they go about their work with residents living with dementia. This study is part of my PhD qualification.

What will it mean for this care home? One of the best ways to find out about care in care homes and how workers learn to do their job is to spend time observing everyday events in the care home, and getting to know what living and working in a care home is like for residents and staff.

Over the next 6 months I will be spending time in the home observing daily life and finding out about the experiences of some residents and care staff. This means you may see me sitting in the shared spaces of the home, taking part in activities and events and talking to staff, residents and visitors. I will be taking notes about what I see and hear in relation to particular residents, staff and visitors who have been consulted and given consent for me to involve them in the research.

The research should not affect the normal routines and care in the home. If you think that the research is affecting the daily routines or care-giving you should let me or the manager know immediately. I will stop or change the research activities to make sure that they do not affect normal routines or care.

Who will be directly involved? This project focusses particularly on certain residents living with dementia, the staff who care for them and the people who visit them. Not everyone living, working or visiting the home will be involved.

What will it mean for me? If you are likely to be directly involved (participating in observations or interviews) I will speak to you directly, let you know more about the research and give you a chance to tell me whether you wish to take part or not. No one has to take

part in the project and if you do not want to, research activities will not take place when you are present.

If you are not directly involved, you may still see me as I conduct the research in the home. However, I am not recording any information about you. I am not allowed to do this unless I have asked for your permission. You can talk to me at any time (just like any other visitor) and our conversation will not be part of the research. Every effort will be made to ensure that research activities will not affect you.

However, if you do not feel comfortable with this even though you are not directly involved, you should let me know, as the research should not interfere with your normal daily life or make you feel uncomfortable at all. You can tell a staff member, the manager, or myself at any point that you would prefer the observations to avoid you completely. I will then make sure that observations of others do not take place when you are present. In addition, when I am in the home there will be posters displayed in the areas where I am observing and the staff on duty will know that I am observing. This means that you will know where I am and can avoid the observations should you wish.

What will happen to the results of the study? The results of the research will be written up in a final report that is part of my PhD qualification. The results might also be used to write articles, reports or to make presentations. The aim of these will be to help other people understand how care workers learn to care for people living with dementia.

The name of the home, the residents, staff and visitors who take part are not used in the final report. It will not be possible for people who did not take part to identify the home, or any individual who did take part.

Who is organising or funding the study? This study is organised by me, with the support of a team of research supervisors at the University of Worcester. The study is funded by me and the University of Worcester.

Who has reviewed the study? This research project has been reviewed and given a favourable opinion by the Social Care Research Ethics Committee. A research ethics committee is a group of people who review research projects to ensure they protect the dignity, rights, safety and well-being of researchers and research participants.

What if something goes wrong? If for any reason you are not happy about the way the research is being done you may use the contact details below and steps will be taken to rectify the situation immediately

Dr John-Paul Wilson,
Association for Dementia Studies, University of Worcester, Henwick Grove, Worcester, WR2 6AJ. Telephone: 01905 542196

Further information:
If you would like any more information about this study, or there is something that is not clear please contact me, using the contact details on the front page. There will also be a meeting arranged at your care home on:

Please feel free to come along and meet me and hear more about the research.

Isabelle Latham, PhD Student
Association for Dementia Studies
University of Worcester
Henwick Grove
Worcester, WR2 6AJ
i.latham@worc.ac.uk
01905 542326

"Learning to Care" Research Project: manager consent form

		Please tick	
1.	I confirm I have read the information sheet dated 271013 V3 for the study. I have had the opportunity to consider the information, ask questions and have these answered satisfactorily	Yes	No
2.	I understand that my agreement for my care home to participate is voluntary and that I am free to withdraw at any time, without giving a reason.	Yes	No
3.	I agree to the researcher engaging with residents, staff and visitors to the home in the course of the research project . I understand that the participation of each person is voluntary and they are free to withdraw at any time.	Yes	No
4.	I agree to the researcher observing residents and staff who agree to participate as they go about their daily lives and work in the care home	Yes	No
5.	I understand that relevant sections of the data collection during the study may be looked at by individuals from the research team and that anonymised data will be used in analysis and publication of findings	Yes	No
6.	I agree to my care home taking part in the study between _____ and _____	Yes	No

Name of Registered Manager	Date	Signature
Name of Researcher	Date	Signature

consentformmanager V2 220913

Appendix 4: Resident information sheet and consent form

Please remember:

You do not have to take part. It is your decision. If you don't want to, that is okay. You do not have to give a reason. If you do take part and decide that you want to stop, you are free to do so at any time.

Whatever you decide, this will not affect the care you get here.

The Social Care Research Ethics Committee has approved this research.

Thank you very much.

University of Worcester

Learning to Care Research Project

Information Sheet

University of Worcester
Henwick Grove,
Worcester,
WR2 6AJ

01905 542326

Photo of researcher: Isabelle Latham

I am a PhD student at the University of Worcester. My project looks at how care workers learn to do their work. I am doing this research in your home.

What will the study involve?

I would like to see what care is like here for you. To do this I would like to look at some information the home keeps about you and watch the care you receive throughout the day. I will make notes about what I see. I will also ask staff questions about what they do.

This information will tell me more about how care workers learn to do their work with you.

I will be at the home for a few days every week for the next six months.

What will happen next?

If you may like to take part, I will explain the project to you and answer your questions. You can then decide if you want to take part or not.

If you have a close relative they may talk to you about the project to help you decide if you want to take part. You do not have to take part and it will not affect the care you receive.

Will my involvement be confidential?

All information we collect will be kept confidential. I will not use anyone's name when I make notes or write the research report. If I heard or saw something that made me think that somebody could be hurt or in danger, I would not keep this confidential. We would follow safeguarding procedures that could involve reporting this to the local authority.

What if I have a concern?

If you have any concerns or questions, please talk to me or a member of staff. Please ask if you or your relative would like to speak to us. We will arrange to meet you and answer any questions.

Isabelle Latham, PhD Student
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Worcester, WR2 6AJ
i.latham@worc.ac.uk
01905 542326

"Learning to Care" Research Project: resident consent form

		Please tick	
1.	I confirm I have read the information sheet dated 220913 V2 for the study. I have had the opportunity to consider the information, ask questions and have these answered satisfactorily	Yes	No
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason.	Yes	No
3.	I agree to the researcher/s observing me as I go about my daily life in the care home.	Yes	No
4.	I understand that relevant sections of the data collection during the study may be looked at by individuals from the research team and that anonymised data will be used in analysis and publication of findings	Yes	No
5.	I agree to take part in the study	Yes	No

Name of Resident _____ Date _____ Signature _____

Name of Researcher _____ Date _____ Signature _____

In the event that the resident is not able to provide informed consent please complete the section overleaf:

The resident did not appear to be able to provide informed consent about taking part in the research. Below is a description of how he/she responded to discussions about the research

Based on this, and after discussion with his/her personal consultee. I think that

_____ (name of resident) :

1) Did not shown any distress, discomfort or anxiety regarding the research and therefore can be included as a participant (unless they withdraw consent or show distress, discomfort or anxiety at a later stage).

