Redefining professional boundaries: Relationship-based practice in the care for older people with dementia

Faye Grinter

Submitted to Swansea University in fulfilment of the requirements for the Degree of Doctor of Philosophy

Swansea University

2023

Supervisors:
Professor Fiona Verity
Dr Christian Beech
Dr Michele Raithby

Abstract

In recent years, relationship-based practice has emerged as a pivotal framework in social work, particularly in child and family practice. However, its application in residential care for older people with dementia remains underexplored. This gap is significant amidst a globally ageing population and increasing demand for social care, especially in a sector facing workforce challenges. Social care workers in residential settings establish crucial caring relationships with people with dementia. However, these often contend with managerialist influences.

This thesis aims to understand effective relationship-based practices in residential care for people with dementia, focusing on the experiences of residents and staff. It explores necessary cultural and practical changes to enhance support for these practices. Using a case study approach in two residential social care settings in South Wales, the study identifies principles of effective relationship-based practice through documentation analysis, direct observations, and interviews with staff and residents. A social constructionist ontological approach, recognising that social realities are constructed through interactions, is utilised to understand how residents and staff co-create the social environment and influence the effectiveness of relationship-based practices. The results were analysed using qualitative content analysis, from an ethics of care perspective, providing deeper insights into what constitutes effective care practices for people living with dementia.

Analysis suggests that laughter, touch, and closeness are vital elements of effective relationships. The findings emphasise that a 'one size fits all' approach is ineffective, as some residents prefer distance. Time was found to be crucial in fostering positive relationships, while current professional boundaries and lack of time are barriers. This thesis advocates for cultural and contextual shifts in residential social care to enhance the practical and emotional dimensions of social care relationships. It suggests that practice and professional boundaries should better align with a relationship-based approach to care in residential settings.

Dedications

I want to dedicate this thesis to two important women who, while not here to see it to completion, were both guides and inspirations behind it.

To my supervisor, Dr Michele Raithby. I was lucky enough to have Michele guide me through the first years of my PhD. Her ideas, knowledge, and passion have shaped this thesis.

To my Nanna Zena. I know she would be incredibly proud.

Acknowledgements

I wish to express my gratitude to the residents who welcomed me into their homes, for engaging with me with interest, and responding to me with such warmth that I looked forward to going in each day to conduct my interviews and observations. This gratitude is only compounded by the knowledge that the UK went into lockdown due to COVID-19 so soon after the interviews (just days in some cases). I do not need to consult the research to know the huge impact this would have had on the lives of these participants. I was not able to follow up with people individually yet returning from my maternity leave in 2021, and listening again to their voices and stories, has had a great impact on me. It is the desire to honour their stories and time that has pushed me through the final months and years of this PhD. Thank you, too, to all the staff who welcomed me into their place of work and approached my research and questions with open minds. I am incredibly grateful for their honesty and willingness to speak, and I was touched by the care, compassion, and commitment they showed to the people they cared for.

I wish to thank Professor Fiona Verity for her support and guidance throughout my PhD journey. I wish to thank Dr. Christian Beech and Dr. Michele Raithby, my supervisors who not only provided invaluable guidance throughout my PhD, but I was also lucky enough to have as lecturers throughout my undergraduate Social Work degree. Thank you to my husband Alex for his love, help and patience, and for holding the fort at home to give me much needed time and space to write. I want to thank my mum. Her drive to help others and passion for social work have been a source of inspiration my whole life. Thank you to my parents and my parents-in-law, wonderful grandparents who have loved and cared for my children, meaning I knew they were in safe hands while I worked. And finally, thank you to my two children, both born during this PhD. As important as the role of ‘PhD student’ has been in my life, it pales in comparison to the role of being your mother.

Table of Contents

List of Figures

List of Tables

Chapter 1 Introduction

1.1 Introduction

This thesis explores approaches to social care practice in residential settings for older people living with dementia. This was achieved through an exploration of how people living with dementia and staff experience relationships in these settings, how a relationship-based approach to practice could be supported, and what the potential implications for professional boundaries might be. Relationship-based practice is an increasingly influential framework through which social work and social care are practised and understood. The research base in relationship-based social work is becoming well-developed, particularly in child and family practice. However, more attention needs to be paid to how relationship-based practice approaches could be developed in residential care for older people with dementia. Social care workers develop and sustain long-term relationships through which they support the people in their care. Despite this, social care practice is still heavily influenced by the managerialist approaches that have dominated in recent decades. People with dementia have specific and often complex support needs, while the social care sector is currently experiencing an ongoing workforce crisis.

Alongside this resurgence in relationship-based approaches to practice, society across the globe is ageing. Not only will this potentially increase the number of older people requiring residential social care support, but it also means a possible increase in the number of people needing support with age-related illnesses such as dementia. In the UK, the age at which a person is considered ‘older’ is generally understood within different contexts, rather than the existence of a universally defined threshold. Government policies often reference specific ages, such as the state pension age, currently set around 66 and gradually increasing. Social Care Wales contributes guidelines that outline eligibility for services aimed towards older adults. Academic perspectives commonly categorise older adults as those aged 65 and above, reflecting distinct health and social care needs compared to younger age groups (Office for National Statistics (ONS), 2023; Social Care Wales, 2022). For the purpose of this thesis, when referring to ‘older people’, it can be taken to mean adults above the age of 65.

1.2 An introduction to relationship-based practice

Relationship-based practice is not a straightforward concept, and the development of its understanding in research literature has been a meandering journey (O’Leary et al., 2010; Ruch et al., 2018; Wilson et al., 2011). While the literature on relationship-based practice is focused heavily on social work (Dimes, 2019; Dix et al., 2019; Ruch et al., 2018; Wilson et al., 2011) this research seeks to answer the question of how relationship-based approaches to practice might support residential social care in its endeavours. To do this, the thesis will explore approaches to relationship-based practice in social work literature, aiming to understand how their frameworks might be applied within residential social care settings.

Relationships are central to achieving the goals of social work; relationships with people, with society and with organisations (Ruch, 2005). Relationship-based practice is founded on this concept, that human relationships are crucial and should be at the core of all good practice. A growing body of literature and research has put forth the argument that the relationship is ‘at the heart of social work’, and along with emotional intelligence, is the key to effective assessment and intervention (Dix et al., 2019; McLeod, 2010; Ruch 2005; Ruch et al., 2018).

Older people with dementia in the UK are supported within the health and social care system, receiving assessment, care, and support from both social workers and social care workers. The social work and social care professions both seek to support people through relationships to achieve their goals, but they play very different roles in doing so. These roles will be explored below.

Social work is defined by the International Federation of Social Workers as ‘*a practice-based profession and an academic discipline that promotes social change, development and social cohesion’* (IFSW, 2014). Social Care Wales defines social work, in the first national agreed definition of the role, as ‘*a profession that supports,* *empowers and safeguards the most vulnerable adults and children in society'* (Social Care Wales, 2024). Social work is a protected title, requiring specific qualifications and registration with bodies such as Social Care Wales in Wales, while the other devolved nations in the UK have different regulatory bodies (Social Care Wales, 2024). Social workers provide assessments for support and intervention as specified under key legislation across the UK in areas such as child protection, older adults, adult safeguarding, and mental health.

Similarly to social work, social care services become involved in people's lives at the point where they need additional support (Social Care Wales, 2024). A social care worker is defined by Social Care Wales (2017, p. 7) as *'a paid worker contributing to the delivery of social care and support'*. Social care workers do not require the same level of qualification as social workers, and practice involves the provision of personal care and support (Social Care Wales, 2017). Despite not requiring the same level of qualification, social care can still be considered a profession due to its training requirements, adherence to professional and ethical standards, and the specialised knowledge and skills necessary to effectively support people. While social work involves professional assessments and statutory duties, social care offers essential practical support, including intimate and hands-on personal care involving touch, or work of the 'body' (Cox, 2007; Twigg et al., 2011). This type of care includes assistance with daily activities such as bathing, dressing, and feeding, as well as emotional support.

The focus of this research is centred on social care workers, who play a key role in providing daily care to people living with dementia in residential settings. The exploration of the literature on social work, however, provides valuable insights into how relationship-based practice could be applied in social care settings. This is due not only to both fields providing support to people in need but also because existing research primarily focuses on issues within social work contexts. It would be remiss to ignore the contributions of relationship-based social work models, frameworks, and research and the potential learnings that might be applied from such models to support the development of effective relationship-based practice in residential settings.

Both social workers and social care workers seek to support people of all backgrounds and ages. As the demographic of the global population becomes increasingly older, it follows that the population requiring social support will reflect this change. The people who social work and social care support, and thus develop practice relationships with, will always span all age demographics. However, increasing numbers of older people will require increasing numbers of professionals with specific expertise to support them with their needs. Before completing my social work degree and practising as a social worker in a childcare setting, I practised as a residential social care worker, so I have first-hand experience in both roles. It is this background, in addition to working in a user involvement role in a dementia charity, that led me to take an interest in exploring ways in which residential care for people living with dementia can be improved.

1.3 The ageing population and dementia

The global population is changing; it is ageing rapidly (World Health Organisation (WHO), 2022). The skillset of the social work and social care sector will need to change to keep pace with this shift in population demographic (Skills for Care, 2022b). The World Health Organization estimated the global population aged 60 and over was 1 billion in 2020, and this number is expected to double to 2.1 billion by 2030 (WHO, 2022). In England and Wales, the proportion of the population aged 65 and over increased from 16.4% in 2011 to 18.6% in 2021, meaning there are approximately 11 million people over 65 living in England and Wales (ONS, 2023).

The ageing of global societies is frequently portrayed negatively and represented as placing an increasing burden on society. News media run stories warning of the need to ‘*brace*’ for the ‘*Silver Tsunami’* and voicing concerns about health and social care systems ‘*buckling*’ (Forbes, 2022; The Guardian, 2023). However, the increase in the population age *has* led to an increased number of older adults in need of social care and support (Lloyd & Sullivan, 2018). Globally, more than 58 million people are currently living with dementia, a number projected to exceed 150 million by 2050 (Alzheimer’s Disease International et al., 2020). The globally changing demographics of the population highlight the increasing need for social work and social care practitioners to develop knowledge and skills specific to effective practice with older people. The ageing population will impact the type of care provision required, particularly with the increased prevalence of age-related conditions such as dementia.

The term dementia refers to a range of symptoms stemming from disorders that affect the brain. These symptoms encompass memory loss, challenges with cognition (for example, thinking, problem-solving, and language), and alterations in mood or behaviour (WHO, 2023). Rather than a single disease, dementia comprises a group of symptoms linked to various conditions, such as Alzheimer's disease, vascular dementia, and Lewy body dementia, leading to a progressive decline in cognitive functions, including memory (Alzheimer’s Society, 2023). Ageing is associated with several factors that increase the risk of developing dementia. These include neurological changes and issues with vascular health, with conditions like hypertension and diabetes contributing to vascular dementia. Genetic factors, such as certain forms of Alzheimer's disease, and lifestyle choices can also elevate the risk (Alzheimer's Society, 2020; Livingston et al., 2020). In addition to cognitive decline, individuals with dementia may experience behavioural and psychosocial symptoms such as aggression, psychosis, depression, and wandering (Kaplan & Berkman, 2011).

This medical perspective highlights the physiological aspects of the condition. This traditional medical model, which focuses on the disease and its symptoms, often neglects the social and environmental factors that can impact the well-being of individuals with dementia (Gilliard et al., 2005). A social model of disability perspective emphasises the need to address societal barriers and create supportive environments and the importance of understanding and addressing these broader impacts. This model advocated for supportive environments and inclusive care approaches that enhance the quality of life for both people with dementia and those who support them (Gilliard et al., 2005). It is essential to recognise that dementia is not a natural part of the ageing process and can have a deep impact on a person's daily life (NHS, 2023).

As ageing is associated with several risk factors for developing dementia, the likelihood of a person developing dementia increases with age. Therefore, as the population ages, the number of individuals affected by dementia is likely to increase. It is estimated that 94.8% of those diagnosed with dementia are aged 65 and older (Alzheimer's Society, 2019). It is estimated that globally, the number of people living with dementia is increasing by 10 million each year (WHO, 2023). In the UK, the number of people with dementia was estimated to be close to 1 million in 2021, a figure expected to rise to 1.6 million in 2050 (Alzheimer's Research UK, 2022). These figures mean that currently, it is estimated that 1 in 11 people over the age of 65 have dementia in the UK (Alzheimer's Research UK, 2022). Awareness and understanding of dementia are growing in many parts of the world, yet globally, it remains that a dementia diagnosis is often accompanied by stigma and social isolation (Alzheimer's Disease International, 2019).

The increasing awareness of dementia in the UK can be observed in government literature and policy. The Prime Minister's Challenge on Dementia 2020 aimed to increase early detection of dementia and promote knowledge and understanding of how to minimise the risk of developing dementia. The plan was to develop joined-up health and social care working practices while promoting personalised support for people living with dementia (DOH, 2016). In Wales, the Welsh Government introduced the 'Dementia Action Plan for Wales', which set out an action plan recognising the rights of people with dementia while aiming to reduce stigma and increase support (Welsh Government, 2018). This thesis seeks to develop an understanding of how policies such as those described above might contribute to enhancing the support provided by social care staff to people with dementia in residential settings through developing relationship-based approaches to practice.

1.3.1 Dementia care and support

Dementia not only affects families but also resonates throughout communities. This means social work and social care have a role to play in supporting individuals and their families whilst simultaneously ensuring the wider systems within which they interact are responsive and supportive to needs (Cox, 2007). Within England and Wales, people with dementia access social support across a broad range of adult social work and social care settings. Social care support for people with dementia involves paid carers providing either domiciliary care[1] or residential care[2] to individuals to meet their personal and social care needs in residential care settings, often referred to as 'care homes' (Age UK, 2022). Some residential settings also provide health care through employed nurses and are usually referred to as nursing homes (Age UK, 2022). In the UK, there are approximately 17,000 residential care settings, of which approximately 70% are residential 'care homes' and the remaining 30% are nursing homes, according to data compiled by carehome.co.uk[3] (2022).

Within residential care settings, it is estimated that 70% of residents have either a diagnosis of dementia or a severe memory problem (Wittenberg et al., 2019). Although data on the number of qualified social workers working specifically with adults is unavailable, in England, there are currently approximately 17,000 social workers working across all sectors, including child & family, mental health and older adults (Skills for Care, 2022a). In comparison, the number of social care workers in residential care settings in England currently stands at approximately 650,000 (Skills for Care, 2022b). To understand how to effectively support people with dementia, it is important to consider where and by who dementia care is primarily delivered. Across England, the figures above suggest that most of the work for people with dementia is carried out by social care staff because there are significantly more social care workers (650,000) in residential care settings than social workers (17,000) across all sectors in England. This disparity indicates that most direct care for older people with dementia, who make up a significant portion of residential care residents, is likely provided by social care workers rather than social workers. Therefore, this thesis focuses on relationship-based practice within social care rather than social work.

---

[1] Domiciliary care is the provision of community based paid care to support individuals and meet their health and social care needs within their own home (National Health Service (NHS), 2021).

[2] Residential care settings are settings providing individuals with accommodation and personal and social care, also known as care homes (Age UK, 2022).

[3] Carehome.co.uk lists all care homes registered with their country's regulatory body. UK total includes Channel Islands and Isle of Man as well as the four countries listed (carehome.co.uk, 2022).

1.4 Risk and relationships in practice

The concept of risk is particularly pertinent in both adult social work and social care, where the notion of risk is exacerbated by the perceived vulnerability of harm to older adults (Manthorpe, 2015). Workers must balance the older person's rights to autonomy and self-determination against the need to put measures in place to promote safety and minimise risk (Manthorpe & Samsi, 2013; Lymbery & Postle, 2010). However, this balance has skewed towards an increased reliance on assessment tools and move away from 'social work' and towards a care management approach for older people. This has been linked to the increased focus on risk prevention across social work and social care (Faulkner, 2012; France et al., 2012; Littlechild, 2008; Parton, 1996).

In risk assessment practices, risk is defined through gathering, analysing, and converting quantifiable knowledge into calculations used for prediction (Parton, 1996). The universal acceptance of the risk assessment and prevention paradigm in social work and social care reflects an ideological position characterised by what Scourfield and Welsh (2003, p. 405) describe as the *'inescapable politicisation of expertise.'* This political influence has led to an abundance of reactive risk management policies and procedures. Concurrently, societal perceptions of risk shaped by media, government, and public opinion are '*increasingly impacting upon professional practices'*, as highlighted by Littlechild (2008, p. 662).

This shift in focus emerged due to the move towards neo-liberalism within Western societies, such as the UK. Since the 1990s, many politicians and policymakers have sought scientific, positivistic methods which *'can reduce risks and tackle future social problems'* (France et al., 2010, p. 1195). Risk assessment has an '*aura of science'* (Scourfield & Welsh, 2003, p. 400). Thus, risk prevention practice being touted as quantifiable and predictive has seduced professionals who '*perceive that if they do not eliminate risk, they will be open to severe criticism'* (Littlechild, 2008, p. 665).

Neoliberalism has transformed social care and social work in the UK by introducing market-driven reforms, promoting managerialism, and prioritising risk management

(Rogowski, 2012). While these reforms aim to increase efficiency and accountability, they also pose challenges to delivering relationship-based care and addressing complex social needs effectively. Navigating the balance between neoliberal policy imperatives and the values inherent in providing care remains a critical challenge for practitioners and policymakers alike (Chadzitakis et al., 2020).

This policy shift has been especially marked in the adult practice context, with a move towards managerialism and risk reduction, most notably with the previous tendency to refer to adult social workers as '*care managers'* (Lymbery, 1998, p. 863). This has contributed to the shift from a professional to an administrative-based culture within practice. The increased levels of paperwork and computer-based assessment and care management systems have been identified as a threat to adult social work by Ellis (2014, p. 2279), who argues it left workers *'feeling deskilled whilst making relationships with service users more difficult'.*

As social workers became subject to increased scrutiny, with practice becoming subject to increasing procedural instructions, assessment and recording became increasingly reductionist (Postle, 2002). Such assessments have been argued to deskill social workers, who become involved in administrative-style risk assessing practice with increased levels of auditing and regulation over previous approaches of promoting change through the development of effective relationships (Parton, 1998; Pollack, 2010). Neoliberal policies promote the efficient use of resources and emphasise accountability for outcomes. In social care, this has translated into performance metrics, targets, and standardised procedures aimed at demonstrating value for money and improving service delivery in what Chatzidakis et al. (2020, p. 15) describe as the *'corporate seizure of care homes from the public sector'.* There have, however, been legislative attempts to shift practice.

The Social Service and Wellbeing Act (Wales) 2014 was introduced in 2016 to move away from a resource-led practice ethos towards a more strengths-based and needs-led approach. This shift in policy approach has coincided with the shift (back) towards placing the relationship at the centre of practice (Hollinrake, 2019; Ruch et al., 2018). This thesis seeks to understand how a shift towards an effective relationship-based approach might be supported in residential care settings for people with dementia and how staff might manage the contested risk and boundaries in developing effective relationships with the people they support.

1.5 Return to a relationship-based practice

Relationship-based practice is not a new concept, the roots of which can be traced back to the psychoanalytical and psychosocial practice models of the mid-twentieth century (Ruch, 2005; Rogers, 1961; Hollis, 1964). There is a lengthy literature on relationship-based practice in social work, with the ideal working relationship described as a two-way process where both parties change and learn (Hingley-Jones & Ruch, 2016 Ruch et al., 2018; Trevithick, 2003). The return to a relationship-focused practice is thought to be a reaction to the shift in social work practice towards managerialism and bureaucracy, explained throughout this introduction (Hollinrake, 2019; Ruch et al., 2018). McLeod (2010) argues that the pursuit of procedural rather than relationship-based approaches to practice has arisen as a defence mechanism to criticisms of the profession and the risk, uncertainty, and anxiety inherent in social work.

Proponents of relationship-based practice models suggest the approach enables practitioners to make sense of an individual’s unique experiences and behaviours within the broader social contexts within which they live (Dimes, 2019; Hollinrake, 2019; Ruch et al., 2018). They put forward that understanding, supporting, and developing relationships are key to such support as life begins in relationships, and personal identities develop within a relational context (Dimes, 2019; Dix et al., 2019, Hingley-Jones & Ruch, 2016; Hollinrake, 2019). Advocates of a relationship-based approach assert that by developing relationships through empathy and establishing rapport with service users, professionals can explore issues using the strong grounding of the relationship as a tool to encourage positive change.

The effect of this repositioning of care challenges the relationship-based approach to practice, based on the traditional values of respecting the service users’ right to autonomy and self-determination. Postle (2002, p. 336) suggests ‘*the possibility for* *optimism exists in re-evaluating ways of working and the importance of the core nature of the social work relationship'.* It is acknowledged that developing and maintaining a meaningful working relationship is central to effective practice with older people (Dimes, 2019; Todd, 2017). Focusing on the working relationship requires professionals to look within to explore how they can create an environment with appropriate boundaries that allows the person they are working with to thrive. The professional can experience a different way of working and connecting, seeing themselves as cocreators in an intervention rather than 'doing to'. The model acknowledges that each care encounter is unique, with attention needing to be paid to the specific circumstances of the individual while also recognising the practitioner and service user both bring a range of experiences and emotional responses to the encounter (Ruch, 2018a).

The recent developments in relationship-based practice have been spearheaded by a body of work from several academics (Dimes, 2019; Dix et al., 2019; Hollinrake, 2019; Ruch et al., 2018). The approach that this thesis will centre around is the practice model put forward by Gillian Ruch. Ruch (2005) proposes a relationship-based practice model that draws upon the psychoanalytical influences that informed child and mental health social work from the 1940s onwards, and the psychosocial approaches to practice often associated with social work in the 1960s. Central to these models is the recognition that past experiences impact our current behaviours, with the understanding that professional relationships can evoke feelings associated with other, not necessarily connected, previous experiences (Ruch et al., 2018). Ruch argues a relationship-based approach to practice appreciates the importance of working in ways that ensure collaboration and partnership, in addition to acknowledging the power imbalance in professional relationships.

The possibility of limiting the managerial processes to enable increased focus on an individual's situation and journey is welcomed by those for whom the ability to develop constructive professional relationships has been hampered by the increasing administrative obligations (Murphy et al., 2013). The framework put forward by Ruch et al. (2018) is based on child and family social work practice, and while the theoretical underpinnings will differ to practice with older adults, the approach has an increasingly detailed knowledge base. A further model for applying a relationship-based approach to adult social work practice was put forward by Dix et al. (2019). The authors suggest a framework entitled ‘IDEAS’, which focuses on a strengths-based approach to practice, building on and widening the approach taken by Ruch et al. (2018) to ensure applicability to practice with adults.

Both practice models will inform and guide this thesis in exploring the application of a relationship-based approach to practice in social care for older adults with dementia, in a residential setting.

1.6 The boundaries of support

Social care workers engage with individuals in their time of need, often following the breakdown of personal and societal relationships (IFSW, 2014; Skills for Care, 2022a). Within these caring relationships, people receiving care share highly personal information and feelings (Alexander & Charles, 2009). Yet, workers are required to maintain professional distance while limiting personal disclosure. As O’Leary et al. explain:

> *‘Managing this delicate process has been conceptualised as maintaining ‘professional distance’, premised on the belief that a psycho-*social separation *will encourage rational scientific objectivity.’* (O’Leary et al., 2013, p. 137)

Workers are expected to establish and use relationships to create appropriate levels of intimacy to achieve change and goals. However, the quality, consistency, and continuity of relationships with service users have been cited as critical factors contributing to poor outcomes in high-profile, tragic cases in the UK (Munro, 2011; O’Leary et al., 2013). As O’Leary et al. argue:

> ‘*The social work relationship has adopted restrictive artificial barriers that are not in keeping with the profession’s values and some of the realities of practice.’* (O’Leary et al., 2013, p. 136)

Navigating and applying professional values is a core element of practice with older people with dementia. Workers often face a considerable ethical dilemma as dementia progresses and decision-making capacity becomes impaired. Social workers and social care workers are required to negotiate delicate ethical boundaries using professional judgement, informed by their knowledge and experience. However, increasingly working with people with dementia, like all areas of practice, is bound by regulations and policies to protect service users from harm. This has been argued to have a negative effect on the relationship created or formed with the people needing services (Cooper, 2012; Todd, 2017).

The potential for discrimination and exploitation exists within all working relationships. To minimise the chances of such occurrences, professional boundaries are advocated (Cooper, 2012; O'Leary et al., 2013). Within the UK, each country has its own professional code of conduct and regulatory body that qualified social workers are required to register with (Wiles, 2011). Currently, in Wales, care managers[4] are required to register, but registration for social care workers is not mandatory (Social Care Wales, 2017). Social Care Wales (2017) has produced professional boundaries for social care workers, and it is a requirement that care managers ensure their staff are familiar with these boundaries. Historically, professional boundary guidelines created in the social work field were heavily influenced by the more traditional professional boundary models of the medical profession (O'Leary et al., 2013; Wiles, 2011). These risk management strategies were aimed at members of society who are thought to be '*unable or unwilling'* to manage their own risk and their own lives, skewing the power towards the workers over the people being supported (Pollack, 2008, p. 1264).

Boundaries put in place to protect the people receiving services from potential harm by practitioners focus on the negatives, the '*what ifs'* and the '*worst-case'* scenarios (Coady, 2015; Doel et al., 2010; Huby et al., 2014). The concept of professional boundaries separates the worker and the person being cared for, and over time

---

[4] Social Care Wales refers to managers of care homes as care managers, not to be confused with the term 'care manager' used previously to describe the role of a social worker, or similar, who oversees the coordination of care for service users (Social Care Wales, 2017).

common metaphors have evolved to describe the violation of such boundaries, for example, '*crossing the line'* (Doel et al., 2010, p. 1879). If professional boundaries, and the codes of conduct that enforce them, are too far removed from the realities of the practice environment, there is the potential that they will be ignored or discredited (Alexander & Charles, 2009). If relationships between older people with dementia and professionals are to improve, the current restrictive and medical-based professional boundaries need to change.

1.7 Person-centred practice

Person-centred practice has had a considerable impact on practice and policy in dementia care in recent decades, aiming to place the person and their individual needs and preferences at the centre of their care (Brooker, 2003; Kitwood, 1997; Murphy et al., 2013; Nolan, 2004). Taken at face value, a person-centred approach and a relationship-centred approach to practice appear to be similar. The main difference between relationship-based practice and person-centred care, however, lies in their focus. Relationship-based practice emphasises building strong, trusting relationships between care workers and recipients, prioritising the quality of these interactions to achieve positive outcomes (Ruch, 2005; Ruch et al., 2018). Person-centred care, on the other hand, focuses on placing the individual at the centre of decision-making and care planning, tailoring support to their preferences and goals, and ensuring their autonomy (Kitwood, 1997).

Dementia does not only impact the individual, as highlighted previously in this introduction, but it also has a profound impact on daily life for their friends and families. The individual needs to be understood within the context of their wider relationships, which often provide increasing amounts of informal care as a person's dementia progresses. The personal, social, and economic costs of unpaid and informal care for people living with dementia in the community cannot be ignored (Kaplan & Berkman, 2011). Informal carers often also experience increased health and social problems and therefore have additional support needs to ensure they can continue providing care for their loved ones (Kaplan & Berkman, 2011). This could explain why support is frequently sought late in the process, and interventions are often crisis management. This results in support responding to breakdowns in caregiver relationships, as opposed to being able to provide support to people in the earlier stages of dementia in a preventative way (Manthorpe et al., 2008).

People with dementia have unique histories, and they need to be understood within the context of those histories to ensure that any support put into place will meet their individual circumstances and needs. Social care and social work professionals need to be mindful that their presence alone can be viewed as a physical manifestation of potentially cumulative losses they have already experienced in life (Todd, 2017). These could be the loss of their autonomy, memory, and important relationships, all of which would have a significant impact on their life. As Murphy et al. point out, the potential for the development of relationships in '*potentially conflicting circumstances is clearly both challenging and* constrained' (Murphy et al., 2013, p. 714). This professional relationship is a dynamic process that can give rise to both practical and ethical challenges unique to this service user group and the stage of life during which the work takes place (Todd, 2017).

As discussed throughout this introduction, the professional relationship, when placed at the core of practice and used appropriately, can provide a base for supporting people and effecting change. Through developing an understanding of a person's individual needs, situation, and context, it is possible to tailor support to be delivered in a way that will be well received and meets their needs. Thus, a focus on developing and supporting effective relationships has the potential to provide a suitable base for ensuring that these needs are understood. It is only once a person's situation and needs are understood that they can be met.

