

Making every relationship matter: a practitioner toolkit for relational care with older people



CONTENTS

1. Why this toolkit?	2
2. How can it be used?	2
3. How the toolkit came about	2
4. Relational care and its key components	4
5. Relational care in action	6
6. What makes relational care practice work?	8
7. Illustrative vignettes for individual and group reflection	11
8. Questions and Answers	25
9. Acknowledgements	28

Suggested Citation:

Larkin, Mary; Gopinath, Manik; Kartupelis, Jenny and Wilson, Anthea (2023). Making every relationship matter: a practitioner toolkit for relational care with older people. The Open University.

DOI:<https://doi.org/10.21954/ou.ro.00015a57>

1. Why this toolkit?

Working life is busy and can be stressful when you feel pulled in all directions. It would be fair to ask, why spend time reading this toolkit? Working in the care of older people can be enormously rewarding in terms of seeing the difference you make not only to the lives of older people and their families but also to your own team and the local community. These relationships all matter day-to-day, so making them easier to form and maintain also makes life easier and often happier. That does not necessarily mean you have to put in any more effort. The environment you work in, the daily routines, the design of the rooms, furnishings and personal objects, and the right technology can all help those vital relationships get going and work for you.

So, this toolkit is meant for everyone involved in the care of older people: care staff, managers, maintenance people, cleaners, gardeners, and most of all providers of care who have the power to make real change. In fact: everyone who matters.

2. How can it be used?

You can use this toolkit in different ways, depending on the time you have, your role, and what you want to get out of it. It might be part of a formal individual or group learning programme, a discussion group, a team meeting, or something you can dip into over a cup of tea. You could start with a one-minute read of the case study in [Section 5](#) and see what sounds familiar.

If you only have a few minutes, have a look at [Section 6](#). This explains the factors in a care setting that help sustain good relationships. You might look around your own care setting and see if there are some small changes that will make a difference, then talk these over with your manager or in a group session.

You will find the reflective exercises in [Section 7](#) very useful for individual and group training sessions. They will help prompt thinking and discussion about making wider changes in, for example, time allocation, décor, planning, attitudes to risk and safety, and much more. In general, group sessions work well because they enable interaction that can move the conversation forward into action. There are also some Q&As at the end, for those times when you meet a challenge.

3. How the toolkit came about

The information and ideas here are based on the recognition that everyone needs somewhere that gives them a feeling of home – a place where they can be secure, comfortable and have a sense of belonging, control and ownership. Older age and health-related changes can bring a move from what we know as our home. Given that we have a relationship with our home, we have relationships with the items in our home and we have relationships with the people in which we share this space called home, how can we ensure that whatever their circumstances, older people feel ‘at home’? And how can everyone who works with them also have that feeling of security and belonging?’

Over the last ten years or so, these questions have been addressed by several studies that involved talking to people in care settings, observing what matters and what generates contentment. These have shown that the answer to the questions above is a practice called 'relational care'. This is an approach which builds on a natural progression from person-centred care, taking it to a new level and shifting the emphasis from the individual alone to the person as part of a network of supportive and mutual relationships. Relational care has been shown to be more effective in improving the wellbeing of those living and working in care settings and enabling them to enjoy a much fuller life. In essence, it represents a move from a one-way flow of care towards mutuality in caring relationships whereby people are not solely 'givers' or 'receivers'. It prioritises the creation of an environment that people can feel is truly their home, where they can contribute as much as they can and wish to the lives of their peers and communities. These networks, in turn, improve wellbeing and increase autonomy, providing more purpose and meaning in life for everyone concerned.

This toolkit is a practical and easy-to-use guide to relational care for those managing and working in older care settings. It can be used help steer changes to practices and facilities. The knowledge shared within it is based on a research project into the practice of relational care carried out by The Open University. This project involved visiting and talking to a variety of people in different care settings for older people (care homes, sheltered housing and a day centre) in which relational care was already being practiced.



Note:

All place names have been fictionalised. Unless specified otherwise the generic term 'care setting' is used throughout the toolkit. Similarly, the term 'resident' is used to refer to all older people receiving any kind of personal care in any care setting.

4. Relational care and its key components

Our detailed research shows that relational care, in order to flourish, needs an environment that enables interdependence, which is a natural human state; we are not born to function separately from everyone around us, or to be seen as an isolated collection of needs. The critical components of relational care we identified are: an **atmosphere** of respect, trust and inclusivity that nurtures belonging; a purposeful focus on **relationships**; and a **physical environment** that helps to nurture relationships and autonomy. A number of features that are often interrelated – some reliant on practice and some on the physical space – contribute to these three key components. The model below shows the features that we found to be most important.

