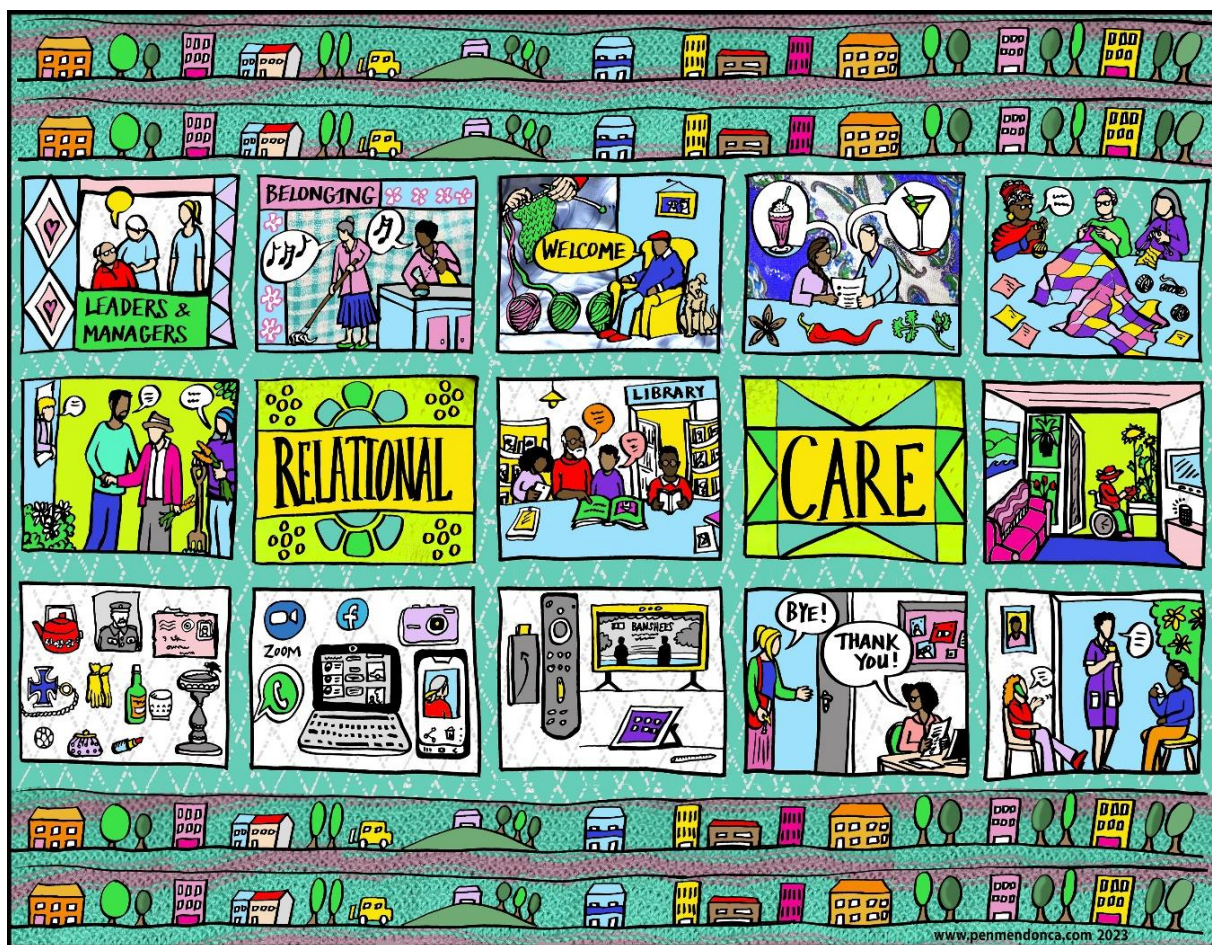


# The value and practice of relational care with older people

A research report by The Open University



May 2023

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## **Forewords**

The relationships we have with other people are one of the most important influences in the quality of our lives. This is true at every stage in life, but as we age and we need more support, our relationships become even more important, and they can be the primary definer of our quality-of-life. Understanding how to develop positive relationships when delivering care is vitally important, and all too often, care is distilled into a process, rather than being a true reciprocal relationship based on an interaction between people and underpinned by the values of respect, dignity, reciprocity, and mutuality.

In this study by The Open University, there is clear evidence of what factors influence high quality care, and this research has messages for everyone in the care sector and its conclusions are far-reaching. I hope it will be the foundation of a new approach that can be delivered across a range of services because the study graphically illustrates that whatever challenge a person faces, and whatever service they receive, the thing that remains important is the relationships that they have with others, and particularly the people who support them. If we get this right, we not only transform the lives of the people we support, but it also delivers a much richer and satisfying experience for those who deliver care and support.

**Professor Martin Green OBE, Chief Executive, Care England**

The need to be recognised for your value and contribution to communities and people does not stop as you become older. There is no arbitrary age related cut off point for the give and take that characterises the interdependence underpinning human relationships. Yet the care of older people is often represented as one way set of wants and needs.

Relational care recognises this and offers an approach that highlights the importance of building the key elements of respect, trust and inclusivity in a care system fit for the future. This report speaks to the primacy of human relationships and encourages a re-balancing of the lives of older people. It shows that holding relationships at the heart of care is central to the experience of those receiving care and support, and also enhances the experience of the care workforce. The report also focuses on the importance of the physical environment in which care is delivered, acknowledging that interdependence can be both nurtured and developed in settings which facilitate both relationships and autonomy.

With this in mind, I really welcome this positive contribution to our understanding of relational care that this report offers and the practical support offered by the toolkit resources to embed this way of working in a range of different models of care.

**Professor Vic Rayner OBE, CEO, National Care Forum**

## **Welcome from the Hallmark Foundation**

Relationships matter to all of us. The quality of our relationships is fundamental to ageing well. And we know that good relationships in care can have multiple benefits – for older people drawing on care and their families, for the retention of care workers and for the quality of care and inspection ratings.

That's why the Hallmark Foundation has been keen to support this research by the Open University and its outputs. Hallmark Care Homes have been implementing relational care for years because we know it works. Relational care supports happier older people, it makes our homes happier places, and it makes for happier team members. A real win-win-win which I recommend to all care providers.

I would particularly like to thank the team at The Open University who have worked on the research and the project advisory group for their insights.

We want to hear from you about the impact of this work and the toolkit. We want it to make a real difference to older people and their families and all those they have relationships with. And we want to show other care providers how to make it happen too.

Thank you for all you do to improve care and support ageing well in the UK.

**Avnish Goyal CBE**  
**Chair, Hallmark Foundation and Hallmark Care Homes**  
**Chair, Care England**

## Acknowledgements

We wish to extend our gratitude to everyone who has helped us produce this report, and without whom it would not have been possible.

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April Dobson, Head of Dementia Care and Wellbeing, Hallmark Care Homes

Professor Vikki Entwistle, Chair in Health Services Research and Philosophy, University of Aberdeen

Dr Kellyn Lee, University of Southampton, and CEO of Material Citizenship

Dr Lorraine Morley, Consultant and Researcher at AgeTech Intelligence and Allia Impact Ltd.

Professor John Swinton, Chair in Divinity and Religious Studies, University of Aberdeen

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We are more than grateful to the managers, staff and residents of the care settings we visited – for their time, hospitality and wisdom.

Last but not least, our thanks to Pen Mendonca, who joined us at the end of the project to bring our ideas to life with her original illustrations.

Dr Manik Deepak-Gopinath

Dr Joseph de Lappe

Jenny Kartupelis MBE

Professor Mary Larkin

Dr Anthea Wilson

## Executive Summary

Relational care is a developing approach to supporting older people, gaining traction as part of a wider movement towards new attitudes to, and re-visioning of adult social care. In essence, it represents a natural progression from person-centred care in that it emphasises the primacy of relationships and human interdependence, the need to give as well as receive, and to be recognised as having an intrinsic value, rather than seen as a collection of needs and demands to be met by others. Physical environments and day to day practices can become facilitators of interdependence and the multidirectional flow of care central to relational care. To date, a number of benefits of relational care have been identified such as, improving the wellbeing and quality of life of those living and working in care settings and increased staff satisfaction, creativity, motivation and retention. However, the emerging literature about relational care is characterised by a lack of conceptual clarity, and there is insufficient objective evidence about the factors that contribute to relational care, possibly constraining its potential.

This report is based on a seminal study which aimed to build on and extend existing knowledge about relational care, enabling recognition of its presence and identifying what supports its practice in the care of older people. The project team was led by The Open University and comprised two leading academics in the field, a relational care expert, two research associates and an Advisory Group.

The study took place in five care settings for older people across the four UK nations in which relational care was already being practiced. These included three residential homes, one day centre and one supported sheltered housing complex, all of which varied in terms of size and ownership. A qualitative mixed method approach using semi structured interviews and ethnographic observational methods was adopted. Ethical approval was obtained from The Open University's Human Research Ethics Committee (HREC).

The field research, informed by a rapid review of academic and grey literature relevant to the aims of the study carried out by the project team, involved one-day observational visits to each of the selected care settings. During these visits interviews with managers, members of staff, residents or day centre users, volunteers and family members were conducted. A total of 19 interviews were carried out. Detailed observations of the overall environment and relational care in practice were also made. The observational notes were written up and the interviews were professionally transcribed. NVivo was used to support the organisation and coding of the interview transcripts and the observational notes. Follow-up audio-recorded semi-structured interviews on Teams with four of the five care managers previously interviewed in the first stage were carried out to ask questions arising from the initial interrogation of the data. These interviews were also transcribed and analysed and used, alongside the feedback from the Advisory Group, to refine findings from the first stage of the field research

An iterative process of interpretation of the data by the whole team enabled understanding of the look and feel of relational care, the processes involved, and the features of the social and physical environment that are conducive to its practice. The themes identified were

developed into a comprehensive model of relational care which can be adapted for use in a range of care settings. This model shows the three key components of relational care in practice: an atmosphere of respect, trust and inclusivity that nurtures belonging; a purposeful focus on relationships; and a physical environment that facilitates the nurturing of those relationships and of individual autonomy. The model also shows the different and often intertwining features within each key component – some reliant on practice, some on physical space, and some on both.

An [accompanying toolkit](#) was produced by the project team for all involved in social care: carer staff, ancillary workers, managers and providers. This can be used to support the move to relational care. It offers practical and easy-to-use guidelines for those managing, and working in, older care settings.

In addition to proposing the first known definition of relational care, producing a relational care practice conceptual diagram and providing further research ideas, this study has the potential to influence social care policy in the UK in a number of ways. These include recruitment and retention of the social care workforce; workforce skills; planning and design of facilities; statutory regulation; and policy and planning.

In sum, this is the first empirical study that addresses what relational care looks and feels like from the perspective of older people, care staff and others who work in care settings, managers, family members and volunteers. In the process of demonstrating relational care in practice, by addressing the gaps in, and building on, existing literature, it is at the same time a seminal work in that it comprehensively identifies features of relational care that can be used for the purposes of implementation and assessment. As such it can be seen as a critical part of a vision for the future development of care practice.



## Introduction

The history of ‘social care’ stretches back into times long before it could be recorded but has always raised profound questions about the balance between society and the individual, between personal and collective responsibility. Where older people are concerned, it also challenges our thinking about ‘their value’ and ‘our values’. Tensions and challenges between ‘their value’ and ‘our values’ are constantly brought to the fore and played out in long-term residential care environments – in particular, how to encourage and promote change in ways that considers the wellbeing of and treat people living and working in care settings with respect.

Older people living in care (including residential and nursing homes) and participating in community settings such as day centres consistently identify meaningful relationships and connections as being important for their quality of life and wellbeing (Owen et al 2012; Orellana, Manthorpe and Tinker, 2020; Hutchinson et al 2022). Moving into and living in a care setting can however – for various reasons – present a challenge to establishing new relationships there and maintaining existing ones (Villar 2021). Consequently, older people in care homes are more likely to experience loneliness and social isolation (Victor 2012; Barbosa Neves, Sanders and Kokanovic, 2019). Research also identifies that good care relationships support and facilitate residents to experience a sense of belonging, connectedness, engagement, autonomy and wellbeing (Brown Wilson and Davies, 2009; Kang et al 2021; van Loon et al 2023).

The current general approach to care – person-centred care – embodies a commitment to the primacy of the individual. Whilst there is no universally accepted definition of ‘person-centred care’, it places the emphasis on the older adult as an individual whose wishes and needs should be the guiding principle in care decisions. However, there can be an inadvertent failure in this approach to recognise adequately that every individual occupies a unique place in relation to friends, family, carers, their community and society. An emphasis on independence and a one-way flow of care as the primary goals to be pursued, can lead to loneliness and disenfranchisement and deflect attention from equally important concerns, such as staff wellbeing and its links to residents’ care and wellbeing (Kartupelis, 2021; Damant et al., 2023).

Our starting point for this report is the moral and ethical stance arising from the premise of care ethics (Barnes et al., 2018); we believe that there are better ways of caring for older people and that considerable progress has been made given that these ways are already practiced in a number of care settings the UK. We have endeavoured to capture this practice in order to point the way to creating environments of thriving and fuller lives for older people and all involved in their care.

The concept of ‘relational care’ (sometimes referred to as relationship-centred care, initially proposed by nursing theorists, Nolan, Davies and Brown in 2006) has been more recently developed in the context of supporting older people (Woodward & Kartupelis, 2018; Kartupelis, 2021) – to recognise the primacy of relationships and prioritise the evidence that humans are born to be interdependent, and that very few thrive in situations of isolation or loneliness. We need to give as well as receive, to be recognised as having an intrinsic value,



rather than seen as a collection of needs and demands to be met by others. Where possible, our emotional and physical environments therefore need to facilitate our interdependence and a reciprocal flow of care.

Benefits of relational care that have emerged include its effectiveness in improving the wellbeing of those living and working in care settings and enabling them to live a fuller, more meaningful life. Other significant outcomes identified are increased staff satisfaction, creativity, motivation and retention – all of which help address critical sectoral issues of the wellbeing, training, retention and expansion of the social care workforce (Woodward & Kartupelis, 2018; Kartupelis, 2021).

Although the vital importance of relationships is now widely accepted in the care of older people, favouring the conditions for these to get established has a long way to go, in policy, planning and practice. This can in part be attributed to the way that relational care is a dynamic all-pervasive process affecting everyone in different ways – rather like love, joy or indeed hope – and is therefore not directly measurable, hence too easily dismissed. There are, however, strong and tangible signs of its presence, such as a supportive material environment and managerial ethos (Baylis, 2017; Kartupelis, 2021).