1.8 Relationship-based practice with older adults with dementia

The complexity of working with people with dementia requires a high level of professional skill, knowledge, and practice, and arguably, a practice that requires a relationship-based approach (Todd, 2017). Despite the recent increase in literature promoting a relationship-based approach to practice, the predominant focus is on relationship-centred practice in a childcare social work setting (Howe, 1998; Huntley, 2002; McLeod, 2010; Ruch, 2005; Ruch, 2011) and the overarching theories it is based upon (Alexander and Charles, 2009; Trevithick, 2003; Murphy et al., 2013). While authors have sought to adapt and refine Ruch's framework for relationship-based practice to apply it to adult social work (Dimes, 2019; Dix et al., 2019; Hollinrake, 2019; Todd, 2018), research in this area is limited and the applicability to social care largely unexplored.

As laid out previously in this chapter, most of the care provision for older people with dementia living in residential care is provided by social care workers (Skills for Care, 2022a). Despite this, most of the available literature on relationship-based practice is overwhelmingly focused on the social work and nursing professions. It is the social care workers who undertake much of the day-to-day care in residential settings and, therefore, the ones whose working relationships have the greater impact on people's day-to-day lives. Social care is widely acknowledged to be underfunded, with a high staff turnover (Skills for Care, 2022a). While the relationship skills and knowledge required by both domiciliary and residential social care are significant, it is a profession often reduced to perfunctory tasks related to hygiene and eating (Carey, 2015; Carey et al., 2019).

To explore how people living with dementia and social care staff experience relationships in residential care settings, knowledge of the impact of dementia on relationships is vital. For people with dementia, their relationships are often impacted by the progression of their dementia symptoms. This impact is wide-reaching, touching their relationships with the people around them, professionals, and their wider social environments. Kitwood (1997) argues that relationships are central to maintaining personhood following a diagnosis of dementia, suggesting that relationships play a significant role in allowing people with dementia to preserve their sense of self. Sabat (2006, p. 300) points out that a '*person is a person through others',* a statement which Wiersma and Pedlar (2008) agree with, suggesting that the provision of opportunities to develop personal and meaningful relationships is vital to enhancing personhood. The need to extend the understanding of dementia beyond the medical model to capture a more dynamic and contextualised perspective is acknowledged by Bartlett and O'Connor (2010).

There has been a necessary shift away from bureaucratic and risk management-driven social care and social work practices towards a renewed emphasis on relationship-based approaches. This shift is especially pertinent in adult social work, which has been heavily influenced by managerialist practices, coinciding with the challenges posed by an ageing population. As society ages, the demand for social work and social care interventions addressing age-related issues continues to rise. Additionally, the political and policy landscape in the UK has been in a considerable state of flux throughout this study. There has been a change in government from a Conservative and Liberal Democrat coalition to a conservative government, there have been five Prime Ministers (GOV.UK, 2023), the UK left the EU, experienced the COVID-19 pandemic, and the UK continues to experience a cost-of-living crisis (UK Parliament, 2023)[5]. The impact of these changes will have had on the practice and culture of social care in the UK be discussed in Chapter 3, but these political and economic shifts have generally resulted in increased financial pressure on social care providers, reduced funding, and significant challenges in maintaining service quality and accessibility for those in need (King-Dejardin, 2019; Schrack et al., 2022; Sweeney et al., 2022).

The approaches to developing effective working relationships with people remain the same, whether being applied by qualified social workers or social care staff. While the distinction is made throughout this introduction, the term ‘relationship-based practice’ will be used throughout the thesis to refer to both practices. The literature and rhetoric across social work and social care have been overwhelmingly positive regarding relationship-based practice, however, how such practice is delivered effectively when working with older people is still unclear. As is the impact a refocussing on relationships would have on managing professional boundaries within residential social care. Daily, social care workers are required to work with difficult interpersonal situations, with people at a time of crisis. The people they work with are experiencing social and emotional struggles, for which they require assistance and support (Ruch et al., 2018). This is often accompanied by a move into a residential setting, fraught with difficulty and loss. It is these difficulties that are the focus of any intervention, making

---

[5] And as of 5th July 2024, the UK has voted for a Labour government with a new Prime Minister. The changes to the policy landscape because of this change in leadership is yet unknown but is likely to have an impact on the social care sector, and the implementation of the findings of the study.

it easier to understand why it can be hard to develop and sustain a practice focused on the relationship. It also makes it easier to understand the importance of developing a clear and succinct understanding of relationship-based practice and of what changes, if any, are needed to support social care workers to attain it.

1.9 This study

1.9.1 The research questions

Taking into consideration the information laid out in this introduction so far, this thesis seeks to explore perspectives on relationship-based practice within the context of residential care for people living with dementia. In exploring this, the research will examine approaches in social care to develop policy and practice relevant evidence to support the application of relationship-based practice, with a focus on the implications for professional boundaries in social care practice.

Consequently, the research questions that guide this study are as follows:

- How do people living with dementia and social care staff experience relationships in residential social care homes?
- How could knowledge of how effective relationship-based care is delivered in residential settings shape professional boundaries?
- How might residential care's culture and practice need to evolve to support relationship-based practice?

Finding answers to these questions is important, because only through establishing how an effective relationship-based practice with older people with dementia is delivered effectively can a model for good practice be shared. Through furthering the understanding of good practice, the compatibility of current professional standards and boundaries could be reviewed. If professional boundaries, as the literature suggests (Alexander & Charles, 2009; Cooper, 2012; O'Leary et al., 2013; Wiles, 2010), have been historically constructed around the concept of risk avoidance and constraining professional relationships, it is necessary to redefine professional boundaries to support and encourage relationship-based practice.

1.9.2 The structure of the thesis

To answer the questions laid out above, the thesis is structured as follows. Chapter 2 contains a narrative review of the literature on dementia care, the impact dementia has on relationships and explores relationship-based approaches to care. Chapter 3 is a continuation of the literature review, containing a more in-depth exploration of the trajectory of social work and social care practice over recent decades, with a particular focus on the political environment which has had such an impact on legislation and policies which govern practice. This knowledge of the wider context within which practice takes place is key to developing a thorough understanding of relationship-based practice. Through conducting these in-depth literature reviews, an up-to-date knowledge of relationship-based practice was developed which was drawn upon to inform and guide research methods and questions.

Chapter 4 explores and defends the application of the social constructionist perspective when exploring relationship-based practice. The theoretical and conceptual tools required to understand the research topic are laid out, including how the topic can be understood through the lens of an ethic of care. The chapter goes on to describe case study methodology; the methodology used in this research. The practicalities and ethical considerations of conducting the case studies are outlined. Chapters 5, 6 and 7 contain the qualitative content analysis of the documentation, observations and interviews conducted as part of the case study approach. Chapter 8 provides an in-depth discussion of the results, while Chapter 9 explores the potential application of the findings to practice, including considerations of what might need to change in the current practice context and culture. Finally, Chapter 10 contains the conclusion along with recommendations for further research, while exploring the limitations of this study.

1.9.3 COVID-19

The data collection phase of this study was planned for December 2019 to June 2020 but unfortunately had to cease due to COVID-19 restrictions introduced in the UK in March 2020. COVID-19 is known to have had a significant impact on the residential care sector, both globally and in the UK (Jordan et al., 2020; Nyashanu et al., 2022; Schrack et al., 2022; Sweeney et al., 2022). The pandemic disproportionately affected older people, with the majority of COVID-19 related deaths (86%) in the UK reported amongst people aged 65 and over, with 39% of these occurring in people aged over 85 (Office for National Statistics, 2023). Furthermore, across the UK, residential care settings reported large and sustained outbreaks with high fatality rates (Jordan et al., 2020). The number of deaths of care home residents involving COVID-19 from 14th March 2020 and 21st January 2022 across England and Wales was 42,189. 92.5% of these were confirmed COVID-19, and the remainder were suspected cases (Office for National Statistics, 2022).

While the pandemic and resulting lockdowns did not have an impact on the data collected, in the months and years that followed it will have undoubtedly had a significant impact on the lives of the participants of this study. The data collected does not include any reference to the pandemic, however, it would be remiss not to contextualise the findings of this thesis in the aftermath of the COVID-19 pandemic. Some of the findings are especially poignant when framed by the knowledge that, in some cases only days later, participants were subject to strict lockdown restrictions that had a significant impact on the relationships they attribute such importance to. The impact of the pandemic on the individual participants is not known.

Chapter 2 Literature Review Part 1

2.1 Introduction

This thesis aims to explore relationship-based practice within the context of dementia and residential care by answering the following research questions:

- How do people living with dementia and social care staff experience relationships in residential social care homes?
- How could knowledge of how effective relationship-based care is delivered in residential settings shape professional boundaries?
- How might residential care's culture and practice need to evolve to support relationship-based practice?

Chapter One introduced the research topic, justifying the research questions with a brief overview of the current literature, knowledge, and practice context. The introduction covered relationship-based practice in social work, dementia care, adult social work and social care, and explored concepts of risk and boundaries. These will now be explored in greater depth by undertaking a thorough, narrative review of the available literature. A narrative approach allows the contextualisation of research findings within broader social, historical, or cultural contexts, enabling the weaving together diverse perspectives and findings into a coherent narrative or storyline, providing a deeper understanding of this research topic (Baumeister & Leary, 1997). By integrating different types of literature, this review can best capture the complexity and nuances of the topic, leading to the approach to be chosen over a more structured approach to synthesising the literature, such as a systematic review or meta-analysis. Narrative literature reviews are *'comprehensive narrative syntheses of previously published information'* (Green et al., 2006, p. 103) and *'can tackle broader and more abstract questions'* (Baumeister & Leary, 1997, p. 311), making a narrative approach best suited to review the current knowledge on this thesis topic

The research questions this thesis sought to answer explore relationship-based practice in residential social care for dementia. While specific, this is simultaneously a broad and varied area of practice. This thesis also sought to situate an understanding of relationship-based practice within the current practice culture and context. To do this, it is essential to understand today’s residential social care practice within the wider, historical practice context. As outlined in the introduction, this thesis explores relationship-based practice within residential care settings, focusing on the social care sector. However, it would be remiss to ignore the contributions of relationship-based social work models, frameworks, and research. These models can offer valuable insights and potential applications to enhance social care practices.

To support the thesis in answering the research questions, a large amount of literature was explored and synthesised to ensure the research topics were fully understood, examined, and contextualised. The initial review of the literature included research and theoretical discussion on dementia care, relationship-based practice, social care as a profession, and the impact of dementia on relationships. It became evident that following this initial literature search and review, there were further topics requiring exploration. These topics were identified during the initial search phase and provided a further layer of context and understanding to the topics covered in the second and third research questions. Thus, the decision was taken to split the literature review across two chapters. This chapter explores the literature needed to answer the first question; ‘How do people living with dementia and social care staff experience relationships in residential social care homes?’, while the following chapter will review the literature required to answer the final research questions into professional boundaries, and what changes would be required to current practice culture. The second literature review chapter, chapter 3, covers the historical context of social work and social care in the UK, managerialism, risk, autonomy, and interdependence.

As noted above, this chapter will focus on the dementia context of social care, exploring relationships and relationship-based practice within this area. The literature reviewed includes both research and theoretical explorations into the topic field. While the focus is on relationship-based practice in social care, specifically residential care, there is a growing body of literature on relationship-based social work. As noted above, relationship-based social work literature is also explored in this chapter, providing rich insights into a relationship-focused practice that informed the development of the research questions and methodological approach.

2.2 Conducting the search

An in-depth narrative literature search was conducted to enable a thorough review of the available literature on relationship-based practice with people with dementia and in residential settings. The initial search plan aimed to encompass all aspects of relationship-based approaches to practice, including the professional relationship, models or frameworks for relationship-based practice approaches, and barriers to successfully developing effective relationships. The process of critical appraisal of the literature identified in this narrative review began with defining the scope and objectives of the review. A comprehensive literature search was then conducted using the defined search strategies and inclusion criteria. Initial screening of search results was based on titles and abstracts, followed by a thorough assessment of full-text articles to select relevant studies. Each included study is appraised to evaluate its methodological quality, considering aspects such as study design appropriateness, sample size and generalisability. Findings from selected studies were then extracted and summarised to identify patterns, discrepancies, or gaps in the literature. This synthesis is then interpreted in relation to the research question, discussing strengths, limitations, and implications of the findings.

2.2.1 The search terms

Before commencing the search, the subject was broken down into four main themes. These themes were identified as:

1. **Social work and social care**
2. **Relationship-based practice**
3. **Dementia**
4. **Residential care**

Using these themes, keywords used during the search were established using previous knowledge of related terminology, a thesaurus and different spellings and synonyms. The main keywords were identified as follows:

Theme 1: **Social work, social care, social worker, social services**

Theme 2: **Relationship-based practice, relationship-centred practice, relationship-based approach, professional relationships, social work relationships**

Theme 3: **Dementia, dementia care, dementia social care, dementia social work**

Theme 4: **Residential care, care homes, nursing homes, nursing care, residential settings**

During the search, *social work* was truncated to *social work** to ensure all variants of the term were examined, for example, *social worker(s) and social working.*

2.2.2 The initial search

Literature was accessed through a search of online databases, including the Swansea University iFind database which incorporates Science Direct and Applied Social Sciences Index and Abstracts. Additionally, Google Scholar was accessed with caution to ensure a thorough search. Finally, relevant publications by Government sources plus policies, research and reviews commissioned by the Department of Health and agency-based grey literature were accessed. Swansea University's library catalogue, iFind, was also accessed to obtain published books relating to both the search topic and methodology.

The initial search was conducted using the following terms:

Table 1 - *Initial Search Terms*

Social work*	Relationship(s)	Dementia
or Social services	***or*** Relationship-based	***or*** Dementia care
Or Social care	***or*** Relationship centred	

The use of Boolean operators ***or*** and ***and*** enabled the search to be broadened to include synonyms. To illustrate, using the above table a search could resemble the following:

> Social work* ***or*** Social services
> ***and***
> Relationship-centred ***or*** Relationship-based

As a result of the search terms including ‘relationship’ several studies were found that included the term ‘relationship’ in the broader sense of the word, such as causal relationships in medical research. As the term ‘relationship’ is key to the literature search, it was not possible to eliminate such results. Instead, the decision was taken to simply discount any articles that were deemed irrelevant to the study topic following a brief overview of the article. The period for the articles was limited to the previous two decades.

Once the initial narrative review of the literature for inclusion in this chapter was completed, it became apparent there exists a limited quantity of studies undertaken in the United Kingdom regarding relationship-based practice with people with dementia and older people. Thus, the decision was made to widen the terms to include articles and research based on child and family practice. The literature search was intentionally broad to include as many sources of knowledge as possible. However, the decision was taken to limit the search to publications in the English language. It is therefore acknowledged that relevant literature published in other languages may have been overlooked.

2.3 The dementia context

The first topic reviewed in this narrative literature review is the context of dementia care practice. This thesis sought to explore experiences of effective relationship-based practice for people living with dementia in residential care[6]. Perhaps more pertinent to

---

[6] Residential care is defined for the purpose of this thesis as settings providing individuals with accommodation and personal and social care, also known as care homes (Age UK, 2022).

this thesis is the impact that the fragmentation of adult social work and social care settings has had on the people developing relationships with adults receiving services (Carey, 2015). This move towards marketisation of care has resulted in most support being delivered to older adults, including those with dementia, by social care workers as opposed to qualified social work professionals (Lymbery & Postle, 2010; Manthorpe & Martineau, 2016). Across much of the UK, social workers '*experience few opportunities to provide a continuing role with older people who have made the transition to residential care'* (Higgs & Hafford-Letchfield, 2018, p. 230).

To fully understand current dementia care practice, it is essential to review where dementia care sits structurally within the broader context of adult social care. Adult social care is influenced by the wider political and societal context, and thus practice and policy have changed notably over recent decades. This shift towards a system of care management is explored in greater depth in the next chapter of this literature review, however, it is important to note the provision of services to people with dementia will be discussed throughout the remainder of this chapter and the next, in the context of both social work and social care.

2.3.1 What is dementia?

Dementia is a broad term used to describe a collection of symptoms caused by disorders affecting the brain, in which there is a progressive decline in a number of areas of function. These symptoms may include memory loss, difficulties with thinking, problem-solving, or language, and changes in mood or behaviour (Alzheimer's Society, 2023). Dementia itself is not a specific disease, but a group of symptoms that can result from various conditions or diseases, such as Alzheimer's disease, vascular dementia, and Lewy body dementia. Alongside this decline in cognitive function, people with dementia may develop behavioural and psychosocial symptoms, known as BPSD, which can include:

> *'Behavioural and psychological symptoms of dementia include agitation, depression, apathy, repetitive questioning, psychosis, aggression, sleep*

> *problems, wandering, and a variety of inappropriate behaviours.' (*Kales et al., 2015, p. 1).

All people with dementia will have at least one of these symptoms, which are progressive and have an impact on daily life for the person with dementia, their family, and their friends (Alzheimer's Society, 2023; Kales et al., 2015). There are almost 900 million people aged 60 years and over living worldwide, and increasing life expectancy is contributing to rapid increases in this number (Prince et al., 2015). This increase is associated with an increased prevalence of age-related, chronic illnesses including dementia. It is estimated that globally, over 55 million people live with dementia, with this number rising by 10 million each year (WHO, 2023). In the UK, the number of people with dementia was estimated to be close to 1 million in 2021, a figure expected to rise to 1.6 million in 2050 (Alzheimer's Research UK, 2022). Awareness and understanding of dementia are growing in many parts of the world, but globally it remains that a dementia diagnosis is often accompanied by stigma and social isolation (Alzheimer's Disease International, 2019).

The impact of dementia is broad-reaching and varied and can be understood at three main levels; the person with dementia, their family and friends, and wider society (Prince et al., 2015). Cox (2007) notes that dementia not only affects families but resonates throughout communities, meaning social care can both directly support individuals and their families, whilst ensuring the wider systems within which they interact are responsive and supportive to needs. As a result, care professionals are called upon to provide support for individuals affected by dementia in a wide range of settings throughout the continuum of care. Over the course of dementia, professionals must ensure that support is accessible and adequate to needs, reduce barriers to services, and promote a supportive environment rather than one that further exacerbates stress. Within the UK social workers provide support across the lifespan of dementia in a variety of settings, however, there are no dementia-specific social work teams (Kaplan & Berkman, 2011; Manthorpe et al., 2008).

Social work and social care professionals perform a wide range of dementia support tasks across different settings, including Community Mental Health Teams, community-based teams for older people, residential homes, hospital settings and adult safeguarding teams (Kaplan & Berkman, 2011). Adult social workers frequently practice within multi-disciplinary teams, meaning issues of contested intra-professional boundaries will often come into play within such teams. Social work support is often provided over the long term, for example when supporting people with dementia to live within their own homes or to successfully transition to residential care. In these situations, social workers are required to implement an interdisciplinary approach to care, relying on and working with professionals from a variety of health and social care backgrounds, including nursing and occupational therapy (Kaplan & Berkman, 2011; Lymbery & Postle, 2010). Within a hospital setting, social workers may encounter individuals with dementia and their families at '*times of crisis'*, requiring carer support in addition to the successful coordination of hospital discharge (Kaplan & Berkman, 2011, p. 366). In community teams, social workers will often perform a case manager role for people with dementia, with a focus on the coordination of services rather than the provision of direct work.

Within the context of adult social work, older people requiring social support often have complex needs arising from long-term conditions that challenge the health care system that still practices within a medical model focused predominantly on cure (Nolan et al., 2006; Theurer et al., 2015). Nolan et al. (2006, p. 3) argue a consequence of this is that '*working with older people has never had a particularly high status and does not have the kudos associated with more 'hi-tech areas'*. Additionally, some traditional social work roles have never achieved widespread use within adult social services. Lymbery and Postle (2010, p. 2518) observed that when undertaking community care reforms '*the idea that anyone could carry out many of the tasks of qualified social workers in adult services was common'.*

When referring to the work of social support services, it should be acknowledged that qualified social workers form a minority of the workers undertaking direct work with people with dementia on a daily basis (Manthorpe et al., 2003; Xie et al., 2014). Instead as Manthorpe et al. (2003, p. 164) state, '*most work in dementia care is undertaken not by professionals but by unqualified care assistants domiciliary care workers and family members'*. This means that many social work departments have moved away from the direct provision of services towards commissioning external services. As Xie et al. (2014, p. 421) point out, a *'central objective of the community care reforms was to promote the development of non-statutory service providers through a competitive market'.* The authors conducted research with representatives from 25 Local Authorities in England, finding that the extent of non-statutory organisations' involvement in care activities varied markedly; most organisations had short-term contracts resulting in insecurity and reinforcing the need to work to target. The House of Commons published a report calling for reform of social care in England in 2024, welcoming recent initiatives to 'professionalise' the workforce but highlighting concerns around slow progress and the lack of a long-term workforce plan (House of Commons Committee, 2024).

2.3.2 Who provides dementia care?

As a result of the fragmentation of adult services discussed previously in this chapter, most of the relationship work with older people is no longer undertaken directly by social workers (Carey, 2015; Xie et al., 2014). Instead, this work is done by care workers within a fragmented social care 'market', with services provided by a combination of local authorities and independent (both for-profit and not-for-profit) care providers (Eynon & Conroy, 2017). Skills for Care publishes data on the care workforce in England. In 2022, they estimated that 17,900 organisations were providing care across England in 2021/22 (Skills for Care, 2022). These figures are in sharp contrast to thirty years previously, when 150 Local Authorities across England regulated, managed, and supplied the vast majority of care services (Carey, 2015). Social Care Wales provides similar data for Wales. In 2021 they estimated that 91000 people are employed across social work and social care in Wales, with residential care for adults being the largest part of the sector, comprising 28 percent of the workforce (Social Care Wales, 2022). Social Care Wales estimates that as of 2021, the independent market is twice the size of local authority-run services in terms of staffing numbers, consisting of 2000 commissioned services compared to 22 local authorities (Social Care Wales, 2022). Care workers can either work within residential care settings or are employed to provide services to people within their own homes and communities (Silarova et al., 2022).

At 9.9%, the vacancy rate for 2022/23 in adult social care was the second highest recorded since Skills for Care started gathering data in 2012/13 (Bottery & Mallorie, 2024). The drop from the peak in 2021/22 was due to a significant rise in the recruitment of overseas staff. From March 2022 to March 2023, approximately 70,000 individuals began direct care roles after arriving in the UK. This increase followed changes to government immigration policy in February 2022, allowing overseas care workers with a licensed sponsor and a minimum salary of £20,480 to fill these positions.

Data produced in 2022 suggested that 13% of the social care workforce are 'non-UK' migrant workers (Skills for Care, 2022c), a number likely to be higher today, given the data provided by Bottery and Mallorie (2024). Turpenny and Hussein (2022) conducted a scoping review examining the outcomes and sustainability of migrant home care workers in the UK, particularly in light of Brexit implications. It explores the impacts of these workers on the healthcare system, the economy, and their contributions to care quality and sustainability amidst changing immigration policies and highlights concerns from the perspective of service users as '*cultural and linguistic proficiency'* (Turpenny & Hussein, 2022, p. 35). The researchers conclude that migrant care workers *'combine the risks and vulnerabilities of migrant status with the pressures of an already marginalised social care sector'* (Turpenny & Hussein, 2022, p. 38).

2.3.3 Practice with people with dementia in social care

There is a small body of research exploring dementia care within residential settings, with a selection of key studies summarised below. These studies contribute to understanding this underrepresented group and together emphasise the complex interplay of social interactions, individual experiences, and caregiving approaches crucial in enhancing the quality of life for people with dementia in residential settings.

Milne (2011) explored the realities of people with dementia residing in care facilities by reviewing current sources of evidence. Social interactions emerged as key, with relationships among residents, staff, and visitors playing a crucial role in fostering a sense of belonging and emotional well-being, countering feelings of loneliness. Milne highlighted the importance of autonomy and decision-making for residents, advocating for supportive environments that empower individuals to maintain a sense of control over their lives. Milne (2011) found residents tend to prioritise non-disease-related domains of quality of life, which is somewhat different than those identified by relatives, care home staff and more objective measures.

Clare et al. (2008) explored the subjective experience of individuals with dementia living in residential care. Through unstructured conversations with 80 participants, the researchers conducted interpretative phenomenological analysis on 304 transcripts. They found that people living with dementia in residential settings experienced challenging emotions such as loss, isolation, fear, and worthlessness. The researchers found that participants coped by accepting their circumstances, though some expressed frustration and anger. Participants were able to describe aspects of their situation and present an understandable emotional response to it, '*grounded in a strong retained sense of self and identity*' (Clare et al., 2008, p. 719).

Haunch, Downs and Oyebode (2023) explored nursing home staff's experiences of meaningful engagement with residents with advanced dementia. The study involved semi-structured interviews and informal conversations with 21 staff members across seven nursing homes, followed by inductive thematic analysis to identify recurring themes. Four themes emerged regarding staff interactions with residents with advanced dementia: initiating meaningful engagement, recognising subtle reactions, practicing caring behaviours, and demonstrating patience and perseverance. Additionally, two themes focused on the timing of these engagements: the challenge of insufficient time for formal interventions and the utilisation of personal care time for meaningful interactions. A significant finding was the barrier posed by limited staff time for implementing formal care improvements, prompting staff to integrate meaningful engagement into personal care routines.

2.3.4 Gender roles and the status of care work

Care work is consistently defined within the literature as occupations within which workers provide an in-person, or face-to-face, service *'in meeting the physical, psychological and emotional needs of adults and children, old and young, frail and able-bodied'* (King-Dejardin, 2019, p. 58). In Wales, of the 91,000 people employed in social work and social care in Wales, 81 percent are female (Social Care Wales, 2022).

Modern and democratic societies place great emphasis on gender equality within the workplace (Block et al., 2019). However, it is estimated that women and girls perform more than three-quarters of the unpaid care work globally, dominating health and care occupations while continuing to be assigned lower status and paid lower salaries than those in traditionally male-dominated fields (Block et al., 2018; King-Dejardin, 2019).

As Block writes:

> *'Over recent decades, efforts to promote gender equality have included laws, policies, and programs designed to dismantle barriers to women's advancement, with a recent focus on increasing women's representation in science, technology, engineering, and math careers (STEM), as well as leadership positions.'* (Block et al., 2019, p. 112)

Block et al. (2019) conducted four quantitative studies across 754 participants to explore the asymmetry in support for changing gender roles. The researchers' findings highlight the inverse has not happened. There has been no push to address the underrepresentation in traditionally female-dominated careers, with the authors stating:

> *'People indicated greater support for social action to rectify the gender imbalance in male-dominated as compared to female-dominated fields'* (Block et al., 2019, p. 127).

Block et al. (2019, p. 128) suggest these biases have the potential *'to create a self-fulfilling prophecy whereby people are also less interested in addressing pay inequalities in female-dominated fields'* yet, were more men to enter these occupations, the salaries may rise. Block et al. (2018) conducted a quantitative study with 979 students exploring why men and women devalue care careers. The researchers found evidence to suggest that men's and women's desires to enter certain careers with higher salaries are predicted by the core values they internalise. The researchers found that even when controlling for perceptions of the current labour market, differences in people's communal values consistently predicted perceptions of the value of care careers, over and above gender.

2.4 Relationships, dementia, and ageing

To explore how an effective relationship-based approach to practice with people with dementia is delivered, knowledge of the impact of dementia on relationships is key. The relationships of people with dementia are often impacted by the progression of their dementia symptoms. The impacts of ageing and dementia, with a focus on relationships, will be explored throughout the following paragraphs.

2.4.1 Relationships and dementia

Kitwood (1997, p.7) argues that relationships are central to maintaining personhood following a diagnosis of dementia, suggesting that relationships play a significant role in allowing people with dementia to preserve their sense of self. Sabat (2006, p. 300) points out that a '*person is a person through others*.' Wiersma and Pedlar (2008, p. 107) agree with this sentiment, stating that '*providing opportunities that foster deep and personal relationships is vital to enhancing personhood.*'

The need to extend the understanding of dementia beyond the medical model to capture a more dynamic and contextualised perspective is acknowledged by Bartlett and O'Connor (2010, p. 18), who point out:

> *'The medical model has been strongly critiqued for its undue focus on deficits and therapeutic nihilism – the person with the disease is defined only by loss and what they cannot do.'*

The authors argue there is a need across research and practice to recognise that people with dementia both influence and are influenced by interpersonal and social relationships and '*the importance of a more textured, multidimensional lens for contextualising the experience, specifically one that incorporates the importance of sociocultural context'* (Bartlett & O'Connor, 2010, p. 25). Davies and Gregory note that traditionally, research and practice around dementia from biomedical, psychological, and sociological perspectives have mainly:

> *'focused on persons with dementia and their spousal caregivers as individuals living in parallel life spaces, rather than considering the unified history and context of marital relationships.*' (Davies and Gregory, 2007, p. 481)

There is a clear need to look beyond the individual with dementia and seek out the knowledge and understanding which situates them within the wider context of their relationships and environments.