A relational care model

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

You may well already be doing some or most of these things, and some other shifts to relational care can easily be introduced by making changes to existing practice. Others may seem more challenging, and require a change of direction in practice, management or, ultimately, from the provider running the care setting. Depending on your role, you can start with the easier ones, and then become more ambitious! Helping you to propose or effect such changes is the subject of the rest of this toolkit.



5. Relational care in action

Drawing on our visits to the care settings, we have created the following case study about a fictional care home we called Fairview House to demonstrate relational care in practice. Numbers are used to refer and link you to the suggestions in [Section 6](#) below for ideas about implementing particular features important to each of the three components of relational care – **atmosphere, relationships and physical environment**.

Creating a Home

Fairview House is in an English market town on the Scottish borders and has around 40 residents, about half of whom are living with dementia. Originally a very large, old vicarage, it was converted to its current role in the 1970s and has since been fully repurposed and redecorated by a large care group in the voluntary sector, which bought it in the early 1990s. It still has quite a quirky interior, with nooks and crannies rather than straight corridors, and a variety of accessible bedrooms for individual occupancy [\(8\)](#). Good natural light is evident all around, and the repurposing of the building – which included the addition of a conservatory – has brought much more light into the dining room [\(1\)](#). There is also a separate a room for staff to relax in and have as their own ‘space’ [\(13\)](#).

The square entrance hall is furnished with sofas [\(3\)](#) which are similar in style to that which residents may have been used to before they moved in [\(9\)](#). It also has a large noticeboard with information about activities and requests for residents’ views [\(2\)](#). To the right of the entrance hall a door stands open to the manager’s office [\(12\)](#). A resident comfortably settled on a small sofa, greets visitors with a welcoming smile [\(3\)](#).

The manager, Jean, has worked here for over 30 years – having joined as a care attendant and been supported through a journey of formal and informal learning to reach her current post. The retention and longevity of Fairview's staff is something of which they are proud [\(6\)](#).

The home’s place in its community has played a role in this: it benefits from being able to recruit from nearby because it is known and respected. Additionally, staff may have friends or family already here. Some residents know the staff from previous lives too, having been their teachers, parents’ friends and so on. The philosophy is that “It’s important to include all the relationships that surround a resident.” [\(7\)](#)

Fairview House aims to be part of its locality in every sense, by opening its doors and large garden to people nearby who may enjoy the facilities [\(7\)](#). Residents can also help to maintain the garden if they wish [\(1\)](#). Similarly, it’s easy for residents to go into the town for shopping, to see friends, or go to a place of worship. Some may need to be accompanied, in which case the view is, that this should be a shared pleasure for them and the carer who goes with them [\(4\)](#).

The two large lounges have been split into four distinctive areas, with chairs and coffee tables which are easy to move and arrange into different groups. The TV is contained in one area such that it does not dominate. Another of the areas has tea and coffee making facilities so residents can sit there with their guests [\(7\)](#). Whilst the whole arrangement encourages interaction, conversation and small group activities the areas can be rearranged to create a more open space for music or watching the TV together for a special programme [\(8\)](#). Just off one of the lounges is a small alcove where there is a collection of laptops and iPads for those residents who want to use them with or without the help of a member of the staff team [\(10\)](#), [\(11\)](#).

Another feature of Fairview House is its ‘personalisation’. Residents’ photos, pictures, and ornaments are part of the communal spaces and the décor, so everywhere reflects the ‘family’ that lives there. Like the sofas in the entrance hall, the décor and the furniture has been chosen to reflect residents’ tastes, rather

than the bland luxury of a hotel (9). This is achieved in part by consulting all concerned when changes are made – residents and staff – and also by understanding the local culture (2).

The well-used garden, with carefully laid paths, various resting points and a covered gazebo for the summer, is accessed through a conservatory designed to ‘bring the outside in’. The conservatory is a warm, light, comfortable place giving views over the open country in which many of the residents would have been brought up and some would have farmed (2).

Marie, the activities champion aims to get residents and staff alike involved in craft groups, music, talks, celebrations and outings. All the activities are planned together, as a community, so everyone can look forward to them. She helps steering groups of residents to put on celebrations for national and sporting events. Time is built into rotas to allow for some staff participation, and to give as much flexibility as possible to accommodate residents’ hobbies. In Marie’s words, an example of the latter is: “If there’s something they want to bake we would bring everything out to them into the dining room, if they were making a cake or something like that.” Similarly, residents are able to contribute to their care home community as they wish to and can, for instance by gardening, sorting the books and puzzles and so on (1), (4).

Meals are an important part of the day, with lunch in particular bringing most people together. Those living with dementia are helped by the staff, and also by their fellow diners (5). The meal arrangements and variety of the rooms give a choice of environment, privacy, quiet or company (8). Access to objects not only of emotional but also of practical significance is also very important to autonomy and to forming relationships (9). The staff at Fairview House are given the flexibility and time to recognise these individual needs (1).