This report is based on a seminal study which builds on and extends existing knowledge about relational care, enabling recognition of its presence and identifying what supports its practice in the care of older people. The project team was led by the Open University and comprised:

- Co-Principal leads: [Dr Manik Gopinath](#) (Lecturer in Ageing) and [Professor Mary Larkin](#) (Professor of Care, Carers and Caring)
- a relational care expert: [Jenny Kartupelis](#) MBE
- research associates: Dr Joe de Lappe and Dr Anthea Wilson
- Advisory Group: this was chaired by Jenny Kartupelis and included leading adult care academics, consultants, and providers (see Acknowledgements)

The study took place in five care settings for older people in which relational care was already being practiced. It aimed to explore and promote the practice of relational care more widely with respect to care settings in order to:

(a) improve the delivery of care and support services

(b) address the critical sectoral issue of the wellbeing, training and expansion of the social care workforce

In acknowledging the seminal nature of this report and its accompanying toolkit the authors simultaneously acknowledge that these are not definitive texts on relational care. Nevertheless, this work is intended to produce the information and tools that both enable providers and practitioners to embed relational care, and act as an advocate for a practice that we believe can be transformative in the current context of social care for older people. The authors also hope that it will stimulate the further research, constructive debate and discussion required to enable all those who deliver and receive social care to reap the benefits of relational care practice.

In this report you will find information about:

- an overview of what is known about relational care in the context of long-term care for older adults
- the key objectives of the project
- how the team carried out the research
- the main findings and why they matter
- the contribution this study makes to enabling relational care and its influence on social care in the UK.

## Literature review for the report

This section provides an overview of what is known about relational care in the context of long-term care for older adults through a rapid review of relevant academic and grey literature. While long-term care refers to the provision of a combination of health and social care services in a variety of settings, the review focuses on care in the context of residential and day care settings (including those providing nursing and dementia care). Given the short timescale of this research project a rapid review to synthesise current knowledge on relational care was used. The rapid review approach is increasingly being used in both health and social policy (Thomas, Newman and Oliver, 2013; Featherstone et al 2015). This approach provided us with a systematic approach to reviewing a specific body of literature, carefully balancing the need for an accelerated review alongside ensuring that the review was fit for purpose and as set out in our search strategy (Wollscheid and Tripney, 2021).

### Search strategy

A rapid review of literature was conducted by a single researcher during April 2022 to consider the extent, breadth, and range of literature concerning what was known about relational care in older adult care settings. In consultation with the Advisory Group, the research team guided the nature and size of the body of literature reviewed.

The review was limited to peer-reviewed articles published globally in English with no limit as to date of publication. Four databases were searched iteratively using “relational care” as a key term: OVID, PubMed, Scopus, and Google Scholar. This yielded 398 results of which 127 were duplicates leaving 271 results. Following screening, 227 of these results were excluded as irrelevant to the review leaving 44 papers. This was because they did not focus on relational care given to older adults aged 65+ in older adult care settings such as residential and nursing homes or day care centres. The majority of papers excluded focused on aspects of relational care in health care settings, or they focused on the wrong population. Eleven papers were found which were relevant to the review but written in French with no English translation. These papers are noted only because they represent a substantial segment of relevant papers found on the topic. Excluding those 11 papers, 34 papers were included for review to which an additional nine papers were added through hand searches and based on Advisory Group inputs making 43 papers in total. The few books published on the subject, which arguably offer the most comprehensive studies of the nature and practice of relational care in respect of older people in the UK, are not encompassed within the corpus of knowledge recognised by academic search criteria. We have nevertheless drawn on these and other relevant reports and cited them in the references.

An update of the rapid review was carried out in March 2023. This yielded a further 11 papers. We did not assess the included papers for quality as they had been peer reviewed.

### Themes

A thematic approach to synthesising knowledge on what is known about relational care in the literature was adopted. The key themes that emerged are discussed below.

### ***The concept of Relational Care***

Many proponents of relational approaches to care do not proffer an explicit definition. Those that have done so argue for a *foregrounding of interpersonal relationships*, attentiveness to the *relational needs* of older adults and recognition of the *bidirectional and/or multidirectional relationships involved*. For example, drawing on feminist and nursing theorists, Novy et al (2022) put forward a working definition of ‘relational care’ as ‘... a *bidirectional process, one in which the agency of both people – those who give and those who receive care – is recognized (pg. 2)*’. Other commentators maintain that from a relational perspective ‘care’ is conceptualised not “*solely as a product, an outcome, or a service,*” but rather as a *relationship built upon “trust, mutuality, and respect”* (Armstrong and Braedley, 2013, cited in, Barken and Lowndes, 2018). In a similar vein, Nolan, Davies and Brown (2006) have for long advocated a ‘relationship-centred care’ approach that emphasises positive interdependent relationships – which extend beyond care home residents to include staff and family members – as being fundamental to provision of good care and wellbeing.

Whilst it can be said that an accepted definition of relational care is still evolving, the concept of relational care signals: a rebalancing in language; a focus that encourages noticing and recognising both giving and receiving in care relationships; and an emphasis on the wellbeing of all people involved in care interactions/encounters, for instance, residents, relatives and staff. Such a focus helps avoid binary interpretations of caregiving-receiving which sometimes tend to get emphasised in the narrower interpretations of person-centred approaches in practice.

### ***Why relational care?***

Driving the conceptual shift towards a relational focus are a set of interlinked concerns. One relates to the ongoing privileging of physical over socio-emotional and spiritual needs of older people. This is despite an increasing focus on and practice of person-centred approaches to care. Our review highlighted ongoing tensions that staff experience between addressing the socio-emotional and spiritual needs of residents and responding to the pressures of highly regulated care work environments (Banerjee et al 2015; Miller and Barrie, 2022). This has implications for wellbeing of care home residents who may not only receive de-personalised care but also are not seen as ‘human beings’ (Storm, Braedley and Chivers, 2017). Another concern relates more broadly to the discourse of care, where simplistic notions of caregiving as flowing from the caregiver to the care receiver are employed. Consequently, care is not only made invisible and de-valued but, implicitly, older care home residents are also positioned purely as recipients of care (Novy et al 2022). A third concern pertains to the strong emphasis on individual autonomy, independence and decision making in narrower interpretations and applications of person-centred approaches to care, especially care for people with dementia, (Jonas-Simpson et al 2022). The review showed that researchers are beginning to respond to these concerns by highlighting the limitations of person-centred care in terms of the way it obscures embodied selfhood and the relational embeddedness of human life, thereby potentially threatening wellbeing of people with dementia (Denier and Gastmans, 2022).

### ***Care staff and resident relationships***

The review highlighted that the majority of research arguing for or citing relational approaches to care focuses on the value of resident-care staff interactions and relationships. It showed that many frontline care staff recognise the value of meaningful interactions and relationships with residents as a way of attending to their relational needs, i.e., social and emotional needs (Daly and Szebehely, 2012; Banerjee et al 2015; Storm et al 2017; Muller, Armstrong and Lowndes, 2017; Miller and Barrie, 2022).

Knowing and being known is not only seen as important for assessing and delivering good care in personalised ways but also promotes trust-building and reciprocation in one form or another. Examples included the way it led to staff creating opportunities for residents to experience participation in valued activities and identities, or encouraging them to tell their stories and importantly, to contribute to the life of the care home and/or wider community (Rockwell 2012; Heggstad and Nortvedt, 2015). This suggests active listening on the part of staff to demonstrate genuine interest and identify what is meaningful to residents with the intention to act on this. Some also articulate the mutual benefits of meaningful engagement and interaction often expressed in terms of experiences of mutual recognition and appreciation, satisfaction, joy and happiness for both residents and staff (Banerjee et al 2015; Jonas-Simpson 2022).

One study also makes visible the role played by domestic staff in attending to the socio-emotional needs of residents through developing relationships with them (Muller, Armstrong and Lowndes, 2017). This draws attention to the absence of any exploration of relationships between residents and other staff members (e.g., handymen, gardeners and administrative staff) in the practice of relational care.

While context of each study varies (e.g., mealtimes, daily care, end of life care) some common themes emerge. These relate to features and aspects of the ways in which care is enacted, the role of creative practices and the physical environment to facilitate relationships, and challenges to relational caring

### ***Relational care practices***

Practices that support closer relationships addressed in this review included: staff building trustworthy and respectful relationships with same group of residents, to know and be known by them; seeing care as a shared endeavour; interacting with residents during and beyond everyday tasks; being attentive to residents' relationships with other people, the environment and material objects; making efforts to understand and be understood, especially with people living with dementia; comforting, listening and being listened to; enabling participation in the life of the community; choosing and using technology that promotes rather than substitutes for human engagement; in other words, 'doing with' rather than 'doing to' (Storm, Chivers and Braedley, 2017; Prasad, 2019; Kartupelis, 2021; Novy et al 2022). Some commentators highlight the role of 'object-person' relationships in care practices (Lovatt 2021; Lee and Bartlett, 2022). This emerging body of work recognises the role of everyday material objects (e.g., curling tongs, photographs) in facilitating interactions and relationships amongst residents, and between residents and staff as well as supporting identity maintenance and decision making for residents.

However, literature focusing specifically on practices that foster relational care for mutual participation, reciprocity and wellbeing from the perspective of residents and staff is largely absent. A qualitative study on end-of-life care in 20 nursing homes across Northern European and American countries is an example of research which identified some such practices (Banerjee and Rewegan, 2016). Those identified included: staff forums for sharing knowledge and experiences for informed end of life care decision-making; open conversations with families about dying to clarify preferences and build consensus about care needs at end of life; sitting with the resident at end of life; a memory book honouring the deceased residents that offers residents and staff alike the opportunity to condole; and allowing the deceased person to stay in the room to enable people to pay their last respects.

### ***Creative practices***

An emerging body of research about the limitations of person-centred care and medical models of care argues for 'relational forms of care' and 'living'(e.g., intergenerational interaction and living) to promote involvement of people with dementia as engaged and valued citizens (Prasad, 2019; Røhnebæk, 2020; Jonas-Simpson et al 2022). Here the emphasis is on generating opportunities and spaces through creative practices (e.g., art, intergenerational interaction) to support relational care practice. This enables people with dementia to experience engagement through socialising and participation and enables reciprocity, recognition and contribution. While stressing the benefits of art-based activities in promoting the wellbeing and agency of all involved, commentators note that this requires developing relationships beyond the care home to include families, volunteers and the wider community. As such, this body of work also points to the significance and consideration of relationships between care settings and wider community as an important focus in the practice of relational care. Furthermore, some stress the need for collaborative skills to engage with wider communities (Røhnebæk, 2020).

### ***Environment***

The role of the physical and social environment of the settings in facilitating relationships is yet another theme. Built environments and spaces can be intentionally designed to encourage flow and spontaneity, i.e., ease of movement and offer opportunities to experience social interaction and participation in the daily life of the community. Features of these environments and spaces identified as being important within relational care include well-maintained interiors overlooking green spaces or streets where people can be observed, home-like ambience and design, family-style dining areas and co-location of care settings next to markets and services (e.g., community and activity centres) to enable getting out and about for residents and relatives (Ducak, Keller and Sweatman, 2015; Prasad, 2019; Jonas-Simpson et al 2022).

The physical and social environment is also important in supporting relational approaches to end-of-life care. For instance, private space for goodbyes in the form of purpose-built rooms and appropriate care and facilities (e.g., rooms for overnight stays) for families; permitting staff to sit with the resident and for grieving (Banerjee and Rewegan 2016).

### ***Challenges to relational caring***

Lack of time to encourage relationships and/or sit and interact with residents is often cited as an issue in reviewed literature. Perception and use of time can however vary amongst staff for

instance, *doing with* residents (e.g., singing together) can shift and align the pace of care activities (Novy et al 2022). Furthermore, a ‘fun’ relational care activity, such as singing, while beneficial for residents can also be perceived as challenging and embarrassing as it requires care workers to step out of their comfort zone and professional boundaries, suggesting the need for a different mindset and skill set (Røhnebæk, 2020).

Novy et al (2022), however, note that the issue of time also relates to whether relationships as the basis for good care are valued, i.e., seen as worthwhile and accordingly prioritised. Additionally, if (creative) activities are seen as interventions rather than as mediums to achieve relational care, embedding (creative) practices of relational care in everyday care interactions can be challenging (Jonas-Simpson et al 2022).

When relationships are experienced as meaningful, not being able to spend time to comfort and support residents, especially when they are upset or agitated is hugely distressing for care staff (Storm, Braedley and Chivers, 2017). Banerjee et al (2015) further note that end of life care heightens the need for, and time required to provide relational care – being present for the dying person, building trust and consensus amongst staff and families about uncertainty of the dying process and supporting both staff and families.

In the context of end-of-life care, however, relational care approaches can also present a challenge. This is exemplified in the end-of-life care where the experience of grief amongst staff often goes unrecognised and unaddressed with implications for staff wellbeing, engagement and building relationships. Lack of appropriate support for processing grief may encourage scepticism about relational approaches to care (Banerjee et al 2015; Molloy and Phelan, 2021).

### ***Staff-staff and staff-care home relationships***

Literature that explicitly attends to relationships amongst care staff and staff-care home (organisation) relationships is limited. Storm and colleagues (2017) use the term ‘relational care model of organisation’ to consider staff-care home relationships but do not offer an explicit definition. Drawing on an ethnographic study of two nursing homes in Canada, they distinguish between relational and rigid models of organisation. A ‘relational care model of organisation’ is understood as one that promotes a culture of relationship building between residents and frontline care staff and by extension, continuity of resident-staff relationships. In practice, this translates into bottom-up approaches to teamwork and responsibilities that are not determined by adherence to specific care norms or routines and occupational hierarchies. Emphasising worker discretion and flexibility in decision-making, care staff have the freedom to decide what, when and how (e.g., flexibly decide whether to work alone or in pairs) care tasks are accomplished, in ways which favour relational needs and resident preferences. In addition, the review highlights that lack of care worker discretion in organising day to day care interactions, rotation of staff, inadequate staffing combined with heavy workloads and insufficient time often result in poor working relationships amongst the care team (Daly and Szebehely, 2012; Banerjee and Rewegan 2016).

Similarly, in relation to cleaning staff, Muller and colleagues (2017) note that settings that favour relational needs and flexible division of labour work towards blurring divisions between cleaning and caring. Yet, the skills and relational care provided by cleaning staff may not be



formally recognised or rewarded, for example, through acceptance into care teams. Furthermore, knowledge that cleaning and other housekeeping staff, such as receptionists and maintenance people hold about residents and their families may not be communicated and shared with wider team unless they are recognised and included as full members of the team. Poor working relationships amongst staff, staff hierarchies and lack of timely sharing of information are likely to adversely impact residents' and staff experiences of care.

Others highlight the need to pay attention to broader structural issues, such as understaffing, and de-valuation of care staff reflected in low status and pay (based upon assumptions of care provision as a 'low skill' occupation) that require a policy response and cannot be dealt with at the level of care homes (Banerjee et al 2015).

Commentators argue that a relational model of organisation is not only considerate of both residents and staff but better able to deal with conflicts relating to gender and race. Storm et al. (2017) notes that care homes that encourage relational care, and especially personal discretion in organising everyday work were also more accepting of male (Asian) care workers and viewed positively by female co-workers. (In)equitable gender and race relations can shape whether and how care workers are accepted by residents and other staff. Olaniran-Alimi, Natalier and Mulholland (2021) describe how despite being skilled and trained, female African care staff are routinely denied the opportunity to develop relationships of care with residents who resist being cared for by them. Furthermore, this is reinforced by colleagues who rely on a resident's right to choose who provides their care, thereby reproducing discrimination and racism.