2) Showed some distress, discomfort or anxiety which may be connected to the research and therefore should not be included as a participant.

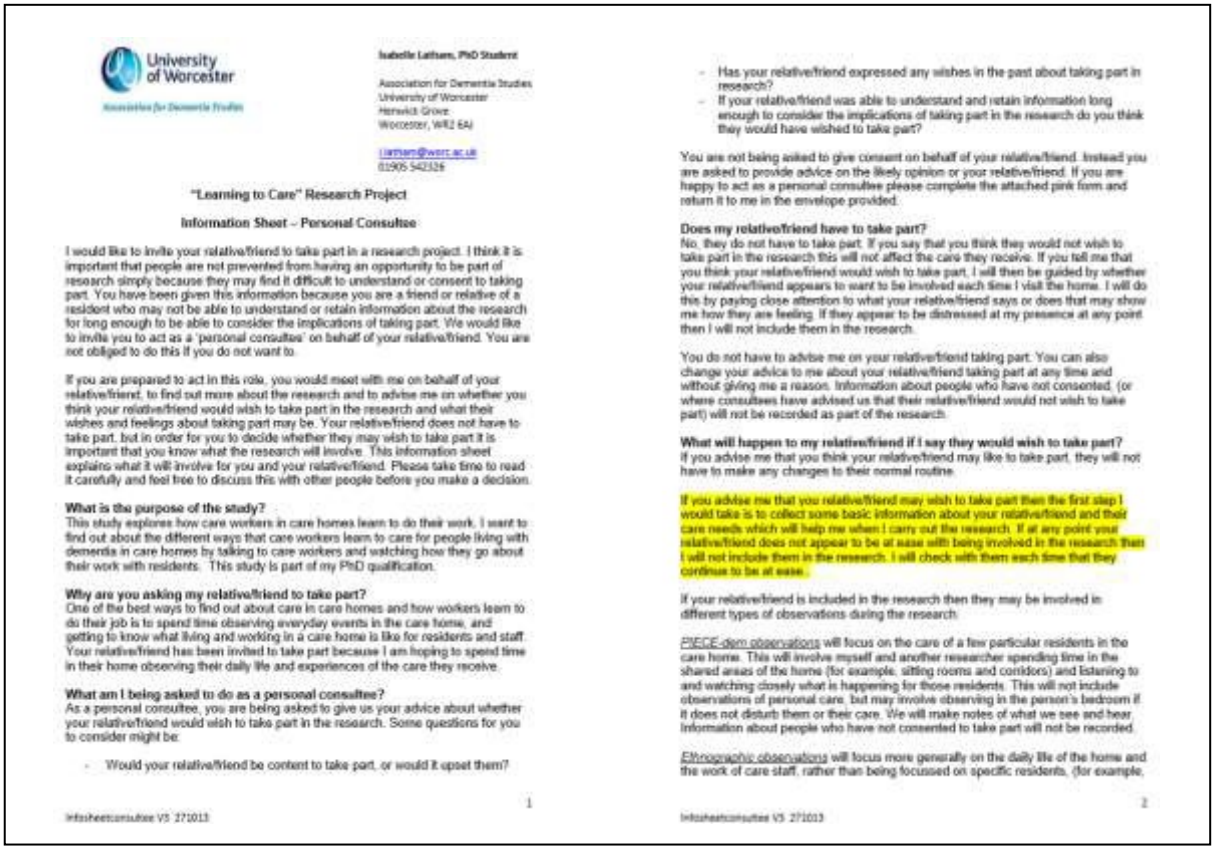
(please tick as appropriate)

Name of researcher _____ Date _____ Signature _____

Name of consultee _____ Relationship to resident _____ Date agreed _____

consentformresident V2 220913

Appendix 5: Consultee information sheet and consent/declaration form



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"Learning to Care" Research Project

Information Sheet – Personal Consultee

I would like to invite your relative/friend to take part in a research project. I think it is important that people are not prevented from having an opportunity to be part of research simply because they may find it difficult to understand or consent to taking part. You have been given this information because you are a friend or relative of a resident who may not be able to understand or retain information about the research for long enough to be able to consider the implications of taking part. We would like to invite you to act as a 'personal consultee' on behalf of your relative/friend. You are not obliged to do this if you do not want to.

If you are prepared to act in this role, you would meet with me on behalf of your relative/friend, to find out more about the research and to advise me on whether you think your relative/friend would wish to take part in the research and what their wishes and feelings about taking part may be. Your relative/friend does not have to take part, but in order for you to decide whether they may wish to take part it is important that you know what the research will involve. This information sheet explains what it will involve for you and your relative/friend. Please take time to read it carefully and feel free to discuss this with other people before you make a decision.

What is the purpose of the study?
This study explores how care workers in care homes learn to do their work. I want to find out about the different ways that care workers learn to care for people living with dementia in care homes by talking to care workers and watching how they go about their work with residents. This study is part of my PhD qualification.

Why are you asking my relative/friend to take part?
One of the best ways to find out about care in care homes and how workers learn to do their job is to spend time observing everyday events in the care home, and getting to know what living and working in a care home is like for residents and staff. Your relative/friend has been invited to take part because I am hoping to spend time in their home observing their daily life and experiences of the care they receive.

What am I being asked to do as a personal consultee?
As a personal consultee, you are being asked to give us your advice about whether your relative/friend would wish to take part in the research. Some questions for you to consider might be:

- Would your relative/friend be content to take part, or would it upset them?

- Has your relative/friend expressed any wishes in the past about taking part in research?
- If your relative/friend was able to understand and retain information long enough to consider the implications of taking part in the research do you think they would have wished to take part?

You are not being asked to give consent on behalf of your relative/friend. Instead you are asked to provide advice on the likely opinion of your relative/friend. If you are happy to act as a personal consultee please complete the attached pink form and return it to me in the envelope provided.

Does my relative/friend have to take part?
No, they do not have to take part. If you say that you think they would not wish to take part in the research this will not affect the care they receive. If you tell me that you think your relative/friend would wish to take part, I will then be guided by whether your relative/friend appears to want to be involved each time I visit the home. I will do this by paying close attention to what your relative/friend says or does that may show me how they are feeling. If they appear to be distressed at my presence at any point then I will not include them in the research.

You do not have to advise me on your relative/friend taking part. You can also change your advice to me about your relative/friend taking part at any time and without giving me a reason. Information about people who have not consented, (or where consultees have advised us that their relative/friend would not wish to take part) will not be recorded as part of the research.