As with all care homes, or community facilities, Fairview House has to deal with loss, and the inevitability that members of that ‘family’ will pass away. Staff are supported in bereavement (4), and family members are helped to be with their loved ones by rearranging rooms, adding a small bed, bringing in meals and providing solace if it is wanted (7). Staff are also enabled to go to funerals (4).



6. What makes relational care practice work?

Whatever your role in the team, you can think and talk about the suggestions below for making relational care practice work in your care setting. The suggestions relate to the key components and features in [Section 4](#), and you can explore them further in the 13 correspondingly numbered vignettes in [Section 7](#) if you have time. The following summary provides a comprehensive and quick reference.

Atmosphere

1: Leaders and managers create a home-like environment in which all those in it can flourish and thrive

- non-institutional appearance, avoiding a hospital or hotel look
- home-like features
- staff given the time to attend to individual resident's social and emotional needs
- design of the garden makes it easy to follow the paths, enjoy and rest in
- residents can help to maintain the garden if they wish
- the setting offers views of landscapes or streets that are familiar to residents
- intergenerational and community relationships between those who work in and live in/use the care setting are encouraged

2: Residents feel a sense of belonging and are sufficiently 'at home' to enjoy freedom of expression and find meaning in their lives

- staff have the freedom to be creative in their approach to care and to engaging with residents in shared activities
- pre-admission assessments and meetings help to ensure a good 'fit' for residents, address any potential problems and ensure the nature of the community is not disrupted
- residents can play a role in the life of the care setting, using objects and carrying out tasks that fit their sense of identity
- residents and staff are consulted when changes are made
- different cultures and backgrounds are enjoyed and their distinctive contributions valued
- noticeboards support a sense of togetherness and fun, and can be used to canvass opinion

3: Visitors experience the setting as welcoming and accommodating

- there is a comfortable and informal welcome area
- residents welcome and acknowledge visitors
- staff recognise and welcome visitors
- residents can easily offer their visitors refreshments
- everything feels clean and is fresh-smelling

Relationships

4: Between staff and residents

- care tasks are seen as part of relationship-building; there is flexibility in the rosters for staff and residents to take a mutual interest in each other; and continuity of staff-resident relationships is enabled as far as possible
- residents have autonomy to make decisions about what they want to do and are enabled to do it
- the team are encouraged not to be risk-averse
- risk assessments are mutually agreed with the aim of enabling as much freedom of choice as possible
- staff are given time to enjoy doing individual resident's hobbies with them
- bereavement support for staff and residents

5: Amongst residents

- purposeful opportunities for interaction amongst residents are created
- opportunities for residents to build and sustain relationships and help each other are created but staff leave these to develop naturally

6: Amongst staff (including staff and management)

- continual communication between staff is made easy and natural
- staff train and support each other informally
- management encourage and provide informal and formal staff training
- there is a culture of sharing, respect and flexibility

7: Relationships between the care setting, the family and the wider community

- families are kept informed of what their relatives have been doing
- friends and families are welcome to join in meals, activities and outings (by arrangement where necessary)
- residents are enabled to keep in touch with their relatives using technology
- family members are supported at the end of a resident's life e.g., by enabling them to sit or sleep in the resident's room, bringing in meals and providing emotional support if it is wanted
- there is local staff recruitment to increase the likelihood of them having pre-existing relationships with residents which can then be developed further
- volunteers are encouraged and appropriately supported and trained to offer talks, company, help with gardening etc.
- members of the public have access to some of the facilities by arrangement e.g., garden
- there is at least one designated area with tea and coffee facilities where residents can sit with their guests

Physical environment

8: Room layouts allow for private and communal spaces (inside and outside)

- spaces for shared, communal interaction in both small and large groups
- a regular daily meal in the dining room where staff and residents can be together, but respect for residents' choices if they want to eat in a different way as they have always done e.g., alone, or with a tray on their lap
- the meal arrangements and variety of the rooms give a choice of environment, privacy, quiet or company
- residents have their own rooms to which they can return at any point in the day
- routes to specially equipped bathrooms (e.g. with hoists) are not via busy areas

9: Recognition and encouragement of meaningful objects and activities

- residents' photos, pictures, and ornaments are in their rooms and parts of the communal areas
- décor and furniture are similar to what residents may have been used to before they moved in
- objects are actively used to make connections between people and enable autonomy, for example, items that facilitate shared interests and social interaction

10: Use of communication technologies

- digital apps, such as those with joint activities to encourage conversation and interaction or tell the story of a person's life so that the value of that life is understood and can be shared
- use of social media, such as Facebook, to connect friends and families and communicate with family members about what their relatives have been doing
- use of discreet electronic care records to release time for relationships
- bringing the outside in, e.g., with web cams