Owen and Meyer (2012) adopt a relationship-centred care approach to explore relationships between care home managers and staff from the perspective of managers. Managers revealed that practicing relational care means a shift in leadership style from 'telling staff what to do' and 'handling residents' to 'doing with'. This required incorporating practices of open dialogue and listening, validation, appreciation and role modelling – to manage conflicts as well as to promote connectedness amongst staff and with older people.

Relational approaches to care can influence staff recruitment and retention. Lack of attachment between residents and staff is a strong predictor of staff burnout and turnover. (My Home Life, 2007); Gallagher makes the point that abusive behaviour can arise from the devaluation of caregivers' (Scott ed., 2017). Kartupelis (2021) citing these, concludes, 'Once relationships become established, less maintenance time is needed, making not only for a happier situation but a more cost-effective one. Continuity of care is both a moral and economic imperative' and the link between relational care and staff retention should be 'given priority').

### ***Care home - family members and wider community relationships***

Although research identifies and acknowledges the role of family members in meeting the relational needs of their loved ones in the care home, there is very limited exploration of how care home-family relationships are developed and maintained. Drawing on ethnographic fieldwork in nine Canadian and six European care homes, Barken and Lowndes (2018) identify practices that support meaningful relationships with care home staff and participation of family members in the life of the homes. Underpinning these practices was effective

communication between staff and families together with time and resources to support communication and welcoming environments. However, they found that such practices are an exception as opposed to the norm.

Barken and Lowndes (2018) found that where staff spent time with families to share and exchange knowledge at the very outset and on an ongoing basis, this facilitated a safe environment within which any conflicts and complaints were voiced and attended to. The mutual dimension to these family-staff relationships was evident in the way that staff valued any appreciation they received from family members. Families reported valuing opportunities for meaningful participation and support to maintain relationships to the extent desired. Opportunities for participation included being able to join in meals and having spaces in which for families could interact. Homes that were located near markets, or services facilitated family engagement by offering families opportunities to take their loved ones out, for example for a walk or a meal. During end-of-life care staff support for family members through information sharing and being available to them, and the provision of physical spaces, (such as overnight rooms) to stay with the resident was valued by family members. Staff in turn appreciated opportunities to attend funerals as part of the grieving process and to maintain contact with families.

Pereiria, Myge and Hunter (2012) explore volunteers' experiences of volunteering with people with advanced dementia in the context of end-of-life care in Canadian care settings. The study highlights how volunteers build multi-directional relationships with residents, families and staff. Spending time with residents helped volunteers to learn about dementia, recognise non-verbal cues, be flexible and tolerant in relating and enacting empathy. This in turn strengthened communication, interaction and mutual recognition between volunteers and residents. The volunteers also worked with family members to learn more about residents and how to interact with them, and families appreciated it when volunteers could spend time with their loved ones, especially where routine visits were not feasible. Staff help and assistance to understand the role boundaries and requests for informational support were appreciated by volunteers. Equally, being called upon to assist staff was affirmation of their role as members of the care team.

### ***Discussion***

Although the focus of this review on residential and day care settings only, and the use of search term 'relational care' specifically, may have resulted in some relevant references being missed, it does give important insights into how the concept of relational care is understood and employed in literature.

We found that the term 'relational care' was rarely explicitly defined. The majority of the studies identified relational care as synonymous with meeting the socio-emotional needs of older adults in addition to physical personal care. As such, building relationships was seen as important in meeting the socio-emotional needs of older adults. A few articles emphasised the bidirectionality of relationships between care staff and resident. Here the emphasis was on building relationships of trust for mutual engagement and wellbeing. These two distinct interpretations suggest diverse understandings of relational care that are likely to shape and influence care practice(s) in different ways.

The literature profiles the centrality of relationships for residents, staff, families, and volunteers. Some studies address different types of relationships (such as, between staff and families, wider community and care homes, volunteers and amongst care staff). In so doing they also highlight the significance of considering the perspectives of families, staff, non-care staff and volunteers as well as exploring how different configurations of relationships (e.g., amongst staff, staff-volunteers, volunteers-families) shape experiences of care and wellbeing for all involved. Relatively few studies focus separately on different types of relationships, suggesting the need for further research to acknowledge and take account of the multiple relationships involved in the dynamics of long-term care. More research is needed to explore resident-resident relationships in care settings.

The rapid review also sensitises us to some relational approaches to care: doing with rather than doing to or telling; creating opportunities for engagement and contribution; appreciating; open communication; sharing, pooling and exchanging knowledge; flexible working practices; continuity of staff and support for families, staff and volunteers (including appropriate training). The significance of physical environment, locality and objects in facilitating and sustaining relationships is also highlighted. However, literature that specifically explores relational approaches to care and how to develop practices that support positive relationships (e.g., amongst staff, staff- families, staff-residents) is limited.

In addition to providing some invaluable insights, the rapid review highlights gaps in knowledge and suggests the need for:

- further definitional clarity of the term 'relational care'
- further research to account for the multiple relationships within an explicit recognition of bi-directional nature of care relationships amongst different actors
- extending the understanding of care staff to include housekeeping staff, such as cleaners, administrative staff, maintenance people and gardeners
- developing an understanding of how interactions within different types of care relationships shape and influence experiences of care for all involved
- identifying and characterising interactions between care actors in different kinds of relationships with a view to capturing both what relational care looks like and processes that make it work in practice
- the role of time
- the role of objects and the physical environment

Our review of literature informed the development of our research questions, our methodological approach to data collection and a topic guide for the interviews and observations in the care settings (see Methodology section and Appendix 1).

## Methodology

The focus of this seminal study was on identifying factors that support exemplar relational care practice. It addressed three key questions pertaining to the presence and practice of relational care in the care of older people:

1. What does it feel and look like?
2. What processes and mechanisms are involved?
3. What features of the physical space enable this type of care?

In answering these questions, the study aimed to:

- identify the dimensions of relational care
- produce a model of relational care that can be adapted for use in a range of care settings
- produce a toolkit that can be used to delineate and assist adoption of the key criteria that support relational care
- promote the use of relational care through practice and policy to improve wellbeing in the sector

A qualitative mixed method approach was adopted which included semi-structured interviews and ethnographic observational methods involving the use of field notes. Ethical approval was obtained from The Open University's Human Research Ethics Committee (HREC).

Conceptually, the data collection, analysis, and outputs were underpinned by Appreciative Inquiry (AI), a strengths-based organisational model that seeks to engage stakeholders in positive self-determined change (Cooperrider, Whitney and Stavros, 2008; Sharp, Dewar, and Barrie, 2016). AI identifies what already works and builds on it through recognised steps to meet the aims of the study. These are: discover, dream; design and deliver.

The researcher sensitised himself to care settings by undertaking some preliminary visits before carrying out field research in five care settings across the four UK nations. These included residential homes, day centres and supported sheltered housing all of which varied in terms of size and ownership. Domiciliary care was excluded because of the confines of the study and the significant differences between domiciliary and residential care practices. In consultation with the Advisory Group, the care settings were purposively sampled as exemplar case studies of relational care in practice. The field research, together with a topic guide for the interviews and observations in the care settings (see Appendix 1) were informed by a rapid review of academic and grey literature relevant to the aims of the study.

One day observational visits were made to each of the selected care settings during which the following interviews were conducted:

- with a manager, a member of staff, and resident or a day centre user. Where possible a volunteer, and a family member of a resident/day centre user were also interviewed. The intention was to elicit their views and experiences of relational care in practice. A total of 19 interviews were carried out.
- detailed observations of relational care in practice e.g., how it was expressed in the observed relationships between those present, how it was experienced, and how the

physical environment of the care setting manifested relational care. Where approval was obtained photographs of the physical environment of the setting were taken.

After each visit, the observational notes were written up and the interviews were professionally transcribed. NVivo was used to support the organisation and coding of the interview transcripts and the observational notes. An iterative process of interpretation of the data by the whole team enabled theme and vignette development. The themes and vignettes which were then developed informed the project report and the toolkit.

The researcher subsequently conducted follow-up audio-recorded semi-structured interviews (see Appendix 1) on Teams with four of the five<sup>1</sup> care managers previously interviewed in the first stage. These interviews were used to ask questions arising from the interrogation of the data and gather feedback about the first draft of the relational care toolkit. The data gathered were transcribed and used, alongside the feedback from the Advisory Group, to refine both the report and the toolkit.

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<sup>1</sup> One of the care managers did not have the availability due to pressure of work commitments and a holiday clash

## Findings

In line with the tenets of Appreciative Inquiry, the research team identified exemplars of relational care practice through an iterative process of data interpretation. This was primarily an inductive approach, in which each team member identified and refined their conceptual understanding of relational care by repeatedly engaging with the interview transcripts and the ethnographic notes. Three main themes emerged from this iterative process as we sought to create a cohesive response to the questions about the look and feel of relational care, the processes involved, and the features of the physical environment.

As exemplars of good relational care practice, the settings we investigated demonstrated that they had practices and were able to provide conditions that nurtured human flourishing and trust. The analysis was underpinned by a focus on relationships. This was because our review showed that relationships between staff and residents, the most widely studied aspect of relational care, were significant not only for establishing how staff might foster relationships with residents, but also any reciprocity in those relationships. We also found that relationships amongst the staff were important for establishing whether the principles of relational care extended to interactions between staff. Similarly, as a result of doing the rapid review we were interested to know how relationships amongst residents could develop and thrive in a conducive care setting. As it was also clear that care settings, being embedded in communities, needed to connect with those communities in order to thrive, relationships between the setting and the wider community, including families, were another important focus in our analysis.

Fundamentally, we explored how these settings could function as nurturing communities, through relationships. As such, exploring people's relationships with objects and the physical environment became a significant element of this research as well. Therefore, we also maintained a focus on how relationships with places, spaces, objects and technologies could underpin and facilitate relational care.

By maintaining a focus on the four relationship categories alongside the physical environment, we hoped to reveal rich insights into how the various relationships worked, how they could be maintained in a residential or day care setting and their effect on people's lives.

In response to the three overarching questions underpinning the research regarding the look and feel of relational care, the processes involved, and the features of the physical and material environment, the resulting three main themes identified were:

1. An **atmosphere** of respect, trust and inclusivity that nurtures belonging
2. A purposeful focus on **relationships**.
3. A **physical environment** that facilitates relationships and autonomy.

During the final stage of the analysis these themes and their subthemes were developed into a model of relational care. This can be found in Figure 1 and is discussed in detail using data from the study in the rest of this chapter<sup>2</sup>. As demonstrated in the discussions, many of the components of relational care overlap.

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<sup>2</sup>

**M/F** are used to denote whether the respondents were male or female.

The key used for the settings where the data was obtained is:

**S1** Day care centre

**S2** Supported Sheltered Housing

**S3** Residential care home with specialist dementia care

**S4** Nursing homes with dementia care

Unless specified otherwise the generic term 'care setting' is used. Similarly, the term 'resident' is used to refer to all older people receiving any kind of personal care in any care setting.



**Figure 1: A model of relational care**

An <b>atmosphere</b> of respect, trust and inclusivity that nurtures belonging	A purposeful focus on <b>relationships</b>	A <b>physical environment</b> that facilitates relationships and autonomy
<ul style="list-style-type: none"> <li>• Leaders and managers create a home-like environment in which all those in it can flourish and thrive</li> <li>• Residents feel a sense of belonging and sufficiently 'at home' to enjoy freedom of expression and find meaning in their lives</li> <li>• Visitors experience the setting as welcoming and accommodating</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Between staff and residents e.g.</b> <ul style="list-style-type: none"> <li>➢ Staff undertake activities 'with' rather than 'doing for' residents</li> <li>➢ Residents can take active roles and are involved in decisions and planning</li> <li>➢ There is mutual togetherness, reward, mourning, and fun</li> </ul> </li> <li>• <b>Amongst residents e.g.</b> <ul style="list-style-type: none"> <li>➢ Residents have opportunities to support one another and develop friendships</li> <li>➢ Mealtimes are protected and valued as opportunities for conversation</li> </ul> </li> <li>• <b>Amongst staff (including staff and management) e.g.</b> <ul style="list-style-type: none"> <li>➢ Communication systems support effective practice and teamwork</li> <li>➢ Trusting relationships and flexibility ease the management of actual or potential conflict</li> <li>➢ Work-life balance is supported and respected amongst the staff</li> <li>➢ Staff feel respected and valued, which empowers and enables them to nurture others</li> </ul> </li> <li>• <b>Between the care setting, the family and the wider community e.g.</b> <ul style="list-style-type: none"> <li>➢ Family relationships, friendships and relationships with significant animals are fostered</li> <li>➢ The setting acts as a focal point for the local community</li> <li>➢ The community/locality outside the setting is accessed/accessible</li> <li>➢ There are regular celebrations of national events and local milestones</li> </ul> </li> </ul>	<p>Examples include:</p> <ul style="list-style-type: none"> <li>• Room layouts allow for private and communal spaces (inside and outside)</li> <li>• Recognition and encouragement of meaningful objects and activities</li> <li>• Use of communication and other technologies to release staff time</li> <li>• Use of assistive technology to support autonomy and foster relationships such as mobility aids, gadgets and entertainment equipment</li> <li>• An 'Open door' to the manager's office</li> <li>• Private spaces for staff</li> </ul>

## 1. An atmosphere of respect, trust, and inclusivity that nurtures belonging

Creating an atmosphere of respect, trust and inclusivity that nurtured belonging depended heavily on leadership encouraging certain attitudes and values to cascade through the whole setting. We learnt from staff that they valued coherent and supportive approaches to practice. Residents told us about what made them feel at home, and we observed instances where residents were able to express aspects of their identity as well as their opinions. The impressions gained by visitors of a home-like, welcoming place resulted from a range of efforts to create this environment.

A home-like environment enables sense of belonging, freedom to act, and is also warm and accommodating for everyone who lives, works or visits the facility. This section presents how such an environment can be achieved in practice, from fostering a sense of being at home, to everyone feeling a sense of belonging and freedom, and to presenting a welcoming accommodating environment. Within that, leadership is key.

### Creating a home-like environment



The ability of staff and managers to create a home-like environment in which all those in it flourish and thrive greatly depended on the quality of leadership. Leadership had the power and ability to facilitate a relational care environment that permeated and encompassed the working lives of the staff as well as the everyday lives of residents and their families. Managers also valued their relationships with the local community, reaching out and maintaining community bonds and realising the all-round benefits of porous boundaries. These 'porous boundaries' extended to staff, residents, and their families. Leadership started with recruiting the right staff, as well as helping staff to feel at home.

*'it's about making sure the person is right for the role. So I think what we try and remember is at the end of the day this is the residents' home and it has to be a member of staff who truly cares' (Care manager (F), S4)*

*'when I entered [S3], the atmosphere, the welcome and the staff, the first manager that I met, she was a... very wonderful lady and I'm glad that I worked for her ...*

*everyone welcomed you with a smile ... so that's what made me just say, OK, this is where I want to be' (Care worker (F) S3)*

Relational care leadership also gave staff permission to talk, spend time, and nurture relationships with residents. Flourishing and thriving would be difficult without sufficient staffing levels. One setting we visited reported recruiting to 120% to provide a buffer for holidays and staff training, and another 110%. Where there was sufficient staffing, this allowed for flexible access to staff training as well as opportunities for formal and informal learning conversations between staff and managers. Since the Covid-19 pandemic, the amount of e-learning had increased substantially. Also of note were the opportunities for informal learning. Staff could exchange information during everyday conversations and, for example, in regular 'stand-up' meetings.