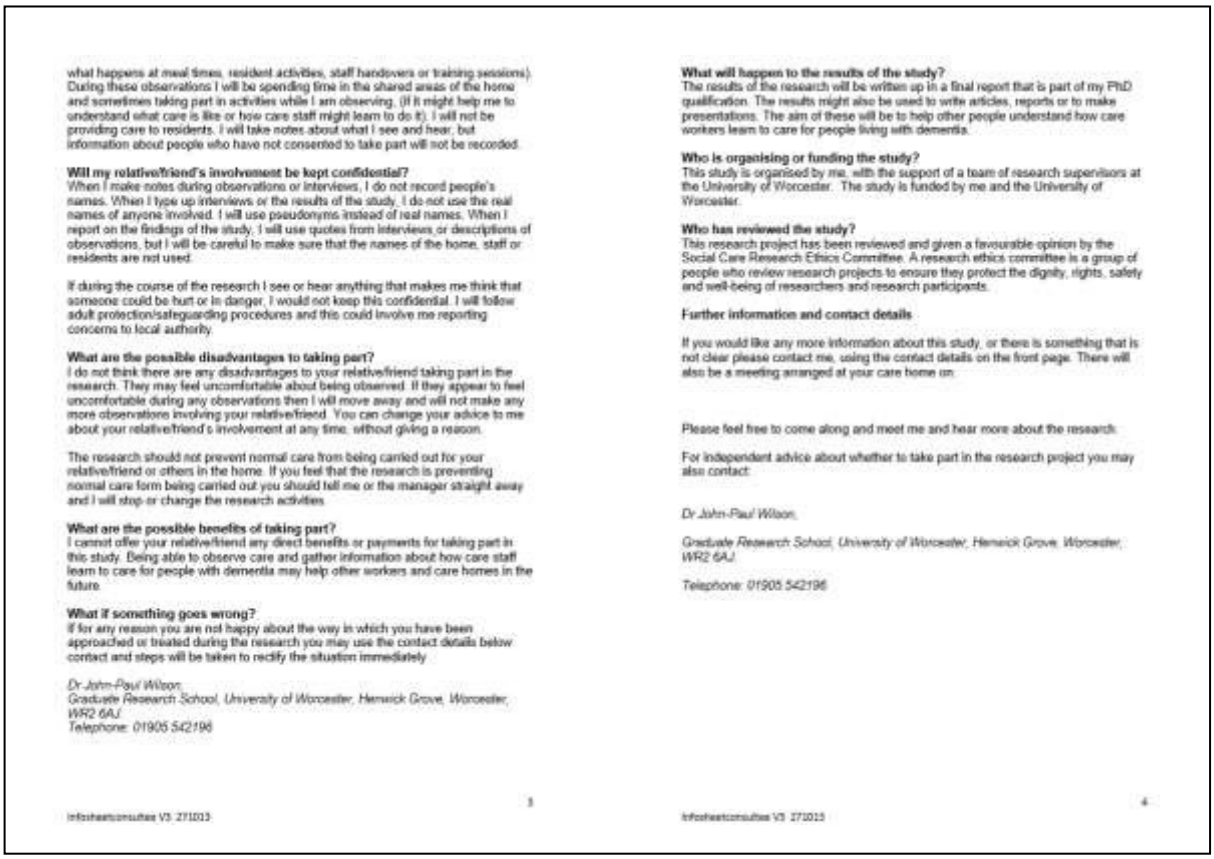
What will happen to my relative/friend if I say they would wish to take part?
If you advise me that you think your relative/friend may like to take part, they will not have to make any changes to their normal routine.

If you advise me that you relative/friend may wish to take part then the first step I would take is to collect some basic information about your relative/friend and their care needs which will help me when I carry out the research. If at any point your relative/friend does not appear to be at ease with being involved in the research then I will not include them in the research. I will check with them each time that they continue to be at ease.

If your relative/friend is included in the research then they may be involved in different types of observations during the research.

PIECE-dem observations will focus on the care of a few particular residents in the care home. This will involve myself and another researcher spending time in the shared areas of the home (for example, sitting rooms and corridors) and listening to and watching closely what is happening for those residents. This will not include observations of personal care, but may involve observing in the person's bedroom if it does not disturb them or their care. We will make notes of what we see and hear. Information about people who have not consented to take part will not be recorded.

Ethnographic observations will focus more generally on the daily life of the home and the work of care staff, rather than being focussed on specific residents, (for example,



what happens at meal times, resident activities, staff handovers or training sessions). During these observations I will be spending time in the shared areas of the home and sometimes taking part in activities while I am observing, (if it might help me to understand what care is like or how care staff might learn to do it). I will not be providing care to residents. I will take notes about what I see and hear, but information about people who have not consented to take part will not be recorded.

Will my relative/friend's involvement be kept confidential?
When I make notes during observations or interviews, I do not record people's names. When I type up interviews or the results of the study, I do not use the real names of anyone involved. I will use pseudonyms instead of real names. When I report on the findings of the study, I will use quotes from interviews or descriptions of observations, but I will be careful to make sure that the names of the home, staff or residents are not used.

If during the course of the research I see or hear anything that makes me think that someone could be hurt or in danger, I would not keep this confidential. I will follow adult protection/safeguarding procedures and this could involve me reporting concerns to local authority.

What are the possible disadvantages to taking part?
I do not think there are any disadvantages to your relative/friend taking part in the research. They may feel uncomfortable about being observed. If they appear to feel uncomfortable during any observations then I will move away and will not make any more observations involving your relative/friend. You can change your advice to me about your relative/friend's involvement at any time, without giving a reason.

The research should not prevent normal care from being carried out for your relative/friend or others in the home. If you feel that the research is preventing normal care form being carried out you should tell me or the manager straight away and I will stop or change the research activities.

What are the possible benefits of taking part?
I cannot offer your relative/friend any direct benefits or payments for taking part in this study. Being able to observe care and gather information about how care staff learn to care for people with dementia may help other workers and care homes in the future.

What if something goes wrong?
If for any reason you are not happy about the way in which you have been approached or treated during the research you may use the contact details below contact and steps will be taken to rectify the situation immediately.

Dr John-Paul Wilson,
Graduate Research School, University of Worcester, Henwick Grove, Worcester, WR2 6AJ
Telephone: 01905 542198

What will happen to the results of the study?
The results of the research will be written up in a final report that is part of my PhD qualification. The results might also be used to write articles, reports or to make presentations. The aim of these will be to help other people understand how care workers learn to care for people living with dementia.

Who is organising or funding the study?
This study is organised by me, with the support of a team of research supervisors at the University of Worcester. The study is funded by me and the University of Worcester.