11: Use of assistive technology to support autonomy and foster relationships such as mobility aids, gadgets and entertainment equipment

- accommodate new concepts in mobility, e.g., those that raise the height of the user to allow for normal conversation
- new services to take the risk and worry out of visiting or travelling so that the world remains open, but safe
- devices which support the senses so one's role in the world is maintained
- access and training in appropriate technology for staff and residents
- good internet connectivity

12: An 'Open door' to the manager's office

- the manager's door is visible to all those who live, work and visit
- the manager is visible, receptive and welcoming
- the manager's door is 'open' except when confidential matters are being discussed

13: Private spaces for staff

- a designated space in which staff can socialise, have snacks and relax

7. Illustrative vignettes for individual and group reflection

Each vignette illustrates how the features of the key components can be translated into practice. Bear in mind they all overlap to a certain extent, because that is the nature of relational care – it all works together. The vignettes and the questions that accompany them can be used selectively for individual reflection by practitioners and facilitated groups on specific areas of practice and the environment. They can also help with ideas about how to move towards implementing relational care more generally.

Atmosphere

1: Leaders and managers create a home-like environment in which all those in it can flourish and thrive



'Home is not a place, it's a feeling' is a quote often used in various forms. This vignette is based on observational notes made during a visit to a care home and captures the 'feeling' of home and family, and some of the ways this can be generated.

After lunch I meet another resident, Joe, who joins us briefly. Joe says that he likes helping clear away after lunch, and that his greatest pleasure is just 'being nosy'. He says he "Likes to ask the staff about their lives, be part of the place," and adds, "It's a family here and we're all part of that family". Two members of the staff team – Ian and Marie (both of whom have been working here for more than five years) – pass by and join in. Ian says, "It's always has been and it always will be, to me, like a big family, like an extended family, that's what I love about it, we're all as equal as each other and we're all treated the same. That good working relationship it filters down to the team leaders, to the whole care staff, to everyone in the home." Both Ian and Marie go on to describe the relationships in Holly Trees House in the language of family ties; the residents are 'mum' or grandparents. Marie says, "I find that sometimes they'll look at you almost like a granddaughter or something, I feel like they just have this bond with you."

What is your first reaction to reading this vignette?

Is this a place you would want to work in?

What factors might contribute to a care setting having a homely feeling?

What might be the advantages for the residents and the staff in the vignette?

What problems might arise and how could these be overcome?

2: Residents feel a sense of belonging and sufficiently 'at home' to enjoy freedom of expression and find meaning in their lives



In this vignette, the researcher describes what happened when he interviewed the care manager of a day centre.

When we had finished the care manager's interview in her office, I noticed a picture board with staff photos and names on the entrance wall between the outer and inner door. The care manager pointed out one of the pictures to me – a smiling woman in the same staff shirt as other members of staff. The woman was a centre user called Minnie who had 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 the staff members and contribute by cleaning tables and tidying up. The manager suggested that when she did this her level of dementia was such that she believed she was a member of staff. The staff themselves encouraged her to do this – they valued the cleaning she did and understood how much it affirmed her sense of identity and status. She valued the opportunity to do it.

What do you think is the significance of the staff shirt to Minnie and how she feels about herself?

To what extent do the staff have freedom to involve Minnie in the running of the day centre?

What are the advantages for Minnie and the day centre staff?

Can you think of any problems and how these might be overcome?

3: Visitors experience the setting as welcoming and accommodating



This third vignette is about Ellie whose mother - Betty - lives in a care home in a town close to Ellie's village. She describes a typical visit to Betty.

I nearly always find Len, one of the residents, sitting on a sofa in the small, square hall; well-placed for the 'job' he has assumed as welcome committee! He always asks me "What's the weather like out there?" He's usually got his elderly golden retriever Bess with him; when someone new visits, Len will ask her to "Trot off" if the newcomer isn't fond of dogs. I usually put my head round the nearby door to Sue's (the manager) office to say hi. Then I go and find Mum in one of the two small lounges. She is often in the one without the TV – comparing knitting progress with other ladies. Whenever a member of the staff team sees me, I'm always asked if I want a cuppa.

What makes Ellie feel so welcome?

If you were a member of staff in this home, would the welcoming atmosphere make your job any easier, different, or more challenging?

Are there other ways of helping visitors experience the home as welcoming?

Relationships

4: Between staff and residents



In Vignette 1 we saw how the feeling of being an intergenerational family can grow. Vignette 2 showed how staff supported Minnie's autonomy by enabling her to fulfil her desire to help with cleaning and tidying up. The following extract from an interview with a sheltered housing cleaner called Elaine demonstrates the value of *all* those in care settings taking a mutual interest in each other.