Additionally, careful and purposeful choice of language could set a suitably respectful tone for a home-like care setting. Rather than using terms derived from medical jargon such as EMI (Elderly mentally infirm) or care jargon such as 'double handling', alternatives were introduced, namely 'dementia care' and 'two people needed to assist someone'.

Above all, the managers in the care settings held dear their values, based on respect for others, that they endeavoured to keep alive for everyone. One manager mentioned the 'five values' promoted in their organisation: growth, individuality, togetherness, openness, and quality. 'Living' any values relied on an organisational culture that allowed embedding of these relational care values such that they were taken to be part of life.

*'I think it's just about [staff] feeling involved, feeling important, valued. You know, if they know that they've got the support there, not just from management but their colleagues as well, and working as a team, you know, knowing that you're supporting each other.'* (Care manager (F) S4)

A key ingredient of a home-like environment is a sense of belonging, which is the next sub-theme to be discussed.

## A sense of belonging for everyone



For residents to feel a sense of belonging, they needed to feel sufficiently 'at home' to enjoy freedom of expression and find meaning in their lives. We observed residents voicing their opinions (negative as well as positive) as well as finding other ways to express themselves. By developing a sense of belonging and freedom of expression, it appeared that residents were able to find meaning in an initially unfamiliar home setting.

The value of a sense of belonging was seen in the following account of a daughter talking about what happened after her mother had settled into supported sheltered accommodation; having meaningful interactions with staff and fellow residents meant that her mother had begun to thrive.

*'When mum first came in and she met all the different staff... and they had commented the next time they saw me how much mum had come out of her shell. She was telling me about Kevin and his daughters, about Barbara and her husband, about one of the other girls winning on the bingo and those sorts of conversations and even about the other residents who were coming and going. For me, [addressing her mother] your world suddenly got huge again, which was lovely.'* (Daughter of a resident, S2)

We noted how residents were able to express themselves freely through choosing how they spent their time, knowing how to raise issues, being supported to do things they enjoyed, and having the freedom to appreciate the simple pleasures of life. For example, staff told us that it was up to residents if they wanted to get out of bed at a certain time, or whether they ate breakfast in their room. A cleaner explained how residents in sheltered accommodation had a number of routes if they wanted to complain; they could send an email to 'head office' with a complaint or bring up issues in a meeting between staff and residents.

Regarding enjoyment, some residents described what they enjoyed doing and the flexibility of choice afforded to them. Staff and residents alike gave us examples of how residents were facilitated to express themselves through meaningful activity and by enabling simple pleasures.

*'I enjoy most of the activities that are put on for the residents. If there's a quiz on, I'm your person.... I watch a lot of television because I'm very interested in sport, and I've been very fortunate since I came here that there's been wall to wall sport. But I can do other things as well... As far as I'm concerned I wake up and think right, what am I doing today? When am I going to do my Gaelic? Who's coming to visit...? What's on the noticeboard for entertainment?' (Resident (F) S4)*

*'We used to have a lady here ... and she used to bake bread and ... if she wanted to bake bread that was absolutely fine.' ('Host' (F) S4)*

*'M\_\_ she's got a pot of flowers out in the garden, a nice big pot of pink flowers and she'll sometimes, when the weather's nice she'll sit out there in the afternoon.'* (Lifestyle lead (M) S4)

A sense of belonging could be strengthened by having a welcoming and accommodating environment, which is the subject of the next section.

### **A welcoming and accommodating environment**



The impressions gained by visitors of a home-like, welcoming place resulted from a range of purposeful efforts to create this environment. This experience could be created both by the look and feel of the home and also welcoming practices by all who occupied the setting's community.

The first impression a visitor gained of a care setting could be highly influential. A warm welcome and a pleasant smell helped people to feel they could belong in the setting. In the next quote, a resident remembered previous experience of looking for a home for her mother.

*'Well one of the things that struck me when I was looking for a home for my mother the minute that I went into a home was the smell. I've got a very acute sense of smell, and so had she. And this smells better than my home did.'* (Resident (F) S4)

The impact of a clean and tidy environment was noted during our research visits, as were other physical features such as good internal and natural lighting and windows looking onto attractive vistas. An external resemblance to domestic residences in the vicinity could also heighten the anticipation of a homely welcome. Simple behaviours such as saying 'hello' to visitors on passing inside the home were also signs of a welcoming and accommodating environment. Including visitors in shared activities indicated a place that was accommodating to others. Ultimately, it was the people who created this sense of belonging.

*'I just connect with everybody, that's what makes my day, you come in and nobody feels out of place, you just feel like you're part of the furniture.'* (Host (F) S4)

An atmosphere of respect, trust and inclusivity reflected how these settings were creating a home-like environment, fostering a sense of belonging for residents, and shaping a welcoming and accommodating place for people. The next theme discusses how a purposeful focus on relationships can underpin relational care – the second main theme in our findings.

## **2. A purposeful focus on relationships**

A focus on the value of relationships and their transformative potential lies at the heart of relational care. Achieving good relational care depends on a range of practical measures, some of which did not seem difficult to adopt, given the right support. This theme reflects the various permutations across four relationship categories: between staff and residents; amongst residents; amongst staff; and between the setting and the wider community. Under this theme of a purposeful focus on relationships, we identify some of the mechanisms that can facilitate the benefits of relational care.

According to one care home manager, no-one was excluded from this complex network of relationships:

*'It's about the relationships we've got with everybody... I include the team, the visitors, the residents, you know, everybody... Trying to involve everybody in every aspect of it and just being there for people and building relationships...when somebody is coming to look at the home... the relational care starts from that very first meeting. Whoever it is, it could be the social worker. It could be the daughter, the son. It could be anybody, but that relational care starts then ... It's like a cascade from that minute.'* (Care manager (F) S4)



## Relationships between staff and residents/day centre users



Our ethnographic study enabled observing the two-way relationships between staff and residents. Residents in these settings were not expected to be passive recipients of care, for example, residents and staff alike were encouraged to genuinely share in the fun and rewards arising from activities and conversations. This mutuality also extended to mourning losses, alleviating stress, celebrating joyful life events or planning and looking forward to them. The three sub-themes expand on this mutuality, where the emphasis is on staff doing things ‘with’ rather than ‘for’ or ‘to’ residents so that the latter could take active roles and be involved in decisions.

### ***Staff undertake activities ‘with’ rather than ‘doing for’ residents***

This idea of ‘doing with’ could often be subtle, seen in the way the care and the life of the setting was negotiated on a minute-by-minute or day-to-day basis. A key to the success of residents and staff ‘doing with’ was that both gained something from the experience, whether it be a shopping trip, enjoying a visit to the theatre or cinema, or simply eating together. Sometimes, ‘doing with’ could involve an activity meeting the psychological or emotional needs of both a staff member and a resident:

*‘And obviously with the dementia they’re just as stressed as me at times. So just taking them out for a walk destresses me, destresses them, off we go, let’s just go and get 10 minutes out.’ (Care worker (F) S1)*

At other times, there was mutuality observed by staff, simply by having conversations while undertaking personal care:

*‘I like to sit and like to hear what happened when they were young and things like that, we’re always like talking to them, that’s mostly we’re doing that and then taking care of them, washing them, doing normal things.’ (Care worker (F) S3)*



The subtleties of 'doing with' rather than 'doing for' meant that our field visits were crucial for uncovering these practices. With some probing we were able to discover, for instance, that the positioning of a bird table outside a resident's bedroom window had been a joint undertaking between a staff member and the resident, and that gardening could be a joint activity in which the important part was the process of gardening rather than creating a perfect garden. Observing the shared joy of participating in a quiz was another example we saw of staff and residents 'doing with'.

***Residents can take active roles and are involved in decisions***

In some of the care settings visited, residents could be found acting alongside staff, sharing tasks. These instances provided us with vivid examples of what it could look like when the balance of care shifts from staff 'doing things for residents' to 'doing things together', a further extension of the idea of 'doing with'. The extract below illustrates the ingenuity of staff showed by involving some of the men who attended a day care centre in simple maintenance jobs.

*'The other day we're building a screen, and one of the staff just took three men in the back room and they didn't really help but they thought they were helping holding screws and things like that... and then they think they're buildings things.'*  
(Care worker (F) S1)

Similarly, we observed how a woman attending a day centre was facilitated to act as a cleaner alongside the staff. The woman had previously been employed as a cleaner where she had worn a staff shirt. When she attended the centre, she liked to wear the same staff shirt as members and contribute by cleaning tables and tidying up. The care manager suggested that when she did this her level of dementia was such that she believed she was a member of staff. The staff members encouraged her to do this; they valued her contribution and understood how much it affirmed her sense of identity and status.

Involving residents in decisions could happen through more formal meetings as well as in them helping with the entertainment, for example. A resident who loved being a Bingo caller, for example, would take up that role in a regular Monday Bingo session.

Sometimes, enabling the autonomy of residents could present a challenge for staff to protect a person's safety. On these occasions, staff needed to assess the level of risk and work with the resident and if necessary, their family, to come to an acceptable resolution for all involved.

*'a lady ... likes to go outside all weathers walking in the garden. Now that in itself is not a problem, but obviously safety, she could fall. She [has] dementia, so she does forget things and gets confused. And equally, she's not always a hundred percent able to look at the weather outside and assess the risk of what she wears. So ... she's agreed to let us know when she's going out and when she comes back*

*in so that we're aware she's outside. And we can also then have a quick check to make sure, if it's raining, has she got a waterproof coat on.'* (Care manager (F) S4)

***Mutual togetherness, reward, mourning, and fun work both ways***

Staff gave us examples from their experience of mutuality that illustrated rewards, fun, loss and mourning. A sense of togetherness was evident where residents and staff shared in general family news as well as the pleasures of life's high points, such as the family wedding of a staff member.

*'My first response is to knock the door and then go in and say hello, good morning, how are you? Let them tell you. If their family calls, I'd say will such and such call today, or have you had a wee phone call? Just generally about them, or about what they're going to do... I have four children and my daughter has just got married. So they're all eager to hear about my daughter's wedding and see some pictures and things. So yeah, I share a bit of, not all of my life but snippets of my life.'* (Cleaner (F) S2)

A sense of fun could be shared, partly by staff drawing on their personal interests when participating in activities with residents; a care worker who was interested in history enjoyed running a history and reminiscence quiz in the care home. Another told us how she loved to chat and find out about the past, and therefore really enjoyed the time she spent listening to residents sharing their stories.

A sense of loss could also be experienced mutually between staff and the families of residents. The following example is an account of the heartbreak shared as a resident's condition deteriorated during the lockdown period of the Covid-19 pandemic, when relatives were not allowed to visit.

*'You would FaceTime their family and they'd be there crying, and you'd be crying with them because it's heartbreaking because they can see the change and you've seen the change and it was hard, it was really hard.'* (Host (F) S4)

Clearly, the more difficult emotions, including those related to bereavement, created challenges for all involved. Managers recognised the need to provide support for staff, who had developed close bonds with late residents, and all had responsibilities in supporting bereaved families.

## Relationships amongst residents



Relational care practices most importantly extended to the relationships that residents or centre users developed amongst or between themselves. These relationships were harder to determine, because of the difficulty in obtaining first-hand narratives from residents and because relationships could be so embedded in daily lives that they may be difficult to articulate. Much of this behaviour was observed during mealtimes and during joint activities rather than being discussed in the interviews. Partly for this reason, we noticed how important mealtimes could be for relationships. We also looked for examples of other opportunities for residents to support one another and develop friendships.

### ***Opportunities for residents to develop friendships***

The relational care environments appeared well equipped for supporting the spontaneity and autonomy amongst residents that is required for mutual support and friendships. In the dining space, residents could be observed chatting to each other on their own tables and across tables; it was evident that they were enjoying engaging and interacting with each other over lunch. We observed several occasions where residents were able to support one another and develop friendships. For example, one lady helped to interpret for another who was having trouble with her speech and with making herself understood. On another occasion, two residents showed compassion for another who was self-conscious about her bruises caused by a fall. They spoke to her in a reassuring tone, tried to allay her fears, and encouraged her to take part in the wider conversations they were having at the dining table.

During our snapshot visits, opportunities to witness friendship formation were limited, although this resident was clearly describing the spontaneous development of a friendship:

*'Jack is the first person I met and he was helpful to me when I arrived, and we've been friends ever since, and we happen to be up on that floor.'* (Resident (F) S4)

We observed a quiz which provided an ideal context for consolidating friendships. The activity coordinator encouraged wider participation by differentiating questions for residents with or without cognitive decline. The quiz also highlighted the helpfulness

amongst residents that had developed. For instance, a resident who used to be a teacher seemed to take special pleasure in helping others through the quiz by giving prompts and hints. Additionally, during the quiz, residents became increasingly engaged not only with the questions but with the conversations they were having in their groups with each other.

The settings in our study hosted residents in various stages of cognitive decline, and with or without a dementia diagnosis. Our observations of residents helping one another with activities or communication were therefore significant as they indicated the potential of relational care to enrich people's lives through supportive resident-resident relationships.

### ***Mealtimes are protected and valued as opportunities for conversation***

The care settings placed great importance on protecting opportunities for relationship-building during mealtimes. Snacks and meals were purposefully provided in the dining room and other communal spaces so that residents could be encouraged to mingle. Whilst families were welcome to join their relative at mealtimes if they gave advance notice, families were steered away from calling or visiting at mealtimes without pre-arrangement to avoid potential distractions to the interactions during meals.

*'we just let families know what times residents will be having their meals so that they can avoid those times. Even during visiting, we let them know what times residents will have their meals so that they can avoid those times, and what time'* (Deputy manager (F) S3)

This practice also highlighted how the care setting recognised the importance of relationships with families, again understanding the significance of mealtimes for social interaction. Although such strategies for encouraging social contact were in place, residents' wishes to eat alone were respected.

*'some people, it's their preference, ... they want their meals, they want everything in their rooms, so that's their preference and others, they want to sit with others in the lounge, that is also their preference.'* (Deputy manager (F) S3)

It is worth noting, however, that where residents did choose to eat alone, there was no lack of encouragement for them to join others at mealtimes. Also worth noting is the value staff placed on mealtimes for discreet monitoring of wellbeing or changes to residents.

### **Relationships amongst staff, including staff and managers**

Leadership and management skills, again, underpinned and maintained effective relationships amongst staff teams. We observed the communication systems necessary to support effective practice and teamwork, trusting relationships, and work-life balance for staff. Managers took the attitude that meeting the needs of staff was integral to meeting the needs of everyone. In making the effort to meet staff needs, managers felt that they could help staff feel respected, valued and empowered to nurture others.

### **Supportive communication systems**

There were some important tools that supported effective team communication, most notably a communication book, and care records. A communication book was a low-tech solution to continuity of care, which we observed in the day care and sheltered accommodation settings. Most often, it enabled the day-to-day communications and messages between staff concerning various incidents or arrangements, or tips regarding residents.

The limitations of written communication, whether on paper or electronic, were also recognised, and staff adopted strategies to back up written communications with actual conversations.