Who has reviewed the study?
This research project has been reviewed and given a favourable opinion by the Social Care Research Ethics Committee. A research ethics committee is a group of people who review research projects to ensure they protect the dignity, rights, safety and well-being of researchers and research participants.

Further information and contact details

If you would like any more information about this study, or there is something that is not clear please contact me, using the contact details on the front page. There will also be a meeting arranged at your care home on:

Please feel free to come along and meet me and hear more about the research.

For independent advice about whether to take part in the research project you may also contact:

Dr John-Paul Wilson,

Graduate Research School, University of Worcester, Henwick Grove, Worcester, WR2 6AJ

Telephone: 01905 542198

Isabelle Latham, PhD Student

Association for Dementia Studies
University of Worcester
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Worcester, WR2 6AJ

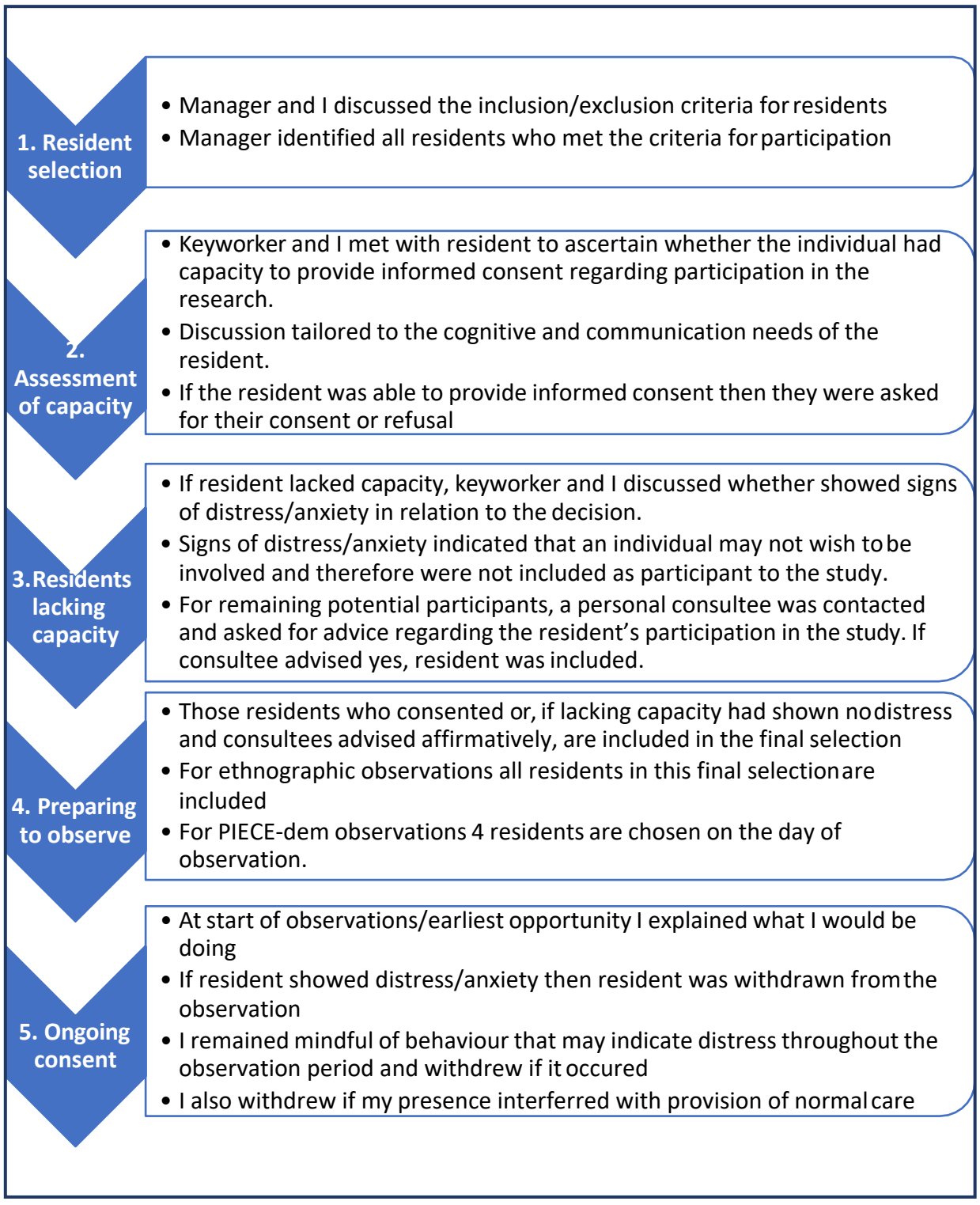
i.latham@worc.ac.uk
01905 542326

"Learning to Care" Research Project: Personal Consultee Declaration Form

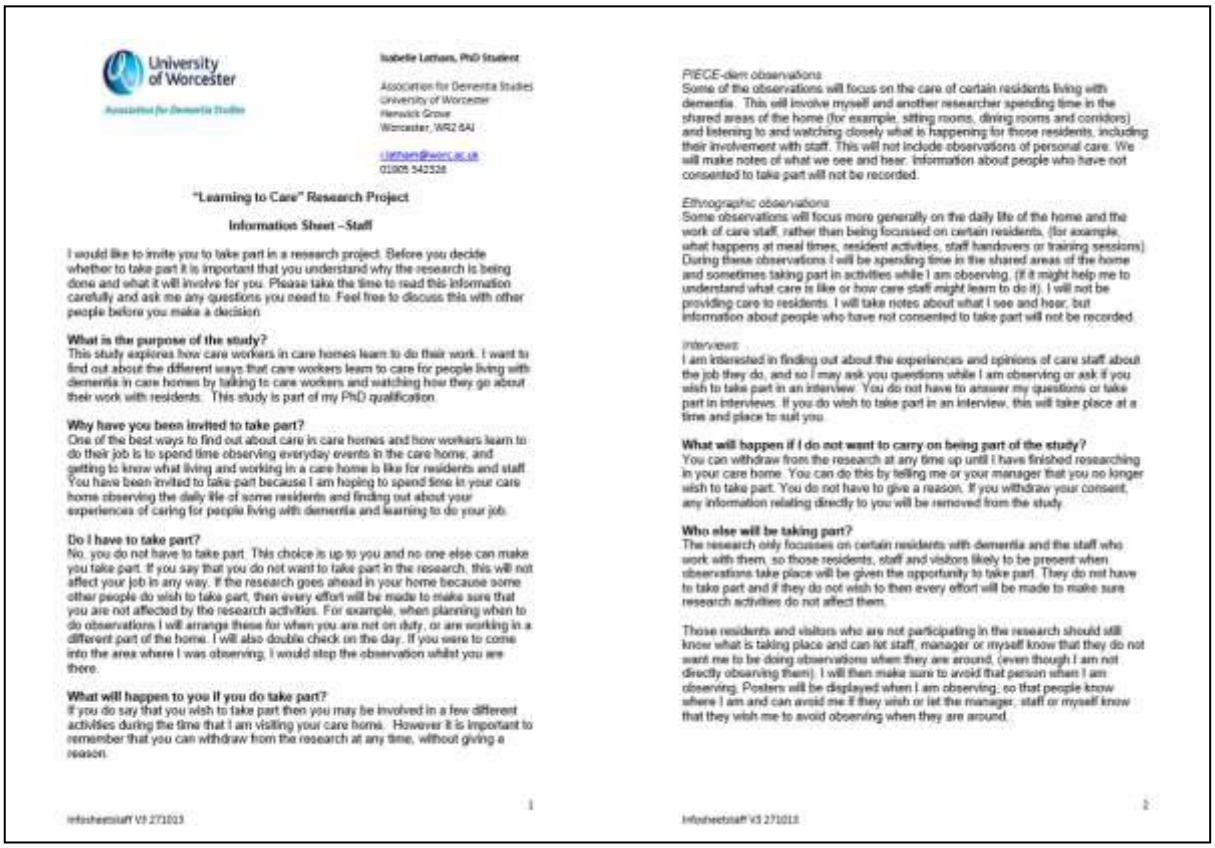
		Please tick	
1.	I ..... have been consulted about .....'s participation in this research project. I confirm I have read the information sheet dated 270113 (V3) for the study. I have had the opportunity to consider the information, ask questions and have these answered satisfactorily	Yes	No
2	I understand that I do not have to act as a personal consultee and am able to stop acting in this capacity at any point.	Yes	No
3	In my opinion.....would have no objection to taking part in the above study.	Yes	No
4	In my opinion.....would have no objection to the researchers observing his/her day to day activities and care in the care home where he/she lives.	Yes	No
5	I understand that relevant sections of the data collection during the study may be looked at by individuals from the research team and that anonymised data will be used in analysis and publication of findings	Yes	No
6	I agree to act as a personal consultee	Yes	No