2.4.2 Dementia and the impact on primary caregivers

The caring relationship between people with dementia and their primary caregivers was found to be a focus within the research literature. The term 'carer' is used in the UK to refer to family members and other informal carers who provide regular, unpaid, and significant support to adults with disabilities, older people, and those unable to live independently (Hussein & Manthorpe, 2011). A carer is defined in the Care Act 2014 as '*an adult who provides or intends to provide care for another adult.'* Caring concerns relationships between people, including both labour and feelings; feeling concern for, and taking charge of, other people's well-being. The phrase to 'care for' is frequently used to convey a sense of the bonds that tie us to people (Waerness, 1984). Pickard et al. (2016) explored the visibility of unpaid care in the UK using large-scale surveys with over 35,000 responses and 2400 interviews. The findings indicate that carers who are known to councils provide extremely long hours of care, with the majority providing care for 100 or more hours a week. Although the term ‘carer’ can refer to anyone who provides care, for people living with dementia, it is often their spouse who provides most of their unpaid care.

Jansson et al. (2001) explored patterns of spousal caregiving in dementia. Qualitative data from observational studies of 8 couples in Sweden indicates that providing care was both physical and emotional, with caregivers caring both for and about their partners. The results also indicated that carers manage their situation in different ways, highlighting the complexity and multi-dimensional aspects that make each caregiving situation unique. The researchers noted both the psychological and practical implications that caring has on relationships and found that ‘*they were caring for as well as about their spouses’* (Jansson et al., 2001, p. 811). This study provides valuable insights into spousal caregiving in dementia, highlighting the dual roles of caregivers in providing both physical and emotional support. However, the qualitative nature of the study, based on observational data from a small sample of 8 couples in Sweden, limits its generalisability and may not fully capture the diverse experiences of caregivers in different cultural contexts.

Youell et al. (2015) explored relational intimacy in long-term relationships where one partner has dementia in the UK through interviews analysed using Interpretive Phenomenological Analysis. The researchers showed how dementia affected their relationships and disrupted intimacies, highlighting ‘*that caring relationships are not just about care, and that becoming a carer involves a major shift in established relationships, for both partners’* (Youell et al., 2015, p.947). Becoming a carer results in the relabelling of long-term intimate relationships, from husband or wife to ‘carer’. The study highlighted the challenges dementia can cause in relationships and the continued importance of intimacy. The authors point out the difficulty partners have in articulating their experiences, which is compounded by the general representation of older adults as asexual beings.

These results build upon findings from a study of 47 partners of people with dementia conducted by Ballard et al. (1997). The research found that 22.5% of people in relationships continued to have sexual relationships following the diagnosis of dementia, with all of those reporting the continued sexual relationship being satisfied with the situation. Conversely, 38.7% of partners who were no longer sexually active reported dissatisfaction with the absence of a sexual relationship. These studies highlight the importance carers place on continued intimacy and the detrimental effect the shift in the nature of their relationship can have. While Ballard et al. (1997) provide significant insights into the sexual dynamics of relationships affected by dementia, the reliance on self-reported data and the relatively small sample size of 47 partners may limit the generalisability of their findings to broader populations.

Daly et al. (2012) utilised a grounded theory approach to explore how informal carers of people with dementia in Ireland manage alterations to relationships within their social worlds. Through 31 interviews, the researchers identified carers' main concerns as living on the fringes, experiencing dementia-related stigma, and a shift to living a different life. The study highlighted the imperative for workers, or formal carers, to engage in support that enables social connectedness for both people with dementia and their carers.

Botsford et al. (2011) explored the impact ethnicity has on the relationships between people with dementia and their partners. The findings indicate that ethnicity alone cannot account for individual responses to dementia in a relationship, with the researchers instead highlighting the need for an awareness of cultural factors to be balanced with sensitivity to the unique life experiences and relationships of the individuals. They also highlight the impact dementia has will vary across every relationship. The researchers found some couples '*described the relationship as becoming closer, whilst others said that they were becoming more distant.'* (Botsford et al., 2011, p. 2211). They highlight the impact the evolving nature of the relationship itself, and the experience of dementia, have on each other.

Quinn et al. (2012) conducted research into the impact of relationships and motivations on dementia caregiving outcomes. Data from 447 responses to a questionnaire indicated that the relationship quality and motivations within the relationship before taking on the caregiving role had an impact on the future quality of the relationship. The authors suggest:

> *'Understanding the influence of motivations on caregiving outcomes would aid the provision of more effective support. For instance, caregivers who have higher extrinsic than intrinsic motivations may require more support to help them cope with caregiving.'* (Quinn et al., 2012, p. 1824).

These findings are interesting when compared with research previously conducted by Norton et al. (2009), who examined the effect of the closeness of the relationship between caregiver and recipient and functional decline in people with Alzheimer's Disease. Through data gathered from 167 participants in the USA, the results indicated that with closer relationships participants declined more slowly in cognition and functional capacity. The authors suggest that '*interventions that focus on collaborative aspects of care dyads have shown promise in improving these relationships'* (Norton et al., 2009, p. 565).

The research into the impact of dementia on the relationship between the individual with dementia and their primary caregiver provides important knowledge on the impact the quality of the relationship before receiving the dementia diagnosis has on the caring relationship. As Youell et al. (2016) point out, while caregiving partners are active in the maintenance of closeness in relationships, they require continued support to cope with the emotional and physical aspects of their caring role. The implications of this suggest that for people with dementia, ensuring the professionals working with them understand their relationship history when providing support is essential. Such knowledge may support professionals in identifying those who are more likely to struggle with the transition to a caring role. Also evident from the research is the difference in the impact of the caring role on different genders. Male carers are more likely to struggle with the implications of reduced intimacy in their relationships and thus may require further support. However, what must be noted is that not all people with dementia have carers. For those who live alone in their communities without the support of a spouse or primary carer, these findings would have little impact on their support needs.

2.4.3 The impact of dementia on wider relationships

Dementia has an impact that reaches beyond the immediate primary caregiver relationship. As dementia progresses, relationships with wider family and support networks are affected. All relationships are important when considering an individual's support needs, and all relationships will provide a degree of support. Alm et al. (2014) explored the experiences of family relationships when a family member has dementia. The qualitative data from 17 interviews with people with dementia, their spouses and children identified two main themes. Participants experienced changed relationships through lost closeness and loneliness, and secondly, supporting relationships with the family developed, such as shared responsibility and appreciation. The researchers suggest that '*support should focus on creating relationships between members of the support group and giving opportunities for conversations about changes within the families and difficult decisions'* (Alm et al., 2014, p. 526).

Celdrán et al. (2009) explored the impact of dementia on an individual's grandchildren through a qualitative survey with 138 respondents in Spain. The researchers found that participants showed mainly positive changes in their relationship with their parents and acknowledged the influences their parents have in their relationships with their cognitively impaired grandparent. They point out that:

> *'Having a grandparent with dementia might lead to a deeper reflection on life, new personal resources, as empathy or sense of responsibility, enhance family ties or develop a variety of coping skills.'* (Celdrán et al., 2009, p. 256).

Harris (2013) conducted research into dementia and its impact on friendships in the USA. Through a combination of focus groups and interviews with people with dementia, their care partners and friends, Harris examines the quality of friendships and the protective factors that enable relationships to be sustained despite the diagnosis of dementia. The findings indicate that people with dementia do have friends that remain, and often have a wide variety of friendships. However, the stigma surrounding dementia does have an impact on relationships as Harris points out:

> ‘*The stigmatizing impact of the diagnosis of a dementing illness can still be felt on personal, couples, and societal levels, and thus can affect friendship relationships’.* (Harris, 2013, p. 160)

The results indicate that individuals may not feel comfortable going out in public with someone who has dementia because of their potentially unpredictable and embarrassing behaviour. Another publication by Harris (2011), using the same data set focused on the eight interviews held with the friends of people with dementia. Using a grounded theory approach to analysis, Harris highlights that friendships can provide an important source of comfort, support and meaning to the lives of people with dementia yet can be difficult to maintain ‘*because they can no longer bear to see the changes that are taking place in their diagnosed friend’ (*Harris, 2011, p. 305). While Harris (2011) offers valuable insights into the supportive role of friendships for individuals with dementia, the study's focus on a small number of interviews with friends and its use of grounded theory, while insightful, may not fully capture the diversity of experiences and challenges faced by broader populations. Grounded theory approaches, while providing rich insights, can be criticised for potentially subjective interpretations.

2.4.4 The impact of ageing on relationships

In addition to the body of research exploring the impact of dementia on wider relationships, studies into the impact of ageing more generally on individuals’ social relationships were explored. This literature is of relevance, as individuals with dementia are impacted by the broader consequences of ageing in addition to their dementia diagnosis. Bonifas et al. (2014) conducted a qualitative research study in Canada to explore how living in a long-term care home influences the quality of residents’ relationships with peers, family members and friends. Through 23 semi-structured interviews, the researchers explored residents’ perspectives on the nature of social relationships in residential care settings. The findings indicated residents can be reticent about engaging with peers exhibiting behavioural symptoms, *‘describing them as “crazy” and undesirable friends’* (Bonifas et al., 2014, p 1332). Additionally, connections between residents are often superficial in nature meaning residents feel lonely and isolated from their external community. Individuals' own health conditions and limitations were also found to hinder the development of peer relationships. The literature also suggests a link between social relationships and positive health outcomes for older people.

Watt et al. (2014) investigated social relationships linked to health-related behaviours with older adults. By examining data from US national health and nutrition surveys, the large quantitative study of 4014 older adults found physical activity to be related to the size of friendship networks. The authors found social relationships to be independently associated with different health-related behaviours and argue that '*strengthening and developing social relationships amongst older people should be a priority in health promotion' (*Watt et al., 2014, p. 9). These results correlate to those of a similar study by Chang et al. (2014). By analysing responses of 2965 US health and retirement survey responses, the researchers found '*perceptions of positive social relationships were associated with greater involvement in leisure activities and greater involvement in leisure activities was associated with better health in older age'* with both physical and mental leisure correlating significantly (Chang et al., 2014, p. 516). Such results suggest that fostering meaningful relationships between older people, including those with dementia, has the potential to create a positive impact on both physical and mental health. While Watt et al. (2014) and Chang et al. (2014) present interesting data on the beneficial effects of social relationships on health-related behaviours among older adults, their reliance on self-reported data might limit the ability to establish causal relationships between social interactions and health outcomes.

The perspective and involvement of people with dementia were often absent from the literature exploring ageing, dementia, and relationships. However, La Fontaine and Oyebode (2014) undertook a synthesis of qualitative research, including the person with dementia. The authors found the accounts of people with dementia demonstrate continued emotional awareness, as well as awareness of the impact dementia has on the family member caring for them. They point out that in the research they synthesise:

> '*[The people with dementia] have demonstrated that they continue to actively work with others in their family to maintain their relationships; to make sense of the impact of dementia and to manage the changes that it brings.' (*La Fontaine & Oyebode, 2014, p. 1264)

2.4.5 Dementia and social isolation

Naue and Kroll (2008) explored the impact of the concepts of identity and difference on people with dementia through an analysis of different identity concepts, suggesting that those living with dementia are assigned a negative status on receipt of diagnosis. The authors suggest being given the identity of the 'demented other' means that people with dementia are '*no longer understood as 'full persons', capable of making reasonable decisions' (*Naue & Kroll, 2008, p.32). Not only are people with dementia confronted with the loss of meaningful relationships, but they also face a loss of identity and social ostracism. Bastian and Haslam (2010) conducted two studies across 143 participants into the human effects of ostracism in Australia. The researchers found:

> '*People feel less human when they experience ostracism, see others who ostracize them as less human, and believe that they are viewed as less human by those others compared to when they feel included'* (Bastian & Haslam, 2010, p. 112).

Research conducted by Ostwald et al. (2002, p. 303) explored the perspectives of people living with dementia in the USA through 50 interviews, analysing responses to the question *'How have things been going for you lately?'* The findings highlight a key theme of loss and attempts to manage losses. The researchers point out that participants '*choice of themes as well as their verbal and nonverbal expressions suggested that they were experiencing a significant amount of stress, especially related to their relationships with family and friends'* (Ostwald et al., 2002, p. 303). These findings agree with Bastian and Haslam's (2010) argument that socially excluded individuals are perceived in a dehumanised fashion, suggesting that, as

Kitwood (1997) put forward, relationships are key to personhood and maintaining a sense of belonging for people with dementia.

While the previous paragraphs have discussed relationships, and the impact dementia and ageing have on people's ability to develop and sustain relationships, this chapter will now move on to discuss relationship-based practice. Although relationship-based practice specifically regarding ageing and dementia will be explored later in the chapter, initially relationship-based practice more broadly will be explored. This will cover both the social work and social care professions.

2.5 Relationship-based practice

A relationship-based approach to practice views the relationship between the professional and the individual or family they work with as an '*integral component of any professional intervention'* (Ruch, 2018a, p. 32). In effective relationship-based practice the worker '*needs knowledge and skill in the handling of complex dynamics of helping relationships'* (Ruch, 2018a, p.29). A strong relationship forms the foundation for an effective, empowering intervention that enables people to be supported in making decisions and taking action to improve the situations they find themselves in. Relationship-based approaches to practice acknowledge that each professional encounter is different and that the families and individuals who social work and social care professionals engage with are all unique (Ruch, 2018a).

Relationship-based approaches place a clear emphasis on the professional relationship as being purposeful and instrumental as 'the vehicle for change' (Ruch et al., 2018; Turney, 2018). Murphy et al. (2013, p. 717) argue that '*social work cannot be relationally based in the sense that it is an expression of person-centred practice'* reflecting the complexities and often contested nature of social work practice. The onus is therefore placed on the professional to define the relationship boundaries, including the roles and degree of autonomy afforded to those in receipt of services (O'Leary et al., 2013). As a result of the complex nature of professional relationships across social work and social care, this literature review sought to extrapolate what a genuine and sound approach to relationship-based practice within social work and social care might be, and how this might be applied in the context of adult, and more specifically dementia, care.

2.5.1 Relationship-based practice in health and social care

Relationship-centred care is a term used in some adult health and social care literature, based on work undertaken by professionals in the USA when exploring the challenges facing the healthcare system (Nolan et al., 2006; Tresolini, 1994). Following the conclusion that the medical model of a disease and cure-based system was inadequate, a model based on a relationship-centred approach was put forward that instead focused on the social, economic, environmental, and economic contexts of health (Nolan et al., 2006). In parallel to medical specialisation, Rudebeck (2019) highlighted general medical practice in Sweden, which evolved outside of hospitals to become a relationship-based discipline of primary care. Patients and general practitioners, as Rudebeck (2019, p. 340) points out, '*value relational continuity*', arguing '*this is in itself a strong argument for providing relationship-based care*' within medicine. The aim was to create a service that provides care centred on the interactions among people as a foundation for therapeutic activity and medical care.

The concept of a relationship-based approach to care was taken further by Nolan et al. (2006) in the 'Senses Framework', which aimed to support healthcare workers to develop a relationship-based method of practice to better meet the needs of older people receiving care. Nolan et al. (2006) sought to explore a framework for practice for working with older people that went beyond the 'person-centred care' approach that practice heavily focussed on. The person-centred care model, espoused by Kitwood (1997), was put forward as a framework for supporting people with dementia focused on the interpersonal relationship with that individual, acknowledging that dementia is not a linear progression and that each person will experience the set of symptoms differently, meaning each person will therefore require an individualised model of support.

The person-centred care model was introduced as an alternative to the previously dominant medical model of dementia care. While person-centred care focussed on valuing people with dementia as individuals, viewing the world from their unique perspectives to create a positive psychosocial environment, the relationship-centred approach put forward by Nolan et al. (2002; 2006) aimed to promote a more inclusive vision of dementia care practice (Ryan et al., 2008). While person-centred care considered the needs of people with dementia individually and separately, the relationship-focused approach of the Senses framework sought to instead see people with dementia within the context of their relationships (Ryan et al., 2008). The framework comprises the six senses Nolan et al. (2006) view as prerequisites for positive and effective relationships within the context of care and service provision. These are summarised in the below table:

Table 2 - *The Senses Framework*

A Sense of Security **For older people:** Attention to essential physiological and psychological needs, to feel safe and free from threat, harm, pain and discomfort. **For staff:** To feel free from physical threat, rebuke or censure. To have secure conditions of employment. To have the emotional demand of work recognised and to work within a supportive culture.
A Sense of Continuity **For older people:** Recognition and value of personal biography. Skilful use of knowledge of the past to help contextualise present and future. **For staff:** Positive experience of work with older people from an early stage of career, exposure to positive role models and good environments of care.
A Sense of Belonging **For older people:** Opportunities to form meaningful relationships, to feel part of a community or group as desired. **For staff:** To feel part of a team with a recognised contribution, to belong to a peer group, a community of gerontological practitioners.

A Sense of Purpose **For older people:** Opportunities to engage in purposeful activity, the constructive passage of time, to be able to pursue goals and challenging pursuits. **For staff:** To have a sense of therapeutic direction, a clear set of goals to aspire to.
A Sense of Fulfilment **For older people:** Opportunities to meet meaningful and valued goals, to feel satisfied with one's efforts. **For staff:** To be able to provide good care, to feel satisfied with one's efforts.
A Sense of Significance **For older people:** To feel recognised and valued as a person of worth, that one's actions and existence is of importance, that you 'matter'. **For staff:** To feel that gerontological practice is valued and important, that your work and efforts 'matter'.

Note: Adapted from *The Senses Framework: improving care for older people through a relationship-centred approach.,* by Nolan et al. 2006, p. 22. (https://core.ac.uk/download/pdf/99946.pdf)

The distinction between relationship-based practice and person-centred care lies primarily in their focus and approach. Relationship-based practice emphasises the importance of building strong, trusting relationships between the care worker and the care recipient. It prioritises the quality and depth of the relationship to achieve positive outcomes. This approach recognises that the nature of the relationship significantly impacts the effectiveness of care and support provided (Ruch, 2005; Ruch et al., 2018). Person-centred care places the individual at the centre of decision-making and care-planning processes. It involves tailoring care and support to the specific preferences, values, and goals of the individual receiving care. The person's autonomy and right to make choices about their own care are paramount (Kitwood, 1997). While both approaches prioritise respectful and compassionate care, relationship-based practice emphasises the quality of interactions and the therapeutic alliance. Placing the individual at the centre is argued to detract from the importance of the professional relationship, which is key to effective intervention and support (Murphy et al., 2013).

The vision of relationship-based care put forward by Nolan et al. (2006) is based on the fundamental concept that positive and effective care can only be delivered when the six senses outlined in the above table are experienced by all parties in the relationship (Nolan et al., 2006; Ryan et al., 2008). The translation of its approach to relationship-based practice in a residential care setting might be achieved by ensuring staff are enabled to create a supportive environment that balances both staff and residents' needs. Research was conducted into the use of the SENSES framework in practice by Cooper, Meyer, and Holman (2013). The authors investigated how facilitation can drive practice change in nursing in rehabilitation wards for older adults. Using an action research approach, the study analysed interviews and field notes to pinpoint factors that enabled staff to engage in change activities. The SENSES framework was found to help staff overcome learned helplessness, fostering more effective practice development. The authors suggest it '*can therefore be seen that by enabling staff to experience the senses, they were able to engage with development activities that allowed changes in practice to be achieved'* (Cooper et al., 2013, p. 1734).

The challenges involved in translating this framework into practice can stem from the fact that established practices and cultural norms within care settings can be resistant to change, complicating the integration of new ethical standards. Kor et al. (2022) conducted research drawing on the lived experiences and perspectives of young people and practitioners in therapeutic residential care to examine what constitutes relationship-based practice. Eight young people and twenty-six practitioners across three residential care services in Australia participated, with the researchers describing relationship-based practice in therapeutic residential care as a '*double-edged sword'* (Kor et al., 2022, p. 672). Practitioners in this recognised the benefits of relationship-based practice whilst remaining aware of the potential pitfalls of it being misconstrued or exploited, the authors explain that on one hand, relationship-based practice provides practitioners with numerous informal settings and opportunities to engage with young people in meaningful discussions, while on the other hand, concerns about child maltreatment in care underscore the heightened need for safeguarding professional boundaries (Kor et al., 2022).

2.5.2 Relationship-based practice within Indigenous communities

The literature search conducted into relationship-based practice also highlighted the existence of a body of research within Indigenous communities, across New Zealand and Australia. Bennett et al. (2011) note that social work practice with Australian Indigenous communities is generally regarded as complex, with such communities experiencing significant historically shaped disadvantage and oppression. Through research with both Indigenous and non-Indigenous social workers in Australia, the authors suggest that effective practice is a result of prioritising the development of relationships with Indigenous people and communities. The relationships are characterised by reciprocity, integration and placing value on both Indigenous and Western world views (Bennett et al., 2011). The authors highlight the 'need to establish rapport and to demonstrate empathy with a focus on listening and not questioning are reinforced' (Bennett et al., 2011, p. 819).

McAuliffe et al. (2015) also explored relationship-based social work practice with Australian Indigenous families, finding that procedural and legalistic approaches, in addition to limited cultural competence, limited social workers' capacity to take empowering action when supporting families. The authors state:

> *'The understanding of connections between social, familial and cultural context, and the need for assessments to be undertaken within this framework, sets a foundation for exploration of practice with Indigenous families and communities where the interconnectedness of these contextual factors are particularly important.'* (McAuliffe et al., 2015, p. 366)

Cortis (2011) argues that to improve engagement and practice with under represented communities, such as Indigenous communities, social workers must focus on building relationships with people receiving services and utilising networks and partnerships with communities.

Bennett et al. (2017) conducted research with Aboriginal and Torres Strait Islander social workers, again finding that improving cross-cultural relationships will increase practice knowledge and promote a more effective and sustainable relationship between people receiving support and social workers. Although the geographical and social contexts of Indigenous communities are different to those of the communities and groups focused on in this thesis, the model of a relationship-based practice to bridge the cultural divide between workers has relevance and importance.

2.5.3 Relationship-based practice in social work

This thesis aims to explore relationship-based practice in the context of dementia care in residential settings. However, as discussed in the introduction to this thesis, relationship-based practice is not straightforward. The journey social work and social care practice have taken to come to the present-day understanding of relationship-based practice is a meandering and politically influenced one. While distinct from the models for relationship-based practice explored in the preceding paragraphs, the model for a relationship-based social work practice put forward by Ruch (2018) contains similar themes and key concepts. Gillian Ruch is a professor of Social Work at The University of Sussex and co-editor of the book Relationship-based Social Work: Getting to the Heart of Practice.

The framework put forward by Ruch (2018) is based on child and family social work practice, and while the theoretical underpinnings will differ in practice with older adults, the approach has an increasingly detailed knowledge base. Ruch's (2018) framework for relationship-based social work has become widespread across the sector, with the potential to provide learnings and insights that can be applied to relationship-based practice more broadly. The decision was therefore taken to widen the search to include relationship-based social work research in this literature review, to apply insights and practice knowledge to relationship-based practice in a residential care setting.

The relationship between social workers and those in receipt of services is the medium for engagement, a source of information and a means for providing support and help (McLeod, 2010; Ruch 2018). The Oxford English Dictionary defines a relationship as:

> *'The state or fact of being related; the way in which two things are connected; a connection, an association' (*Oxford English Dictionary [OED], 2022a)

It is widely acknowledged that, to some extent, all social work is conducted through the connections, or relationships, between the social work professionals and the people they support. Whether the intervention is more therapeutically focused, or whether the relationship is more formal and time-limited, the relationship is still central to achieving the desired outcomes of the intervention (Ruch, 2005). Ruch states:

> *'Given that all social work interventions involve an interpersonal dimension, to a greater or lesser extent, it could be argued that all social work practice is by definition relationship-based. This perspective, however, denies the specific characteristics of relation-ship-based practice.'* (Ruch, 2005, p. 113)

Historically, the relationship between practitioners and the people they support was viewed as a core element of the Social Work profession, a vital component of good practice. However, before the current resurgence in interest in relationship-based approaches, relationships between social work professionals and people receiving support became increasingly '*confused and ambivalent'* (Howe, 1998, p.45), while relationship-based approaches *'fell out of favour'* (Trevithick, 2003, p. 163). An understanding of the meandering course relationship-based approaches to practice have taken throughout social work history can help in situating and understanding, the current iteration of the practice.

The recent return to the rhetoric of relationship-based social work is thought to be a reaction to increasingly risk-centric and bureaucratic social work policies and practices throughout the preceding decades (Trevithick, 2003). It is widely acknowledged in social work literature that such managerialist practices minimised the standing of professional judgment and intuitive reasoning by advocating reductionist and rationalist approaches to practice (Munro, 2011; Trevithick, 2014). Trevithick (2014, p. 307) argues managerialism's *'greatest weakness is its failure to recognise the importance of emotions'* while Munro (2011, p. 20) states in her review of Child Protection that '*the emotional dimensions and intellectual nuances of reasoning are undervalued in comparison with simple data about service processes such as time to complete a form.'*

People receiving support were reduced to being straightforward and rational, which Ruch (2005, p. 112) points out '*dismiss understandings of individuals, which acknowledge the irrational and emotional aspects of human behaviour.*' Trevithick (2014, p. 299) argues that an increased focus on risk over need '*highlights the extent to which our social work values and professional ethics are being trapped within narrow and ideologically based marketisation of human need – a development that needs to be resisted.'* As Munro (2011, p. 134) points out '*the false hope of eliminating risk has contributed significantly to the repeated use of increasing prescription as the solution to perceived problems.'* Munro (2011, p. 20) states that bureaucratic approaches provide *'an incomplete account of the intricacies of working with children and families'* and '*undervalues the fact that the work is done in a relationship with children and family members so that the importance of continuity in human relationships is overlooked'.*

Through developing an understanding of relationship-based practice, Hingley-Jones and Ruch (2016, p. 246) suggest the 'seductive' de-personalised and evidence-based approaches 'held sway' due to their positivistic and simplified nature. The literature unpicking managerialism and individualism in social work and social care practices is further explored in the next literature review chapter to provide a backdrop to the interest in relationship-based practice. Through developing an understanding of relationship-based practice, Hingley-Jones and Ruch (2016, p. 246) suggest the 'seductive' de-personalised and evidence-based approaches 'held sway' due to their positivistic and simplified nature. The literature unpicking managerialism and

individualism in social work and social care practices is further explored in the next literature review chapter to provide a backdrop to the interest in relationship-based practice. The next section of this chapter will explore the framework for approaching relationship-based social work, developed by Ruch et al. (2018).

2.5.4 Framework for a relationship-based social work

As alluded to by describing the recent increase in relationship-based practice as a 'resurgence', such approaches to practice are not a new phenomenon. Relationship-based practice as a model draws heavily upon both the psychoanalytical influences that informed social work from the 1940s onwards and the psychosocial model advocated by Hollis (1964). It is these models that Gillian Ruch (Ruch, 2005; Ruch et al., 2018) draws upon in the proposed model for relationship-based practice. The emergent relationship-based model for practice responds to the shortfalls in existing approaches to practice and conceptualisation of human behaviour, such as the dominance of bureaucratisation and managerialism over recent decades described above (Howe, 1998; Sudbery, 2002; Trevithick, 2003; Ruch, 2005).

Whatever problems social work seeks to alleviate, be it child abuse, mental health or support in later life, Sudbery (2002, p. 150) points out that '*all involve perturbations in emotions and relationships'*. Social work professionals must aim to develop a working relationship that provides '*the medium through which the practitioner can engage with the complexity of an individual's internal and external worlds and intervene'* (Ruch, 2005, p. 113). Trevithick (2003, p. 167) notes a key component of this task is to ensure that a narrative of their current situation is understood, and '*to find out what is going on and how—if at all—past events may be being replayed in the here-and-now'*. Ruch (2010) proposes a model for relationship-based practice, informed by Hollis' psychoanalytical approaches, that is characterised by the following key understandings of social work:

- *Human behaviours and the professional relationship are an integral component of any professional intervention.*

- *Human behaviour is complex and multifaceted. People are not simply rational beings but have affective (both conscious and unconscious) dimensions that enrich but simultaneously complicate human relationships.*
- *The integral and external worlds of individuals and inseparable, so integrated (psychosocial), as opposed to one-dimensional, responses to social problems are crucial for social work practice.*
- *Each social work encounter is unique, and attention must be paid to the specific circumstances of each individual.*
- *A collaborative relationship is the means through which interventions are channelled, and this requires a particular emphasis to be placed on the 'use of self'.*
- *The respect for individuals embedded in relationship-based practice involves practicing in inclusive and empowering ways.* (Ruch et al., 2018, p. 21)

Ruch's model seeks to offer a way of approaching relationships that acknowledges the visible and invisible components inherent in all relationships while recognising the important connections between the interpersonal and broader social contexts within which they are embedded. As discussed in the preceding paragraphs, Trevithick (2003; 2014), Ruch (2005, 2018) and Ruch et al. (2018) appear to agree that an essential component of any successful relationship-based intervention is the ability to respond to people's emotional needs and development, and to any difficulties they may experience in forming and maintaining appropriate relationships. Ruch (2005) suggests for social work professionals to effectively support individuals, families, and communities, that practice models must acknowledge and respond to the complexities of both the people and the social structures with which they engage.