*'We have monthly meetings with team leaders, so we look at what we are doing and we expect team leaders to cascade those things down to staff on the unit. Then we have the monthly general staff meeting with all staff, the kitchen, the housekeepers, the care staff, so we discuss a number of issues, including activities on the unit... and then we expect staff to act on the decisions we have made.'*  
(Deputy manager (F) S3)

Staff viewed care records as crucial tools for good communication in the provision of good care. Well-kept and accessible care records relied on staff exchanging and sharing relevant ongoing knowledge and information about residents. In turn, this could facilitate relationships between staff and residents and amongst staff by strengthening teamwork and enabling staff to work effectively. It was clear that care records were only valuable to supporting residents if they were updated regularly and built on regular communication and exchanges between staff.

Digital hand-held care planning technology could enhance the convenience of making care records and reduce the time involved, and therefore support staff-staff communications. Care staff appeared to appreciate the ease with which they could record tasks and other information digitally and quickly.

*'I find it really very helpful to us, because for example it used to be like you have to write, get up this morning, wash and dress. But this is like a tick, you have to tick everything that you've done with this person. Medication as well. If this person is unwell you have to document that you've informed the GP. If someone needs to be seen by the dietician. Everything is in here, it's a really great help. And you notice as well because this like a communication machine to us.'* (Care worker (F) S4)

Staff told us that they were able to record more details of care by these electronic means, which everyone benefited from.

### **Work-life balance**

The success of relational care also relied on managers being mindful of the lives of staff beyond the workplace. When asked what helps make staff feel content, a deputy manager said:

*'I think it's listening to them. ... I have one carer this week who phoned me and said, my auntie, the doctors are saying she won't live for long, can I have emergency leave for the week to be with her? I said, that's fine.'* (Deputy manager (F) S3)

The staff rota was also a key focal point with the potential to foster good team relationships. A request book could help to facilitate appropriate allocation of shifts. Good forward planning along with some mutual goodwill could also enable staff preferences to be considered:

*'We have a book there that if they say please could I have this day off because I've got a hospital appointment or whatever, and we just change it round. If I can't change it round they can ask the others if anyone would mind swapping with them.'* (Care manager (F) S1)

It could be challenging for managers to meet the rostering needs or wishes of all their staff all the time. Some preferred long shifts, others short shifts. A manager we spoke to would try to group shifts together so that staff could have several days off in a row. Despite these efforts, covering the care was the prime driver in rostering and staff needed to accept compromise at times.

### ***Trusting relationships and flexibility***

Conflict can potentially occur at many levels: amongst residents, amongst staff, between residents and staff, and between the setting and regulatory bodies or the wider community. Good communication and information sharing, teamwork, and a foundation of good relationships appeared to help in the management of conflict. In the following example in which staff were exercising vigilance over a potential clash between day centre clients, close teamwork was key to heading off conflict.

*'So that chap, ... you know that if he went near [\_\_\_] that it would kick off, because they're both very strong characters. So ... because you can see the mood changing, and once we know then obviously the girls step in. And if they don't like the look of me, then the next one's behind me until somebody can calm them down.'* (Care manager (F) S1)

The importance of managers who could listen well and respond to staff needs was also seen as necessary whenever problems came up. A care staff member explained to us how important it was that she could discuss any problems with colleagues, including the manager. It was also important to her that her manager acted promptly upon any concerns.

The value of good communication, especially discussing, negotiating and being open to feedback emerged as important practices to ward off any potential conflicts with care inspectors and for building trust and reputation.

*'I think there's a lot of care homes out there still have fear of the inspectors, but again it's communication. It's about if they say something you're not happy with it's about having the conversation with them to find out how they came to that and, you know, show them what you've got to disprove that. You know, you've got to be there. You've got to be supportive with them. You've got to show them what they're looking for, not just hide away from them.'* (Care manager(F) S4)

Trusting relationships, then, depended on openness, support, negotiation, and flexibility.

### ***Staff feel respected and valued***

The managers we spoke to repeatedly emphasised the importance of ensuring staff knew they were respected, valued, and therefore empowered to nurture others and receive nurture. We sensed that this empowerment could extend to staff being open to reciprocity with residents, therefore accepting that residents could also show an interest in and adopt a caring attitude towards them, as previously illustrated.

Care staff described how they felt able to discuss anything that could be potentially uncomfortable with their managers. Managers who adopted an open attitude to feedback from staff and residents could smooth the way towards trusting relationships. If a manager had previously worked in a hands-on care role, this appeared to help cultivate trust and mutual understanding within the team. In the following interview extract, a manager told us how her background as a care worker helped her to be approachable.

*'Every week I'm checking in on people. Are you OK, any problems, do you need any help with anything?... A lot of the time they'll just want to vent about things, and I get that because I've been there. They just want to get something off their chest ... because I've done the job and still do the job and I've worked my way up, they know that I know what they go through on a day-to-day basis ... so they feel very comfortable coming to me and asking for advice about things; whereas maybe they mightn't feel as comfortable with senior management who've never done the job.'* (Support manager (F) S2)

Consistency in team communications was instrumental in helping staff to feel valued. Regular staff meetings, along with maintaining open channels of communication, could ensure everyone understood what they needed to do, and how. Perhaps the litmus test of whether or not staff feel respected and valued is seen in the small gestures, such as making the effort to say goodbye at the end of a shift.

*'You've got to make people feel valued and respected, because if you don't respect people they're not going to respect you ... when somebody's going home they rarely leave the home without, if I'm in the office, calling, cheerio G\_\_ and I will always, if I can, say, thank you for today ... It means a lot to me when somebody takes the time to say they're going.'* (Care manager (F) S4)





Sometimes, new staff felt the attraction of the setting as a workplace because of family connections.

*'Why I came to [care home], well, one of my family works here, my mother works here and my sister. My mum had been a carer here for, I think, four or five years prior to me starting ... and she enjoyed it here, she said it was nice to work here and when I came here I felt like I fitted in straightaway, everyone was really nice.'* (Lifestyle lead (M) S4)

This example also shows how important family connections and word of mouth could be for recruitment and retention of staff.

The healthcare teams based in the community were also nurtured as part of the wider network of relationships. This included GPs and the multidisciplinary primary care team. Again, staff in a care home valued the importance of developing harmonious relationships and respectful communication.

### **Developing the setting as a focal point for the local community**

Being open to members of the community also enhanced the vibrancy and the welcome of the setting. A care manager explained how close-knit the relationships could be within the locality:

*'We had a huge Jubilee party that we invited the locals to, so there was quite a lot of people who would have come to our day care services, so we made sure and asked them first, because it's keeping those links. Because a lot of the time they're ex-neighbours or they're family members, everyone round here is related.'* (Care manager (F) S4)

As a focal point for the local community, the care settings we visited were ideally placed to draw people in to prepare for and enjoy special events or regular occasions. Special events attracted people across the generations to gather together and take part in the life of the setting. Valuing this multigenerational aspect of community links became a frequent message in the data, as exemplified here:

*'So any summer fayres we've had, anything weekends. At Christmas all the kids came with Father Christmas, dressed as the elves and the fairies. So we bring our pets in. ... families, especially my family have always been involved. They did all the pot plants outside for us. My husband, when we were doing the work on the building, he was here every day painting. He was doing it for me, whereas I was doing it for work. So everybody's family, they're all supportive of us here. I know it's an old cliché, we are one family.'* (Care manager (F) S1)

Regular religious services were also able to bring in the wider community. There were different ways of delivering religious services, which diversified during the Covid-19 pandemic. One care manager described how each Sunday a different denomination would arrive to take a

service, along with people arriving from the local area. During the pandemic, some of the local priests were able to record services and put them onto YouTube for the care home to access.

### ***The community/locality outside the setting is accessed***

Links with the local community were also fostered through outings. Although these were inevitably much more popular in the summer when the weather was more amenable, special occasions such as Christmas also prompted the organisation of visits. Planning was important, as was involving residents in the planning, doing it together and looking forward to it together, which was a crucial element of relational care.

*'In the summer we will try to plan outdoor events ... residents going to the park, residents going for shopping. We have a few residents who will want to shop every day. ... the other time they had gone to Royal Albert Hall for a tea dance where people are invited. ... next weekend ... one of our sister homes, they had invited them for a Christmas lunch.'* (Deputy manager (F) S3)

*'Last week [the activities coordinator] took a couple of gentlemen down to the pub because she'd been talking to them and the two of them were sitting there and said, do you know what, the one thing I want right now is a cold pint from a pub. So the next day ... her and one of the other staff just took them down to the local pub and sat outside with a pin.t.'* (Care manager (F) S4)

Staff would often think up ways of making outings relevant to residents, such as supporting them to take letters and cards residents had written to the post office.

Newspapers could provide a valuable link to the wider world and some care settings enabled this link by providing a newspaper stand where the residents could go and pick their newspapers. The librarian local to one of the homes would come in regularly to top up books. We also noted that some residents were able to use computer tablets for accessing news and other sources of information.

### ***Celebrations of events and milestones***

Sporting and cultural events punctuated life in the care settings. The settings we visited looked for opportunities to celebrate a special occasion. In so doing, they were recognising the wider cultural significance of certain events and were able to foster the community feeling within the home, giving people opportunities to work together.

*'We're lucky to have a really large, beautiful garden, we've used that a lot, so we've had our own Glastonbury in the garden ... we've had some of the bands and singers who come to us ... And we've had them out in the garden with our shandies and whatever. We try, all the big major sporting events and things like that, we celebrate, so when Wimbledon's on, we all sit and watch Wimbledon and they get their Prosecco and their strawberries and cream and their scones and everything. We had a huge Jubilee party that we invited the locals to.'* (Care manager (F) S4)

The next section discusses the third and final theme about how the physical environment and material objects facilitate relationships and autonomy.

### **3. A physical environment that facilitates relationships and autonomy**

During the research visits, it was clear that the physical environment facilitated the development and maintenance of multiple layers of relationships. This was a complex theme encompassing, in part, the arrangements of physical spaces, such as room layouts, and the use of objects, including communication technologies and other equipment. Assistive equipment could also be key to enabling autonomy. Privacy could be important in relationships too, as well as access to communal spaces that signal a welcoming environment. For example, we observed the contrast between the practice of the manager's door being 'open to all' and the privacy of a staff room where the staff could relax and recuperate.

#### **Private and communal spaces (inside and outside)**



Room layouts provided spaces for shared, communal interaction in both small and large groups. We observed that the spaces in the residential units were sized to balance the need either for company or privacy. Residents' rooms were located nearby to communal spaces with residents free to choose spending time on their own or with others. In communal spaces, flexible seating arrangements allowed the physical environment to be adapted according to the activity. It seemed important that the television did not dominate a room, and that there was a welcoming focal point around which people could gather naturally.

During one visit, for instance, we observed one resident sitting in a chair near the TV in the lounge space watching a programme, while two other residents were conversing on the sofas arranged around the fireplace, creating a focal point to draw people together. One of the two residents would move to watch some TV from an armchair, then go to sit beside the other resident on a sofa to chat about what they had seen. They would then go back to an armchair to watch more TV, and the cycle of TV followed by conversation would begin again.

Hence, the arrangement of the communal spaces allowed a resident to exercise autonomy and be flexible in her engagement with others. Similarly, a care manager explained how they

re-modelled their use of space to maximise opportunities for relationships to develop but recognising that resident preference for peace and quiet would vary.

*'We wanted to have spaces where people could come together, whether it be for lunch or downstairs watching television. But we also wanted spaces where if you had somebody who couldn't handle a busy environment or just wanted some peace and quiet and not be in their room but be somewhere else. The smaller lounge at the side as well we've found has been great for families. ... it's somewhere they can go, have a cup of tea, have a cup of coffee, have a blether between themselves.'* (Care manager (F) S4)

Creating spaces in ways that are attentive to diverse activities, engagement and needs appeared integral to making relational care work well.

Room layouts were also key to creating mealtime environments that were conducive to social interaction. Whilst the practices around choice and autonomy during mealtimes were discussed in the sub theme about relationships amongst residents, the use of spaces at mealtimes was also important. A sense of togetherness could be generated by opportunities for conversation or simply feeling connected by seeing others moving around:

*'It's like at the meal table, I like to see, as I'm having my meal, I like to see people coming and going and things.'* (Resident (F) S4)

Over a lunch, we observed residents chatting to each other in the dining space on their own tables and across tables. It was evident that they were enjoying engaging and interacting with one another. We also observed the importance placed on allowing residents to eat their meals in private if they wished.

The outdoor space was important to people, whether it was directly accessed or could be seen through the windows. Generally, links to the outdoors and a sense of spaciousness were thought beneficial to wellbeing and mentioned by residents and staff. Generous views through windows, accessible gardens with suitable shelter, and large lounges seemed to offer a sense of spaciousness.

## Meaningful objects and activities



Objects could be meaningful because they served some practical purpose and enabled residents' engagement in hobbies or the activities of daily living. Décor and furniture were often recognised as being both meaningful and useful objects that needed to satisfy residents' tastes. Conversely, photos, pictures, ornaments and mementos, while serving no practical function, were valued either for their aesthetics or their links with past lives, or both. In recognising people's relationships with such objects, whether in their own right, or in their role of promoting relationships with other people, the settings we observed endeavoured to supply or encourage the use of functional objects. Residents were encouraged to decide where to place photos, pictures and ornaments, which could be anywhere from their own room to the communal areas, including outdoors.

### ***Furniture, ornaments and décor***

In residents' rooms, we saw objects of value personalising the rooms. For example, a resident discussed a photo album of pictures of her husband when he was demobbed from the RAF in Tunisia after World War II. Her husband had been decorated during World War II, and she had his medals as well as her wedding ring, but her most precious possession was an old letter, from his previous employers, welcoming him back after the war. She kept these objects in her wardrobe in an old, clearly much treasured large handbag.

We noted that décor and furniture in the communal spaces could be similar to what residents may have been used to before they moved in, as in the type of colours (cream, light blue, pink, grey) that those of a certain age were likely to have used in their own homes, and furnished with the type of furniture they would have used as well e.g., wood framed furniture with tapestry prints.

### ***Objects connect people and enable autonomy***

One resident we spoke with had chosen to have her wind chime located not directly outside her bedroom window but in the communal garden. This was so that others could have the pleasure of it as well as her, and she could see it during

meals or when she was in the garden. This way, the resident was herself exercising her autonomy over her relationship with this object and considering other people's opportunities to enjoy it and maybe connect with her. Gardening and knitting, as meaningful activities, were also encouraged and evidenced during our visits.

*'So we've got V\_\_ who knits all day, and she'll knit squares. And once she's got so many her husband will give them me and I take them home, and my sister sews them into blankets. And we bring them back and there's yours V\_\_. She wraps them up for presents for the other ladies. And she gets so much out of that knowing that she's done, she's knitted for 50 years, and we've got some of the blankets around.'* (Care manager (F) S1)

Sometimes, meaningful objects could encourage a sense of autonomy by relating to a past job. This could demand a more elaborate approach to support meaningful activity, as shown in the case of a day centre client who used to work for the Water Board. The staff took a photo of him with water engineers and created a file with water company leaflets. The man reportedly found this package to be a useful and meaningful object to interact with that would help him at times of agitation. We also observed a resident who used to be a cleaner and was facilitated to carry out cleaning tasks wearing a staff uniform.