Whenever we get a new resident I always show them how to use the washing machine and the easy way to make their bed. When we have done that – it might happen over a few weeks – I ask them to show me something they can do. I have been very surprised about what I have learnt from the residents! Last week Priti (a resident) showed me how to use an iPad which I couldn't do before. She was over the moon when I grasped it. It's also my job to talk to them about what's on the menu and help them choose. I often tell them what I would like to eat and would not like to eat – we have a lot of fun when that happens!!! I feel having the time to talk them through the menus helps me to get to know them and for them to know me.

To what extent do you think Elaine is empowering the residents and giving them a sense of value?

What are benefits to all concerned of Elaine having the time to spend with residents in this way?

Any there any problems that you think might arise when staff and residents take a mutual interest in each other?

5: Amongst residents



The story of Olia and the knitting club below shows how Lou – the care attendant in a sheltered housing complex – helped the residents to develop relationships that were mutually beneficial.

Olia was very quiet when she first came and just wanted to stay in her flat, however hard we all tried to get her mix with other residents. She seemed quite happy to sit in her room alone doing the knitting she loved doing so much. One day I had to call on her with a message and had a long chat with about her knitting. I then came up with the idea of setting up a knitting club. I called Olia the 'Master knitter' and she really liked that. I told her, "You can show other residents how to knit." I went to the group so that I could support her in showing the other residents who came along how to do different things with their own knitting. The club really took off and members were soon extending their knitting skills and Olia made new friends – I saw in her the lounge having a coffee with two of her other knitters last week!

How did Olia benefit from Lou setting up the knitting club?

How did the other residents benefit?

Do you see any potential problems that might arise as a result of the knitting club being set up? How could these problems be overcome?

6: Amongst staff (including staff and management)

This vignette is about Cara who has been employed as a domestic cleaner at Sunview residential care home for eight years.

Cara takes great pride in keeping the home clean, knowing that smells matter in making a place welcoming. Whilst she cares about the tasks, what Cara loves most about her work is being able to make time to 'sit and chat' with residents when doing her cleaning rounds. She knows the residents and their families very well and they know her too – indeed she told the interviewer how keen they are to hear about her daughter's wedding and tell her in turn about their memories of family weddings and the happy times they had. Cara mentions that spending time daily with residents in their 'personal space' means she can easily tell when residents are not their 'normal self'. She says that the manager respects and appreciates her observations and inputs and that she can say to the manager, "Keep an eye on so and so because I think there may be something up." She and other cleaners are routinely included in all team meetings and training like any other member of the care staff.

Should everyone working in a home be encouraged to build relationships with residents?

What contributions do you think staff such as cleaners, handymen, gardeners etc. make to the life of the care home? How might their contribution be different to those giving personal care?

Is including everyone in staff meetings a good practice or could there be some problems?

7: Between the care setting, the family and the wider community



King Edward House is a purpose-built day care centre; it was originally in a community centre used by numerous groups and the staff (all local) were consulted about the design of the new accommodation. The manager – Bob – talks about how having a garden and a proper kitchen means that they...

"...can hold events, for all the community to join in. We had a fete the other Saturday advertised mainly by word of mouth, people just seemed to enjoy a wander round the garden and having some refreshments. All sorts of people came – staff and the older people we look after and their families. Others have helped fundraise for craft equipment, some have helped with the garden, some just wanted to see the place and have a nose around and chat. Many brought in dogs, a few of whom were regular visitors as we see pets as providing important therapy. I heard a few of our older people calling it their 'second home'. He then went on to explain how they use Facebook to let family members know what their relatives have been doing. This was because, "So often some of the people go home and say, 'Oh I've done nothing, I've had nothing to eat, I've had this, I've had that. ...' 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? So we've got the Facebook page. We have everybody's permission before any pictures are taken or put on'."

A team leader in one of the care homes described residents' relationships with local nurseries and schools:



'So we've got the intergenerational aspect of it. We've been able to have something called Silver Readers so that the residents can help out by listening to children three times a week. The school rings us and we've got a mobile phone we take the phone to a resident and they listen to the children reading.'

What sort of relationships with families and the wider community do you think are important?

What are the benefits of these relationships and to whom?

How can relationships with families and the wider community be enabled by staff?

What issues do you think need addressing when setting up arrangements with the wider community?

Physical environment

8: Room layouts allow for private and communal spaces (inside and outside)



This observational note makes some useful points about room and furniture layout:

One resident sitting in one of the chairs near the TV in the lounge space was watching a programme, while two other residents were having an intermittent cyclical conversation 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. The space facilitated engagement.

Why do you think the design of the lounge in this care setting allowed residents both private and communal space?

How do you think spaces in your care setting (both inside and outside) could be reorganised to allow space for residents to meet their changing needs to be alone and with others?

What needs to be done to put into practice any reorganisation you have identified?