Ruch's (2005, 2018) model focuses on child and family social work and translating its insights into practical, policy-oriented solutions in residential dementia care settings could present several challenges requiring strategic approaches. The complexity of social care delivery for people with dementia, characterised by diverse needs among residents, is likely to pose a significant barrier to maintaining consistent and meaningful relationships. High staff turnover and resource constraints might also limit the time and attention social care staff can dedicate to building relationships (Block et al., 2018; King-Dejardin, 2019). Additionally, existing policy frameworks in social care settings often prioritise efficiency and task-oriented care over relational aspects, suggesting a need for advocacy and policy changes to support a shift towards relationship-based care (Chatzidakis et al., 2020).

The preceding paragraphs have explored the literature available on relationship-based practice across social work and social care. What has emerged as a common theme throughout the models based on psychoanalytical approaches is the importance the '*use of self*' plays in enabling workers to establish and maintain successful relationships with the people they care for (Ruch et al., 2018, p. 21). This sense of self will be explored in greater detail in the coming paragraphs. Through understanding the role sense of self plays in relationship-based practice, it is hoped to develop a better understanding of how the approach might be applied in adult social care.

2.5.5 The role of 'sense of self'

The social work professional's sense of self is important; however, it is not just self, but also '*self in relation to others'*, that needs to be considered (Ward, 2018, p. 74). Ward explains:

> *''Self', in this set of assumptions, represents continuity in our personality, security in our identity and reliability and consistency in relationships – it is our human nature.'* (Ward, 2010, p. 61)

As Ward (2010) points out, the encounter between the social work professional and the person receiving support is not a neutral encounter, but instead a potentially highly charged encounter between a paid professional and an individual who is likely to be in crisis, under stress or threat in terms of their self. Relationship-based practice has the potential to contain anxieties for people receiving support by enabling them to feel in control of their emotional, social, and mental states (Howe, 1998).

Their sense of self must be managed and reflected upon to ensure effective relationships are developed, thus providing a sound base for positive interventions. Ruch points out a holistic and reflective practice:

> *'Enables practitioners to engage with the complexities of the self in professional practice and avoid the temptation (and risk) of resorting to a 'safe' reductionist position.'* (Ruch, 2005, p. 119)

Reflective practice has the potential to contribute to effective relationship-based practice by ensuring the subjective sources of social work knowledge are attended to, whilst simultaneously embracing the professional use of self (Ruch, 2005).

A result of the focus on the reconceptualisation of the nature of human behaviour by the emergent model of relationship-based practice is that there are implications for both how people receiving services are viewed, and how social work professionals conceptualise themselves within their professional role (Howe, 1998; Ruch 2005; Ruch et al., 2018). Morrison points out that a relationship is an emotional experience and the emotionally and the '*emotionally and morally demanding nature of social work requires that practitioners give thought to issues of resilience and coping strategy'* (Morrison, 2007, p. 258).

Howe (1998, p. 53) argues the need to acknowledge the social work professional is not a 'neutral observer' but '*instead affects and is affected by others'* and by the relationships developed with people receiving support. The self-awareness required to acknowledge this involves developing a clear understanding that the way professionals present themselves is likely to influence the interaction and communication between the parties. Failure to do so could lead to unsuccessful outcomes. Trevithick (2003, p. 169) points out that in a situation where both people receiving support and the professional feel defensive or guarded, developing a '*sound foundation on which to build future work'* might be more difficult.

Ruch (2005, p. 119) notes a criticism of earlier models of relationship-based practice in social work was the tendency to '*marginalise the social dimensions'* of people's lives. Howe (1998, p. 49) suggests that relationship difficulties within social work and social care are due largely to the impact of childhood experiences which can '*upset children's ability to develop useful and effective social and emotional understanding'*. Within a relationship-based approach to practice, the relationship between the professional and the person receiving services is both the starting point and the medium, of the intervention (Ruch, 2005, 2018). Sudbery (2002, p. 151) argues that the primary resource in a relationship-based model *'is the social worker themselves and their use of relationship.'* At the outset, the social work professional does not know whether a productive relationship can be formed, nor to what degree previous emotions and difficulties will be brought into the relationship. Therefore, as Sudbery (2002, p. 151) notes '*it is the quality of the social worker's response which determines the effectiveness of service'*. Both Morrison (2007) and Winter (2009) agree that the formation, maintenance, and nurturing of professional relationships are dependent on the use of self, or emotional competence.

When complex or multifaceted relationship problems are encountered, a successful outcome may only be possible when time is taken, and empathetic skills are utilised, to establish a meaningful and constructive working relationship that enables the professional to see life from the perspective of the person they are supporting (Ruch, 2005; Trevithick, 2003). Thus, Ruch (2005, p. 113) argues that relationship-based practice enables professionals to '*recognize the interpretative nature of social work activity, the importance of reflective responses to unique and unpredictable situations and the holistic nature of human behaviour.'*

Ruch (2005, p. 113) suggests the potential of a relationship-based approach is found in '*its ability to transform the current obstacles to effective practice into building blocks for a more responsive and realistic model of practice'*. Ruch (2005) further notes the trend of marginalising the social dimensions of people's lives can also be observed in relation to professionals themselves, where a sole focus on the 'professional self' can minimise the organisational context within which they are situated. Winter (2009, p. 458) agrees that a focus on interpersonal skills, self-knowledge and self-management of thoughts and emotions is particularly pertinent when placing importance on the professional relationship as *'helping to secure the best long-term outcomes.'*

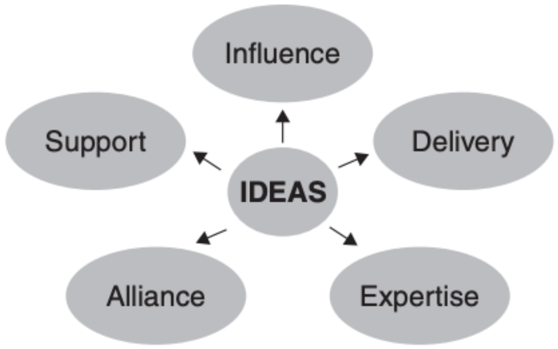
2.5.6 Relationship-based social work with adults

The IDEAS model is a framework for relationship-based social work with adults put forward by Dix, Hollinrake and Meade (2019) in their book entitled 'Relationship-based Social Work with Adults'. While again aimed at social workers, the framework can provide sound learning for a model for practice in social care. The model draws on strengths-based approaches to practice, and Dix and Meade (2019, p. 47) explain:

> *'IDEAS stands for Influence, Delivery, Expertise, Alliance, and Support. The IDEAS model utilises a framework as an attempt to explain, as simply as possible, a set of interconnected knowledge, skills, attitudes and personal qualities, which research evidence suggests are all part of what it takes to be an effective practitioner in the human services.'*

The below image depicts the IDEAS model developed by the authors:

Figure 1 – *The IDEAS Model*



Note: Retrieved from Dix, H. & Meade, J. (2019). The IDEAS model. P. 48

Each element of the model is explained in detail by the authors, which for the sake of brevity has been condensed below:

Influence: '*The ability to have and to use influence is essentially about the conscious and positive use of role and personal authority'* (Dix & Meade, 2019, p. 48).

Delivery: *'Delivery, refers to the professional tools and systems that support practice and the ability to use them with skill'* (Dix & Meade, 2019, p. 49).

Expertise: '*Expertise refers to knowledge of research and theory in relation to a specific field, and how to translate this into practice, acknowledging the importance of 'practice wisdom', i.e., knowledge acquired through professional practice and people's lived experiences'* (Dix & Meade, 2019, p. 50).

Alliance: '*[Alliance] refers to the use of relationship as a mechanism for change – both with the people who use services and in working with other professionals.*' (Dix & Meade, 2019, p. 52).

Support: *'In order for all of the above elements to exist, organisational support needs to be provided at all levels of management. It is important that social workers feel able to take risks, to be creative and to learn from situations if they do not go as planned, without feeling that they will be dealt with punitively.'* (Dix & Meade, 2019, p. 53).

2.5.7 Theories informing relationship-based practice

To fully understand a relationship-based approach to social work and social care practice, it is important to explore the theoretical background informing the models. Ruch's model is embedded within child and family social work practice, and as a result, draws upon the frameworks and theories that child and family social work draws upon. While Ruch's approach to relationship-based practice is one this thesis draws heavily upon, the research questions focus on how such a practice might be effectively enabled with adults with dementia in a residential care setting. Thus, the theories which might underpin a relationship-based approach to practice with older people are likely to differ, as relationships are explored with a set of people with different concerns and at very different stages in their lives. Relationship-based practice aims to enable practitioners to make sense of an individual's unique experience and behaviours within the broader social contexts within which they live (Ruch, 2018a, p. 22).

Central to attachment and psychoanalytical theory is an emphasis on the significance of an individual's early life experience for their subsequent development (Ruch, 2018b). Psychoanalysis and social work practices overlap in multiple areas. Both practices value the development of an understanding of individuals, the situations they find themselves in and how they seek knowledge to understand themselves, other people, and the broader societal contexts (Trevithick, 2011). Establishing an understanding of what is happening, and why, enables a foundation for future interventions to be established. Psychoanalysis, like social work, also emphasises the quality of the relationship being established between the professional and the person receiving support. Trevithick (2011, p. 407) highlights a fundamental aspect of a psychodynamic approach is *'the importance of helping people to understand themselves and the world around them'*. Attachment theory emphasises the impact the quality of early social relationships, or attachments, have on the psychological and social development of an individual. Being exposed to adversity throughout childhood can result in difficulty in forming a stable sense of self and consequently appropriate relationships as an adult (Howe, 1998). Howe explains:

> *'Attachment theory, as an example of relationship-based thinking, offers the prospect of developing practices that are intellectually insightful and evidence-based. They allow social workers to keep their cognitive and emotional bearings in situations of high stress, demand and drama. And of course, sound assessments are essential requirements if interventions are to be appropriate and effective.'* (Howe, 1998, p. 51)

John and Trevithick (2012) point out that a psychosocial perspective acknowledges that in addition to external factors, 'internal processes' and responses to external stimuli can influence behaviour. When attempting to develop an effective social work relationship, the practitioner is armed with the knowledge that the more 'trust', ‘openness’ and ‘understanding’ present in the relationship, the greater the likelihood that the person receiving support will be able to acknowledge and process areas of reality that have previously been rejected (John and Trevithick, 2012, p. 66). Therefore, as Ruch et al. (2018) also note, central to the relationship-based models is the recognition that past experiences have an impact on our current behaviours, with the understanding that professional relationships can evoke feelings associated with other, not necessarily connected, previous experiences.

Ruch et al. (2018) take the relationship-based model of practice further by incorporating concepts complementary ideas based in systems theory. Unlike previous models of relationship-based practice, John and Trevithick (2012) note that the new model put forward enables the impact of the outer world, the societal and environmental influences. As humans, we are influenced by, and have influence on, our social worlds. However, not everyone has equal capacity to shape the world around them. John and Trevithick (2012, p. 76) argue those experiencing high levels of social and systematic disadvantages are ‘less engaged in shaping’ their external worlds. The problems people experience can be viewed as a combination of the external difficulties they face and any internal difficulties they may experience. Sudbery (2002) highlights this is a key characteristic of social work and its simultaneous focus on both the internal and external, the individual and social and the subjective and objective. In addition to acknowledging the systematic disadvantages experienced by some individuals, central to current relationship-based practice models is the fact that the social worker’s activity is not limited to processing the psycho-social aspects of an individual within the professional relationships.

2.6 Relationships in practice

As a result of the increasing discourse around relationship-based practice, the body of literature and research is growing. There have been a number of studies conducted into relationship-based social work specifically and further studies conducted into the professional relationship in practice (Alexander & Charles, 2009; Bell, 2002; Beresford, Croft & Adshead, 2008; Bowers et al., 2009; Dearden, 2004; Ferguson et al., 2020; Gilburt, Rose & Slade, 2008; Gilligan, 1998; Jordan, 2017; Kendrick, 2013; McLeod, 2007; Munro, 2001; Oliver & Charles, 2015; Winter, 2009). These studies do not explicitly put forward frameworks for a relationship-based practice or analyse the outcomes of a relationship-based approach. Instead, they offer insight into how relationships are navigated by both social workers and people receiving services, what is perceived to constitute a 'good' relationship and what barriers exist to the creation and maintenance of relationships in practice.

Although the focus of this research is social care with older people, as highlighted previously the body of literature on relationship-based social work and practice with children and families has the potential to provide further context, knowledge, and understanding of the topic of this thesis due to the overlapping nature and similarities between the professions and practice areas.

2.6.1 Relationships in practice with children and families

Alexander and Charles (2009) conducted a small (ten-participant) qualitative study into another complexity in the social work relationship, reciprocity. By exploring reciprocity with social work practitioners, Alexander and Charles found that social work relationships are complex, evolve over time, and the closeness is often influenced by the person receiving support. Again, the results highlight the complexity of the practice relationship and acknowledge the sophisticated skills and reflective practice required to successfully navigate relationships. The researchers point out the disconnect between training and practice, where social workers are warned against dual relationships[7], potentially placing workers in '*untenable positions*' where they are required to choose between adhering to professional codes of conduct and developing meaningful relationships with people (Alexander & Charles, 2009, p. 5).

Dual or multiple relationships occur when social workers relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively (NASW, 2017).

Ferguson et al. (2020) conducted a fifteen-month ethnographic study to explore how social workers establish and maintain long-term relationships with children and families. The researchers introduce the concept of a ‘holding relationship’. This is described by Ferguson et al. as relationships involving reliability, critical thinking and getting alongside the children and families to connect with them in emotionally meaningful and intimate ways. This requires professionals to be reliable, and immerse themselves in their day-to-day existence, drawing on psycho-dynamic approaches to support professionals to make sense of the emotional relating involved in such relationships. While the authors offer valuable insights into the concept of 'holding relationships' in social work, their ethnographic approach, while rich in detail, is potentially limited in its generalisability beyond the specific contexts and settings observed during the study period.

Winter (2009) focused on factors that hinder the development of effective social work relationships. By drawing on qualitative data from thirty-nine interviews with social workers regarding their relationships with young children, the results indicate that highly bureaucratic tasks such as meetings and form fillings were frequently given higher priority than building, maintaining and nurturing relationships. Additionally, high staff turnover and uncertainty regarding the professional role of the social worker were cited as barriers to forming successful relationships. In line with findings from Alexander and Charles (2009), the research highlights how pre-existing practice norms focus on maintaining professional distance to protect the social worker, resulting in a relationship-based focus going against the status quo. Winter argues that factors hindering relationships are not solely structural and resource-related and suggests policy and training do not address the deeper issues of attitudes, values and emotional competence crucial in enabling social workers to develop positive practice relationships with people.

McLeod (2007) investigated issues of power and relationship when listening to looked-after young people through data obtained in interviews with eleven young people and eleven social workers. All the young people who participated described a valued relationship with at least one social worker. Particularly appreciated were social workers who had taken the trouble to get to know them and had stayed a long time, however, social workers felt their ability to form meaningful relationships was hindered by high caseloads. In line with other studies, the young people cited sharing and reciprocity as positive qualities in the social work relationship (Alexander & Charles, 2009; Coady, 2015). McLeod (2007) concluded that services should focus not only on behavioural and organisational outcomes but also on emotions and general well-being to enable workers to use relationships effectively. Again, as with many studies outlined in this literature review, the study's reliance on a small sample of eleven young people and eleven social workers may limit the breadth of perspectives and generalisability of findings to larger populations or different contexts.

Oliver and Charles (2015) focused on how front-line practitioners employ strengths-based and solution-focused approaches when navigating the social work relationship. Although they used a mixed method approach to question 225 statutory workers in Canada and interviewed twenty-four, only a small number were found to implement a strengths-based approach, meaning the sample focused on was small. Despite this, they found successful, strengths-based relationships to be centred on a shifting balance of collaboration and authority where, rather than denying their expertise, the social worker offered it as a resource for working productively together. Oliver and Charles suggest this approach of enacting firm, fair and friendly practice is one method of developing positive conditions within the constraints of legislated relationships.

As previously acknowledged, a focus in current research on relationship-based approaches to practice focuses on social work within child protection. As a result, several studies exist that elicit the views of children and young people, and what they value within a social work relationship. McLeod (2010) explored the views of young people in care regarding their perception of the role of the social worker. Using the same data set utilised in the 2007 study, McLeod focused on data from eleven semi-structured interviews with young people, gathered as part of the mixed methods study. The results indicate that young people felt a ‘good’ social worker is like a friend and an equal, challenging the notions of the professional social work role. McLeod highlights that the friend aspect poses a dilemma for social workers, who have a professional role distinct from friendship, while the desire to be ‘equal’ stems from feeling alienated by class and the perceived power held by the social worker, which

McLeod suggests can be summarised with core professional values of respect and empowerment.

McLeod’s findings are in line with previous research conducted by Bell (2002), another small-scale study exploring the views of 27 children and young people on their involvement in child protection investigations. Through data obtained from semi-structured interviews, Bell found that participants valued relationships where emotional support was combined with practical help, where they were respected, listened to, and empowered. These results correlate with a previous study conducted by Gilligan (1999) using case illustrations of how mentoring involvement for young people involved with social workers. The findings indicated that most valued were relationships with adults they trust, with similar cultures and backgrounds. Both Bell (2002) and McLeod (2007, 2010) found that young people valued the continuity of social workers.

Dearden (2004) explored the views of young people with experience of local authority care through fifteen qualitative interviews. The study highlighted that young people found strong support from adults a protective factor, with stability and continuity being key elements of such support. They valued staff who took the time to listen and talk with them, encouraged them to believe in themselves and made them feel valued. Dearden highlights the need for services to intentionally build relationships around young people.

These findings were in line with a previous study conducted by Munro (2001) into the views of fifteen children in local authority care. Through unstructured interviews, the qualitative study found social workers were viewed as powerful and, in the cases of positive working relationships, as a ‘very strong ally’ (Munro, 2001, p.7). However, young people complained about high turnover in workers causing disruption and hindering the ability to develop positive relationships. Issues of power were again a central theme, as was continuity and reliability. Despite the small-scale methodology of studies like McLeod (2010), Bell (2002), Dearden (2004), and Munro (2001), their consistent findings regarding the importance of continuity, respect, and empowerment in relationships between young people and their social workers add credibility to the findings and understanding of what children and young people value in social work interactions.

Brown et al. (2018) explored relationship-based practice in a culture of fear through a qualitative study of the experiences of 26 residential childcare workers in Northern Ireland. The researchers sought to understand relationship-based practice in a context dominated by reports of historical institutional abuse. Their findings highlight that relationship-based practice has not been fully understood or embedded into practice because of the culture of fear that pervades the residential childcare system. The researchers theorised, through the lens of Furedi's (2006) sociological framework for understanding fear, the impact such a culture has on practice and argue that those impacts are amplified by the low status of care workers.

Research has shifted towards the recognition that having a positive and sustained relationship with their social worker promotes well-being and increases the success of interventions with children and families (Bell, 2002; Dearden, 2004; McLeod, 2010; Munro, 2001). Following a period in social work where practice across the board has been heavily influenced by target-driven, procedural, and neo-liberal approaches to practice, relationship-based practice is regaining stature. The findings from the review of available research agree that high turnover of social work staff inhibits the formation of effective relationships. Continuity is repeatedly cited as a factor in positive social work relationships, with people from various backgrounds valuing sustained support.

A key theme emerging from the literature is one of power. It appears people receiving social work support are acutely aware of the power imbalance that exists in the social work relationship. When the social worker uses their power sensitively, to promote rights and advocate on behalf of the people they work with, this was found to promote effective working relationships. Conversely, negative uses of power that inhibit the development of positive relationships include coercion and the use of threats.

A further consistency evident from the available research is the value placed on equality and reciprocity. The term 'friend' appears, with informality and humour being a key component of a 'good' relationship. This, perhaps, goes back to the overarching theme of power. By incorporating a more two-way relationship, the power imbalance is somewhat redressed. Jordan (2017) explains that humour use is a neglected aspect when examining relationship-based approaches to social work and puts forward a case for a focus on humour after conducting a review of the available literature. Jordan suggests humour is necessary for successful relationships but acknowledges it can also be a risky undertaking for social workers and explains the concept of 'gallows humour', humour used in bad or hopeless situations, as a way in which social workers can manage the stress of work.

2.6.2 Relationships in practice with older adults

In addition to the body of research into child-focused social work services, the literature search located a small number of studies focusing on the social work and social care relationship with adults in different settings. Beresford et al. (2008) utilised data from a large-scale qualitative participatory research study of what people receiving support want from specialist palliative care social work[8]. The results focus on the aspects of a range of patients with life-limiting illnesses or facing bereavement, valued from social work interventions. Through interviews and group discussions with 111 participants, the centrality of the social work relationship was frequently cited as the most important aspect of an intervention, along with the continuity of the professional relationship. Friendship with the social worker was also valued, as was the concept of reciprocity and flexibility in the relationship. Participants wanted the relationship to be a two-way process and appeared to value the social workers interpreting their professional boundaries in a flexible way to meet specific needs. The researchers point out that no participant ever stated their social worker was over-friendly or too informal.

In another user-led, participatory research study, Gilburt et al. (2008) explored the themes and processes that defined the experience of hospitalisation for nineteen participants who had stayed in psychiatric mental health wards in the UK. Although

---

Palliative care social work is conducted by registered *social workers* that work predominantly or exclusively with people living with terminal illnesses (APCSW, 2021).

not specifically focusing on social work relationships, the results indicated that relationships with both peers and staff formed the core of the experiences of people receiving support. The authors highlight that building and maintaining strong, therapeutic relationships themselves can be an agent for change, leading to increased positive outcomes for service users. Positive relationships were exemplified by good communication and trust, while coercion and enforcement were deemed aspects of negative relationships.

Findings of research conducted by Keeling and van Wormer (2011) into the social work relationship with individuals who had experienced domestic violence correlate with the Gilburt, Rose and Slade (2008) findings. Through 15 qualitative interviews, Keeling and van Wormer (2011) found negative attributes of the working relationship included social workers attempting to use coercion and threats of removing children (Keeling & van Wormer, 2011). The authors' recommendations include encouraging social workers to prioritise relationship development, suggesting that this would ensure interventions could be more empowering by allowing decisions to stem from a more effective working relationship rather than an attempt to coerce.

McLaughlin (2016) conducted a small-scale exploratory study of hospital social work. The results indicate that hospital social workers are highly valued for their responsiveness, emotional support, and practical help during the process of hospitalisation. While empowering practice was reported by some carers, discharge pressures had the potential to undermine person-centred practice in the care management process. The social workers reported that their role had become increasingly proceduralised within a target-driven and increasingly bureaucratic culture, leaving less time to address the emotional needs of users and carers.

The negative aspects of the professional relationship were further explored in a report conducted by Bowers et al. (2009) for the Joseph Rowntree Foundation. The report investigated findings from a large-scale project interviewing and holding group discussions with 84 older people living in residential care. Bowers et al. found that disempowering relationships have wide-reaching consequences for older people living in situations where their voices are 'managed' by others, often arising because of concerns and anxieties for older people. The authors suggest that staff need to be encouraged to move away from ‘looking after’ towards a more enabling role that promotes inclusion and citizenship.

2.7 Challenges and potential opportunities

Taking relationship-based ideas and models into residential care practice presents both challenges and potential opportunities to the sector. The challenges in implementing the models discussed throughout this literature review chapter will be summarised in the following paragraphs. It is important to acknowledge that while the existing literature may not extensively cover the practical application of the models, this gap in the literature highlights the need for this research to explore how relationship-based practice might improve how care is delivered in these settings.

Adopting Ruch's model for relationship-based social work in residential dementia care settings presents several challenges. The framework, developed with social work practice in mind, emphasises deep, trust-based relationships between workers and people receiving care, which could be difficult to achieve in residential care due to high staff turnover and time constraints (Ruch et al., 2018; Block et al., 2018; King-Dejardin, 2019). Additionally, Ruch’s model's focus on personalised care necessitates significant training and professional development, which are often underfunded in social care. Balancing the emotional demands on staff navigating professional boundaries while developing strong relationships and maintaining high standards of care would also likely pose significant challenges. Additionally, the model's application in practice could vary significantly based on individual workers’ interpretations and skill levels, potentially leading to inconsistent outcomes in care and support.

Again, despite not being specific to social care and residential care practice, there is the potential for elements of the model put forward by Dix and Meade to be adapted for social care practice (Dix & Meade, 2019). Applying the IDEAS model to adult social work would likely differ from its application to residential social care. These differences stem mainly from the distinct contexts and dynamics of the two settings.

In adult social work, the focus is primarily on supporting people in their own homes or communities, emphasising empowerment, independence, and integration. Social workers in this context often act as facilitators, coordinating services, advocating for people's rights, and providing guidance to help them navigate social systems. Conversely, residential social care involves a more controlled and structured environment where the focus is on providing daily care and ensuring the safety and well-being of residents.

Implementing the IDEAS model in these settings would require adapting its principles to the unique challenges and needs of these environments. The focus on the relationship between staff and residents ('alliance') could be a key feature of adapting the IDEAS model, as would ensuring robust support from the care management of the residential settings ('support'). The model's focus on practice wisdom ('expertise') also has the potential to support social care workers to develop their own professional identity, with the expertise they inevitably develop while delivering care for residents.

To address these challenges based on what this literature search has highlighted, several strategies could be considered. Developing comprehensive training programs might equip caregivers with essential relationship-building skills, encompassing effective communication techniques, dementia understanding, empathy development, and strategies for managing behavioural symptoms (Chatzidakis et al., 2020; Cooper et al., 2013; Deardon, 2004; McLeod. 2007). Embedding relationship-based principles into care protocols could ensure that caregivers have dedicated time and guidelines for meaningful interactions beyond essential tasks (Block et al., 2018; King-Dejardin, 2019; McLaughlin, 2016). Research will be key to understanding the impact of relationship-focused approaches on resident and staff satisfaction, providing evidence to support broader adoption of relationship-based approaches and investment to support it.

2.8 Conclusion

This chapter explored the current literature on supporting people with dementia, and the role of social care in the care provision of this cohort of people. The impact of dementia on relationships was explored, finding that in intimate relationships, informal carers found their role switching from partner to carer, while friendships were impacted by the progression of dementia, potentially based on fear, loss and the unknowns.

The impact of ageing more broadly was explored, with the literature suggesting that peers can be reticent, with declining physical and cognitive abilities having an impact on people’s ability to form and sustain relationships.

The literature on relationship-based practice was then explored. This was done by covering both social work and social care literature. While the focus of this thesis is on relationship-based approaches to care in social care, the literature review highlighted a larger and growing body of literature on relationship-based social work, included for the potential insights and understandings it can provide. The models for relationship-based practice highlighted in this literature review chapter were ‘The senses framework’ for relationship-based care with older people with dementia (Nolan et al., 2006), Ruch’s model for relationship-based social work (Ruch, 2018), and the IDEAS model for relationship-based social work with adults (Dix et al., 2019). The insights provided by these models will be explored in relation to the findings of this research in the discussion chapter.

As demonstrated by the variety in frameworks, approaches and contexts brought to light by this literature search, what constitutes relationship-based practice within social work and social care is unclear and, arguably, even contested. However, there appears to be an emerging consensus that a shift in focus which places the relationship at the centre of practice has the potential to benefit all players. While the research outlined in this chapter provides a good insight into various approaches to relationship-based practice, it is clear that research exploring how the approach might be implemented in a residential social care setting for older people with dementia is missing. This is where this study will be able to provide further knowledge, shedding light on how relationship-based approaches might be used to improve care provision for this growing population.

Most of the available research is qualitative and conducted with small participant numbers, reducing the comparability between studies and meaning that the findings are not necessarily representative. However, what is clear is that relationships are complex. No two care relationships will be the same. What constitutes a good professional relationship is therefore difficult to pinpoint and difficult to put into policy and practice. However, the growing body of literature on relationship-based practice appears to agree that investing time and emotional intelligence into the relationship is key to effective assessment, planning and intervention (Munro, 2001; McLeod, 2010). To answer the research questions of how an effective relationship-based approach might be supported in the context of dementia care within a residential care environment, the theoretical underpinnings and historical context of adult, dementia and residential services need to be understood. These will be explored in greater depth in the next literature review chapter.

Chapter 3 Literature Review Part 2

3.1 Introduction

This chapter provides further depth and context to the literature explored in chapter two. The first part of the literature review focussed on the dementia context of social care and relationships. It also explored the literature and research on relationship-based practice across social work and health and social care. These topics were explored to provide a knowledge base to support the answering the question:

- How do people living with dementia and social care staff experience relationships in residential social care homes?