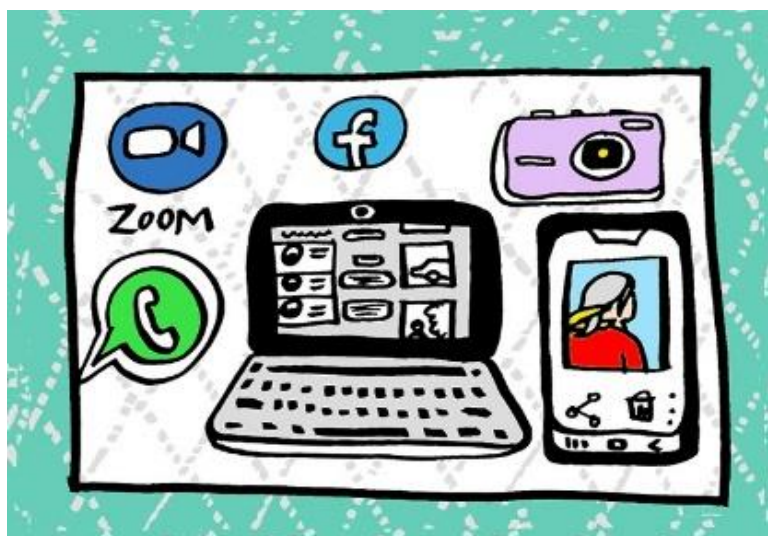
Functional objects, clearly, can facilitate independence or a sense of autonomy. This extract exemplifies how important it was to a resident to have the means to make her own hot drinks without having to ask anyone.

*'I did like a nice cup of tea late at night and that sort of thing, but there was no means of getting it other than that that was given me by the night staff. However, I was granted permission to have my own kettle, and I was thrilled to bits. ... And then I was able to have another piece of equipment, which was a refrigerator, and sometimes it's those little things that mean so much to you.'* (Resident (F) S4)

The next section discusses how communication technologies featured as enabling objects.



## Use of communication technologies



Communication technologies featured strongly in the settings we visited. Social media, such as Facebook and WhatsApp, connected residents with their friends and families, and also allowed care settings to communicate with family members about activities. Residents could also use information technologies for entertainment, news, banking or other functions.

In the following interview extract, relationships with the families of day centre clients could be strengthened by staff using social media to communicate the day's activities, including what residents had eaten.

*'I have had this with a few families before, what have they done today? Some families we don't see because they come in taxis, and they ring up and go could you just let me know what they've done? They get home, what have you eaten today? Nothing. What have you done today? Nothing. And I think that's where technology would come in.'*  
(Care worker (F) S1)

People have relationships with objects in many ways. Even bank accounts can be considered meaningful objects, despite being non-tangible most of the time, although the money within is real. In an increasingly digital world, we found evidence of residents experiencing digital devices as essential items for maintaining relationships with their money, visual memories, entertainment options, and information, as in the following account.

*'Yes, I have a tablet to keep my bank account etc. ... I use it for storing photographs, and... iPlayer, I like to watch Netflix. But my favourite is Google. Something comes into my head. ... I'll get most of my news on my iPad, I get it from that. ... I spend ages on Google. First thing in the morning after breakfast I check Google, and I have one of those apps for breaking news on it. ... It's more specific, to me it's better.'* (Resident (M) S2)

Conversations could be initiated via technology, as in the case of the 'ViewSonic', a tablet which provided one care home with access to a range of games, music and movies. Technology



can also support conversation through devices such as ‘Talking Mats’, which we heard about from one of the providers participating in the research.

We also saw that the use of digital record-keeping by staff while attending to a resident enabled the resident to engage with greater autonomy in their own care records.

*‘[A care worker] can be sitting with a resident talking and recording it and showing them their care plan and saying right I’m just putting down, you’ve just had your lunch so what did you have and we’ll put that in. And sometimes they find it fun saying, oh make sure and put my cup of tea in as well, so it involves them in their own care planning.’ (Care manager (F) Scot)*

### Assistive technology



Assistive technology covers a broad range of objects and devices. Here, we discuss briefly the role of mobility aids in facilitating relationships and autonomy, as observed during our research visits. In the first interview, a resident described how essential her mobility aids were for facilitating outings with her daughter, and how the physical space enabled her to store and access her equipment.

*‘My daughter comes and she will maybe take me out for a walk if it’s lovely weather ... I have a wheelchair here that’s downstairs in the entrance hall in the cupboard and I’ll go down there with my rollator and it goes into the cupboard and the wheelchair comes out and then we’ll walk all around [place name].’ (Resident (F) S2)*

A resident who was unable to walk any distance inside his care home had bought himself an electric wheelchair. The manager wanted to allow him this autonomy, and also negotiated with him on safe operation of the wheelchair. This could have been a very challenging situation for the setting, considering the need to balance everyone’s safety with the individual resident’s autonomy and independence. This example reveals the potential for conflict to arise where the use of equipment is concerned, and how relational care has the potential to facilitate the negotiation of safe practices, based on its foundation of open, trusting relationships.

Many times, we heard about the enthusiasm of staff to facilitate walks with residents, which involved each resident being supported in a wheelchair by a member of staff.

*'We've got like a local Co-op that they might walk down to if they've got, like we've got quite a few ladies who write cards to families, so the activity coordinator will walk them in their wheelchairs down to the Co-op to post their cards. They go out for ice-creams or some of them just generally want to go out for a walk.'* (Host (F) S4)

The physical environment could also enable access to key people, as discussed next.

### **'Open door' to the manager's office**



The success of relational care also relied on managers being at the heart of the 'family'. The idea of managers having an 'open door' to all those who live, work in and visit a care setting could extend to the door literally staying open and being visible as well as a more figurative concept of the manager being approachable and receptive.

During our visits, we observed that care manager offices tended to be located near the entrance to the building and the door was invariably open or ajar. This projected a sense of the manager being available and accessible. At times, residents would approach the manager in their office, wanting to discuss something. The same was the case with residents' friends and relatives, for example, offering to make the manager a hot drink.

For staff, the 'open door' could be an invitation to vent or let off steam, as this manager described:

*'I think it's just, our door's always open as well, so we've said, even if they're having a really bad day or something's going on at home, come into our office, scream into the cupboard if you want and then go back out, we're there for them.'* (Care manager (M))

As important as it seemed for managers to be accessible and available, we also discovered the importance private areas for staff.

## Private spaces for staff



With the focus on relationships and creating spaces and opportunities for people to get together, it can be easy to overlook the need for staff privacy at times. So far in this report, we have noted the variety of private and communal spaces used by residents but not the separate facilities for staff. Clearly, it is important for staff to have a designated space in which they can socialise amongst themselves, have snacks, and relax. We found that normally, this was located in a less accessible area.

### Final comments on the findings

In presenting the details of the themes and subthemes, we did not want to lose sight of the bigger picture, namely what relational care looks and feels like, and its implications for all who are involved in some way in the care setting. These final comments draw out the overarching narrative within the findings. A care setting that nurtures and pays attention to all relationships can favour and sustain human flourishing and build resilience. An atmosphere of respect, trust and inclusivity that nurtures a sense of belonging can have positive implications for staff recruitment and retention and judging by the voices we have heard, clearly benefits the older people for whom it is home. A welcoming environment makes everyone happier. Transitions into a residential home can be stressful and even traumatic for older people and their loved ones, often occurring at a time of crisis, as revealed in our interactions with the participating settings. Anything that smooths the path to feelings of trust and belonging must be worthwhile.

A purposeful focus on relationships can enable and sustain relational care. While there may be many care settings that pay attention to relationships, a notable feature of the relational care settings we studied is that relationships were brought to the fore, talked about, and rendered indispensable. One might go as far as to say that relationships sat at the heart of the whole business, from the perspectives of the providers, through the managers, to the teams on the 'front line'.

This purposeful focus also showed in the way that staff teams cared about residents' relationships with other people, animals, objects and places. These teams recognised the importance of this vast network of relationships in the self-worth of their residents and how their identities and life meanings were wrapped up in this complex web. The physical spaces within the setting and the various facets of the external community all became tools for life enhancement in the hands of accomplished 'relational carers'. One should also not overlook the temporal aspects of relationships; supporting reminiscence, although important, was balanced with supporting anticipation of future events and activities, including making plans together with residents.

Perhaps some of the more challenging adjustments could be seen in the demand for flexibility and creativity in the care teams and leadership. We saw the need for flexibility in staff rotas as well as a willingness to try out new ways of working, or simply letting residents take the lead in planning activities or to reciprocate care. Giving staff the freedom to bring their authentic, creative selves into their work could risk some discomfort, but also open up new, beneficial ways of working. A provider told us about how they were moving away from employing a specific activity coordinator to an arrangement whereby all staff, whatever their formal role in the team, could engage with residents in conversations or actions, according to their personal interests and skills.

As we focused on our model framework for relational care in this report, we kept sight of a few residents who specifically said they were mindful of not wanting to stop staff for a chat, knowing how busy they were. This seemed to be an indication of care flowing from the resident to the care staff and an appreciation and understanding by the residents of a wider context than their own needs. We could also have taken it to indicate that although the staff in these settings had embedded relational care into their practice, even for them, it could be challenging to stop and talk on some occasions.

## The contribution of this study to enabling relational care

As explained at the beginning of this report, this study aimed to build on and extend existing knowledge about relational care by identifying indicators of its presence and practice in the care of older people. In achieving these aims it is the first empirical study that addresses what relational care looks and feels like from the perspective of older people, care staff and others who work in care settings, managers, family members and volunteers. In the process of demonstrating relational care in practice, it has also comprehensively identified features of relational care that can be used for the purposes of implementation and evaluation.

Through its manifold outcomes - spanning ways in which it can support relational care knowledge and conceptual development, practice and research – and its potential to influence social care in the UK, the overarching contribution of this study is the sectoral improvement it can potentially effect, thereby improving the lives of older people and all those who care for them. These outcomes and influences are discussed in this section.

### 1. Outcomes

To date the study has resulted in many unique and we believe useful outcomes:

#### **Model of relational care**

The study has led to the production of a model of relational care (see Figure 1 on p22) which can be adapted for use in a range of care settings. In the Findings chapter we saw how this model shows the three key components of relational care in practice: an atmosphere of respect, trust and inclusivity that nurtures belonging; a purposeful focus on relationships; and a physical environment that facilitates nurturing those relationships and supporting individual autonomy. The model also shows the different and often intertwining features within each key component – some reliant on practice, some on physical environment, and some on both.

#### **Relational care toolkit**

The [accompanying toolkit](#) for care staff, leaders and providers can be used to support the move further towards relational care. It is a practical and easy-to-use guide for those managing, and working in, older care settings to successfully realise the full potential of relational care. In addition, it can help steer any changes to, or expansion, of facilities. Within it are a quick reference guide, a case study, a summary about the key features of relational care in older adult care settings, reflective exercises based on real-life situations which can be used for individual or group learning and reflection, and some ideas on meeting the challenges of change.

#### **Online relational care professional development resources**

Plans are being progressed to develop freely accessible professional development and training resources about the value and use of the relational care model and toolkit. These materials will be available on The Open University's world-renowned and award-winning [free learning platform OpenLearn](#) from October 2023.

### Definition of relational care

Yet another significant outcome is the way that the study has advanced conceptual clarity about relational care by enabling the development and refinement of existing conceptualisations (Kartupelis, 2021). By bringing together the rapid review and the research findings the authors have developed a definition of relational care which encompasses its central tenets: interdependence, the mutuality of relationship, the environment and the multidirectional flow of care. This definition is as follows:

*Relational care is based on the recognition that human wellbeing requires interdependence; it represents a move away from seeing individuals as a collection of needs to be met by others towards mutuality in caring relationships whereby no-one is solely a 'giver' or 'receiver' of care. Central to relational care is the role of emotional, physical, social and spiritual environments. These facilitate relationships where there is a multidirectional flow of care and create supportive networks, enabling all those involved to contribute as much as they can and wish to the lives of their peers and communities.*

### Relational care conceptual diagram

By combining our findings we have produced the first conceptual diagram of relational care and its practice that encompasses multidirectional relationships in care settings. This is presented in Figure 2 on page 51 and shows the dynamic inter-relationships between the people who live and work in a care setting, the physical environment and objects within it, and the wider community and locality. The following is an outline of what the conceptual diagram illustrates:

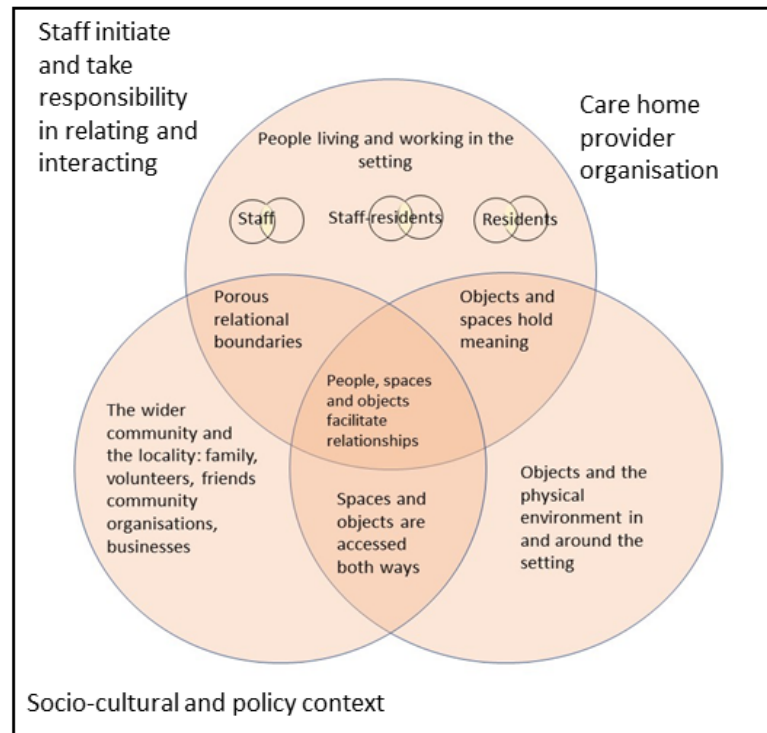
- the different kinds of relationships that need to be considered in the practice of relational care are relationships between people living and working in the setting who interact and engage with one another in a variety of multidirectional ways: staff-staff interactions (including managers), staff-resident interactions, and resident-resident interactions (top overlapping circle). Far from being insular, porous boundaries permit this internal community to interface with people, organisations and places in the wider community and locality (bottom left overlapping circle). The care setting's physical environment is accessible and welcoming to people who live and work and visit the care setting (bottom right overlapping circle). The porosity of boundaries and resulting interactions are sensitive to the culture and values of a possible umbrella organisation and occurs within a specific socio-cultural and policy context.
- the care setting community recognises the significance of relationships with its own physical environment and the objects within. At the special interface between people and environments and objects, meaningful objects and spaces are identified and engaged with, contributing to sense of identity, purpose and autonomy for all people involved and as an ongoing practice. The special interface between the wider community (including family, volunteers, friends, community organisations and businesses) and the physical environment of the care setting encourages movement of people and objects either way across this boundary contributing to a mutual sense of belonging.