---------- Name of Participant (Resident)		---------- Relationship to consulteee
---------- Name of Consultee	---------- Date	---------- Signature
---------- Name of Researcher	---------- Date	---------- Signature

Appendix 6: resident capacity and consent process



Appendix 7: Staff information sheet and consent form



University of Worcester
Association for Dementia Studies

Isabelle Latham, PhD Student

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01905 542538

"Learning to Care" Research Project

Information Sheet – Staff

I would like to invite you to take part in a research project. Before you decide whether to take part it is important that you understand why the research is being done and what it will involve for you. Please take the time to read this information carefully and ask me any questions you need to. Feel free to discuss this with other people before you make a decision.

What is the purpose of the study?
This study explores how care workers in care homes learn to do their work. I want to find out about the different ways that care workers learn to care for people living with dementia in care homes by talking to care workers and watching how they go about their work with residents. This study is part of my PhD qualification.

Why have you been invited to take part?
One of the best ways to find out about care in care homes and how workers learn to do their job is to spend time observing everyday events in the care home, and getting to know what living and working in a care home is like for residents and staff. You have been invited to take part because I am hoping to spend time in your care home observing the daily life of some residents and finding out about your experiences of caring for people living with dementia and learning to do your job.

Do I have to take part?
No, you do not have to take part. This choice is up to you and no one else can make you take part. If you say that you do not want to take part in the research, this will not affect your job in any way. If the research goes ahead in your home because some other people do wish to take part, then every effort will be made to make sure that you are not affected by the research activities. For example, when planning when to do observations I will arrange these for when you are not on duty, or are working in a different part of the home. I will also double check on the day. If you were to come into the area where I was observing, I would stop the observation whilst you are there.

What will happen to you if you do take part?
If you do say that you wish to take part then you may be involved in a few different activities during the time that I am visiting your care home. However it is important to remember that you can withdraw from the research at any time, without giving a reason.

PIECE-dem observations
Some of the observations will focus on the care of certain residents living with dementia. This will involve myself and another researcher spending time in the shared areas of the home (for example, sitting rooms, dining rooms and corridors) and listening to and watching closely what is happening for those residents, including their involvement with staff. This will not include observations of personal care. We will make notes of what we see and hear. Information about people who have not consented to take part will not be recorded.

Ethnographic observations
Some observations will focus more generally on the daily life of the home and the work of care staff, rather than being focussed on certain residents, (for example, what happens at meal times, resident activities, staff handovers or training sessions). During these observations I will be spending time in the shared areas of the home and sometimes taking part in activities while I am observing. (If it might help me to understand what care is like or how care staff might learn to do it). I will not be providing care to residents. I will take notes about what I see and hear, but information about people who have not consented to take part will not be recorded.

Interviews
I am interested in finding out about the experiences and opinions of care staff about the job they do, and so I may ask you questions while I am observing or ask if you wish to take part in an interview. You do not have to answer my questions or take part in interviews. If you do wish to take part in an interview, this will take place at a time and place to suit you.

What will happen if I do not want to carry on being part of the study?
You can withdraw from the research at any time up until I have finished researching in your care home. You can do this by telling me or your manager that you no longer wish to take part. You do not have to give a reason. If you withdraw your consent, any information relating directly to you will be removed from the study.

Who else will be taking part?
The research only focusses on certain residents with dementia and the staff who work with them, so those residents, staff and visitors likely to be present when observations take place will be given the opportunity to take part. They do not have to take part and if they do not wish to then every effort will be made to make sure research activities do not affect them.

Those residents and visitors who are not participating in the research should still know what is taking place and can let staff, manager or myself know that they do not want me to be doing observations when they are around, (even though I am not directly observing them). I will then make sure to avoid that person when I am observing. Posters will be displayed when I am observing, so that people know where I am and can avoid me if they wish or let the manager, staff or myself know that they wish me to avoid observing when they are around.

Will my involvement be kept confidential?
When I make notes during observations or interviews, I do not record people's names. When I type up interviews or the results of the study, I do not use the real names of anyone involved. I will use pseudonyms instead of your real name. When I report on the findings of the study, I will use quotes from interviews or descriptions of observations, but I will be careful to make sure that the names of the home, staff or residents are not used.

If during the course of the research I see or hear anything that makes me think that someone could be hurt or in danger, I would not keep this confidential. I will follow adult protection/safeguarding procedures and this could involve me reporting concerns to local authority.

What are the possible disadvantages to taking part?
I do not think there are any disadvantages to you taking part in the research. However, you may find that you feel uncomfortable during observations or interviews. If you feel uncomfortable at any time you may withdraw from the research and I will take care to ensure other parts of the research do not involve you.