The literature search into these topic areas highlighted areas of interest that required more in-depth exploration to provide a richer understanding, while also providing an evidence base to support the thesis in answering the remaining research questions:

- How could knowledge of how effective relationship-based care is delivered in residential settings shape professional boundaries?

- How might residential care’s culture and practice need to evolve to support relationship-based practice?

Chapter two, the first part of this literature review, identified authors who argued the recent revival in interest in relationship-based approaches to practice in response to managerialist approaches to practice in recent decades. To contextualise the current approach to relationship-based practice, it is important to situate it within the rich history of social work practice, and therefore this chapter incorporates an overview of the political and cultural landscape and its influence on social work and social care. The history of relationship-based practice throughout social care is also explored while paying particular regard to the political and practice context. Further areas of literature explored in greater depth in this chapter include risk, paying particular attention to risk in the context of older people and dementia. While the concept of risk, and risk-averse practice, is linked to managerialist practice it is also linked to personalisation and autonomy (Manthorpe et al., 2008; McLaughlin, 2016; Parton, 2008). Literature on personalisation in social care, and its link to the concepts of autonomy, independence and interdependence were also investigated and included in this chapter.

Next, to produce a solid knowledge base to answer the question of how the findings of this thesis could influence, or shape, professional boundaries, literature on professional identities and professional boundaries is explored and discussed. Finally, the data collection phase of this thesis was planned for December 2019 to June 2020. Unfortunately, as described in the upcoming methodology chapter in greater detail, the global COVID-19 pandemic, data collection was required to cease in March 2020. Although the data does not explore the impact the pandemic had on participants, it nonetheless is relevant to the research questions. Therefore, the literature review was later extended to include research exploring the impact of COVID-19 on people with dementia and those living and working in residential care settings.

3.1.1 The search terms

The literature search to identify research and theoretical literature that inform this review was conducted using the same method laid out in Chapter Two, utilising the same databases. Further search terms were identified through recurring themes that came up when synthesising the literature in Chapter Two of this thesis. The topic themes' recurrence indicated that a more in-depth understanding was required to inform this thesis and support the answering of the research questions. The search themes were identified as:

1. **Historical context of relationship-based practice**
2. **Independence and Interdependence**
3. **Autonomy**
4. **Risk**
5. **Professional Boundaries**

Using these themes, keywords used during the search were established using previous knowledge of related terminology, a thesaurus and different spellings and synonyms. The main keywords were identified as follows:

Theme 1: **History / journey / development of relationship-based practice / social care / social work or relationship-centred practice / social care / social work**
Theme 2: **Independence / interdependence in social care / residential care /**
Theme 3: **Autonomy, self-determination, independence and autonomy, choice, control (in social care)**
Theme 4: **Risk, risk-averse practice, risk assessment, risk management**
Theme 5: **Professional boundaries, professional guidelines, ethical guidelines, professionalism, social care role.**

Again, these were used including the terms social care or social work using Boolean operators ***or*** and ***and,*** enabling the search to be broadened to include synonyms. To illustrate, using the additional search terms identified above, a search would have resembled the following:

Professional boundaries ***or*** Professional guidelines

The decision was taken to limit the search to publications in the English language. It is therefore acknowledged that literature published in other languages may have been overlooked.

3.2 History of social work, social care, and relationship-based practice

The research questions put forward in this thesis focussed on exploring how people living with dementia and social care staff experience relationships within residential social care settings, in addition to what would need to change in the current practice culture and context to successfully embed a relationship-based approach. To answer these questions an understanding of current residential care practice is vital, yet this cannot be truly understood without situating today’s practice on the trajectory adult social work and social care has taken throughout its history. Equally important to this understanding is that it is not only adult social work and social care that has been subject to a shift in practice philosophies and policies throughout its history; social work as a whole has been heavily influenced by the political and societal environment within which it is constructed.

3.2.1 The origins of relationship-based practice

As discussed in Chapter 2, the current interest in relationship-based approaches to practice has been referred to as a reaction to the managerialist, reductionist and individualist recent past of social work and social care across all practice domains (Ruch et al., 2018). This idea pervades throughout the reviewed literature, which acknowledges the recent emergence of relationship-based practice came in response to the neo-liberal political influences on social work and social care (Ruch, 2018a). It is therefore vital to understand this return to a more relationship-centric rhetoric within the context of the historical shifts in practice to successfully answer the questions set out in this thesis. Jones (2007, p. 42) described how the practice philosophy within adult social care has developed across a continuum of doing 'to' people, to doing 'for' people, to doing 'with' and 'by themselves'. Jones (2007, p. 45) explains this conceptual shift has been reflected in policy changes and 'increasingly separating legal frameworks' across adult and children's social work. The 1940s saw a move away from institutionalised care, in the form of geriatric hospitals and mental health asylums, towards more community-based approaches (Jones, 2007).

As discussed in Chapter 2, the roots of relationship-based practice can be found in the psychoanalytical and psychosocial processes of the 1940s and the subsequent decades (Ruch, 2005; Ruch et al., 2018; Trevithick, 2014). While psychoanalytical theory underpinned the casework practices of childcare social work in the UK in the first half of the twentieth century, the 1960s saw the psychosocial model of practice, developed by Hollis (1964), become widely incorporated into practice as the most appropriate and well established for social work practice (Ruch, 2005). Parton (2007, p. 258) explains that social work departments were established, focusing on carrying out work with individuals and families in the communities '*providing a humanistic element to* *the welfare state'*. The relationship between social workers and people receiving services was deemed a 'primary tool' (Parton, 2008, p. 258).

The emergence of social work practice was closely associated with the political and economic changes that took place over this period, '*in response to a number of interrelated social changes and anxieties about the family and community'* (Parton, 2008, p. 254). Social work developed between the private sphere of the household and the public sphere of the state (Parton, 2008, p. 254). Parton explains:

> *'The practices of social workers was seen as a positive solution to a major social problem for the liberal state, namely how could the state sustain the healthy development of family members who were vulnerable and dependent, while promoting the family as the 'natural' sphere for caring for those individuals.'* (Parton, 2008, p. 254)

The 1960s also saw a shift in adult care towards smaller residential and nursing homes, yet while the transition towards community-based care was still taking place, the predominant philosophy was that of doing 'to' older people. Jones (2007, p. 42) points out that the approaches of this decade still contained elements of control, in addition to care, describing the 'dong to' as '*containing and controlling as well as caring'*. Ray and Phillips (2012) note this move away from institutionalisation coincided with wider concern regarding the ageing population, resultant implications for public expenditure and an increasing emphasis on cost efficiency.

From the end of the 1960s, the popularity of the relationship-based, psychosocial approach began to wane as critics challenged the Freudian roots of the psycho-analytical theory and the expert-orientated and pathologising interpretation of individuals was deemed incompatible with statutory social work (Payne, 1997; Ruch, 2005). As social work continued to practice in the space between the individual and the state, it again was impacted by the shift in the political context. The tendency for social work to be susceptible to trends and shifts in ideologies is evident throughout recent decades, as the profession is prone to shifting ground on key issues in response to demands of political powers and critical demands (Trevithick, 2003).

3.2.2 The ‘rolling back of the state’

The rolling back of the state throughout the 1980s and onwards was the result of the (then) new Conservative government’s belief that the welfare state had ‘expanded too far’, and that welfare provision ‘reducing the scope of the individuals to make choices’ (Harris, 2008, p. 672). The emergence of a fractured and individualistic society supported the downsizing of state provision, and an increase in capital investment and a free economy. This purportedly meant the provision of opportunities for individual growth and freedom, where the ‘private is elevated over the public’ (Noble, 2004, p. 293). This move towards managerialism saw professional social work practice become increasingly accountable. As Sayer states:

> *‘Social work used to be a largely intuitive activity with individual professionals able to stamp their own personalities and values on their work, but now under the new ethos of managerialism the aim is service standardisation’. (*Sayer, 2008, p. 10)

The 1980s also saw increased importance placed on community care and provision to support people within their own homes. This change heralded a shift in philosophy from doing ‘to’ to doing ‘for’ older people. Jones (2007, p. 42) frames such an approach as ‘*paternalistic but often also patronisingly assuming ‘cosiness’ in looking after people’.*

The neo-liberal influence gained momentum throughout the 1990s, with the continued view that welfare encouraged dependency and increased discourse around empowerment, self-help, and strengths perspective, with citizens reminded of their personal responsibility (Gray, 2011; Stepney, 2006). The ideals of neo-liberalism were to facilitate members of society to fulfil their individual destinies as primary agents of their own health and welfare (Collins & McCartney, 2011). Political action became increasingly about the policing of the individual’s behaviour and the management of people’s lives. The emergence of neo-liberalism, and a shift to the right in political ideologies, resulted in the reconfiguration of the welfare state with eligibility criteria becoming increasingly rigid and ‘stringent’ (Pollack, 2008, p. 1266). This coincided with available benefits being reduced and cuts being introduced across the board to state services, including health and social services (Pollack, 2008, p. 1266).

This political shift resulted in a greater emphasis being placed on budget management, ensuring compliance, and ‘adopting dominant risk management ideologies’ (Pollack, 2008, p. 1276). What this led to, as Noble (2004, p. 299) argues, was an increase in individualisation and a move away from the collective, or ‘social whole’. The emergence of a fractured and individualistic society supports the downsizing of state provision and the increase in capital investment and a free economy, providing opportunities for individual growth and freedom and individuals encouraged to plan for themselves over their communities (Noble, 2004, p. 293). The emphasis moves away from the governing of a society, but towards *‘the return of the individual to full discursive rights’* (Parton, 2008, p. 256). The modernisation of adult welfare services was continued by the ‘New Labour’ government throughout the 1990s. Jones (2007, p. 42) highlights this as a move from doing ‘for’ towards doing ‘with’, where ‘partnership and participation’ were key concepts advocated by policymakers.

3.2.3 Care Management, marketisation, and managerialism

Within adult care, the 1990s saw the advent of community care reform following the introduction of the NHS and Community Care Act 1990. The main driver behind the introduction of the act was an attempt to curb public expenditure on residential care. Ray and Phillips (2012) point out the ideological commitment of the government to simultaneously reduce the role of local authorities in the direct provision of services, alongside the stimulation of service provision from the private and voluntary sectors. The community care reforms of the 1990s also saw the establishment of ‘care management’, which advocated a ‘needs-led’ as opposed to a service-driven approach to care for older people (Means et al., 2008, p. 54). Ray and Phillips (2012) suggest this modernisation agenda was underpinned by the desire to improve performance and accountability driven by managerial approaches such as target setting and performance indicators. However, criticism of this approach has focussed on how reforms have not led to consistent improvements in the care of older people. Instead, increasing amounts of time are spent on IT and procedural processes, with assessment being increasingly used as a standardised tool to allocate scarce resources (Ray & Phillips, 2012).

Gilligan (2000, p. 270) argued that this advent of increasingly rigid forms of managerialist influence led to workers being '*expected to act less as professionals using judgement and relationships, and more as technicians following prescriptions and procedures.'* This led to the nuanced knowledge and experience of the social work profession being overlooked. Littlechild (2008, p. 668) acknowledged that positivist-derived risk assessment policies, and the accompanying guidance for social workers, required a 'systematic review' of the evidence available. Littlechild suggests this would mean:

> *'Including untidy and distinctly non-positivistic sets of knowledge concerning how people construct their knowledge of the area they are involved in, and their attributions of the world and the motives of others'* (Littlechild, 2008, p. 668)

Beresford et al. point out that the relationship aspect of social work practice has been undermined by:

> *'The increasing trend for social work within statutory services to be reduced to a time-limited, check-box exercise in which practical needs are scrutinized, but in which the relationship between social worker and service user is very much a secondary consideration.'* (Beresford et al., 2008, p. 1400)

A consequence of the bureaucratisation of social work is that practitioners are required to demonstrate compliance with agency policy and procedure, rather than demonstrating sound judgment, with a priority of administrative competence over therapeutic competence (Gilligan, 2000). By minimising the need for professional interpretation and knowledge, it is argued that social work is becoming de-professionalised. The shift from a professional towards a managerial culture in social work, driven by risk management public policy and care management agenda, has been argued to lead to social workers no longer perceiving themselves as agents for change for the people they support (Gregson & Holloway, 2005; Morrison, 2007).

Social work professionals are expected to work within the constraints of a market-style public management system which does not take into consideration the varied needs and circumstances of the people it serves (Munro, 2011; Trevithick, 2014). People who fail to behave by the standards set out must be dealt with in terms of the marketplace logic and legal requirements, which Howe (1997) argues denies the possibility that human behaviour is often governed by non-rational forces.

The community care reforms discussed above saw professionals performing tasks previously exclusively undertaken by qualified social workers are increasingly referred to as 'care managers' (Lymbery, 1998, p. 863). Care managers are not necessarily qualified social workers and will often undertake the role of assessing need and allocating services (Lymbery & Postle, 2010). The aim of service provision shifted to the prioritisation of people deemed most in need, with an increased focus on the individual and '*essentially matching people to available resources'* as efficiently as possible (Lymbery et al., 2007, p. 98). This is a narrow task and does not ensure that the person gets the care they need and instead is limited by resources. This placed the 'care manager' in the position of managing state resources through '*mechanisms such as 'Panels''* over identifying and meeting the needs of people (Taylor, 2005, p. 1421).

Hallberg and Kristensson (2004, p. 115) point out that the term care manager has been questioned '*because it conveys a top-down and objectifying attitude towards the older person'*. Richards (2000, p. 48) argues that limiting the levels of funding for community care has '*not encouraged the development of complex and reflective skills in work with elders'*, instead reinforcing an approach to assessment that focuses on eligibility criteria that had the potential to actually increase risk. Richards (2000, p. 48) suggests that to improve services, a more person-centred approach would 'enhance' both the persons 'understanding' and 'understanding of their view'. This shift in focus to person-centred focus across all areas of social services contextualises Kitwood's (1997) person-centred approach to dementia care discussed previously in this literature review.

Tsui and Chueng (2004, p. 437) explain that 'Managerialism is a set of beliefs and practices that assumes better management will resolve a wide range of economic and social problems'. Managerialism is not a practice method yet has had a significant influence on social work policy and practice. This impact has been explored throughout academic literature, with a particular focus on the move from social services being direct providers of care to commissioning care instead. Munro (2011, p. 20) points out that '*the assumption that records provide an adequate account of a helping profession has led to a distortion of the priorities of practice'* meaning '*the importance of continuity in human relationships is overlooked'.*

Whilst in previous decades professionals were required to adapt to people's needs, it increasingly became the case that instead those receiving services had to adapt to professional needs or organisational requirements. Trevithick (2011, p. 408) argues this '*creates real problems for those service users who struggle to adapt'.* Tsui and Cheung (2004, p. 440) suggest that '*the advocates of managerialism believe that social problems can be solved by more effective and efficient managerial measures within the structural, budgetary and operational mechanism of organizations.* However, dealing with social problems at an organisational instead of societal level overlooks '*the roots of social problems'* (Tsui & Chueng, 2004, p. 440).

Academics championing relationship-based approaches to practice have lamented the lack of emotion and 'feelings' in practice resulting from the predominant focus on managerialism and market-based care systems (Garret, 2014; Ruch et al., 2018; Trevithick, 2014). Garret (2014, p. 514) observed this is reflected in the 'performance-driven forms of management' and the introduction of increasingly complex IT systems that have increased both the pace and volume of work, in addition to the gathering of statistics and increased monitoring of practice and productivity. Rogowski (2011, p. 163) argued that '*despite the emphasis on evidence-based practice, the success or otherwise of social work practice is now measured in terms of meeting managerial targets'*.

West and Heath (2011, p.214) agree, stating the impact of this can be seen across social work, with work often being divided into teams such as 'intake, assessment, and intervention' with tightly controlled organisational protocols, statutory regulations and risk management strategies. Parton (2008, p. 261) argues the increasing reliance on IT systems for assessment, monitoring and planning in social work means that narratives and relationships between social workers and the people they support are '*increasingly framed by the logic of the database'* they use. Across social work, although particularly evident in adult care, there has been a shift from social services directly providing care to commissioning care from external organisations. This is often referred to as the marketisation of social work. Rogowski defines marketisation as:

> *'The sponsored development of competition in the provision of welfare services together with the introduction of internal markets within public service organisations as a way of making them imitate market relationships.'* (Rogowski, 2011, p. 158)

Rainbird et al. (2011) conducted a qualitative study into the impact regulation of care services has had in the system where the Local Authority's role has shifted from direct provision to the commissioning of care services. The authors found that regulation can encourage '*compliance rather than an expansive approach to skill development'*, leading to a risk of deskilling the workforce and limiting innovation (Rainbird et al., 2011, p. 3739). Research conducted by Postle (2002) agreed with this conclusion. Postle (2002) points out the system has left little time for 'real' work due to increasingly reductionist processes, with the potential to deskill staff. Postle (2002, p. 335) highlights that in '*trying to reconcile spending more time on paperwork and computer work with having less time for making and working within relationships with people',* with staff often fearing litigation.

The impact of working within such ambiguities can have a negative impact on staff morale, with Postle (2002, p. 344) pointing out that 'i*n privileging the needs of the system, this approach renders the relevance of the assessment to the person as secondary.*' Hojer and Forkby (2011) found that tensions arise in Sweden due to market-orientated strategies. The authors explain complexity and ambiguity arise because '*on the one hand, from the complex tasks social workers have to deal with and policy and bureaucratic regulations on the other'* (Hojer & Forkby, 2011, p.105).

They argue this meant moral and value-based work, and the capacity for the social worker to be a positive, collaborative partner is minimised. McLaughlin (2016) conducted a small-scale exploratory study of hospital social work in Northern Ireland. While some carers reported empowering practice, McLaughlin found:

> '*Discharge pressures had the potential to undermine person-centred practice in the care management process'.* The social workers reported that their role '*had become increasingly proceduralised within a target culture, leaving less time to address the emotional needs of users and carers'* (McLaughlin, 2011, p. 135).

Within social work education, the move towards a more reductionist approach and away from the psychosocial approaches coincided with an intellectual purge (Trevithick, 2003). Trevithick (2003 (p. 165) points out this resulted in stripping out social work theories from the curriculum and '*an over-emphasis on social work values, such as anti-discriminatory and anti-oppressive perspective'*. Munro states:

> '*The professional account of social work practice 'in which relationships play a central role' appears to have been gradually stifled and replaced by a managerialist account that is fundamentally different.'* (Munro, 2011, p. 86)

A recurrent theme about what helps, and what is missing, in social work practice is the importance of effective, empowering relationships between social workers and the people they support (Bowers et al., 2009; Munro, 2011; Trevithick, 2014). These relationships are central to providing positive social interaction and effective interventions with the people social work seeks to serve (Bowers et al., 2009). For the re-emergence of psychosocial perspectives on social work and social care practice to be accepted as credible and valid, a clear explanation of the differences between the earlier, rejected practice models and the current model needs to be articulated (Ruch, 2005). Vitally, the capacity of the new model to successfully incorporate the recently established anti-oppressive and discriminatory dimensions to practice needs to be articulated (Ruch, 2005; Trevithick, 2003). As argued by Ruch:

> *'A further obstacle to the widespread adoption of contemporary relationship-based models of practice relates to the shift it requires practitioners to make*

> *from procedural and legalistic responses to ones based on uniqueness, uncertainty and relationship.' (*Ruch, 2005, p. 114)

A relationship-based approach to practice offers the possibility to enable professionals to engage sensitively with, and respond effectively to, people and communities. The residential care sector will need to align current, more managerialist frameworks with the principles and practices inherent in a relationship-based approach to care. To achieve this, a strategic approach will be essential. This could include incorporating and adapting learnings from the existing frameworks outlined in the previous chapter, such as Nolan's Senses framework and the IDEAS framework (Dix et al., 2019; Nolan et al., 2006).

In practical terms, adapting these frameworks might mean considering how existing managerial procedures could be revised to align more closely with relationship-based practice and is a point this research will seek to explore. This might involve thinking about how care planning processes can be adjusted to resident preferences, exploring ways to implement regular staff training on interpersonal communication and empathy, or contemplating how care routines could be restructured to allow more time for meaningful interactions between staff and residents. Finally, it is important to consider how organisational culture might play a role in adapting these frameworks into practice. Reflecting on how to encourage a culture that values relationship-based care and supports staff in doing so could aid in implementing relationship-based approaches in practice.

3.2.4 Personalisation and individualism

As discussed in the preceding paragraphs, adult social care in the UK has undergone a number of transformations in recent years. The advent of managerialism across social work and social care, in addition to an increased focus on risk, brought with it a shift towards individualism and personalisation. The Social Care Institute for Excellence explains:

> *'Personalisation is not just about personal budgets, but about achieving choice and control in many ways and in different settings…. Delivering personalised services will mean different things to different people – it's about self-determination and self-directed care.'* (Social Care Institute for Excellence, 2011)

Brookes et al. (2015, p. 86) explain that '*there are differing views as to the exact origins of the concept of personalisation, but it is generally accepted that, in the context of social care in the UK, it has its roots in community care reform'.* The concept of personalisation increased in popularity following arguments that traditional community care placed a heavy emphasis on an individualised and medical-based approach to physical and cognitive impairment, placing focus on problems and needs over rights. Jones (2007, p. 42) describes this shift in practice philosophy as an intention to ensure people have more choice and control, doing 'by' themselves but with assistance rather than 'care'. Manthorpe et al. explain the move to personal budgets:

> *'The aim is to provide a sum of money to meet the needs of people eligible for social care services, whether by provision of the money itself under Direct Payments or through services arranged by a local authority or arranged by a care broker'.* (Manthorpe et al., 2010, p. 423)

This policy aimed to improve '*outcomes for individuals while concurrently reducing fiscal pressure on governments',* with people purchasing services from a '*service market'* (Carey et al., 2019, p. 1). Leece and Leece (2011) researched perceptions of the role of social work in the managerialist environment of budgets and personalisation. The authors report on empirical research exploring perceptions of 66 people with disabilities and carers in the UK, through a grounded theory approach on data collected through internet forums. The results suggest that '*notions of power and autonomy were fundamental in understanding respondents' views of social work with concerns raised about the power of social workers and statutory organisations'* (Leece & Leece, 2011, p. 204). Participants stated they wanted independent advocacy systems, again referring to issues of power and autonomy.

3.3 Risk

It is widely acknowledged in social work and social care literature that the shift towards managerialism and personalisation outlined in the preceding paragraphs resulted in minimising the standing of professional judgment and intuitive reasoning through advocating reductionist and rationalist approaches to practice (Trevithick, 2014). The recent return to the rhetoric of relationship-based social work is thought to be a reaction to this increasingly risk-centric and bureaucratic practice. Understanding the impact of risk-centric practices is particularly relevant when considering the focus of this thesis; older people living with dementia. The interplay between risk in social work and social care, and literature around risk attitudes towards older people and those with dementia is further explored in the coming paragraphs.

3.3.1 Care management and risk management

Since the introduction of the community care reforms in the early 1990s, which was accompanied by a shift towards care management and needs-based assessment, the social work role has been radically redefined not only by the concepts behind managerialism but also by risk assessment (Manthorpe et al., 2008; McLaughlin, 2016). This shift in focus of social work and social care was not exclusive to the UK; since the 1990s global politicians and policymakers have been seeking scientific, positivistic methods of *'identifying and intervening in the lives of those most at risk of becoming future social problems' (*France et al., 2010, p. 1193). Risk assessment and risk prevention practice gained in popularity due to its '*aura of science'* and '*possibility of prediction'* (Scourfield & Welsh, 2003, p. 400). Horlick-Jones (2005) suggests this emphasis on the evidence base and the assumption that risk can be subject to prediction and control has led to social work practice increasingly articulated through the language of risk and an increasing reliance on assessment tools. Parton explains the social work assessment was:

> *'Seen as strategic in allocating cases to their correct category and thereby coordinating resources and expertise. Professional judgement and decision-*

> *making is essentially concerned with the identification and assessment of 'high risk.* (Parton, 1996, p. 101).

Green (2007, p. 406) argues that risk has become a dominating factor shaping current social work practice, with risk technologies and rationalities *'taking hold in public policy'.*

Thus followed an increased interest in adult safeguarding in both policy and practice, with the concept of adult protection becoming a core function of adult social work (Graham at el., 2016; Lymbery & Postle, 2010; Manthorpe & Martineau, 2016). A key element of recent adult safeguarding practice of particular relevance to dementia social work is the introduction of the Deprivation of Liberty Safeguards (DoLS) in England and Wales. The safeguards were introduced to protect the interests of people with learning disabilities, dementia and neurological conditions resident in hospitals and care homes. Best interest assessors are required to establish whether a deprivation of liberty has occurred when residents lack the capacity to make decisions about their care and treatment (Carpenter et al., 2014).

Carpenter et al. (2014) explored the practice of best interest assessors and reasons why DoLS (deprivation of liberty safeguards) are instigated in England and Wales. The assessors are responsible for looking out for the interests of people with learning disabilities, dementia and neurological conditions resident in hospitals and care homes. The Safeguards apply when residents lack the capacity to make decisions about their care and treatment in circumstances that may amount to a deprivation of their liberty. The researchers found that '*coercive staff behaviour was the strongest predictor of a deprivation of liberty judgement'*, in addition to the use of medication to reduce agitation, restriction of movement and family unhappiness with care (Carpenter et al., 2014, p. 576). Best Interests Assessors must establish whether a deprivation of liberty has occurred.

Sherwood-Johnson (2014) explored the meanings attached by practitioners to the concept of adult protection in the UK. Findings indicated that *'different practitioners could mean different things when each of them talked about having been doing adult* *protection work'* (Sherwood-Johnson, 2014, p. 483). These included that they perceived themselves to have been responding to abuse, harm or high risks, or they were adopting a certain formal, even coercive tone, of work or had formally flagged the work as adult protection. Practitioners drew on and combined these meanings in different ways, highlighting the fact the concept of adult protection in social work is complex and ambiguous.

When combined with the introduction of care managers due to the community care reforms of recent decades, the impact of the risk-averse culture is thought to have had a considerable influence on the practices of adult social workers. Taylor (2006) explored the impact of risk management paradigms in health and social services on decision-making in the long-term care of older people in Northern Ireland. The grounded theory study utilised data from a combination of focus groups and semi-structured interviews focused on the perceptions of risk. The results indicate:

> '*The rationale for decision making seemed to be more about what was defensible than what was right. 'Risk' was little about probabilities, and more about aspirations, fears and justifications'* (Taylor, 2006, p. 1424).

The author highlighted the tension that exists in health and social care practice between avoiding and taking risks, with the distinction being made between considering only possible harms as opposed to balancing those possible harms with the potential for possible benefits. In line with the findings from Postle's (2002) research, fear of litigation was found to drive decision-making. The findings indicate that there is no coherent approach to managing risk, rather, conflicting paradigms exist that are employed as each occasion demands.

In a Joseph Rowntree Commissioned consultation, Faulkner (2012) explored the concepts of risk, trust, and relationships in relation to ageing in the UK. The small-scale qualitative research utilised data from discussions with individuals who use care and support. Faulkner's findings are in line with previous studies, highlighting the complexity surrounding the rights and risk language in social care (Postle, 2002; Taylor, 2006). The culture surrounding risks and rights in both wider society and within individual services has led to risk-averse practices because of the tendency to blame individuals when something goes wrong. Faulkner (2012, p.3) points out that the key themes around risks are significantly different for people using mental health services, with such individuals being perceived as a '*source of risk'* rather than '*potentially at risk'* in vulnerable situations.

Also highlighted is the concept of power, and the power workers have. Small issues can have considerable significance for someone powerless and dependent on care. These findings regarding power correlate with the earlier study by Stanley (1999), which looked at the impact of social worker transactions through a mixed-method study in the UK. The results indicated that '*people using services who can articulate their needs forcefully were better able to exercise choice'* (Stanley, 1999, p. 417). The author argues this results in those experiencing disempowerment being further disadvantaged by the system and more acutely impacted by the decisions those working with them make. This is a concern of managerialism, where Rogowski argues the rigidities of bureaucracy and insensitivity to people receiving services have resulted in the '*distribution and balance of power within social services and social work, including the displacement of traditional professional concern with needs'* (Rogowski, 2010, p. 143). This means that the providers are the ones with the power, and individuals who are already experiencing disempowerment are further disadvantaged by the systems that seek to serve them.

A consequence of the bureaucratisation of social work is that practitioners are required to demonstrate compliance with agency policy and procedure rather than demonstrating sound judgment, with a priority of administrative competence over therapeutic competence (Gilligan, 2000). By minimising the need for professional interpretation and knowledge, it is argued that social work is becoming de-professionalised. The shift from a professional towards a managerial culture in social work, driven by risk management public policy and care management agenda, has been argued to lead to social workers no longer perceiving themselves as agents for change for the people they support (Gregson & Holloway, 2005; Morrison, 2007).