- the central area formed by overlapping circles in the diagram brings together the people, spaces and objects that facilitate multidirectional relationships underpinned by relational care values and practices. Although the relationships are multidirectional, the onus is on staff and managers to initiate and maintain these practices. The diagram outlines key practices for managers and care staff teams central to making relational care possible.
- five management practices are listed on the left-hand side of the diagram: creating an environment that encourages relationship building and trust; rewarding and recognising staff; empowering staff to engage flexibly and creatively; role modelling practices of relational caring; promoting relational care values (e.g., respect, inclusivity, reciprocity, openness). Three interactive staff practices that nurture relationships are set out on the right-hand side of the diagram: flexible and creative approaches to engagement that empower staff, residents, their families, and volunteers; inclusive and regular communication practices; and doing things together. These practices underpin and are underpinned by a combination of values, skills and other practices. We have been careful to not over-specify these practices.



**Figure 2: Relational care and its practice**

- Management practices**
- Creating an environment that encourages relationship building and trust
  - Rewarding and recognising staff
  - Empowering staff to engage flexibly and creatively
  - Role model practices of relational caring
  - Promoting relational care values (e.g., respect, inclusivity, reciprocity, openness)
  - Valuing knowledge and expertise of each member of staff



- Staff practices that nurture relationships**
- Flexible and creative approaches to engagement that empower staff, residents, families and volunteers.
    - situational and self-awareness that enables responsiveness (e.g. knowing, noticing)
  - Inclusive and regular communication practices
    - Combining relational dialogue with everyday tasks and activities
    - Listening with intent to act
    - Exchanging and sharing knowledge and information
    - Mediating role of animals, objects and spaces
  - Doing things together
    - Valuing and appreciating expertise and contributions of all parties
    - Working collaboratively
    - Negotiating responsibilities and risks
    - Role modelling



## **2. Influence**

Whilst acknowledging these significant contributions, the authors simultaneously recognise that the study does have its limitations. For example, it was based on a small sample of care settings and did not include domiciliary care. In addition, although it considers a wide range of relationships, its focus was on those involving care staff and older people. Therefore, the research described in this report must be seen as part of a wider body of knowledge, which, as it is extended, should collectively influence policy and practices relating to older people and social care in the UK. Areas in which our findings and outputs will have a particular part to play, without making claims that they stand alone in this role, are set out below.

### **Recruitment and retention of the social care workforce**

At present the shortfall of care staff in the UK is estimated to be 165,000. The need to bring more, and suitable, people into the sector is possibly the most pressing issue that it is facing. There are a number of reasons this situation has arisen: low hourly pay and poor working conditions (57% of the British public have concerns in this regard) (Nuffield Trust and The King's Fund, 2023); perceptions that the roles are not valued by policy-makers or the public; staff turnover of 25%; and 27% of care workers likely to leave the sector in 2023; loss of staff from Europe due to Brexit and the pandemic; and short-term visas being unattractive amongst other factors. Additionally, it seems that most publicity about social care that reaches the wider public domain is bad publicity about poor care, exploitative private providers, and lack of public funding (The King's Fund, 2021).

Adverse workforce issues are routinely raised (for example, 'Sector Pulse Check 2022'). The research findings outlined in this report have the potential to address many of these workforce issues by improving retention and thus reducing the costs of recruitment and induction; in creating an attractive and well-known workplace in its locality, a care setting can more readily recruit locally through word of mouth, with potential employees already being favourably disposed. When there is recruitment from further afield, new members of staff can be more readily integrated with support from their peers as well as management, and greater acceptance by residents when there is an emphasis on forming a network of relationships.

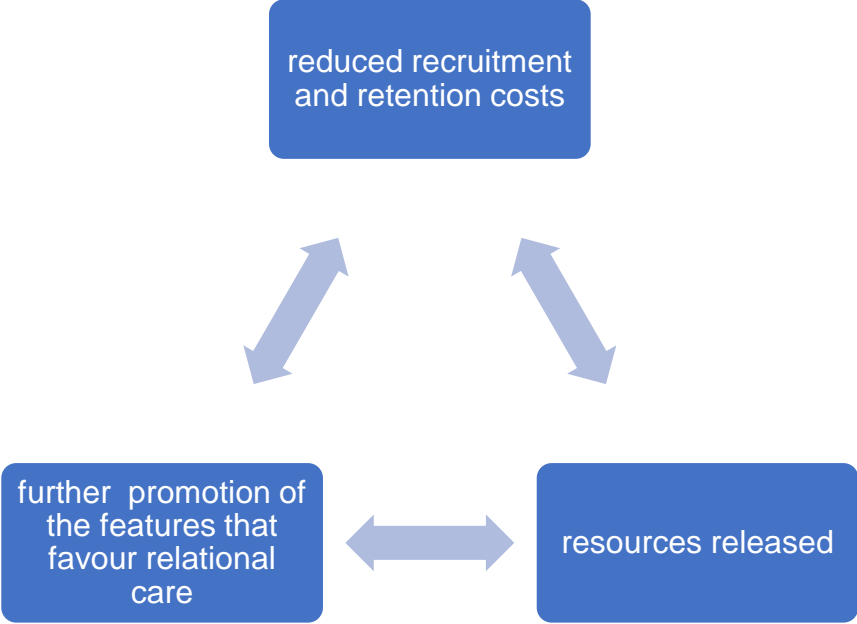
Another feature of relational care practice that enables employers to make clear how much they and older people value care staff; also conducive to staff recruitment and retention is that it relies in part on a substantial degree of flexibility in work planning, with managers being willing to accommodate personal needs, and care staff being willing to change their hours short term to cover for colleagues. This is frequently described as 'give and take' and favours staff retention by avoiding difficult choices between work and home life.

In addition, as relational care encompasses a two-way flow of information between management and staff, it enables informed requests for, and observations on, the need for training. These create more opportunities for staff to progress and have a career in

one setting over a period of decades while advancing their own knowledge and satisfaction.

A stable, content and appropriately rewarded workforce not only facilitates relational care but also reduces recruitment costs. In so doing resources are released for the further promotion of the features that favour relational care. This circular process is illustrated in Figure 3 below.

**Figure 3. Relational care and the social care workforce**



**Workforce skills**

Relational care does not so much require workforce reskilling but rather more of a reorientation and continual development of existing skills supported through reflexive, reflective and open inquiry into ongoing practices of caring (Timmerman and Baart, 2022). The relational care model, toolkit and conceptual diagram (see Outcomes above) usefully point to the way in which the skills of providers, managers, team leaders, care attendants and other staff working (including agency staff) or volunteering in care settings can easily refocus their approaches in order to effect a transition to relational care.

**Planning and design of facilities**

Many organisations planning, designing and developing care settings have already taken on board design that incorporates certain features associated with relational care (Woodward and Kartupelis, 2018), and there are examples of this type of design throughout the four nations. The model of relational care presented in this report provides clear recommendations on the planning and design of facilities that will provide environments where interaction is encouraged, and where people can be free to enjoy a home life that is as normal as possible. In favouring the fullest possible life for residents and staff in this way, the design of care settings can simultaneously support improved wellbeing for those who live and work within them.

### **Statutory regulation**

The change of lens both wrought and required by relational care is clear in the findings of this report; to flourish and be nurturing, relational care needs not only the right environment in practical and material senses, but also one in which the emphasis has shifted from a group of individuals (a 'reluctant community') to a community of common concerns, looking out for others and based on 'give and take'. Individual 'independence' and 'dependence' give way to 'interdependence' and networks of mutuality.

So the question must arise, can the national regulatory standards of the four nations of the UK in any way adjust to this re-balancing between the individual and society, when they are subject to legislation under the control of the individual governments? And would they in any case need to, or can emphases be shifted and re-interpreted within the current national and provider frameworks?

Managers of care settings in our study had found ways of working with regulatory guidance which did not compromise adherence but harnessed the flexibility given by relational care practice to make it easier to meet that guidance. For example, they had been able to interpret 'safety' in a way that this was not overemphasised to the detriment of empowerment and autonomy of older people and ameliorate its constraints with sensible risk assessments. In this respect, we suggest that the encouragement of innovation would be welcome, perhaps with a supplementary guidance paper, and that providers' own inspections frameworks could better recognise mutuality.

We also saw the 'catalytic' and communicative use of technology and new practices such as intergenerational projects with children. Similarly, the literature review undertaken as part of this study highlights innovative projects based on relational care such as those which enable older people to continue the baking they enjoyed or help with food preparation in care settings. We hope that our work on relational care can encourage and empower regulators to promote such innovation as good practice to be shared.

### **Policy and planning**

Currently one in five people need social care and changing demographics mean that this figure is likely to increase. Yet, in contrast to the NHS, adult social care continues to be largely out of sight and continually deferred from the public agenda. Public and policy discourses have centred around flawed or negative assumptions about social care as supporting those who cannot support themselves and casting them as a burden on resources. Indeed, social care is at risk of becoming synonymous with decline and crisis.

Calls for both social and economic investment are long-standing. This project not only shows how a move to relational care within adult social care can have a positive impact on workforce recruitment, retention and morale, but it can also contribute to rebalancing the roles of social care and the NHS, such that both are seen as equally important and complementary. In so doing, the benefits of relational care can contribute to more positive perceptions of the social care sector, as one where people can thrive and flourish; which affords opportunities for creativity and innovation; and is a facilitator of community integration. Improving the image of social care in these ways can attract

much needed and possibly innovative investment, such as Social Policy Bonds (Horesh, 2008), and is a suggested way forward within planning and policy development.

Finally, the implications for the increased mental and physical resilience which relational care inculcates in older people (Kartupelis, 2021) is important to planning for health crises such as a pandemic.

The extent to which these influences will operate depends in part on a robust body of underpinning research. Whilst the knowledge and conceptual contributions above can provide a foundation for the development of this currently under-researched area, a particular issue is the evaluation of relational care. Although laudable strides have been made into understanding the benefits of relational care, evaluations of these benefits can be problematic – measuring improvements in the wellbeing of those living and working in care settings is challenging in the absence of a control group and funding for longitudinal study. The same applies to other established benefits of relational care, most notably improved health and resilience in older people; and staff satisfaction, creativity, motivation and retention. For these very reasons future research needs to include more rigorous evaluation studies in order to evidence benefits.

The role of the material environment highlighted in this study, indicates a need for research which can elevate the importance of object-person relations in care practice. A productive way forward would be to extend the use of the emerging concept of material citizenship. To date this has only been used in dementia care and foregrounds the importance of functional, mundane objects in peoples' lives, to their identities and as catalysts to relationships. It shows how such objects are not only an extension of the self but also that being able to make decisions about and use functional objects enables people to take control and practice everyday citizenship, thereby significantly improve their wellbeing (Lee and Bartlett, 2021; Rix, 2021).

### **Concluding comments**

The authors of this report are not ignoring or diminishing the historic revolutionary role of person-centred care; without the understanding that person-centred care has generated, and its recognition as a great advance on organisation-centred care, we would not have had the basis to develop any concept of relational care. This is because, in essence, relational care is a natural extension of person-centred care and therefore its conceptualisation would not have evolved without the development and acceptance of person-centred practice.

Nor are the authors advocating relational care as a panacea to the many critical sectoral issues at this time. Our intentions are profoundly moral and humane, highly practical and achievable; we aim to promote relational care as a way of providing support based on enabling mutual contribution, value, self-worth, and increasing the resilience and agency of all those involved. By demonstrating how environments can be created where care relationships are multidirectional, and people are not as seen as 'recipients' and 'givers' of care but as equally valued contributors in the mutual enterprise of life, the insights presented in this report can promote and inform the changes required for everyone involved in the care of older people to reap the benefits of relational care practice.

### Appendix 1: Semi-structured interviews and observations topic guide

Building on the rapid review, the intention is to collect data on effecting a paradigm shift in exemplary RC from PCC. Exemplar RC care as connected communities with multidirectional networks of support rather than unidirectional task-orientated care-settings whose focus is on the resident or day carer use.

<b>RC Domains of interest</b> <b>Prompts for main questions</b>	<b>Observation notes to be filled in immediately after</b>	<b>Interview: resident or day care user</b> <b>Starter question then draw from domains</b>	<b>Interview 1: care manager</b> <b>Starter question then draw from domains</b>	<b>Interview: member of staff</b> <b>Starter question then draw from domains</b>	<b>Interview: care setting provider, family member, volunteer</b> <b>Starter question</b>
Autonomy/empowerment e.g., attitudes to risk taking, opportunities for contribution, opportunities for participation (or not) in learning and activities, self-direction, access to management.		<i>Q: what you enjoy doing during your day?</i>	<i>Q: what activities do you plan for residents or day care centre users?</i>	<i>Q: what activities do you enjoy doing with residents or day care centre users?</i>	<i>Q provider: how important are activities for residents or day care centre users?</i> <i>Q family member: when you visit, what activities do you enjoy doing with your loved one?</i> <i>Q volunteer: what activities do you enjoy doing with residents or day care centre users?</i>

RC Domains of interest Prompts for main questions	Observation notes to be filled in immediately after	Interview: resident or day care user Starter question then draw from domains	Interview 1: care manager Starter question then draw from domains	Interview: member of staff Starter question then draw from domains	Interview: care setting provider, family member, volunteer Starter question
Staff and volunteers e.g., recruitment, training, key competences, rotas, pay, expectations, continuity of relationships, family involvement		<i>Q: what are the things that you enjoy doing with the staff?</i>	<i>Q: how do you balance staff needs with residents' or day care centre users' needs?</i>	<i>Q: what do you enjoy most about working here?</i>	<i>Q provider: how do you balance staff needs with residents' or day care centre users' needs?</i> <i>Q family: what is the best thing about the staff at...?</i> <i>Q volunteer: what do you enjoy most about volunteering?</i>

<b>RC Domains of interest Prompts for main questions</b>	<b>Observation notes to be filled in immediately after</b>	<b>Interview: resident or day care user Starter question then draw from domains</b>	<b>Interview 1: care manager Starter question then draw from domains</b>	<b>Interview: member of staff Starter question then draw from domains</b>	<b>Interview: care setting provider, family member, volunteer  Starter question</b>
Physical environment e.g., interior, exterior, equipment, architecture, furniture, communal areas, garden, privacy, staff areas		<i>Q: what do you like about the care home or day care centre itself?</i>	<i>Q: how important is the physical environment of the care home or day care centre to the care given?</i>	<i>Q: what do you like about the care home or day care centre itself?</i>	<i>Q provider: how important is the physical environment of the care setting to relational care? Q family: when you visit what do you like about the care home or day care centre itself? Q volunteer: what do you like about the care home or day care centre itself?</i>