9: Recognition and encouragement of meaningful objects and activities

The first vignette looks at the role of objects and second explores activities.



During an interview with a resident called Edith she discussed objects that she had brought from her home.

"This is a photo album of pictures of my husband when he was demobbed from the RAF in Tunisia after World War II. He was decorated during the War, and I've got his medals as well as my wedding ring. Do you want to see something really special?" She then led the interviewer to her room where in a wardrobe, in an old handbag was a letter from his former employer thanking him for his RAF service and confirming that his job was waiting for him when he returned. The letter emphasised how much his employers valued him. Edith then added "You see that birdbath outside? Well, that's from my house! I just love watching the birds. My husband and I used to go for long walks together to look at the birds." On the way back to the interview room she showed the interviewer the communal areas with facilities for residents to make drinks and snacks. Pointing to the kettle she said, "I was given permission to have my own kettle, and I was thrilled to bits. I know it sounds a silly thing, but there are times when you really want to make your own cup of tea – it's those little things that mean so much to you."

Why do you think Edith says she was 'granted permission' to these objects, and what does that say about current practices? Should there be a change of attitude about this sort of issue?

Why do you think Edith was thrilled to have 'her own' kettle?

How might you feel if you had no access to the objects you use every day like a kettle?

How might these types of objects help you apply relational care?

How might these objects support deeper relationships between staff, residents and relatives?

In another home the interviewer made the following observations about a resident called Dorothy who had early-stage dementia:

She is a great crafter, and she had always helped her local church raise funds for charity by making greetings cards and as she told me, "I didn't just want to leave that life behind." Now she joins in the craft group in the home, helping to lay out the biggest dining table with all the materials once a week. When I met her in her own bedroom, Dorothy showed me a couple of boxes of cards that she planned to take to the church when they next had a coffee morning, something that she could do with a bit of help from care staff as the church is nearby. She showed me a beautiful large card she had just finished for her niece's wedding.

Why is making greeting cards so meaningful to Dorothy?

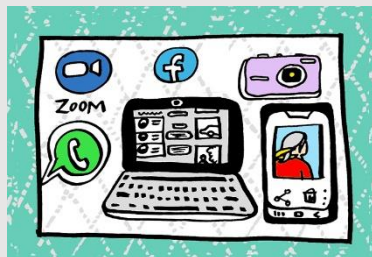
How are staff helping Dorothy to continue her hobby and value it?

How much flexibility is there in your care setting for residents to undertake activities that are meaningful to them now or because of their link to their past?

How can any change in practice be implemented to ensure all residents can do activities that they value?



10: Use of communication technologies



Vignette 7 referred to the use of technology in relational care. An interview with a staff member at a day centre - Robinder – provided some useful tips on using technology for bringing people together and looking to the future

People love the garden and its wildlife, but some find it challenging to spend time outside, especially in colder weather. We've installed a web cam in one of the bird's nests for the last few years, and everyone can watch the eggs hatching, and at least some of the fledglings making it out of the nest. This brings people together in conversation – all of us – as we watch on the screen, and also gets us talking about the future: how soon the birds will grow up, and the outings we're planning for the spring and summer.

Milanka, a care manager described introducing and using electronic care records.

We found there were things that we were missing in the paper notes. You would never remember everything. Eventually we identified an electronic care package that we could put everything into, medication as well. Well, at the start, some of the staff were really worried, but those that were more confident about using technology helped the others. We find we can sit with someone talking and showing them their care plan, as we go, saying 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. I put posters up to say to the families, the staff aren't on their mobile phones, it's the new package we've got, please ask them to show you. It actually frees up time for the staff to spend with the residents.

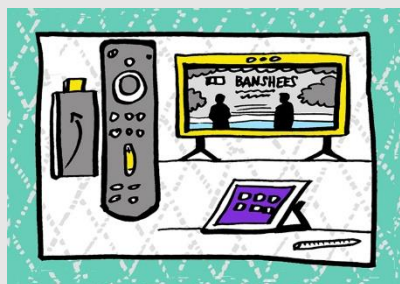
Both Robinder and Milanka draw out some of the advantages of the technologies they talk about. How did they contribute to supporting communication and developing relationships?

Can you think of other advantages?

Can you think of any disadvantages?

Are there areas of your work where the use of communication technologies might promote good relationships?

11: Use of assistive technology to support autonomy and foster relationships such as mobility aids, gadgets and entertainment equipment



These three short vignettes all show how residents' autonomy can be maintained and how peer relationships (see Vignette 5) can be enhanced by the use of entertainment equipment. The first is taken from an interview with a support manager working in sheltered housing accommodation and the second is a resident in the same complex. The third vignette is a short story as told to the interviewer by a volunteer.

"We (the care home) got a Firestick and one of the residents taught herself how to use it. And every evening her and a couple of others would come to the lounge, and she'd be putting the movies and things on for them, and it was great."