3.3.2 Risk, older people and dementia

When considering people with dementia, the notion of risk is usually associated with their '*perceived vulnerability to harm'* (Manthorpe, 2015, p. 274). Many issues regarded as risks for people with a diagnosis of dementia stem from efforts to maintain independence and elements of the life they have always lived (Quinn, 2010). Through conducting the literature review, it became clear there is an established body of research investigating the concept of risk in relation to dementia, particularly around the concept of balancing risk with the rights of people with dementia (Clarke et al., 2010; Manthorpe & Samsi, 2013; Robinson et al., 2007; Quinn, 2010; Taylor, 2006; Waugh, 2010). This body of research will be explored in the coming paragraphs.

Manthorpe and Samsi (2013) conducted a qualitative, small-scale study with adult safeguarding coordinators in the UK to look at how risk is managed when utilising personal budgets for people with dementia. Participants expressed concern about how personal budgets and direct payments may result in financial abuse for people with dementia whose ability to make judgements was in decline. The vulnerability of people with dementia was frequently pointed out, with Manthorpe and Samsi (2013) highlighting the potential for pessimism around personal budgets and protection to increase it concerns are not addressed.

Quinn (2010) explored the concepts of risk and rights, in relation to vulnerability, with social workers working with people who have dementia in a small-scale qualitative study. The findings from interviews with 21 practitioners indicate that the concept of risk is a pivotal factor in all important decisions affecting the quality of life of the people with dementia they work with. Being deemed 'at risk' is a frequent outcome of receiving a diagnosis of dementia. Participants were acutely aware of the need to balance risks with rights, with concerns regarding the risk of people with dementia being deprived of their rights to citizenship and self-determination also being raised.

Waugh (2010) explored risk in community care practice for people with dementia who live alone. Through qualitative interviews, the research explored the issue with practitioners working with older people with dementia. The findings indicate that workers often must balance the rights and best interests of the person with dementia with the interests and anxieties of their families and the:

> *'Constant pressure exerted and experienced to admit this vulnerable service user group of older people with dementia to 'safe', 'protected' residential care*'. (Waugh, 2010, p. 220)

Waugh argues this is '*at odds with the idea of choice'* and person-centred care, thus creating a difficult task for those working with people with dementia (Waugh, 2010, p. 206).

The balance between rights and risks for people with dementia was explored by Robinson et al. (2007) when managing wandering in dementia, taking into consideration a person-centred approach to practice. The qualitative research incorporated the views of several different stakeholders. A key theme for carers was the conflict between the prevention of harm and the facilitation of a person's right to autonomy, with these tensions being found to have an impact on carers' abilities to provide person-centred care. This dilemma was highlighted using assistive technologies such as electronic tracking devices. Carers felt such technologies protected them from potential harm and gave them '*peace of mind'* (Robinson et al., 2007, p. 399). People with dementia felt that the use of such technology placed them at greater risk than wandering itself did and spoke of '*their need for independence and their concern over carer surveillance and the identity of "big brother"'* (Robinson et al., 2007, p. 389).

Clarke et al. (2010) studied the contested territories of risk in dementia care from a nursing perspective. The qualitative, symbolic interactionist study used interview data collected from 55 people with dementia, their carers and practitioners. The results suggest the main contested territories of living with dementia include friendships, smoking, going out, domestic arrangements and activity and found that assessing and managing risks within these territories will support care that is person-centred and respectful of the relationships that contribute to maintaining the person with dementia's sense of self and purpose.

Social workers are sometimes faced with making decisions and acting on behalf of people who lack the capacity to make decisions for themselves, which can often include individuals with dementia. England and Wales, the Mental Capacity Act 2005 (DOH, 2005) was created to protect such individuals and ensure that they are supported to make decisions for themselves (Carpenter et al., 2014). McDonald (2010) explored the impact of the Mental Capacity Act on the decision-making of social workers working with people with dementia in the UK. The findings of the mixed method study, incorporating case files and interviews with social work professionals, indicate that there has been a movement away from a rights-based approach to practice. Instead, decisions were made via a legalistic approach, with defensible decisions being made with roots of such decisions being found in both general approaches to risk and the views on the status of people with dementia concerning their decision-making capacity around risk.

The majority of studies into risk and dementia are conducted on a small scale using qualitative methods, meaning that comparability and applicability across populations are limited. However, the findings contain similar themes. Notably, the influence of risk management paradigms across adult services is acknowledged, particularly in terms of how they shape decision-making processes and care practices. This influence often emphasises the importance of minimising risk and adhering to guidelines, which can sometimes overshadow the need for relationship-based approaches to care (Manthorpe, 2015, Manthorpe & Samsi, 2013). This is exacerbated for people with dementia when taking into consideration the widespread perception of increased risk as a direct result of a dementia diagnosis. There is no single model for negotiating risk (Taylor, 2006) and instead, professionals are relied upon to use their knowledge and expertise subjectively and ensure they take into consideration the need to minimise the risk of harm whilst ensuring that people's rights are protected.

The discourse underpinning health and social policy, guidance, and practice views risk as something that can be objectively measured and quantified. However, Lupton (2005) challenges this notion by arguing that risk is socially constructed by nature, and the identification of risk is not objective but instead is influenced by values and through social and cultural processes. As Quinn states, *'what people with dementia fear for themselves and what others fear on their behalf may differ greatly'* (Quinn, 2010, p.6). It is essential that what is perceived as 'risky' is evaluated from the perspectives of all stakeholders, especially people with dementia (Robinson et al., 2007; Quinn, 2010).

3.3.3 Risk and the media

In addition to the political influences of recent decades, the media has had an increasing impact on social services and the shift towards a risk management paradigm in practice that cannot be disregarded. The negative portrayal of social work in the UK media has been traced back to the 1970s (Ayre, 2001; Rogowski, 2012; Warner, 2013). In 1973, whilst still relatively new as a profession, social work was first linked to the perceived preventable death of a child, Maria Colwell (Ayre, 2001). Maria's death coincided with the ideological shift to the right within UK politics, towards neo-liberalism, which culminated with the 1979 election of Margaret Thatcher and the Conservative Government (Rogowski, 2012). Over subsequent decades ensued a series of high-profile political inquiries into child abuse fatalities (Ayre, 2001; Jones, 2007; Warner, 2013; Warner, 2014).

The increased anxiety caused by the sensationalised media outpouring following a child abuse death puts pressure on politicians to be seen as 'doing something'. When the public becomes mobilised by fear or anger, the government needs to respond to placate society (Altheide, 2013). The two-party political system within the UK exacerbates this effect, as the opposition government can impose further pressure still, blaming the current government and giving the public someone to blame (Warner, 2014). This encourages the government to respond, and thus reactionary or 'knee-jerk' legislation is drafted to ensure the public knows that their government is serious about preventing a similar situation from rising again (Munro, 2011, p. 124).

The legislative and policy reforms which follow child abuse scandals have each provided the public with a false hope of the elimination of risk and the prevention of child deaths, which Munro (2011, p. 134) ascribes to the unrealistic view both the media and public have on the possibility that child protection services can eradicate all uncertainty and risk. Media calls for social work education and training to be improved lead to an increased lack of trust in social workers, which Littlechild (2008) argued raised the likelihood that policymakers issue increasingly reductivist checklists. Another concern linked to the negative portrayal of social work in the media is highlighted by Dimes (2019, p. 61) who suggests the often negative portrayal of social in the media means *'many people have little idea of the nature and context of social work with adults until, through disability or illness, they need help themselves or for someone close to them.'*

3.4 Autonomy, independence, and interdependence

A key concept throughout the literature focussing on risk management and the personalisation of the care of older people is autonomy. Autonomy is closely linked with independence, power and individualism and has been referred to throughout this literature review so far, in passing, when discussing some of the key emerging themes. Care for older people is a highly varied and complex field, comprised of a large number of support and care services to meet an equally varied number of physical, psychological and social needs related to ageing. The type of care provided to older people is dependent on their needs and can take place in both institutional and home environments (Fernández-Ballesteros et al., 2019). The result is an incredibly complex, human situation within which rights, risks, responsibilities, and autonomy interact in increasingly nuanced ways. Autonomy is defined in the Oxford English Dictionary as:

> *'The condition or right of a state, institution, group, etc., to make its own laws or rules and administer its own affairs; self-government, independence.'*
>
> *Or*
>
> *'[The] liberty to follow one's will; control over one's own affairs; freedom from external influence, personal independence.'* (Oxford English Dictionary [OED], 2022b)

The second, more casual definition is the definition of autonomy that most closely aligns with the concepts discussed throughout social work and social care literature. The shift towards personalisation across adult social work and social care was linked with notions of autonomy, with the idea that providing people with increased control and choice over service provision would enable them to retain their autonomy and address power imbalances (Brookes et al., 2015).

Fernández-Ballesteros et al. (2019) put autonomy and person-centred in opposition to previous, paternalistic modes of care. The authors argue that although paternalistic approaches have been considered inherently 'wrong', protection may be required depending on the needs of the older adult. The authors point out that:

> *'Although the promotion of autonomy is intrinsically right, it may be adjusted to the individual baseline characteristics, taking into consideration that a very high level of autonomy demand could overcome the individual baseline, producing anxiety, and suffering.'* (Fernández-Ballesteros et al., 2019, p. 1460)

Carey et al. (2019) conducted a review of the evidence on personalisation schemes in Australia, the UK and Europe, and advised caution around the disproportionate benefit they provide to the middle class. The authors explain that an unprecedented skill is placed on individual skills when managing personal budgets and navigating complex administration systems and tasks. They suggest personalisation schemes have the potential to further 'widen and entrench' inequality between different social groups (Carey et al., 2015, p.1).

Independence, while related to the concept of autonomy, differs in that it stems from the ideology of self-reliance. As Leece and Peace (2009) explain, care literature tends to define independence in terms of the extent of the absence of dependence. McNally and Lahey (2015) discuss the concepts of ageing, dependence, and frailty in legal and ethical terms. The authors refer to the 'frailty' epidemic as an emerging phenomenon, describing the use of the word 'frailty' as a pejorative label which opens older adults up to paternalism and negative stereotypes.

McNally and Lahey (2015) argue these stereotypes enforce the idea that older people, through being 'old', are frail, weak and diminished in their capacity or potential, and this is representative of the broader devaluation of getting older by society, ageism. They consider whether increasing the focus on frailty might form part of the solution to the disadvantages that ageing adults face in maintaining their autonomy. McNally and Lahey (2015) explain that respecting the autonomy of patients (they come from a medical standpoint so use this term) through the informed choice process is ‘nuanced and complicated’ and that frequently, informed choice on aspects of care and treatment does not take into consideration the wider context of that patient’s condition (McNally & Lahey, 2015, p. 178). They suggest that the informed choice process can even become burdensome to individuals and their families.

Houska and Loučka (2019) also caution that the dominant definition of autonomy, as the capacity of individuals to make independent rational choices, might not be suitable for those receiving end-of-life care. They instead suggest there is a need for more nuanced perspectives on autonomy in such cases. The authors conducted a systematic review of the available literature on palliative, or end-of-life, care and found that while maintaining autonomy is a concern of choice and decision-making about care, emphasis should also be placed on supporting people to have autonomy in daily activities, on ‘discussions around dying’ and in contributing to others (Houska & Loučka, 2019, p. 842). The authors refer to this as ‘relational autonomy’, stressing the importance of social relationships and interdependence as a medium through which such autonomy can be shaped instead of being reduced to simple decision-making for ‘passive recipients of care’.

People living in residential care are unable to live according to the ideals of the independent and free decision-maker, meaning traditional concepts of autonomy no longer fit (Sherwin & Winsby 2011; Tolo Heggestad, et al., 2015). Instead, relational autonomy comes from the viewpoint that everyone is interdependent and embedded socially within the structural, social-cultural contexts within which they live, as Mackenzie and Stoljar explain:

> *‘The self-determining self is continually remaking itself in response to relationships that are seldom static.’* (Mackenzie & Stoljar, 2000, p. 240)

Autonomy in end-of-life care is also a key feature of Gómez-Vírseda et al.’s (2019) systematic review of bioethics focused literature. The authors highlight that despite respect for autonomy being a core concept across end-of-life ethics, the individualistic interpretation currently applied to autonomy is being challenged. They highlight how numerous authors claim that autonomy needs to be '*reconceptualised from a relational viewpoint'* while emphasising the need to clarify what relational autonomy might look like in practice (Gómez-Vírseda et al., 2019, p.1). The authors caution that relational autonomy emerges more as a 'reaction against' the individualistic interpretation of autonomy, rather than it being touted as a standalone positive concept within medical and end-of-life ethics. This is an interesting thought when applied to relationship-based practice in social work and social care, given it is widely acknowledged that the approach has emerged as a reaction to increasingly individualistic and managerialist practice. Gómez-Vírseda et al. (2019, p.13) go on to describe relational autonomy as a rich and complex concept, coming from a variety of *'diverse philosophical sources'.*

Dignity, autonomy, and independence are described as core concepts within nursing care. Tolo Heggestad et al. (2015) conducted a qualitative research study into the understanding of dignity and autonomy with 28 residents across six residential settings in Sweden, Norway, and Denmark. The researchers found that negative views about dependence and institutional frames within residential settings, along with negative attitudes by staff, can diminish independence leading to a lack of autonomy. Tolo Heggestad, et al. (2015, p. 11) explained their findings demonstrated that dignity '*comes into play'* at different levels across residents' lives. The cultural level is described as where, in Western society, independence is thought of as a key value related to dignity. The system level is described by the researchers as the institutional structures and routines within which they live, with the 'lowest' level being described as the social, or relational, level where the resident is supported by the professionals via relationships.

The researchers suggest the term relational autonomy may cover all three levels and explain that respecting autonomy within such contexts means respecting residents' rights to make significant decisions regarding their everyday lives, so they can *'live in accordance with their will and their values'* (Tolo Heggestad, et al., 2015, p.11). Tolo Heggestad, et al. (2015) further explain that it is not dependence and vulnerability threatening people's autonomy and dignity, but it is instead the sociocultural context and the institutional structures within the residential settings potentially undermining people's opportunities to exercise their autonomy. They argue that focus should not only be placed on what happens within caring relationships but also should seriously consider how cultural and organisational frameworks impact experiences of autonomy and dignity.

3.4.1 Independence vs. interdependence

The literature search into independence highlighted a body of research focusing on the interplay between independence and interdependence in the care of older people. This body of literature was felt to be of relevance when considering the role interdependence plays in relationships, and the potential learning for relationship-based practice. Throughout the following paragraphs, the concepts of independence, interdependence, collectivism and individualism will be explored through the literature. It must be noted that the terms are often used synonymously, with interdependence and collectivism being concepts that are hard to distinguish from each other. When discussing studies, the terms used will be the terms the authors use to define their topic of study, but it is important to note the overlapping and often synonymous nature of the terms. Independence is defined as:

> *'The condition or quality of being independent; the fact of not depending on another'.* (Oxford English Dictionary [OED], 2021a)

Whereas interdependence is defined as:

> *'The fact or condition of depending each upon the other; mutual dependence'.* (Oxford English Dictionary [OED], 2021b)

McCabe et al. (2021) explain older people often face multiple challenges, particularly around independence and self-determination when transitioning into residential care settings. They conducted research to explore the resident-staff relationship and resident choice through quality-of-life measures with 601 residents across residential care settings in Australia. McCabe et al. (2021, p.1748) found variables of choice in care provision and activities of daily living '*significantly correlated'* with resident quality of life, yet interestingly, they found neither of these variables contributed significantly to quality of life when the staff-resident relationship was included in the model. Their findings demonstrate the importance of positive staff and resident relationships, above other aspects of their lives, including autonomy. These findings link with thought around independence and interdependence, concepts that are in direct opposition. Fitzpatrick and Tzouvara (2018) conducted a review of research covering care home transition in the UK, to explore facilitators and inhibitors to successful transitions into residential care. The review highlighted the importance of interpersonal connections, and for residents to feel like they are 'home', fostering a sense of belonging.

Leece and Peace (2009) caution the contested nature of the term 'independent' often results in a lack of clarity in care-focused literature on whether it refers to people's ability to exert independence through decision-making, or their ability to self-care. Interdependence is a concept that underlies all social interactions, yet people rarely have objective awareness or knowledge of that interdependence (Gerpott et al., 2018). Orehek and Kruglanksi (2018) describe a perennial puzzle in human behaviour as readiness to give up their individual needs for social cooperation to connect with groups, explaining that a core feature of human nature is the ongoing tension between independence and interdependence, explaining that the extent to which they place value on these concepts differs between individuals and society. Baumeister and Leary (1995) use the term 'belonging' to describe this core feature of human nature, the desire for interconnectedness. They describe the belongingness hypothesis as follows:

> *'Human beings have a pervasive drive to form and maintain at least a minimum quantity of lasting, positive, and significant interpersonal relationships.'* (Baumeister & Leary, 1995, p. 497)

Through this hypothesis, the authors explain that interactions need to show positive caring for them to be meaningful, explaining that not all relationship bonds can satisfy the human desire to belong. Baumeister and Leary (1995) explain that they look specifically for the mutual nature of the bonds and that mutuality is good for relationships, giving the example that research conducted by Baumeister and Wotman

(1992 in Baumeister & Leary, 1995) found that love is highly satisfying and desirable only in circumstances where it is mutual.

Belonging and love are needs which, argue, when unmet increase the burden on caregivers for people with dementia. The authors conducted a narrative review of the literature exploring quality of life measures for people with dementia in relation to Maslow's hierarchy of needs. Maslow's 1943 features belonging as one of the basic human requirements. Schölzel-Dorenbos et al. (2010, p. 117) suggest that *'behaviours associated with dementia may be expressions of unmet needs or goals'* and that identification of these needs could influence a framework for supporting older people with dementia.

Orehek and Kruglanski (2018 p. 1) explain that interdependence, while requiring submission to social constraints also offers 'empowerment through coalition'. Conversely, while independence enables freedom *'it also imposes individual responsibility for attained outcomes whether good or bad'* (Orehek & Kruglanski, 2018, p. 1). This description of independence is what relationship-based practice is argued to be a reaction to, a move away from individualistic social policies and ideologies of previous decades. The authors conducted research into personal failure, or a 'bad' outcome, through a quantitative study across two cultural contexts American (Western), and Egypt, Pakistan, and Indonesia (non-Western), finding that failure prompts a shift towards interdependence. The researchers defined failure by asking participants to scale their personal success. They found that when individuals experience personal hardship, they '*may be more likely to turn to their close others, community, tribe, nation, and religion to help them feel stronger and more valuable'* (Orehek & Kruglanski, 2018, p. 10). Conversely, when individuals experience personal success, they may be *'more likely to claim personal responsibility and exhibit independence'* (Orehek & Kruglanski, 2018, p. 10). The authors attribute this to the cultural shift towards independence in more prosperous societies, yet caution more research is required to tease out these links.

Krys et al. (2019) in their research on societal well-being's impact on individualism warn against conceptualising well-being as individual life satisfaction explaining it is a form of well-being which has its origins in Western research and thinking. They offer a Korean proverb as an example of other cultures' approaches to collectivist thoughts around well-being and happiness:

> *'There is no winter without snow, no spring without sunshine, and no happiness without companions.'* (Krys et al., 2019, p. 256)

Through their research with 2,036 participants across 12 countries, Krys et al. found support for the association between '*individual life satisfaction and individualism on a societal level'* yet demonstrated that *'well-being's association with individualism is attenuated when some collectivism-themed measures of well-being are considered'* (Krys et al., 2019, p. 256).

Oyserman and Lee conducted a cross-national search into the literature on independence and interdependence in 2008. They found that cross-national studies showed differences in how the self is defined, how individuals define and interpret their relationships with others and what is valued, in line with individualist and collectivist frameworks. Oyserman and Lee (2008) argue this is important as it demonstrates the difference between real groups, and those differences appear consistent with the hypothesised effects of collectivism and individualism. Gardner et al. (1999, p. 321) pointed out a clear distinction between Western and Eastern cultures is the extent to which people in those cultures define themselves '*in relation to others'*. They frame this as individualism versus collectivism, and independence versus interdependence (Gardner et al., 1999). The authors explain this is based on the extent to which the 'self' is seen as embedded within a larger social network or is viewed as autonomous and unique (Gardner et al., 1999, p. 321). The authors purport that cultural beliefs shape self-constructs, which is an unquestioned concept, yet caution it is an oversimplification to assume that the independence versus interdependence distinction has replicable implications for human behaviour across cultural boundaries.

Panthi (2022) conducted an in-depth, qualitative study into loneliness and boredom in residential care in New Zealand through 34 interviews with residents and staff. Panthi found that older adults in residential care are lonely and bored, despite policies for person-centred care. Panthi (2022, p.96) attributes the 'often-rushed transition' into residential care as having a negative impact on autonomy. However, Panthi also highlights findings that indicate participation in meaningful activities that provided connection with peers or staff that provided connection or feelings of contribution combatted feelings of loneliness which the author states helped participants maintain and develop autonomy and self-determination. The research findings do not make it clear how such connectedness and purpose contribute to independence and autonomy. Perhaps it would be more logical to consider whether the relationships and purpose found in them are instead providing benefits which attenuate loneliness through interdependence and relational autonomy.

Heu et al. (2019) explored loneliness and its relationship with collectivism through a quantitative survey completed study across five European countries. The researchers acknowledge that loneliness is said to differ between collectivist and individualist countries, yet little is known about individual level collectivism, which they describe as perceiving one's social environment as collectivist. Their findings suggested that higher levels of individual level collectivism implied higher social embeddedness, with the further suggestion that loneliness could be '*attenuated by such aspects of collectivism'* (Heu et al., 2019, p. 791).

3.5 Social work and social care as professions

The following paragraphs and subsections will explore the literature available on social work and social care as professions, with a particular focus on professional boundaries, identity, and autonomy. Developing an understanding of how both professions engage with these concepts will provide further context for understanding how professional boundaries within residential social care impact the professionals they guide.

3.5.1 Professional boundaries

Historically, as O'Leary et al. (2013) point out, professional boundary guidelines created in the social work field were heavily influenced by the more traditional professional boundary models of the medical profession. However, social work is a profession that works with individuals in their time of need following the breakdown of personal and societal relationships and can involve placing workers in difficult situations. Littlechild explains:

> ‘*Regulatory guidance can be seen to place social workers ‘between a rock and a hard place’, with a fear of not meeting all of the many government requirements set out in the regulations, while at the same time often being personally threatened by families where abuse of children is taking place.’* (Littlechild, 2008, p. 63)

Within the professional relationship, people share highly personal information and feelings, yet their social workers are required to maintain professional distance while limiting personal disclosure. O’Leary et al. (2013, p. 137) argue this is based on the belief that maintaining a psychosocial separation will promote *‘rational objectivity’*. However, as Alexander and Charles (2009) observe, social workers are expected to establish and use relationships with the people they support to create appropriate levels of intimacy to achieve change and goals.

Professional boundaries have a direct impact on how social workers construct and maintain relationships with the people they work with. Coady (2015) explored how practitioners in Scotland navigate relationship boundary decisions, and the individual, organisation and contextual factors that influence them. Using questionnaires with workers practising within residential childcare organisations, this small-scale study indicates that a clear line separating professional and unprofessional behaviour does not exist. Instead finding great complexity exists, involving a range of considerations including need, relationship, context, and professional identity. Coady (2015, p. 88) concluded that professional education is required to increase confidence in resisting ‘dominant discourse around professional detachment’ and ‘pressure to make risk-averse decisions’.

Doel et al. (2010) explored professional boundaries through a combination of scenario responses and telephone interviews with social workers from nine countries (UK, USA, New Zealand, Canada, Australia, South Africa, Sweden and Germany). The research indicated that for some practitioners, boundaries were a clear demarcation between x and y, often '*consistent with a strong view of right and wrong'* (Doel et al., p. 1879). For others, the concept of boundaries was not clear cut, but instead a disputed territory. The authors highlight that *'the relative absence of grey areas, the shadows, in agency policy documentation about professional conduct is in stark contrast to the reality of everyday practice'* (Doel et al., p. 1884).

A smaller-scale study conducted by Sanders et al. (2012) explored the professional boundaries in end-of-life care considerations for hospice social workers and team members in the USA. The findings again highlight the lack of specific protocols and procedures around boundaries for interacting and responding to the needs of patients and families. However, the study found that the participants in this study felt that more specific guidelines would be beneficial to assist them in navigating complex decisions and to prevent practitioners from being 'forced to develop their own protocols' for interactions (Sanders et al., p. 27). The findings of these studies suggest that when faced with complex situations, workers end up interpreting guidelines in ways they see fit to meet the needs of the people they serve. Yet this requirement to practice within the 'grey' areas also leads to anxiety for workers around whether they are breaking the rules and might be subject to litigation.

3.5.2 Professional identity

The increase in managerialism and reduction in the role of social workers discussed previously in this chapter has been attributed to the '*reduction in the professional status of social work with older people'* by Lymbery (1998, p. 864). This is particularly visible in adult services where social work tasks are often completed by 'care managers', and day-to-day support is provided by social care providers.

In addition to navigating professional boundaries within the social work profession, the literature search highlighted a body of research exploring the issue of professional boundaries between different professions and the impact of professional identity. As social workers are increasingly practicing within multi-disciplinary settings and are required to effectively communicate with professionals from a range of backgrounds, how social workers construct their professional identity and navigate any territorial issues is key to successful interventions. Abendstern et al. (2011) explored integration in the assessment of older people with health and social care needs. The quantitative study used a data set of 76 respondents to a national survey and found that for timely and effective services for older people, accurate information needs to be shared more effectively between the separate health and social care institutions in England.

McLaughlin (2016) conducted a small-scale exploratory study of hospital social work. The results indicate that hospital social workers are highly valued by patients for their responsiveness, emotional support, and practical help during the process of hospitalisation. The study explored the perceptions of social workers by their colleagues. The findings indicate healthcare professionals value hospital social workers for their assessment skills and commitment to patient care, while community-based colleagues perceived them as being particularly skilled in inter-disciplinary working and collaboration.

Abendstern et al. (2016) conducted interviews with multi-disciplinary staff from Community Mental Health Teams (CMHTs) for older people. The qualitative study explored the impact of the absence or presence of social workers on team functioning. Non social work CMHT staff were found to place a high value on social workers in the team due to their specific skills, knowledge, and values. Sims (2011) conducted a mixed-method study with practitioners who qualified from joint training programs in learning disability nursing and social work to explore concepts of professional identity. The results indicate that a key feature of professional identity is influenced by personal perception of the profession, in combination with education and professional socialisation.

Staniforth et al. (2011) analysed 300 social workers' responses regarding professional identity and definition in New Zealand. The findings indicate that social work identity is highly socially constructed, with workers increasingly identifying practice in line with a postmodern view of social work practice, incorporating strengths-based approaches. Leigh (2013) explored the process of professionalisation through a small-scale qualitative study into how child protection social workers might construct their professional identity. The findings indicate that for the participants, social work is more than a job, transcending into personal relationships and merging professional and personal identities. An impact of this is that when subject to criticism, their agency is weakened. The concept of professional identity being linked to personal agency and happiness was explored by research conducted in Canada by Graham and Shier (2010). The small-scale qualitative interview found social work principles; identity formation and a positive connection with the profession can contribute to happiness.

Professional identity construction is highly individualised and subject to change. Although research on how social work practitioners navigate intra-professional boundaries is limited, there exists a body of literature exploring the issues between health professionals of differing backgrounds where the findings can be tentatively applied to similar boundary issues between health and social care workers (Huby et al, 2014; Liberati et al., 2016; Powell & Davies, 2012).

Huby et al. (2014) conducted a qualitative study with health practitioners while a reconfiguration of services took place in England and Wales. The researchers found professional boundaries that underpin professional identity were beneficial, however also produced inequalities that could prevent some groups of professionals from participating fully. A further qualitative study by Powell and Davies (2012) found that professionals resisted attempts to standardise procedures for different professionals and that a substantial amount of time was spent negotiating between different professions.

The concept of interprofessional boundaries hindering decision-making was correlated with findings from an ethnographic study conducted by Liberati et al. (2016). Their research explored the boundaries that existed between professions in a multi-disciplinary setting in Italy. The authors highlighted that effective interdisciplinary work requires bridging of boundaries but acknowledges this can be a challenge when different professional groups are perceived as having varying levels of power. These studies highlight the importance of having a clear professional identity when navigating boundaries between different professions. Although social work is well established as a profession, the struggle remains regarding a lack of recognition and respect from other professions and the public (Lymbery, 1998).

3.5.3 Professional autonomy

Both-Nwabuwe et al. (2020) explored the importance of professional autonomy from the lens of nursing professionals, putting forward a theoretical framework through which the benefits of professional autonomy can be understood. The authors define professional autonomy as:

> *'The freedom to act on one's knowledge base without the need for permission of some authority'* (Both-Nwabuwe et al., 2020, p. 107)

The authors point out that if professional autonomy is not supported by authorities or employers, those professionals do not really have autonomy. They discuss the positive outcomes of nurses having true professional autonomy in terms of being able to work in accordance with their values, and with integrity allowing them to achieve 'self-concordance'.