The research should not prevent normal care being carried out in the home. If at any point you feel that the research is preventing you or others from carrying out normal care for residents you should tell me or your manager straight away. I will stop or change the research activities to make sure that they do not affect normal resident-care.

What are the possible benefits of taking part?
I cannot offer you any direct benefits or payments for taking part in this study. Some people find it a positive experience to take part in research and to share their experiences and opinions. By taking part you are helping me to gather information about how care staff learn to care for people with dementia and this may help other workers and care homes in the future.

What if something goes wrong?
If for any reason you are not happy about the way in which you have been approached or treated during the research you may use the contact details below. Steps will be taken to rectify the situation immediately.

Dr John-Paul Wilson,
Graduate Research School, University of Worcester, Henwick Grove, Worcester, WR2 6AJ.
Telephone: 01905 542196

What will happen to the results of the study?
The results of the research will be written up in a final report that is part of my PhD qualification. The results might also be used to write articles, reports or to make presentations. The aim of these will be to help other people understand how care workers learn to care for people living with dementia.

Who is organising or funding the study?

This study is organised by me, with the support of a team of research supervisors at the University of Worcester. The study is funded by me and the University of Worcester.

Who has reviewed the study?
This research project has been reviewed and given a favourable opinion by the Social Care Research Ethics Committee. A research ethics committee is a group of people who review research projects to ensure they protect the dignity, rights, safety and well-being of researchers and research participants.

What should I do now?
If you are happy to take part in the study, please complete the yellow form attached and return it to me in the envelope provided, or by placing it in the research consent box in your care home. You can also use this form to tell me if you do not wish to take part, although if I do not receive a form from you I will assume you do not wish to take part.

Further information and contact details

If you would like any more information about this study, or there is something that is not clear please contact me, using the contact details on the front page. There will also be a meeting arranged at your care home on:

Please feel free to come along to meet me and hear more about the research.

For independent advice about whether to take part in the research project you may also contact:

Dr John-Paul Wilson,

Graduate Research School, University of Worcester, Henwick Grove, Worcester, WR2 6AJ.

Telephone: 01905 542196

Isabelle Latham, PhD Student
Association for Dementia Studies
University of Worcester
Henwick Grove
Worcester, WR2 6AJ
i.latham@worc.ac.uk
01905 542326

"Learning to Care" Research Project: staff consent form

		Please tick	
1.	I confirm I have read the information sheet dated 271013 V3 for the study. I have had the opportunity to consider the information, ask questions and have these answered satisfactorily	Yes	No
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason. This will not affect my employment	Yes	No
3.	I agree to the researcher/s observing me as I go about my day to day working in the care home.	Yes	No
4.	I understand that relevant sections of the data collection during the study may be looked at by individuals from the research team and that anonymised data will be used in analysis and publication of findings	Yes	No
5.	I agree to take part in the study	Yes	No

Name of Care Staff _____ Date _____ Signature _____

Name of Researcher _____ Date _____ Signature _____

consentformstaff V2 220913

University of Worcester
Association for Dementia Studies

Isabelle Latham, PhD Student

Association for Dementia Studies
University of Worcester
Henwick Grove
Worcester, WR2 6AJ

i.latham@worc.ac.uk
01905 542326

"Learning to Care" Research Project
Information Sheet – Interviews

I would like to invite you to take part an interview as part of this research project. Before you decide whether to take part it is important that you understand why the research is being done and what it will involve for you. Please take the time to read this information carefully and ask me any questions you need to. Feel free to discuss this with other people before you make a decision.

What is the purpose of the study?
This study explores how care workers in care homes learn to do their work. I want to find out about the different ways that care workers learn to care for people living with dementia in care homes by talking to workers, residents and visitors to the care home. This study is part of my PhD qualification.

Why have I been invited to take part in an interview?
One way of finding out about care in care homes and how workers learn to do their jobs is to speak to people involved in the care home and ask questions about their experiences and opinions. You have been invited to take part because I am hoping to interview you and find out your experiences and opinions of care and how staff may learn to do their job.

Do I have to take part?
No, you do not have to take part. This choice is up to you and no one else can make you take part. If you say that you do not want to take part in the interview, this will not affect your job or visits to the care home in any way.

What will happen to you if you do take part?
If you do say that you wish to give an interview as part of this research then I will arrange with you a suitable place and time for us to meet. I will then ask you questions about your experiences and opinions. You do not have to answer all of the questions. With your permission I will audio record this interview and then I will type up the interview so that I have a written record. This interview will then be used when I write up the findings of my study. If you agree to take part in an interview you will be asked to sign a consent form. You can withdraw from the research at any time without giving a reason.

Will my involvement be kept confidential?
When I type up interviews or the results of the study, I do not use the real names of anyone involved. I will use pseudonyms instead of your real name. When I report on the findings of the study, I will use quotes from interviews, but I will be careful to make sure that the names of the home, staff or residents are not used.

If during the course of the interview, I hear anything that makes me think that someone could be hurt or in danger, I would not keep this confidential. I will follow adult protection/ safeguarding procedures and this could involve me reporting concerns to local authority.

What are the possible disadvantages to taking part?
I do not think there are any disadvantages to you taking part in an interview. You may find that you feel uncomfortable sharing your thoughts and opinions with me in an interview. If this is the case you can stop the interview at any time.

What are the possible benefits of taking part?
I cannot offer you any direct benefits or payments for taking part in an interview. Some people find it a positive experience to be able to share their experiences and opinions. By taking part you are helping me to gather information about how care staff learn to care for people with dementia and this may help other workers and care homes in the future.

What if something goes wrong?
If for any reason you are not happy about the way in which you have been approached or treated during the research you may use the contact details below:

Dr John-Paul Wilson,
Graduate Research School, University of Worcester, Henwick Grove, Worcester, WR2 6AJ.
Telephone: 01905 542196

What will happen to the results of the study?
The results of the research will be written up in a final report that is part of my PhD qualification. The results might also be used to write articles, reports or to make presentations. The aim of these will be to help other people understand how care workers learn to care for people living with dementia.

Who is organising or funding the study?
This study is organised by me, with the support of a team of research supervisors at the University of Worcester. The study is funded by me and the University of Worcester.

Who has reviewed the study?
This research project has been reviewed and given a favourable opinion by the Social Care Research Ethics Committee. A research ethics committee is a group of people who review research projects to ensure they protect the dignity, rights, safety and well-being of researchers and research participants.

What should I do now?
If you are happy to take part in an interview, please complete the consent form attached and return it to me.

Further information and contact details

If you would like any more information about this study, or there is something that is not clear please contact me, using the contact details on the front page.