"Yes, I have a tablet to keep my bank account etc. I use it for storing photographs and take it in when someone sends me one, 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, it's like having a friend in the room."

"I used to run the film show. One afternoon I went round and the television set wouldn't work. I was playing with the television set, trying to make it work. I was sitting on the floor by the television and stayed there for the next three quarters of an hour just chatting. At the end I said, "Sorry about that, I'm very sorry about the film show," and one lady said, "Doesn't matter, we've enjoyed sitting here and having a good blather."

What sort of aids, gadgets or entertainment equipment could you use to help residents to be more autonomous?

How could you make better use of existing aids, gadgets and entertainment equipment?

Are there some that you have tried and found not to be very useful or not good value?

12: An 'Open door' to the manager's office



The success of relational care also relies on managers being mindful of the lives of staff in the workspace and outside (see Vignette 6). A manager of a large care home summed up the value of having an 'open door' policy when it came to his own office, both for staff and for residents.

I talk about things with the staff teams, we go through it, we compromise about things if they aren't quite going to work, we take their views and opinions of how things could be done differently or better. We try and make them feel valued and I think that's the most important thing about keeping staff. We offer them as much training as we can, if there's a specific course they want that we can't afford to put them through, we'll try and find funding so they can get it. And again I think it's just, my 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. When somebody's going home they rarely leave the home without, if I'm in the office, calling, cheerio, and I will always say, thank you for today, and I think that just means a lot. It means a lot to me when somebody takes the time to say they're going.

The interviewer then described what happened next....

Lucy, a resident who was over 100 years old, popped her head round the door asking for some assistance. She was a little disgruntled because she felt she'd been waiting a while for help already and wanted to complain about it. The manager invited her in to take a seat on the sofa and went off to find a nurse. Lucy soon cheered up, confident that she would be helped and knowing that she had 'vented' to the right person. Once her immediate needs had been met, the manager made Lucy a cup of coffee.

How does an 'open door' policy help managers show that they value their employees?

How does an 'open door' policy assist managers in helping staff and vice versa?

Are there ways that the relationship between staff and management can be mutual?

How does an 'open door' policy benefit residents?

Do you think the disadvantages of an 'open door' policy outweigh the advantages, and if so, are there any alternatives?

13: Private spaces for staff



Most care settings have somewhere for staff to go to have a break. One of the care attendants – Ali – talked about what made the staff facilities at their care setting so special.

Well, we are really lucky we have shower – it's great when you have done a night shift! We have got own toilet too, and lockers for stuff we don't want to leave lying around. Even though some people just want to have chat, quite a few of us use it just to have a rest or even a bit of a lie down when we are very busy. Most of us bring in our own food – we can heat it up in the microwave. But there are free snacks and drinks if we want them too. It's great because its right at the end of a corridor on the top floor so you can't hear what's going elsewhere! There's is a little room off it which we can use as prayer space if we want. Being a practising Muslim, it's important for me.

What seems to make Ali appreciate this staff area so much?

What do you think staff appreciate or dislike about your staff area?

Are there any changes you could make to the space and facilities for staff?

8. Questions and Answers

We all know that implementing any sort of change never quite goes according to plan! Here are some questions about commonly occurring issues in the move towards relational care, together with what are hopefully helpful answers.

Relational care sounds all very cosy and happy if residents are basically easy-going, but how do you cope with people who are grumpy, or with those who just want to be left alone?

Most people, grumpy or easy-going, do not want to be with others all the time. Therefore, it's essential that everyone can choose when they want privacy and when they want company. However, some people are simply hard to get on with! If there's no immediate danger, then more difficult people can be given time to settle in and feel known and accepted. When that does not work the manager has to adopt their 'parent' role and be very firm in explaining what must not happen. There may well be occasions – hopefully rare – when a resident might have to move elsewhere or, as is more often the case, they or their family will decide for themselves that a move is needed.

It's worth bearing in mind, that because relational care helps to restore autonomy and empowerment, it also helps residents to be more assertive, as they are in a 'safe', accepting environment where they are freer to express themselves in negative as well as positive ways.

If some residents are a bit more shy about speaking up, or don't like to complain, can they be helped to do so without it disrupting important relationships?

Definitely, you can encourage an atmosphere of interaction without anyone feeling they have been put on the spot. For example, one care home we visited had a 'discussion tree' where everyone – not just residents – could add ideas to talk about, negative as well as positive and know these would be discussed together. Of course, it may need a little check to make sure individuals are not singled out or feel 'got at'.

I get it that pets are very important to some people, and you have said that they're part of the network of critical relationships. But what happens when different relationships have to be reconciled – not everyone likes animals, what about people who are nervous or allergic? Can pets be confined to bedrooms or forbidden?