Rogowski (2012) argues the recent changes to social work practice have resulted in de-professionalisation because of the predominant concerns of encouraging managerialism and marketisation. The profession is in danger of losing sight of its core values and purpose, including the uniqueness of the social-centred style of intervention and suggests 'social workers should be wary about encouraging this process because there is a real danger of hastening the demise of a social work identity' (Rogowski, 2012, p. 927). When this argument is combined with the evidence that the impact of job satisfaction of social workers transcends from their professional to personal lives (Graham & Shier, 2010; Leigh, 2013) it is important to ensure that these issues are addressed, particularly considering the knowledge that high staff turnover negatively impacts on the ability of social workers to form meaningful relationships with the people they work with. The influence of managerialism on social work practice is of concern as it has led to an increase in the bureaucratic, administrative tasks that social workers are required to complete and a reduction in professional autonomy. Jacobs et al. (2011) argue this is therefore taking time away from direct work with people, limiting their ability to perform the more therapeutic aspects of their role and hindering the ability to form meaningful relationships.

3.5.4 Professionalism

Professionalism is a foundational concept that incorporates the subject points discussed above, professional identity, autonomy and ethical boundaries, to describe how individuals within specific professions conduct themselves and interact with others. Professionalism encompasses a set of qualities, behaviours, and ethical standards expected in their roles. Central to professionalism is adherence to ethical codes that outline acceptable conduct and integrity, in addition to the requirement to keep up to date with research and practice (Reamer, 2013, p. 61). These codes serve as guiding principles that professionals uphold in their interactions with the people they support, colleagues, and the public.

Professionalism in social work goes beyond theoretical knowledge by emphasising the importance of practical, hands-on experience through practice learning, emphasising the importance of integrating real-world experiences to develop essential skills such as empathy, communication, and ethical decision-making; key components of professionalism (McNay et al, 2012). The title ‘social worker’ is protected, requiring specific qualification through a social work degree in the UK (Social Care Wales., 2024). McNay et al (2012) explain the evolving nature of professionalism in social work, acknowledging the dynamic and changing landscape of practice and the ongoing need for practitioners to adapt and grow professionally.

Although the literature on professionalism focuses on social work, these understandings can also be applied to social care workers in residential settings. Social care workers are also required to practice within ethical boundaries, ensuring interactions are conducted with integrity and trust, and although currently there is no mandatory requirement to adhere to a code of conduct in Wales, the code of conduct exists and outlines the code of conduct which social care workers must work to (Social Care Wales, 2017).

3.5.5 The difference between social work and social care

In the UK, social work and social care are two distinct yet interrelated fields within social services. As previously discussed, social work is a profession that requires specific qualifications and registration with regulatory bodies, such as the Social Care Wales. Social workers are trained to assess and intervene in the lives of individuals and families facing challenges such as child protection issues, adult safeguarding and mental health. They provide direct support, advocacy, and coordinate services to promote well-being and ensure safety within statutory frameworks.

Social care, however, encompasses a broad range of services aimed at supporting individuals who require assistance with daily living tasks, maintaining independence, or accessing community resources. The key distinction lies in professional status and scope of practice. Social work is a regulated profession with a defined set of responsibilities and ethical guidelines, focusing on assessment, intervention, and advocacy within legal frameworks (Social Care Wales 2024). Social workers often engage in complex cases requiring specialist knowledge and skills in safeguarding vulnerable individuals and families. In contrast, social care encompasses a wider spectrum of practical support and services aimed at enhancing quality of life and meeting the daily needs of individuals across different stages of life and circumstances (Carey, 2015; Social Care Wales, 2017). While social work involves professional assessment and statutory responsibilities, social care provides essential practical support, including intimate and personal care Carey, 2015; Social Care Wales, 2017; Social Care Wales, 2024).

‘Conceptualising body work in health and social care’ explores the physical and emotional labour inherent in the requirements of the social care role (Twigg et al., 2011). Care workers engage in direct physical tasks such as lifting, bathing, and assisting with mobility, which are integral to maintaining the well-being and independence of the people they support. Beyond these physical activities, Twigg et al. suggest that 'body work' also encompasses the emotional labour of managing both their emotions and the emotions of the people they support, to navigate intimate care with professionalism. Twigg et al. (2011) highlight how these aspects of 'body work' challenge traditional boundaries between the personal and professional, emphasising the skilled nature of care work and calling for greater acknowledgement and support for the physical and emotional demands placed on social care workers.

3.6 Current culture and context

The third question this study seeks to answer relates to what would need to change in current practice culture and context to support the implementation of any changes needed to embed effective relationship-based practice. This thesis has been written as part of a part-time PhD, punctuated by two periods of maternity leave. When this question was written, the number of changes to the practice culture and context could never have been envisioned. Since the PhD’s inception, these changes have included:

- A change in government from a Conservative and Lib Dem coalition government to a Conservative government.
- Five changes in Prime Ministers (GOV.UK, 2023).
- The UK voted to leave the EU in the referendum.
- The UK left the EU.
- A global pandemic due to COVID-19, which disproportionately affected the participants of this study (Office for National Statistics, 2023).
- The UK has experienced (and still is experiencing) a cost-of-living crisis (UK Parliament, 2023).

The impact these changes will have had on the practice context and culture of social care in the UK will be explored over the ensuing pages. They will be discussed in specific relation to residential care, exploring the impact of the wider socioeconomic and political environment on the sector.

3.6.1 Austerity and the status of care work

The definition of austerity in the context of this thesis is as follows:

> *'Restraint in public spending;* spec. *a programme of government measures designed to reduce public spending and conserve resources, esp. during a time of economic hardship; the conditions resulting from such measures.'* (Oxford English Dictionary [OED], 2023c)

Austerity measures were introduced across Europe following the global recession that happened in 2007, as a means for governments to reduce national debt. As Stuckler (2017) highlight, there are two options for achieving debt reduction. These are to promote economic growth or to reduce government spending to make funds available for debt repayment. Stuckler et al. (2017) highlight that austerity measures have included reduced social spending and increased taxation, which has resulted in both direct and indirect consequences for health and social care. Indirect consequences include socioeconomic factors such as increased poverty and unemployment, while direct consequences include restrictions on access to care.

The impact of austerity measures on the social care budget in the UK has been severe (The King's Fund, 2022). MacDonald and Morgan (2020) conducted a literature review exploring the effects of austerity measures in the United Kingdom, revealing significant reductions in health and social care for disabled, older, and immigrant populations due to stricter government definitions and policies. Their findings indicate that these vulnerable groups face increased challenges in accessing necessary services, exacerbating their marginalisation and negatively impacting their well-being. Glasby et al. (2021) argue that the past decade's austerity measures have severely weakened the adult social care system in England. However, the authors point out that expenditure cuts are seen as more acceptable by the general population when applied to older people than those of working age, which they suggest is a product of the ageist attitudes and assumptions about the role and needs of older people.

In England, Wales, and Scotland, local authorities are legally responsible for adult social care, funded by central grants and local revenue sources like council tax. In contrast, in Northern Ireland, health and social care trusts manage this responsibility due to their integrated health and social care system (Dosworth & Oung, 2023). despite seeking to protect it from cuts, spending has not kept up with needs. The King's Fund (2023) points out that, despite efforts to protect adult social care from cuts, spending has not kept up with needs. As a result, the current social care system faces high levels of unmet needs, providers struggling to deliver quality care for the prices paid, delayed discharges from hospitals, and a workforce crisis (The King's Fund, 2023).

3.6.2 COVID- 19

The introduction of this chapter highlighted the timeframe within which this thesis' data collection took place. The observations and focus groups were conducted between December 2019 and March 2020, unfortunately having to cease due to COVID-19 restrictions introduced in March. While the pandemic and resultant lockdowns did not have an impact on the data collected, in the months and years that followed it will have undoubtedly had a significant impact on the lives of the participants, and is known to have had a significant impact on the residential care sector, both globally and in the UK (Jordan et al., 2020; Nyashanu et al., 2022; Schrack et al., 2022; Sweeney et al., 2022).

The pandemic disproportionately affected older people, with the majority of COVID-19 related deaths (86%) in the UK reported amongst people aged 65 and over, with 39% of these occurring in people aged over 85 (Office for National Statistics, 2023). Furthermore, across the UK, residential care settings reported large and sustained outbreaks with high fatality rates (Jordan et al., 2020). The number of deaths of care home residents involving COVID-19 from 14th March 2020 to 21st January 2022 across England and Wales was 42,189. 92.5% of these were confirmed COVID-19, and the remainder were suspected cases (Office for National Statistics, 2022). It would be remiss not to contextualise the findings of this thesis in the aftermath of the COVID-19 pandemic.

Suárez-González et al. (2020) collected data on the impact and mortality of COVID-19 in people living with dementia across 9 countries, including the UK. The authors reported that people with dementia account for 25% of all COVID-19 related deaths in England and Wales. They went on to explain that in many places, the basic human rights of people with dementia may have been compromised during the pandemic, including access to hospitals, health care and palliative care. The authors point out that '*the ban on all visits to residential settings kept people with dementia detached from vital relationships and family care provision for many months'* (Suárez-González et al., 2020, p. 2).

Daly (2020) examined the policy response to COVID-19 in care homes for older people in the UK, with a particular focus on England during the first 10 weeks of the pandemic. Through a forensic analysis of policy, Daly found there to be a slow, late, and inadequate response to the risk and reality of COVID-19 in care homes as against that in the NHS. Daly also pointed out that the logistical difficulties experienced by residential settings were exacerbated by long-term austerity measures and the 'weak regulatory tradition of the sector' (Daly, 2020, p. 996).

Sweeney et al. (2022) conducted research in the Republic of Ireland, exploring the COVID-19 pandemic as it was experienced by those on the front line in residential care provision for older people. Through a two-phased mixed methods study consisting of both surveys and interviews, the researchers found isolation, loss of connectedness as well as a reduction in the level and quality of care provision led to significant adverse impacts for residents and their families. They found family input into care was suspended, with negative impacts, and staff reported high levels of burnout and trauma.

Nyashanu et al (2020) also explored the impact of the COVID-19 pandemic on frontline healthcare workers, through forty individual interviews. The researchers found participants felt under pressure to accept patients discharged from hospital without being tested for COVID-19, and some who had tested positive. Also reported were struggles with staff shortages and coping with the deaths of colleagues and residents.

Schrack et al. (2022) used data collected in the US through a National Health and Aging Trends study and compared the results of people aged over 70 with and without dementia in the community and residential care settings. The researchers found that the COVID-19 pandemic had a disproportionate impact on the care needs and well-being of older adults with dementia, particularly in residential care settings. They also found in residential care settings, infection was substantially higher, and social contact less common for those with dementia. They found that unlike those with dementia in the community, nearly all (95%) of older adults in residential care settings lived in places that sopped or highly limited outside visitors. The authors also highlighted findings that suggest people with dementia were less likely to engage in mitigation behaviours such as handwashing, suggesting this is a contributory factor to higher infection rates.

Although most COVID-19 restrictions have now been lifted, the impact of the pandemic on the care home sector was significant and cannot be disregarded when discussing the findings of the research conducted in this thesis. Not only would the participants in this study have suffered the effects of the pandemic very soon after their interviews, but the culture and policy context of the sector is still recovering. The findings of research into the impact of the pandemic can provide learning and insight for relationship-based practice going forward.

3.6.3 COVID-19 policy responses and current practice

Prior to the pandemic, new legislation was released in both England and Wales, with aims to shift policy and practice in social care to a more strengths-based approach. The Care Act 2014 in England also recognises the significance of relationships between service users and carers to ensure effective participation (Dix et al., 2019). The legalisation promotes a strengths-based approach to practice while valuing family input into assessment processes. In Wales, the Social Services and Well-Being (Wales) Act 2014 sets out similar goals and values, promoting a strengths-based approach and co-production with service users.

While the COVID-19 pandemic had a significant impact on society, it is acknowledged that older people, people with dementia, and particularly those living within residential care settings were disproportionately affected (Schrack et al., 2022). Social care staff reported high levels of burnout and trauma (Sweeney et al., 2022). People were kept detached from their families and relationships outside the care home for many months (Suárez-González et al., 2020). The settings in this were still experiencing care home specific lockdowns as recently as January 2022, as managers attempted to contain outbreaks to protect residents from the illness.

The data in this study was collected shortly before the first UK-wide lockdown, so the pandemic does not feature in either the questions or participant responses. However, when considering what needs to change in the current practice culture, the impact of the pandemic with the ongoing effects needs to be taken into consideration. The impact on staff was significant, and many experienced traumas related to the pandemic (Sweeney et al, 2022).

The Department for Health and Social Care released a policy document in 2021 containing plans for England to ‘build back’ health and social care following the pandemic. The Government acknowledged the unprecedented challenge the pandemic has on the sector, referring to it as ‘the worst public health emergency for a century’ (Department for Health and Social Care, 2021). The policy, along with promised additional funding, put forward ambitious suggestions for improvement including the following:

- *[TO] offer choice, control and independence to care users – so that individuals are empowered to make informed decisions and live happier, healthier and more independent lives for longer.* (Department for Health and Social Care, 2021)

- *[TO]provide an outstanding quality of care – where individuals have a seamless experience of an integrated health, care and community system that works together and is delivered by a skilled and valued workforce.* (Department for Health and Social Care, 2021)

In Wales, the Welsh Government put out a new plan for Health and Social Care in 2022. The plan put forward included:

- *Residential care will flex over time, enabling and encouraging people to recover their independence wherever possible……there will be a range of support in different settings, which will be personalised to meet people's needs and preferences. This support will enable and encourage people towards more independence and self-management, but always at a pace and to a degree appropriate to the individual.* (Welsh Government, 2022, p. 9)

- *A holistic approach to supporting health and wellbeing will go beyond providing support services in the home or in residential care. …. For many people the support they need will be delivered by different people working closely together – professional and unpaid carers, family and friends, community volunteers, housing organisations and neighbours, as well as themselves. A whole system approach will enable all of these people and teams to work together, harnessing the full range of community assets, and based on a solid foundation of common values, shared information and mutual respect*. (Welsh Government, 2022, p. 9)

While both government policies focus on the needs and wants of individuals, the Welsh Government plan also puts forward a community and relationship-based approach to supporting people outside of residential care. Although the language remains focused on promoting and preserving independence in parts of the Welsh plans, the shift in policy to a focus on recognising the value of relationships and wider communities is notable (Welsh Government, 2022).

3.7 Conclusion

The topics explored in this chapter provide further depth to the knowledge base informing this study. To truly understand the current culture around relationship-based practice, and social care for older people with dementia, it is vital to understand not only where practice is in the present, but how practice got to where it is. This is especially important when attempting to navigate the policy and cultural context of social work, social care and ageing; fields that are inextricably linked and influenced by their wider political environment. Literature seeking to further understanding of care management and managerialism was explored. This enables the current context of residential care provision to be understood, particularly in relation to the development of professional boundaries.

The impact managerialist approaches have had on social work and social care practice is wide-reaching, and situating this thesis against the backdrop of this knowledge enables the findings to be contextualised and understood. This is important when exploring how professional boundaries in current residential care practice might need to change or adapt to support staff in implementing an effective relationship-based approach to practice. Understanding the history is important in understanding the present, and in exploring what the options might be for the future.

This chapter also explored the literature on autonomy and the related concepts of independence and interdependence. This provides greater understanding to support the thesis in answering questions on how effective relationship-based practice could be supported with older people with dementia through understanding the role the opposing concepts of independence and interdependence play in dementia care. How to successfully balance risk and autonomy has long been a challenge for social care, but relationship-based practice takes this challenge further. The challenge of how the residential care sector can support older people with dementia to develop and maintain relationships with those providing their care, and whether the long upheld ‘ideals’ of autonomy and independence are the right ideals for those living in residential care. Risk, and the tendency in recent decades to engage in risk-avoidant practices, is another key area of understanding required when exploring relationship-based practice. The literature on professional identity in social work and social care, and how this is linked to professional autonomy and boundaries, was also explored in this chapter.

The next chapter will lay out the methodological approach taken to answer the research questions, informed by the literature and research laid out in the two literature review chapters. To allow social care professionals to use their professional judgement will always require embracing a certain level of risk, and even more so when engaging with older people with dementia, a cohort highlighted in this chapter to be viewed as particularly in need of being protected from risk.

The literature in this chapter has provided further understanding against which the findings of this thesis can be contextualised and provides further depth of knowledge around managerialism, professional boundaries, and identity. Where this thesis can contribute to knowledge and understanding in these areas is through developing an understanding of how a relationship-based approach to practice could be applied to residential social care for older people with dementia, and what implications such a practice approach would have on professional boundaries. The findings will be set against current practice and context to seek to further understand the role the professional, in this case, the social care worker, plays in developing, maintaining, and navigating relationships with the people they care for.

Chapter 4 Methodology

4.1 Introduction

To approach the research questions this thesis set out to answer, a case study method was used to collect data across two residential care settings in South Wales. When approaching the design of this study, the first step was to revisit the research questions. A clear understanding of the questions ensured the collection of appropriate and good quality data from which relevant findings could be drawn. The research questions detailed at the outset of this study were:

- How do people living with dementia and social care staff experience relationships in residential social care homes?
- How could knowledge of how effective relationship-based care is delivered in residential settings shape professional boundaries?
- How might residential care’s culture and practice need to evolve to support relationship-based practice?

To answer the question of how effective relationship-based practice is experienced by people with dementia and social care staff, a constructivist approach to a case study method was chosen to provide the structure for data collection. The decision-making processes behind the selection of this approach are explored in greater detail over the remainder of this chapter, alongside further explanation of each of the ontological and epistemological concepts and methods. This chapter also explains how the chosen method was applied, exploring ethical considerations and the practicalities of data collection.

4.2 Qualitative vs quantitative research

Social research methodology can be divided into main approaches based upon different belief systems, or paradigms. These approaches are, broadly, qualitative, and quantitative. Quantitative research generally explores numbers and quantities, while qualitative research seeks to discover and describe what people do in their day-to-day lives, and what their interpretation of their actions is (Erickson, 2018). Qualitative research can take on many forms, drawing influence from different beliefs on the social world and how qualitative research should look (Ormston et al., 2014). However, qualitative research studies usually seek to answer the ‘how?’ and ‘why?’ questions, as opposed to quantitative studies seeking to answer the ‘how many’ questions (Murphy et al., 1998).

The research questions put forward in this study sought to explore the subjective understanding of how relationships are experienced by people living with dementia and social care staff in residential social care, and how this might impact future practice and professional boundaries. When answering the question ‘how do people living with dementia and social care staff experience relationships in residential social care homes?’ it was not felt it could be sufficiently answered by any quantitative methods. Therefore, qualitative research methods were deemed most appropriate for this research, as the study sought to explore the complex social environment of relationship-based practice. When answering the research questions, it was particularly important to interpret meaningful interactions between people, and what meaning is attributed to those by the participants.

The differences between qualitative research go beyond which methods researchers employ to answer their questions and to the fundamental assumptions and the worldviews that inform them. These assumptions are commonly referred to as paradigms. They are a matter of ontology, or the theory of being, and underpin social research approaches (Guba & Lincoln, 2018). Methodological approaches cannot be thought of as a set of universally applicable rules or instructions. Instead, methodologies are interwoven with particular perspectives and across different disciplines, including sociology and social work (Guba & Lincoln, 2018).

Ontology and epistemology underpin any research approach and thus influence the methodological approach taken by the researcher (Murphy et al., 1998). Ontology concerns the nature of the social world, while epistemology concerns the nature of knowledge and how we can learn information about the social world (Ormston et al., 2014). When applied to this research, the social world being explored is that of the residential care homes within which relationship-based practice is taking place. The world is constructed between individuals interacting with each other in this environment, and their interactions with the environment itself.

4.3 The social construction of reality

This study seeks to explore phenomena associated with people, their relationships, and their geographical situation, with the goal of understanding the meaning and value participants attribute to their interactions with each other. It was therefore determined that the ontological approach best suited to this study was social constructionism. As Guba and Lincoln explain:

> *'Meaning-making activities themselves are of central interest to social constructionists, simply because it is the meaning-making/sense-making/ attributional activities that shape action.'* (Guba & Lincoln, 2018, p. 167)

Everyday life presents itself as a reality interpreted by humankind and is subjectively meaningful to them as a coherent world. It is a world that originates in their thoughts, emotions, and actions, and it is maintained as real by these (Berger & Luckmann, 1991). This is the basis of the theory of social constructionism and is what will be discussed over the coming paragraphs with particular reference to the areas of application to the research topic. Social constructionism owes much to other intellectual and social developments and can be broadly conceived to be part of the 'postmodernist movement' due to its focus on language as a 'constitutive force' and values the interpretation and meaning behind language (Witkins, 2010, p. 16). This research will seek to understand the reality of relationship-based practice by interpreting participants' responses. Using their language to construct their reality and understand their experiences will be approached through a social constructionist lens. As Witkins explains:

> ‘*Social constructionists do not assume a pre-existing world waiting to be discovered. Rather it is through social interchange that what we take as the realities of the world come into being.*’ (Witkins, 2013, p. 17)

Social constructionism looks at organisation and culture as an emergent reality, something that is created by its key players rather than as an external reality that acts upon individuals (Bryman, 2016). While there have been several key thinkers and writers contributing to social constructionist theories, the approach to social constructionism taken in this research has been heavily influenced by the work of Berger and Luckmann (1991).

Berger and Luckmann are sociologists who became known for their work on the sociology of knowledge. Their book ‘The Social Construction of Reality: A Treatise in the Sociology of Knowledge’ played a key role in the development of social constructionism, first published in 1966 (Berger & Luckmann, 1991). The authors’ focus on everyday reality being derived from, and maintained by, social interactions provided a clear framework for developing insights into the research topic – the relationships existing in care homes that enable effective relationship-based practice. As Berger and Luckmann (1991) highlight, people exist within a geographical designation, they use language employed by those within their societies, and they live within a web of human interactions. The reality of everyday life is organised around individuals’ ‘*here of their body’* and ‘*now of their presence’*, however, the reality of everyday life cannot be fully explained by such immediate presences and instead embraces phenomena beyond the ‘here and now’ (Berger & Luckmann, 1991, p 36).

Meaning in life is experienced through continually interacting and communicating with others, with varying meanings, understandings, and interpretations of their world. Language constructs reality through symbolism and symbolic interaction via religion, philosophy, and art; with language not only enabling reference to these concepts but also creating them (Berger & Luckmann, 1991, p 51). This is of particular interest to this study, as individual experiences will need to be gathered to answer questions about what works in relationship-based practice, and why it works for the individual participants involved. While the reality of everyday life is shared with others, the individual knows themselves best no matter how close the relationship is. This requires reflection, language, and knowledge in addition to an appreciation of the cultural and social context within which participants exist.

4.3.1 The social construction of roles and relationships

Of particular relevance to this research is the concept of roles, and how roles are socially constructed within society through exploration of the roles professional carers take on within residential care settings when providing an effective relationship-based practice. Berger and Luckmann (1991, p. 89) explain the '*origins of any institutional order lie in the typification of one's own and others' performances'*. This implies that individuals share '*specific goals and interlocking phases of performance'* (Berger & Luckmann, 1991, p. 89). This has specific implications for self-experience; that during a course of action, there is a self-identification of the self, with the objective sense of action – the individual has been '*socially ascribed to that action'* (Berger & Luckmann, 1991, p. 91). The authors describe how '*a segment of the self'* is objectified in terms of the socially available typifications '*with that segment of the individual being the 'social self''* which is experienced as distinct to, and even confronting, the true self of an individual (Berger & Luckmann, 1991, p. 91).

Roles represent an institutional order, through the performance of a role itself. So, in this case, the carer taking care of residents. The person is not acting on their own, but instead as a 'carer'. Furthermore, the role represents an entire institutional network of conduct and roles; the role of a carer stands in relation to other carers. Through taking on such a role, the professional carer will be '*inducted into areas of socially objectivated knowledge'*, the knowledge of norms, values and even, as Luckmann and Berger (1991, p. 95) point out, emotions.

The carer will have knowledge of the values and attitudes required of their professional role and know when they are required to *'restrain feelings of compassion'* (Berger & Luckmann, 1991, p. 95). Such an understanding of social constructionism and roles will be essential when looking at relationships between professional carers and care home residents. The analysis of roles is particularly important to the sociology of knowledge because it means we can analyse the overarching relationship-based practice taking place within care homes, but also explore how this specific environment is subjectively experienced by those existing within it.

So, when applied to the research topic it requires us to be mindful of the roles the participants play; the social care staff and the residents themselves. Professional carers will adhere to a specific code of conduct, they are employed and therefore must adhere to rules, regulations and standards set out by their employers. In the case of the professionals participating in this research study, they were required to adhere to both their employers' professional code and the Social Care Wales code of professional practice for social care (Social Care Wales, 2017). However, the professionals who participated are also individuals who come into work with their own set of beliefs and backgrounds which will frame their interpretation and approaches of their professional role. It was also crucial to consider the roles of participants in receipt of care. While not a role bound by professional expectations and boundaries, it is still one that individuals will approach with a certain set of beliefs and expectations of what it is to be 'cared for', and what that means to their identity.

A social constructionist approach provides a theoretical lens through which to examine how social care workers might shape and define their professional identities and roles. This perspective views identities not as fixed attributes, but as roles dynamically constructed through social interactions, language use, and cultural contexts. By applying this approach, it is possible to investigate how social care workers negotiate their identities within the complexities of the residential care setting, considering factors such as institutional norms and power dynamics. This could support the exploration of how language, both within professional discourse and interactions with residents, influences the construction and enactment of roles. By highlighting these processes, a social constructionist perspective enhances understanding of how social care workers navigate their professional responsibilities and adapt to evolving demands. A social constructionist approach not only deepens understanding of how social care workers construct their professional identities and roles but also provides a nuanced perspective on how these constructions shape their relationships with older people.

Expanding on the concept of roles, Berger and Luckmann (1991 p. 117) further explore how social constructionism and the consequent '*symbolic universe'* make possible the ordering of different phases of biography. They explain how each biographical phase is legitimated as a mode of existence; to be a child, adolescent, adult, and older person. A person can look back on their past life, with their biography being intelligible to them in such terms. Understanding this approach means we can consider that ageing itself is a socially constructed concept, with identity intrinsically linked with the ageing process (Mortimer & Moen, 2016). Furthermore, a social constructionist understanding of dementia, emphasising the use of language is significant to this research study as in the social processes where social care professionals are involved, meaning is seen as being created when interactions occur between the individuals (Bosco et al., 2019).

Gergen (1995) explains organisations will see reality differently from one another, and those outside of the organisation. The author suggests the '*world looks different within an organisation that it does to those outside'* (Gergen, 1995, p. 46) and that an organisation will establish what it, itself, determines to be '*good'*. Each person develops their own interpretation and from this, it may be viewed that those with power may have greater influence and control over the discourse and thus interpretation of the social world, in this case, the residential care home setting. This is particularly pertinent when considering the question of professional boundaries within the residential care setting, and their implication for practice. Understanding that what the organisation determines as 'right' may differ from what those practicing within it would view as 'right'.

4.3.2 Situating this study

The research seeks to find out how effective relationship-based practice is supported in residential social care for people living with dementia. While such a question could lead a researcher towards a more positivistic observational approach, when looking in further detail and the context of the question, the ‘what’ the question is exploring is relationships between people in certain times and contexts. It was felt social constructionism would be the ontological framework best suited to exploring this question, ensuring the findings of the study were able to answer the subsequent questions of how professional boundaries might be shaped and what changes might be required in today’s culture and context.

Social research does not take place in a vacuum. The theories that social researchers employ to assist them in navigating the social world influence what is researched and how those findings are interpreted. Existing knowledge in the area of study forms an important part of the background within which the research occurs (Bryman, 2016, p.4). Additionally, beyond existing knowledge, the position of the researcher in relation to the research is critical when approaching research from a social constructionist paradigm.

Reflective practice is essential. Reflexivity is the process of reflecting critically on the self as the researcher; and the human as the instrument (Guba & Lincoln, 2018). It is a conscious experiencing of the self as both enquirer and responder, thus requiring the researcher to come to terms with the choice of the research question, the way they engage in the research process, and the identity taken on in the research setting (Lincoln et al., 2018).