Isabelle Latham, PhD Student
Association for Dementia Studies
University of Worcester
Henwick Grove
Worcester, WR2 6AJ
i.latham@worc.ac.uk
01905 542326

"Learning to Care" Research Project: interview consent form

		Please tick	
1.	I confirm I have read the information sheet dated 220913 V1 for the study. I have had the opportunity to consider the information, ask questions and have these answered satisfactorily	Yes	No
2.	I understand that my participation in this interview is voluntary and that I am free to withdraw at any time, without giving a reason.	Yes	No
3.	I agree to the interview being audio-recorded so that my comments can be typed up and used as research data.	Yes	No
4.	I understand that relevant sections of the data collection during the interview may be looked at by individuals from the research team and that anonymised data, including quotes from interviews, will be used in analysis and publication of findings	Yes	No
5.	I agree to take part in the interview	Yes	No

Name of Interviewee _____ Date _____ Signature _____

Name of Researcher _____ Date _____ Signature _____

interviewconsentform V2 220913

Appendix 9: Care staff and manager/senior staff interview schedules

Care Worker Interviews V3

Tell me a little bit about yourself and how you got here

- how long
- previous experience care/dementia
- why do you work/stay here?

Describe a typical day here

- challenges/good things about dementia care
- most important thing to know in dementia care

Can you think of a time when you learned something really important about the work that you do:

- Working here/ dementia care? Describe in detail
- What prompted the learning (a person or situation? Why?)
- How did it progress?
- What changes did it bring about in your practice?
- How did you know when the learning was complete?
- Are there people or situations you would say you particularly learn from? (why them?)

If you had a problem or something unusual happened with a resident, what would you do?

- How do you work out what to do?
- Who would you go to? (why?)
- Can you remember a time when you didn't know what to do? How did you deal with it?

Tell me about when you first started working here

- What happened?
- Examples of learning what to do/what not to do?
- Shadowing: who did you learn from/not learn from?

Learning generally

What skills/abilities do you think a care worker needs to work here?

- Different between abilities and knowledge
- Best way for someone to develop those skills
- Examples of people who do/don't have those skills
- Times when you didn't have those abilities?

Formal Learning

When a care worker starts working here, how do they learn to do dementia care? (after that/ongoing?)

- What sort of training or education takes place
- Shadowing
- How does it contribute to care here?

End

Is there anything else that you'd like to add, or anything that we haven't covered?

Is there anything you'd like to ask me?

Initial Interview Manager/Senior staff

Intro: Tell me a little bit about yourself and your care home

Care /Dementia Care

Can you describe a typical day in the life of your residents?

Can you describe a typical day in the life of your care workers?

- challenges/good things about dementia care
- most important thing in dementia care

Skills

What makes someone good at being a care worker in dementia care?

- skills needed for dementia care
- attitude needed for dementia care
- best way to learn/develop those skills

Communication

How do staff share information about their day to day work?

- how find out about changes?
- problems?
- advice/guidance?

Specific (exploring particular incidents of care or events)

(explanation of the situation) How do you think staff knew what to do in that situation?

- what's success?
- when would it be different?

General: non-formal learning

What different ways do staff pick up how to do dementia care?

- probe re: attitudes, role models, colleagues, day to day events
- How do different ways influence the way people are cared for?

General: formal learning

When a care worker starts working here, how do they learn to do dementia care? (after that/ongoing?)

- training/education/induction
- How does it contribute to the way things are done here?

End

Is there anything else that you'd like to add, or anything that we haven't covered?
is there anything you'd like to ask me?

Appendix 10: SCREC approval letter

social care
institute for excellence

Social Care REC
An NRES Research Ethics Committee

18 November 2013

Ms Isabelle Latham
PhD Student
Association for Dementia Studies
University of Worcester
Henwick Grove
Worcester
WR2 6AJ

Dear Ms Latham

Study title:	**Learning to Care: an ethnographic study of how direct care workers in care homes learn to care for people living with dementia**
REC reference:	**13/IEC08/0036**
Protocol number:	**N/A**
IRAS project ID:	**130962**
Ethical opinion:	**Favourable (with conditions)**

Thank you for your letters of 04 October and 15 November 2013, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence sub-committee's of the REC during the week commencing 14 October 2013 and on 18 November 2013. A list of the sub-committee members is attached.

Confirmation of ethical opinion

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

Mental Capacity Act 2005

I confirm that the Committee has approved this research project for the purposes of the Mental Capacity Act 2005. The Committee is satisfied that the requirements of section 31 of the Act will be met in relation to research carried out as part of this project on, or in relation to, a person who lacks capacity to consent to taking part in the project.

Site-Specific Assessment

The REC decided that the research did not require Site-Specific Assessment at non-NHS

Second Floor, 206 Marylebone Road, London NW1 6AQ
tel 020 7535 0900 fax 020 7535 0901 www.scie.org.uk

sites as it involves no clinical interventions and all study procedures at sites involving participants will be undertaken directly by the study team.

Conditions of the favourable opinion

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

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at

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

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

Guidance on Research Governance approval is available from the Department of Health supported Research Governance Framework: Resource Pack for Social Care (2nd ed, April 2010) London, which can be found at:

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

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

Approved documents

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

Document	*Version*	*Date*
Covering Letter		04 October 2013
Covering Letter		15 November 2013
Evidence of insurance or indemnity		01 August 2013
Investigator CV	Isabelle Latham	14 July 2013

Investigator CV	Professor Dawn June Brooker	09 May 2012
Investigator CV	Professor Elizabeth Peel	
Letter from Sponsor		12 July 2013
Other: Internal Review	1	19 July 2013
Other: External Review	1	19 July 2013
Other: Pre-Consent Information Summary	1	16 June 2013
Other: PiECE-dem Pre-Observation Summary Questions	1	16 June 2013
Other: Poster General	2	22 September 2013
Other: Poster Observations	1	27 October 2013
Other: Observation Flow Chart	1	27 October 2013
Other: Draft Interview Guide - Care Workers	1	27 October 2013
Other: Interview Guide - Manager	1	27 October 2013
Other: Draft Interview Guide - Visitors	1	27 October 2013
Participant Consent Form: Manager	2	22 September 2013
Participant Consent Form: Staff	2	22 September 2013
Participant Consent Form: Visitor	2	22 September 2013
Participant Consent Form: Consultee Declaration	2	22 September 2013
Participant Consent Form: Interviews	2	22 September 2013
Participant Consent Form: Resident	3	27 October 2013
Participant Information Sheet: Consultee	2	22 September 2013
Participant Information Sheet: Resident	2	22 September 2013
Participant Information Sheet: Interview	1	22 September 2013
Participant Information Sheet: General	3	27 October 2013
Participant Information Sheet: Manager	3	27 October 2013
Participant Information Sheet: Staff	3	27 October 2013
Participant Information Sheet: Visitor	3	27 October 2013
Participant Information Sheet: Consultee	3	27 October 2013
Protocol	4	27 October 2013
REC application	130962/4871 62/27/693	08 August 2013