To force an older person to be parted from a beloved pet is damaging to their emotional and often physical wellbeing. It is important to be clear whether a care setting is pet-friendly, so everyone can make an informed choice. For those that are pet friendly, pets need to be allowed in most of the areas that residents use so that their owners are not prevented from benefitting from all the opportunities available to them to socialise. An alternative to being 'pet friendly' can be having a 'care home pet' (e.g., a cat, dog or guinea pigs). Every care setting needs a degree of autonomy in this respect, to make the decisions that are best for its community as well as individuals.

What are the limits to autonomy? What if residents want to do their own cooking or gardening, or help out in other ways, but may endanger themselves?

Whilst Health and Safety legislation must be followed, in relational care practice it is important to look at ways of working around this to enable people's activities and contributions within the constraints. This should be subject to risk assessment, and good records kept about how and why decisions have been made. For example, it is unlikely that residents can go into the main catering kitchen, but some larger care settings have areas where everyone can bake together, with help and monitoring from care staff. Other care settings enable residents to prepare vegetables if they want, working side by side with a staff member. Gardening can be done as a team, with tasks carefully allocated. Innovation, imagination, and looking at what others have done will generally help to find the right answer.

We found plenty of good examples where risk assessment and making a few changes as a result, achieved all that was needed to ensure people could live full lives, such as guidance on using an electric wheelchair indoors, and company for those who want to walk outside in all weathers.

There is so much assistive technology on the market, for older people to use themselves, and to help with management tasks. How do you choose between it all, and get value for money? Can it help us offer relational care?

This is a real growth area with new products coming onto the market. The first issue to consider is, does this equipment or item make it easier for people to interact, or does it get in the way of forming relationships, or attempt to be a substitute? For instance, when a system to record medications, tasks and shared information releases staff time to interact more with residents it is worth considering. However, it will be counter-productive if it demands a lot of time staring at screens. Similarly, some equipment (robot animals for example) can bring people together or isolate them by becoming a 'pacifier' depending on how it's used.

Recruiting locally obviously has advantages for forming relationships and having a similar background, but given the shortage of staff nationally, that's just not always going to be possible. Can we make relational care work if staff come from very different backgrounds and cultures, or even from overseas?

It is probably going to take a bit longer as management need to give each newly appointed member of staff time and informal training to adapt to different ways of doing things and local expressions of speech. However, it can be a quick process if the new person has joined the team because they already knew other members and chose the care setting for that reason.

Importantly too, the different experiences and expectations of staff need to be optimised. An example can be found in the case of cultures which put more emphasis on the value and wisdom of older people as 'teachers' to younger ones, thereby enabling them to make a new type of contribution. The main point is longevity of staff appointments; relational care becomes much more challenging if there is high staff turnover, so employing those on short term visas is always going to be problematic.

What about making residents from different cultures feel at home as everyone else?

It's the same approach, as acknowledging and benefitting from the different cultural backgrounds of staff. If new residents have different religious or dietary needs it may take time to put things in place, but working with them and their family will make that possible with some planning. It's worth thinking about language – not just about other languages, but whether younger and older people use different phrases that need adjusting. For example, we heard that asking a lady if she 'wants to go to the bathroom' did not get any response but asking her if she 'wants to spend a penny' got an immediate answer.

How can we make relational care work with people with advanced dementia?

It is important to find ways to have conversations with people with advanced dementia so you can find out what their preferences are, how they are feeling, give them choices, and help them be part of the home and maintain relationships with others.

There are a number of items that help to bridge the gap and make communication easier, some simple and some using technology. One example is 'Talking Mats'. This is based on a set of symbols; the symbol sits on a physical mat which gives the older person with advanced dementia a visual focus. The symbols are used by staff to ask questions. The process of sitting down with the Talking Mat also gives the staff involved and the older person the time and space to develop and sustain their relationship. For example, a lady who was becoming socially withdrawn and did not want to come to the dining room for mealtimes despite having been happy to do so before sat with one of the carers on a Talking Mat, and she managed to find out that the lady had a pain in her knee which made walking to the dining room painful. This enabled staff to get her the medication she needed.



9. Acknowledgments

We wish to extend our gratitude to everyone who has helped us to use our research to create this toolkit:

The Hallmark Foundation for their generous grant, and their faith in the value of this work; and in particular to the Foundation's CEO Stephen Burke

The project's Advisory Group, who have given their time and expertise to guide the toolkit, and have added greatly to its value:

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

The managers, staff and residents of the care settings we visited - for their time, hospitality and wisdom.

Pen Mendonca, who has brought 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

Please contact Professor Mary Larkin (mary.larkin@open.ac.uk) or Dr Manik Deepak-Gopinath (manik.deepak-gopinath@open.ac.uk) for any queries.

May 2023