<p>Links/access to wider community e.g., access/transport to local shops, clubs, churches, etc., location of premises, continuation of relationships, intergenerational practice, staff, 'porousness' to families and volunteers</p>		<p><i>Q resident: how often do you go out to nearby shops or other places?</i>  <i>Q day care user: who do you meet up with here?</i></p>	<p><i>Q: how do you help residents or day care centre users maintain their links to wider communities?</i></p>	<p><i>Q: what makes you feel you are part of a wide connected community at the care home or day care centre?</i></p>	<p><i>Q provider: how important is maintaining residents' or day care centre users' links to wider communities to relational care?</i>  <i>Q family: what makes you feel you are part of a wide connected community at the care home or day care centre?</i>  <i>Q volunteer: what makes you feel you are part of a wide connected community at the care home or day care centre?</i></p>
<p>Dignity/respect e.g., free choice between privacy and company, opportunities for shared and private life, how tasks</p>		<p><i>Q: who decides what you do during your day?</i></p>	<p><i>Q: how do you share decision-making between the residents or day care centre users and</i></p>	<p><i>Q: who decides what you do during your day?</i></p>	<p><i>Q provider: how important is shared decision making to relational care?</i></p>



RC Domains of interest Prompts for main questions	Observation notes to be filled in immediately after	Interview: resident or day care user Starter question then draw from domains	Interview 1: care manager Starter question then draw from domains	Interview: member of staff Starter question then draw from domains	Interview: care setting provider, family member, volunteer Starter question
are undertaken and time allocated			<i>others such as staff or volunteers?</i>		<i>Q family: when you visit, who decides what is happening at the care home or day care centre? Q volunteer: when you volunteer who decides what you do during your day?</i>
Technology and innovation e.g., adopting new practices such as Montessori, assessing tech on basis of RC, ensuring tech enhances human interaction, questioning apparent benefits		<i>Waiting for AG feedback</i>	<i>Waiting for AG feedback</i>	<i>Waiting for AG feedback</i>	<i>Waiting for AG feedback</i>

RC Domains of interest Prompts for main questions	Observation notes to be filled in immediately after	Interview: resident or day care user Starter question then draw from domains	Interview 1: care manager Starter question then draw from domains	Interview: member of staff Starter question then draw from domains	Interview: care setting provider, family member, volunteer Starter question
Death/end of life e.g., privacy, staff training, support for staff and families		Unless the resident or day care centre user brings it up, do not ask about end-of-life planning. If they do, ask something general: <i>Q: and you're happy with what's been planned? Or tell me how you feel about what has been planned</i>	<i>Q: how do you support everyone involved with end-of-life for a resident or day care centre user when it happens?</i>	<i>Q: what happens when end-of-life comes for a resident or day care centre user?</i>	<i>Q provider: how important is end-of-life planning for relational care? Q family: please don't answer if you feel you can't, but how ready are you for end-of-life when it comes? Q volunteer: what happens when end-of-life comes for a resident or day care centre user?</i>

## Interview 2: Care manager

### About residents/centre users

1. We've heard a lot about good practice in supporting reminiscence and the importance of meaningful objects related to past lives, and less about their future lives. What do you think your residents look forward to on a day-to-day basis? Can you offer any examples of how you might enable residents to look forward to things?
2. We've been impressed by staff's willingness to give residents choices and ownership of decisions. How do you manage the potential conflicts between safety and autonomy?
  - residents' likes/dislikes and certain issues?
  - what about meeting the intimacy needs of residents or any couples separated by care home moves? Any observations/challenges
  - Do you have a 'pet friendly' policy and if so, have you ever had any issues relating to residents who have fears of animals or are allergic to them? How would it work if a resident wanted to keep their own pet? What are the practicalities? Conversely, how would you manage a situation where a resident wanted to keep a pet in contradiction to the setting's policy?
3. What are the cultural backgrounds of your residents? (Does the setting cater for residents from minority cultures?)
  - What are/might be the challenges in supporting such residents?
  - About families
4. Are families involved in daily life of the care setting (not care resident).
  - Yes/No. Why and how?

### About financial sustainability

5. What is the balance between private and state funded residents in the care home?
  - What are the impacts on quality of care for:
  - Residents
  - Staff?

### About staff

6. How are staff training needs identified? Is this bottom up or does requisite training routinely come down from the organisation or a mixture of both?
  - If bottom-up training needs are identified, how are these paid for?
  - How is work of the care home managed when staff are on training?
  - Are there any specific kinds of training for activity coordinators, cleaners and those from different cultural backgrounds?
  - how long does it take overseas staff to feel at home and form relationships with other staff and residents?
  - Career planning and progression support
7. Are care staff involved in the day-to-day management and running of the care setting?
  - Why is such a practice being adopted?

- How is it organised (e.g., through regular reflections, meetings etc)
  - What are the benefits?
8. What do you think matters most in helping staff feel valued and feel at home?
- access to private areas for rest and downtime – how ‘sacrosanct’ are these spaces?
  - employer values and benefits
  - wider attitudes to social care and the people who give and receive it
  - recruiting from the near locality
  - The residents/clients themselves
  - little things like appreciation

#### About community links

9. Would you say the care home is part of the wider community there?
- Where relationships have been built with communities outside the care home (e.g., local schools, churches, other community and voluntary organisations)
  - In what ways (e.g., intergenerational etc)?
  - Do you think being a part of wider community is important? If yes, why?
  - What sort of work goes into bringing these links into being?
  - Do you have volunteers?
  - How does it work? Are there difficulties? Advantages?
  - How are you rebuilding networks and confidence damaged by Covid?

#### About management

10. What do you think 'relational care' is all about?
- Show the poster. Does it resonate?
11. What are the challenges associated with relational care when the setting is inspected?
- Do the inspectors understand the ethos and practice? E.g., a balance of safety and autonomy?
  - Does RC align with the inspection framework?
12. As the proportion of people needing high levels of care is likely to increase, what challenges to offering good care does this present?
- Prompt: how do you manage this without compromising on quality of care?
- To what extent do you use agency staff, and how do you see the problems and benefits?
  - Ratio of staff to residents in the care home. What is this based on?
  - Separating out or not people with dementia and without dementia through physical design in separate wings?
  - promoting digital care planning packages or not?
13. The size of units seems critical to relational care. How do you manage to break down the setting into smaller ‘family-scale’ units?
- Is it more or less resource intensive?
  - How does it affect flexibility in rostering?
14. Remind me how long you’ve been a manager here.

- Why do you stay?
15. Discuss structure and content of toolkit in follow up interviews. Ask 2/3 care managers if they would look at a draft of the toolkit when ready and comment on the poster

## REFERENCES

- Baylis, A. (2017). *Enhanced health in care homes*. London: The Kings Fund
- Cooperrider, D., Whitney, D.D. and Stavros, J. (2008). *The appreciative inquiry handbook for leaders of change*. Oakland, CA: Berrett-Koehler Publishers
- Banerjee, A., Armstrong, P., Daly, T., Armstrong, H., and Braedley, S. (2015). 'Careworkers don't have a voice: epistemological violence in residential care for older people.' *Journal of Aging Studies*, **33**:28-36
- Banerjee, A. and Rewegan, A. (2017). 'Intensifying relational care: the challenge of dying in long-term residential care.' *Journal of Canadian Studies*, **50** (2): 396-421
- Barbosa Neves, B., Sanders, A., and Kokanović, R. (2019). "'It's the worst bloody feeling in the world": experiences of loneliness and social isolation among older people living in care homes.' *Journal of Aging Studies*. **49**:74-84
- Barken, R., and Lowndes, R. (2018). 'Supporting family involvement in long-term residential care: promising practices for relational care.' *Qualitative Health Research*, **28** (1): 60-72
- Barnes, M., Gahagan, B., and Ward, L. (2018). *Re-imagining Old Age: Wellbeing, care and participation*. Wilmington, Delaware: Vernon Press
- Wilson, C.B. and Davies, S., (2009). 'Using relationships in care homes to develop relationship centred care-the contribution of staff.' *Journal of Clinical Nursing*, **18**:1746-1755
- Damant, J., Ettelt, S., Perkins, M., Williams, L., Wittenberg, R., and Mays, N. (2023). 'Facilitators of, and barriers to, personalisation in care homes in England: evidence from Care Quality Commission inspection reports.' *International Journal of Care and Caring*, **7** (1), 91-113
- Daly, T. and Szebehely, M. (2012). 'Unheard voices, unmapped terrain: care work in long-term residential care for older people in Canada and Sweden.' *International Journal of Social Welfare*, **21** (2): 139-148
- Denier, Y. and Gastmans, C. (2022). 'Relational autonomy, vulnerability and embodied dignity as normative foundations of dignified dementia care.' *Journal of Medical Ethics*, **48** (12):968-969
- Ducak K, Sweatman G, and Keller H. (2015). 'Dining culture change in long-term care homes: transitioning to resident-centred and relational meals.' *Annals of Long-term care*, **23**(6):28-36
- hft and Care England. (2023). *Sector Pulse Check 2022*. London: Centre for Economics and Business Research

Featherstone, R., Dryden, D., Foisy, M., Guise, J-M., Mitchell, M., Paynter, R., Robinson, K., Umscheid, C., and Hartling, L. (2015). Advancing knowledge of rapid reviews: An analysis of results, conclusions and recommendations from published review articles examining rapid reviews.' *Systematic Reviews*, **4** (1):50

Heggestad, A. K, Nortvedt P, Slettebø Å. (2015). 'Dignity and care for people with dementia living in nursing homes.' *Dementia*, **14**(6):825-41

Horesh, R. (2008). *Market Solutions for Social and Environmental Problems: Social Policy Bonds*. [www.SocialGoals.com](http://www.SocialGoals.com)

Hutchinson, C., Cleland, J., McBain, C., Walker, R., Milte, R., Swaffer, K., and Ratcliffe, J. (2022). 'What quality of life domains are most important to older adults in residential care?' *Journal of Aging and Social Policy*, DOI: 10.1080/08959420.2022.2134691

Jonas-Simpson, C., Mitchell, G., Dupuis, S., Donovan, L., and Kontos, P. (2022). 'Free to be experiences of arts-based relational caring in a community living and thriving with dementia.' *Dementia*, **21**(1):61-76

Kang, B., Scales, K., McConnell, E., Song, Y., Lepore, M., and Corazzini, K. (2020). 'Nursing home residents' perspectives on their social relationships.' *Journal of Clinical Nursing*, **29** (7-8):1162-1174

Kartupelis, J. (2021). *Making Relational Care Work for Older People: Exploring Innovation and Best Practice in Everyday Life*. New York: Routledge

Lee, K. and Bartlett, R. (2021). 'Material Citizenship: An ethnographic study exploring object–person relations in the context of people with dementia in care homes.' *Sociology of Health & Illness*. **43**:1471–1485 <https://doi.org/10.1111/1467-9566.13321>

Miller, E. and Barrie, K. (2022). 'Ethical dilemmas: balancing choice and risk with a duty of care in extending personalisation into the care home.' *Ageing & Society* **42**: 1800-1821

Muller, B., Armstrong, P. and Lowndes, R. (2018). 'Cleaning and caring: contribution in long-term residential care.' *Ageing International* **43**: 53-73

Novy,, C., Thomas, R., Grassau, P., Gifford, W., and Hosseini, M. (2022.) 'Relational Care, dementia, and communication challenges in long-term care: a meta-ethnography.' *Canadian Journal on Aging / La Revue canadienne du vieillissement*. <https://doi.org/10.1017/S0714980822000253>

Olasunkanmi-Alimi, T., Natalier,T., and Mulholland, M. (20220). 'Everyday racism and the denial of migrant African women's good caring in aged care work.' *Gender, Work and Organization* **29** (4): 1082– 94 <https://doi.org/10.1111/gwao.12802>

Orellana, K., Manthorpe, J. and Tinker, A. (2020) 'Day centres for older people – attender characteristics, access routes and outcomes of regular attendance: findings of exploratory mixed methods case study research.' *BMC Geriatrics*, **20** (158)  
<https://doi.org/10.1186/s12877-020-01529-4>

Owen, T. and Meyer, J. (2012). *My home life: promoting quality of life in care homes*. York: Joseph Rowntree Foundation. Available at <https://www.jrf.org.uk/report/my-home-life-promotingquality-life-care-homes> [Accessed 14 November 2022]

Pereira, R., Myge, I., and Hunter, P. (2022). 'Volunteers' experiences building relationships with long-term care residents who have advanced dementia'. *Dementia*, **21** (7): 2172-2190

Prasad, G. (2019). *Supported independent living: communal and intergenerational living in the Netherlands and Denmark*. Available at: [Prasad G Report 2018 Final.pdf \(churchillfellowship.org\)](#) (accessed 14 November 2022)

Rix, J. (2021). 'How everyday objects can improve quality of life for people with dementia' *The Guardian* [How everyday objects can improve quality of life for people with dementia | Dementia | The Guardian](#)

Rockwell, J. (2012). 'From Person-Centred to Relational Care: expanding the focus in residential care facilities.' *Journal of Gerontological Social Work*. **55** (3): 233-248  
<https://doi.org/10.1080/01634372.2011.639438>

Røhnebæk, M. (2020). 'The role of narratives in collaborative innovation- transitions towards relational forms of dementia care.' *Journal of Innovation Management*, **8** (3):28-47

Sharp, C., Dewar, B., and Barrie, K. (2016). *Forming new futures through appreciative inquiry*. Iriss Insight 33. Available at: <https://www.iriss.org.uk/resources/insights/forming-new-futures-through-appreciative-inquiry> (accessed 24/04/2022)

Storm, P., Braedley, S. and Chivers, S. (2017). 'Gender regimes in Ontario nursing homes: organization, daily work, and bodies.' *Canadian Journal of Aging*, **36** (2):196-208

The King's Fund (2021). *Public Satisfaction with the NHS and Social Care in 2021: Results from the British Social Attitudes Survey*. London: The King's Fund

The Nuffield Trust and The King's Fund (2023). *Analysis of British Social Attitudes Survey*. London: The King's Fund

Thomas, J., Newman, M., and Oliver, S. (2013). 'Rapid evidence assessments of research to inform social policy: taking stock and moving forward'. *Evidence & Policy*, **9** (1): 5-27

Timmerman, G. and Baart A. (2022) 'The continuing formation of relational caring professionals.' *Medicine, Health Care and Philosophy*, **25** (4):587-602



van Loon, J., Janssen, M., Janssen, B., de Rooij, I. and Luijkx, K. (2023). 'How older adults with physical impairments maintain their autonomy in nursing homes.' *Ageing & Society*, doi:10.1017/S0144686X22001428

Victor, C. R., Scambler, S., and Bond, J. (2009). 'Social Exclusion and Social Isolation' in. Victor, C.R., Scambler, and J. Bond (eds.). *The Social world of older people: Understanding loneliness and social isolation in later life*. Maidenhead, England: McGraw-Hill Education

Villar, F., Serrat, R., Bilfeldt, A. and Larragy, J. (2021). 'Older People in Long-Term Care Institutions: A Case of Multidimensional Social Exclusion'. in: Walsh, K., Scharf, T., Van Regenmortel, S., and Wanka, A. (eds) *Social Exclusion in Later Life. Interdisciplinary Perspectives on Aging*, 28. Springer, Cham [https://doi.org/10.1007/978-3-030-51406-8\\_23](https://doi.org/10.1007/978-3-030-51406-8_23)

Wollscheid, S. and Tripney, J. (2021). 'Rapid reviews as an emerging approach to evidence synthesis in education.' *London review of education*, **19** (1) doi: 10.14324/LRE.19.1.32

Woodward, J. and Kartupelis, J. (2018). *Developing a Relational Model of Care for Older People: Creating Environments for Shared Living*. London and Philadelphia: Jessica Kingsley Publishers