Statement of compliance

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

for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the Social Care REC website – and look at the *'After Ethical Review Section'* for details of further requirements.
The attached document *'After Ethical Review – Guidance for Sponsors and Investigators'* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

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

Feedback to the Social Care REC

The Committee would welcome your views on the service you have received from the Social Care REC and the application procedure. You can do this anonymously by completing our feedback form at:

13/IEC08/0036	***Please quote this number on all correspondence***

HRA/NRES are pleased to welcome researchers and R & D staff at their NRES committee members' training days – see details at

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

Yours sincerely

Professor David Stanley
Chair

Barbara Cuddon
Social Care Research Ethics Committee Co-ordinator
Direct Line: 020 7024 7660

Appendix 11: A detailed account of my thematic analysis

The following explains in-depth the thematic analysis process followed in this study, including examples of coding and sub-coding

1) I read through the whole data set from the site in order to re-familiarise and immerse myself, this time with a solely analytic eye (Morse, 1994; Fereday and Muir-Cochrane, 2006; Braun and Clarke, 2013).
2) Reviewing the data again, I looked for similarity (resemblances and common features) in the data and coded them by writing the term in the margin. This is open/descriptive coding (Ryan and Bernard, 2003b; Corbin and Strauss, 2008; Braun and Clarke, 2013; Maxwell and Chmiel, 2014). It required me to label what I noticed, whether in my own terminology or by using participants' terms. This resulted in a long and disparate range of codes, related to two broad areas:
   - What is care here?
   - How is that care learned here?

   Within my study, my first coding list contained 30 + categories. Examples from Strauss Hill Court are given below:

Participant-led code (emic)		**Researcher-led code (etic)**	
Code	*Example of data*	*Code*	*Example of data*
What works	"it's about what works for them" (interview)	Asking and being told	R goes and asks F what she should do, they chat and R comes back and carries out the suggestions (observation)

3) From this long list of descriptive codes, I then took a third look at the data, this time searching for patterns (as relationships or connections), within and between the codes (Braun and Clarke, 2013; Maxwell and Chmiel, 2014). This is analytic coding and resulted in the combining of similar codes and identifying candidate themes: central organising concepts that make sense in their own right to explain patterns in the data (van Maanen, 1979; Braun and Clarke, 2013; Al Sayah *et al.*, 2014). This process reduced the number of

codes, but increased complexity and interconnection (Braun and Clarke, 2013; Maxwell and Chmiel, 2014). For example, in my analysis of Sunshine Lodge my analytic coding reduced my initial codes to 8 themes, but each had various elements and connections. A simplified example of this is shown below:

Theme	Sub-theme	Elements	Relationship to other themes
What works	1. What works for residents 2. Resources available 3. What is expected 4. What works for me	4.1 Is it possible? 4.2 Is it my responsibility? 4.3 What reaction will it get?	Resident influences Peer influences

There are a number of techniques I used to interrogate the data in this third stage to challenge my interpretations. This was essential to avoid the trap of seeing only what served my purpose or making claims beyond the evidence (Thomas, 1993; Miles, Huberman and Saldana, 2014). These techniques are as follows:

a) I examined each code with the intention of creating a short description so that someone unfamiliar with my work could understand what I had identified. This was accomplished by re-reading all data collected within that code

b) I compared across data types and sources to ascertain contingencies of codes (Hammersley and Atkinson, 2007; Zulfikar, 2014; Rashid, Caine and Goez, 2015). Triangulating in this way within an ethnographic study is not about confirming the validity of data (as would be its purpose in a positivist study) but instead about deepening data and my understanding of it (Hammersley, 1998; Holthe, Thorsen and Josephsson, 2007). For example, in Strauss Hill Court an initial code regarding learning was “use of care plans” I therefore looked at all incidents of that code to see when, where and why it occurred. I discovered that this code only existed within interview data from senior staff. Where care plans were referenced in other data or from different sources it was in opposition to learning; documentary analysis of a resident’s care plan contradicted what I

saw in practice and was told by care staff. This technique was particularly useful in highlighting where a code had emerged from 'elite bias', in which participants who provide more articulate data are over-represented (Miles, Huberman and Saldana, 2014).

c) I looked for relationships and patterns between each theme and its codes by taking each theme and examining what other themes or codes were frequently mentioned within similar data. So, for example, in Sunshine Lodge, I saw a strong correlation between "learning by doing" and other codes related to "boundaries of role". I was then able to separate this data out and explore how and when the two interacted with each other.

d) Finally, I specifically looked for anomalous cases or examples within the data; those that were very different to anything else I had seen or contradicted what patterns seemed to be emerging. This helped in ensuring my findings were not falling to the 'holistic fallacy' in which data is interpreted as more patterned than it truly is (Leininger, 1994; Silverman, 2011; Miles, Huberman and Saldana, 2014) .

4) My fourth stage of analysis was to visually represent the different themes, sub themes and relationships using spider diagrams. Whilst not an explicit part of thematic analysis, I found this alternative way of explaining the data made patterns or false assumptions easier to spot (Wheeldon and Faubert, 2009; Braun and Clarke, 2013; Maxwell and Chmiel, 2014). Moreover, by keeping each iteration of these diagrams it provided a valuable way to track the development of my thinking over time. Once stages 1 to 4 of analysis was complete within each care home, I was them able to move on to comparing across the two datasets. This helped me to see if themes were distinctive to a single care home or, where similarities existed, how they manifested in each home. It enabled me to identify those themes that were significant regardless of the peculiarities of the specific care home. In addition, I found having the two homes was a helpful tool for questioning my thoughts. I often found myself asking the question: *'what would have happened if the same situation occurred in (other) care home'?* This helped me to identify why differences may have occurred and to highlight when these were related to my actions as opposed to the care home and its actors.

5) The final stage of analysis occurred because of an unplanned break in my study, meaning I returned to analysis needing to re-familiarise myself with my data. I decided to use this

opportunity to employ a complementary approach, by coding data again but using NVivo 10 software. As well as helping me to immerse myself again, this meant I could check my themes afresh, exploring them in new ways such as looking for word frequency or volume of coding, something that is much easier electronically (Corbin and Strauss, 2008; Braun and Clarke, 2013).

Isabelle Latham conducted the research presented in this thesis at the Association for Dementia Studies, a research centre at the University of Worcester from 2012 to 2019

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This thesis explains the process of 'learning to care' as experienced by care workers through their day-to-day work with people living with dementia. This is an informal, interpretive and relational process and through better understanding of it workers can be supported to improve their expertise and thus improve care experiences of people living with dementia.

This thesis proposes a learning to care system that better responds to the reality of how workers experience their learning and thus has significance for educators and practitioners in the dementia care field

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