While social constructionism has been defined in numerous different ways, essentially it is an ontological approach that assumes that knowledge is developed (constructed) through human interaction (Berger & Luckmann, 1991). That is, through humans’ interactions with one another but also more broadly through interaction with their geographical, social, cultural, and political contexts. This research explored the roles of professional carers within residential settings, and how they could provide an effective relationship-based practice; a role that the participants take on specifically within the care home setting. But more than that, the research explored the practice’s impact on people living with dementia in these settings. While the residents were the recipients of this care, they were not passive recipients. They had taken on the ‘role’ of the cared for while also coming into the care home setting with a history of very different roles in their past lives. This will have impacted the residents ‘now’, their frame of reference for their ‘now’, and ultimately how they experience relationships with both fellow residents and staff in the residential social care home.

It is essential to note at this point that, I as the researcher have been a social care worker myself, within a residential care home setting. I have also practiced as a qualified social worker within statutory child protection teams and have worked in the third sector with people with dementia. Thus, I came into this study as a researcher with both knowledge and experience in the areas being researched. My own experience as a social care worker was not a positive one, and it was essential to reflect upon my personal experiences and how those may have influenced and shaped my research practice, highlighted by Elo et al. (2014) as being key to minimising bias.

Maintaining researcher reflexivity within the framework of social constructionism involves continuously acknowledging and critically examining one's own perspectives, experiences, and biases throughout the research process. In this context, as a researcher entering the study with prior knowledge and personal experience in the areas under investigation—specifically as a social care worker with a negative experience—it was imperative to reflect deeply on these personal experiences. Elo et al. (2014) emphasise the significance of this introspection in minimising bias and enhancing the validity of qualitative research.

Reflexivity in this study involved actively questioning how my past experiences in social work and social care might shape my interpretations, choices of research methods, and interactions with participants. Social constructionism emphasises that knowledge and meaning are not objective truths but are instead socially constructed through interactions and interpretations. This process included maintaining awareness of potential biases, such as assumptions about social care practices or preconceived notions about the experiences of participants based on my own encounters. By engaging in reflexivity, I aimed to navigate the delicate balance between drawing on my expertise to inform the study while remaining open to new insights and interpretations that emerged from the data.

While a social constructionist approach offers valuable insights, it also poses challenges. Social constructionism is criticised for emphasising subjective interpretations and relativism, which is suggested to lead to a lack of clarity and consistency in understanding. Critics also suggest that while the theory acknowledges that people and groups define social reality, it does not fully address how change is enacted through human activity (Andrews, 2012). However, despite these criticisms, social constructionism focuses on the significance of daily interactions, the use of language in shaping reality, and the social practices people engage in. This makes it an appropriate theoretical approach to this study, which will be used in conjunction with an ethics of care framework. The latter is the focus of the next section of this chapter.

4.4 Ethics of care

The epistemological approach informing this research is 'ethics of care'. Epistemology provides a framework through which knowledge can be both understood and gained. Ethics of care provides a basis to understand care, power and morality which was deemed particularly appropriate when approaching the collection of data to answer the research questions set out in this thesis (Tronto 1993, 2013; Edwards & Brannelly, 2017). The ethics of care is heavily influenced by Joan Tronto's book 'Moral Boundaries: A Political Argument for an Ethics of Care' (1993). While there have been subsequent critiques, the applications of her groundbreaking work in 1993 are still relevant now through approaches to policies and practices (Hankivsky, 2014; Held, 2010). It is a philosophical approach to social work and care which Hollinrake (2019, p. 17) suggests '*connects well with a relationship-based approach to social work with adults using services.'*

Thought on ethics of care has evolved over recent decades, with various contributions to the discussion helping to shape how ethics of care can be applied today. Earliest works describing the ethics of care include Carol Gilligan's work liking care to woman's morality, particularly regarding mothering and nurturing activities and firmly placing ethics of care within feminist thinking (Gilligan, 1982). The feminist approach of ethics of care differs from more traditional, masculine approaches to morality through scepticism of the reliance on reason and rationalist application of rules (Held, 2010). Critique of Gilligan's approach followed with a second wave of theorising on the topic, led by Tronto's 1993 body of work, establishing the importance of care as both a moral and political concept (Hankivsky, 2014; Tronto, 1993).

Thus, ethics of care allows for individuals to be situated and contextualised within their socio-political and cultural environments (Held, 2010; Tronto, 1993). Tronto's (2013) second iteration of ethics of care provides a framework for an in-depth exploration and analysis of power imbalanced relations, highlighting and navigating the moral responsibilities of all engaged. The focus of ethics of care as an approach to morality focuses on the needs of people within relationships, valuing growth and moving towards supporting those being 'cared for' to develop within the context of their self-defined needs (Edwards & Brannelly, 2017; Gilligan, 1982).

The research questions sought to develop an understanding of professional caring relationships between residential care workers and residents. By approaching this with an understanding of ethics of care, the wider political, social, and economic context of care provision could be better understood, along with the impact on those being 'cared for'. The framework can evaluate relationships that exist between families, friends and groups while simultaneously understanding larger-scale political and social relationships (Held, 2010). Such understanding is key to understanding findings and interpreting them in a way that can answer questions based on professional boundaries and practice culture and context. Thus, the ethics of care and its focus on understanding the nuances in professional caring relationships and practice means that it can provide a suitable framework for understanding the data gathered during this research.

Particularly pertinent to this thesis exploring relationship-based approaches of care, is the pursuit of ethics of care to explore what exactly care is. Tronto (1993) explained that while care consumes much of human activity, not all human activity is care. Care is a common word deeply embedded in everyday language, while often described as a necessary relationship between two individuals, individuals can also care for themselves and even objects (Tronto, 1993). Within ethics of care, the relationships of central importance are caring relationships between people (Held, 2010).

Care can describe a relationship, but it can also describe a process. It is ongoing, rarely consisting of a single interaction and it is important to include receiving care as an element of the caring process because understanding the views of those in receipt of care '*provides the only way of knowing that caring needs have actually been met'* (Tronto, 1993, p108). The ethics of care provides a framework to understand the value and necessity of the labour of caring, emphasising the importance of empathy, sensitivity and trust while also being aware of interdependency and relationship-based ethics (Graham, 2007; Held, 2010). The ethics of care writers have transformed the nature of care and provided insights into professional caring practice (Orme, 2002).

Criticisms of ethics of care include questions of whether it is inclusive enough or whether differences amongst women or those providing care have been disregarded (Graham, 2007). Concerns have been raised regarding the conceptualisation of care by ethics of care theorists allowing class and race to be marginalised and perpetuating heterosexual normativity through the description of caring relationships (Graham, 2007; Puka, 1990; Houston, 1990). The issues of class, lower-paid care labour and the cultural differences between areas of Wales were all topics that came up in the interviews that Tronto's (1993) writings on the ethics of care alone would perhaps struggle to address. As Bartlett and Connor explain:

> *'" Caring interactions" are initiated by care staff – usually female, often the most poorly paid, poorly educated and most marginalised group – within an organisational context often driven by for-profit, task-based priorities.'* (Bartlett & Connor, 2010, p. 24).

Virginia Held (2010) questioned whether the ethics of care can handle violence and abuse within caring relationships when either the carer or cared for exhibits abusive behaviour towards the other. Considering these criticisms, Olena Hankivsky (2014) puts forward a framework for an ethics of care that incorporates the theoretical paradigm of intersectionality. Intersectionality is a framework offering a robust way to understand the importance of intersections of difference and their interplay with power (Hankivsky, 2014).

Hankivsky explains how care ethics can benefit from the theoretical insights offered by intersectionality, and for ethics of care to continue to contribute to meeting the needs of people and their social problems, the social contexts, experiences of inequalities and differences between people need to be considered. This cross-over with theories of intersectionality ensures that the ethics of care remains a suitable framework for understanding the professional caring relationships in this research. However, when other writers' critiques and contributions to the ethics of care body of literature are incorporated, they aid in understanding the wider context within which the caring relationships in this study occur.

Important to the research focus on relationship-based approaches to care is the focus feminist ethics of care places on interdependence within relationships, and the power relationships hold based on empathy, respect, and responsiveness' (Hollinrake, 2019, p. 18). As Hollinrake explains:

> *'Both reject the notion of the autonomous, independent human being and stress interdependence.'* (Hollinrake, 2019, p. 17)

4.5 Case Study Method

The use of case studies was deemed the most appropriate method to answer the main questions of how relationships are experienced by residents and staff in residential social care homes. Case study methodology explores how these relate to a case-based enquiry, however, there is no single definition or understanding of what constitutes a 'case' or 'case study' within social research (Schwandt & Gates, 2018). Additionally, the research techniques which come under case studies are varied and can include both qualitative and quantitative methods. In the simplest form, a case is an incident or a unit of something and can be anything (Schwandt & Gates, 2018). As Stake (2018) highlights, a case study design is defined by an interest in individual cases and what can be learnt from specific cases. A case study, then, is '*an empirical inquiry that investigates a contemporary phenomenon (the 'case') in depth and within its real-world context"* (Yin, 2018, p.16).

The advantage of case study design is that a focus on a set of research cases allows the researcher to deal with the subtleties and intricacies of complex social situations, relationships and social processes in a way that cannot be achieved through other methods (Denscombe, 2010). As Denscombe explains:

> *'Relationships and processes within social settings tend to be interconnected and interrelated. To understand one thing it is necessary to understand many others and, crucially, how the various parts are linked. The case study approach works well here because it offers more chance than the survey approach of going into sufficient detail to unravel the complexities of a given situation.'* (Denscombe, 2010, p. 53)

This research study aimed to gain contextual and in-depth knowledge about relationship-based approaches to care for people living with dementia in residential care settings. Denscombe's explanation of case study's suitability for understanding relationships in social settings reinforces the method as a suitable choice in this thesis. Employing a case study approach enabled key meanings and characteristics behind interactions and within relationships to be studied. People living with dementia, particularly in the mid to late stages are underrepresented in research, however, the use of case studies meant that the research would consider not just the voice and perspective of the participants, but also the interactions between them and those around them. As Tellis (1997, p. 8) states, case studies '*give a voice to the powerless and voiceless'*.

To best answer the research questions outlined in this thesis, it was determined that collective, instrumental case studies would be undertaken in key settings. Service providers identified these settings as exemplifying positive practice where meaningful relationships are fostered between people receiving care, their families, and professionals. For this study, the terms 'people receiving care' and 'social care professionals' are used to describe the two groups of participants. The 'case' in the context of this research project is a setting where people with dementia are supported by social work and social care professionals. This encapsulates the physical environment, the individuals living and working within it and the relationships that exist between individuals. Stake (2018) points out, that the selection process in multi-case studies often begins with cases already at least partially identified and the challenge is to discover commonalities and differences. This is particularly relevant to this study, as it sought to explore the commonalities between sites known to demonstrate positive examples of relationship-based practice.

A collective case study involves the exploration of multiple instrumental case studies. The case study approach also allowed for the use of a variety of research data collection methods, such as interviews and observations, to capture the meanings which the participants attributed to relationships and care provision. Data was collected through a variety of evidence sources, including direct observation, interviews, open discussion and through study of available organisational documentation. Instead of solely relying on interview data, which depends on the subjective recall of participants, direct observations enabled the observation of practice in context. However, the option to conduct a case study over ethnographic research was taken as it was felt that the addition of interview data would enrich results, providing the opportunity to pose questions shaped by the direct observation phase of the research, thus providing the opportunity to elicit what elements of relationships and practice are important to participants, amongst other questions. This multi-method approach to data collection ensured a rich data set was obtained for analysis to answer the research questions best.

4.5.1 Data gathering and sampling

For this research, initially, three sites were identified through purposive sampling. Sampling is predominantly purposeful in case study research to ensure the inclusion of information-rich cases for in-depth study to meet the research aims (Palinkas et al., 2013). For this study, settings where positive examples of existing relationship-based practice have already been identified were of central importance in answering the research questions. Sampling was conducted through the identification of such settings through dialogue with a not-for-profit service provider, which owns several residential homes across Wales. While both sites share the same provider, they offer a rich dataset for this study because of their distinct dynamics, diverse resident demographics, varying staff practices, and interactions with the local community, which influence social environments differently. However, it's crucial to consider how market forces, like financial pressures and competition (such as the emphasis on attracting and retaining residents, which could impact admission criteria and service offerings), might subtly influence operations and affect the social environments in these settings. Understanding these influences is vital for accurately interpreting research outcomes and evaluating their broader implications for policy and practice.

Purposive sampling involves deliberately selecting participants or cases that are deemed to be rich in information relevant to the research objectives. In this context, selecting positive examples allowed the identification and analysis of instances where professional boundaries were effectively managed, leading to successful relationship-based practices.

This enabled a detailed examination of practices that contribute positively to relationship-based practice, offering insights into what strategies, behaviours, or interventions could be effective in promoting effective practice. Studying these examples meant it was possible to discern patterns and factors that support the development of professional boundaries conducive to effective and positive relationship-based practice. By highlighting successful practices, and focusing on positive examples through purposive sampling, it increased the opportunity to shed light on best practices and provide practical insights that can inform policy, training, and potentially shape professional guidelines.

4.5.2 Gaining access and COVID-19

The total number of individual case studies in this multiple case study research was two; each site is in the South Wales area. The initial plan was to conduct the case study across three identified sites. The period of data collection was planned between

November 2019 and May 2020. However, data collection came to a halt in March 2020 due to the COVID-19 pandemic, particularly pertinent due to the residential care setting and the vulnerable nature of many of the participants. In March 2020, when the UK went into lockdown, four observations had been completed along with just under two-thirds of the planned interviews. At the same time, as I was required to shield due to personal circumstances, my studies were suspended following a brief analysis and organisation of the data collected up until that point. Following the return from suspension, the initial phase of analysis was completed and options for continuing were discussed. The data gathered through direct observation was deemed sufficient. On completion of the transcription and analysis of interview data, the interview data approached the point of data saturation, and the initial findings were sufficient to answer the research questions.

There was the option of continuing data collection via virtual interviews, but this was deemed inappropriate for two main reasons. Firstly, virtual interviews while they could work with the support of onsite staff would have provided a very different experience for both participant and interviewer, particularly due to the support needs of the participants and the fact that staff would likely need to be present for the interviews to provide support with the technology necessary to conduct the interviews. This would likely have created conflict for participants when discussing sensitive details about relationships with social care staff and would likely have impacted the findings.

Secondly, the large gap in time between data collection before and after a period of leave in normal circumstances may not have caused too much disruption and lack of comparability, however, it is essential to note that during this period the COVID-19 pandemic and lockdowns occurred. Participants were staff and residents of residential care home settings who suffered acutely due to COVID-19 restrictions, with visits from loved ones banned and residents being disproportionately affected by the health impacts of COVID-19 (Jordan et al., 2020; Nyashanu et al., 2022; Schrack et al., 2022; Sweeney et al., 2022). When considering this context and given the nature of the topic being explored, there would have been a significant impact on the comparability of data gathered before and after lockdown.

Consequently, data collection through observations and interviews was concluded, the initial phase of analysis was completed, and focus groups were scheduled to take place once restrictions were lifted. In total 17 interviews were conducted with 18 participants[9], amounting to almost 9 hours of interview data and 4 direction observations, amounting to 8 hours of observation data were conducted across two sites. Multiple sites, or cases, are explored to ensure data is collected from more than one source. As two sites were visited and researched before the pandemic, data was still collected from more than one source.

4.5.3 Focus groups and COVID-19

Focus groups were planned to be held following the direct observations and interviews. They were planned to involve the people receiving care and social care staff in discussions about the initial findings, enabling participants to fully participate and influence the findings of this research project. Unfortunately, in seeking to plan these focus groups, several challenges were experienced. The two main barriers to conducting the focus groups were COVID-19 and staff turnover.

Despite the focus groups being planned to follow the lifting of most COVID-19 restrictions, the residential settings which took place in this study were subject to local lockdowns and care home specific lockdowns in response to cases of COVID-19. This caused the cancellation of multiple planned focus groups; understandably, the health of residents was put first. Secondly, high staff turnover posed a consistent challenge and barrier to conducting the focus groups. The manager of one site left, and following a period of attempted contact the researcher was put in touch with an activity coordinator to plan the focus group. This activity coordinator then left. A similar pattern of staff turnover resulting in cancellation happened on site two. The reluctant decision was taken to stop further attempts to coordinate focus groups, as insufficient time remained to incorporate any findings into the study meaningfully.

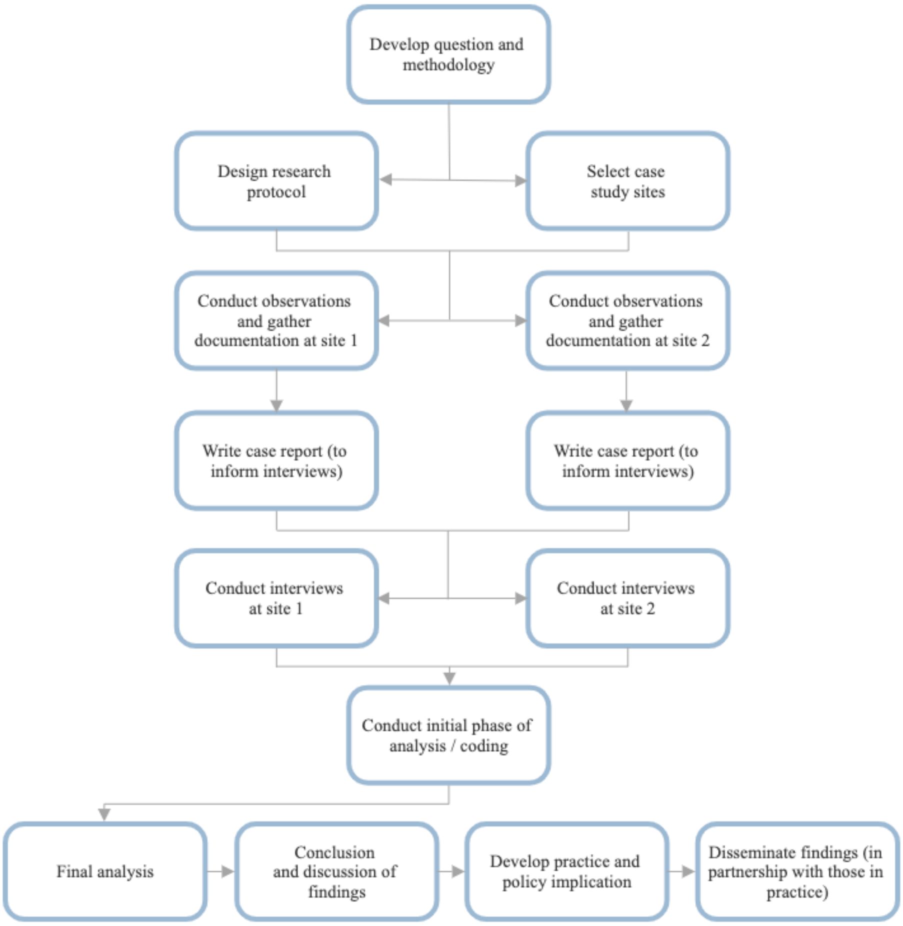
---

[9] The 17 interviews were conducted with 4 members of staff, 13 residents and 1 carer (who accompanied a resident at their request, the carer was the resident's daughter).

4.6 Conducting the case study

The two sites researched in this thesis are residential care homes in South Wales, owned by the same not-for-profit parent company. Each residential home is split into multiple ‘units’, which each have their own set of staff supporting a group of residents who are placed in their ‘unit’ based on need. The focus of this thesis is relationship-based practice, and therefore units were identified where the support needs of residents were due to memory problems. A diagnosis of dementia was not a requirement to reside within the units studied, but instead, residents were placed based on needs due to memory issues. This was usually due to dementia but, for example, one resident was placed in one of the units due to memory problems presenting similarly to dementia but caused by a traumatic brain injury earlier in life. Below is a flow chart developed to provide a visual overview of the case study process followed during this research project:

Figure 2 – *The Case Study Process*



4.6.1 Documentation

The first phase of the case study research was to collect data in the form of documentation. Documentation is relevant to most case study topics, and this type of information can take many forms (Yin, 2018). For this study, the documentation sought included:

- Posters displayed in both public and residential areas
- Information leaflets on display for visitors and residents
- Any images displayed in both public and residential areas
- Information available for members of the public to view digitally, included on the parent company website and the individual pages for each of the research sites

This data was gathered physically during the direct observation stage via contemporaneous notes and photographs, and digitally through screenshots of relevant information on websites. This data collection was conducted before direct observations and interviews took place. The written data was then transcribed and saved alongside any digital images in preparation for analysis.

Gathering and analysing the publicly available website documentation data from the care settings provided the opportunity to analyse the mission statements, values, and philosophies of the residential settings, as presented on their websites. This offers crucial insights into whether and how relationship-centred approaches are communicated by the settings. Understanding the descriptions of services, programs, and amenities on residential settings' websites allowed for a nuanced exploration of how the settings themselves portray relationships, practice and their ethos.

Additionally, scrutinising the transparency and clarity of information provided on these websites reveals how the settings communicate their commitment to effective care to prospective residents, families, and the public. Understanding how the residential settings seek to shape public perception and influence decision-making processes among families seeking dementia care provides another dimension to understanding their values.

4.6.2 Direct observations

Direct observations were conducted to establish an understanding of current relationship practices in the identified settings. Consent and consultee declarations for the observation phase were sought separately from the consent and consultee declarations sought for the interview phase. Please see Appendices A1 and A2 for copies of the participant and consultee information sheets specific to the observation phase of this research, and Appendices B and C for copies of the participant consent and consultee declaration forms that were sought for all participants of the observation phase.

Observation is particularly pertinent as this research sought to explore how effective relationship-based practice is supported and delivered in residential social care. Observing how people living with dementia interact with each other and with staff members was key to establishing how relationship-based practice can be enabled. The interactions observed were not only verbal but also via body language, interaction with the environment and nonverbal expression. Direct observation is a method of collecting evidence for evaluation by watching the subjects in their usual environment without altering or influencing the environment (Murphy & Dingwall, 2007; Yin, 2018). When used in combination with interviews, direct observations can be particularly useful in allowing comparison between participant accounts and actual behaviour (Yin, 2018).

The observations took place across a number of two-hour visits to each site and were guided by a checklist of what to look out for and what details to record. Please see Appendix D for a copy of the observation checklist used. The observations occurred at different times each day to ensure a wide range of data was captured. Available documentation was analysed to elicit meaning and gain an understanding of what information is available to people with dementia and staff. The gathering of documentation related data took place during the direct observation phase of the research. Times were negotiated with each setting, and included being present to observe different mealtimes, during organised activity and during unstructured periods, or ‘relaxation time’. The observations were unstructured, providing flexibility in what was captured while still allowing for comprehensive and rich data. This approach to observation is particularly useful when looking at interactions among individuals and groups, rather than implementing a structured checklist (Given, 2008). Observations were written in the form of contemporaneous notes, which were then transcribed in preparation for analysis.

Conducting direct observations meant I could observe how staff interacted with residents, the physical environment of care settings, and the effectiveness of current interventions. This has the potential to offer insights into how relationship-based theories were applied in practice. This phase provided contextual richness and nuance that documentation and interviews alone could not capture, as through observing the relationships between people with dementia and social care staff in dementia care settings, a more accurate picture can be established as the research is not based solely on participants' recollections during interviews. This is particularly pertinent when the participants were selected due to them having dementia or memory problems. For this research, the observations were conducted overtly and guided by a checklist. Observations aided in identifying examples of positive practice, in addition to contributing to the understanding of challenges faced by staff.

4.6.3 Semi-structured interviews

Interviews were conducted following direct observations to explore further the interactions observed and to gain a deeper understanding of what participants felt contributed to positive and effective working relationships. Please see Appendices A3 and A4 for copies of the participant and consultee information sheets specific to the interview phase of this research, and Appendices B and C for copies of the participant consent and consultee declaration forms that were sought for all participants of the interview phase. Participants and consultees were specifically informed of the recording of the interviews, and the process for securely storing interview data that accompanied this.

Interviews took place with both people in receipt of services and social care staff. They occurred at an arranged date following the observations. Most participants were present during the direct observation phase, however, a number were conducted with participants who were not present for the direct observations as they usually opted to stay in their rooms, for reasons varying between personal choice and illness.

Interviews were open-ended, to develop an understanding of how participants experience the relationship between people receiving services and social care staff. Open-ended questioning enabled flexibility of topics and concepts, ensuring the participant led the discussion (Creswell, 2007). Whilst open-ended, the interviews followed a structure of themes identified in the interview guide, to ensure relevant data was captured and keep the interview on track. Please see Appendix E for a copy of the interview guides used for this study. Separate interview guides were developed for the different participant groups; residents and staff. This was done to reflect the various topics of interest sought from each participant group.

While the topic of relationships overlapped, staff were asked more specific questions regarding professional boundaries, while the topic of ageing and the impact on relationships was explored with residents. These questions were developed by drawing upon the knowledge collated throughout the two literature review chapters. Discussion around individuals' experiences of care, their relationships with practitioners and the environment they reside were the key focus. Interviews were recorded digitally, before being anonymised and digitally transcribed in preparation for analysis.

A core aim of this thesis was to produce knowledge that can be applied in a meaningful way to improve practice in residential social care. Interviews provided qualitative data that enriched the understanding gained from documentation and observation. They offered participants the opportunity to share their personal narratives, opinions, and deeper explanations of behaviours and practices observed during direct observations. Insights from interviews helped uncover subjective experiences, ethical considerations, and personal values that shaped staff members' care practices. Conducting interviews allowed for the exploration of potential barriers to implementing new practice frameworks and policies.

4.6.4 Participant selection

Each case study site was investigated through documentation analysis, direct observation, and participant interviews, followed by a focus group held at each site. The number of participants was determined by the setting the case study took place. This varied according to the number of social care staff and people receiving care present within each setting. Participants included people with dementia and their families, in addition to social care staff present. The proportion of each group of participants reflected the ratios within each setting. Gatekeepers were approached at the case study site who had already agreed to participate in this project and were part of the initial funding proposal. Gatekeepers were asked to identify services and settings where they felt positive examples of relationship-based practice occur. From an initial shortlist, three sites were selected through purposeful sampling which became two once COVID-19 restrictions were implemented, due to the reasons discussed above.

The main criteria for selection were the site demonstrating positive examples of relationship-based practice. Using only positive examples of relationship-based practice ensures that the study draws from effective and proven methods, providing reliable and insightful data for understanding best practices. This approach also increases the likelihood of identifying successful strategies that can be replicated or adapted in similar settings. Services identified were approached jointly with gatekeepers to share information about the study, to ensure the setting was appropriate for the case study and that residents and professionals were willing to participate. Formal, written approval for the research to commence was then sought from the management and service providers of each setting. A site visit was conducted to confirm suitability and to enable potential participants to answer any questions as well as finalising plans and timescales.

Following the identification of suitable case study sites, the researcher approached potential participants along with the site manager and support staff in a group setting to discuss the project and enable potential participants to ask any questions, voice any concerns and meet the researcher prior to the research commencing. There was a 'cooling-off' period of at least 24 hours between the initial discussion and the commencement of any research to allow potential participants to speak with staff members and refuse permission to participate where they may not have felt comfortable refusing in the presence of the researcher. Two potential participants refused at this stage, and this was noted by both staff and the researcher.

4.6.5 Inclusion and exclusion criteria

The inclusion and exclusion criteria for participants were as follows:

People living with dementia

Inclusion criteria for interviews and focus groups:

- Capable of verbal expression
- Resident in identified case study setting
- The ability to indicate their willingness to participate in the project OR confirm informed consent if deemed to have the capacity to make that decision
- A diagnosis of dementia, or presentation of symptoms of dementia (e.g., memory problems)
- Acknowledges dementia/symptoms of dementia
- Ability to communicate in English or Welsh

Exclusion criteria:

- Not capable of verbal expression
- Not service user or resident in identified case study setting
- Inability to express their willingness to participate OR refusal of informed consent if deemed to have the capacity to make that decision
- Does not acknowledge dementia or potential dementia

People living with dementia

Inclusion criteria for observations:

- Resident in identified case study setting

- The ability to indicate their willingness to participate in the project OR confirm informed consent if deemed to have the capacity to make that decision
- A diagnosis of dementia, or presentation of symptoms of dementia (e.g., memory problems)

Exclusion criteria:

- Not resident in identified case study setting (e.g. a resident from neighbouring ‘unit’ passing through.
- Inability to express their willingness to participate OR refusal of informed consent if deemed to have the capacity to make that decision

Social care staff:

Inclusion criteria:

- Employed in providing social support services for people living with dementia, within both statutory and non-statutory services.
- Ability to speak English or Welsh
- Able to give informed consent

Age range:

Given the nature of prospective participants as professionals or individuals living with dementia, all participants were adults (aged 18 plus). There were no exclusion criteria based on age, however, as age is the strongest known risk factor for dementia (above the age of 65 a person’s risk of developing Alzheimer’s Disease or Vascular Dementia doubles every five years) many participants are likely to be older adults (Alzheimer’s Society, 2023). The diagnosis rate for dementia in Wales was only 57% (in comparison to rates of 71% in England and 74% in Scotland and Northern Ireland) in 2017 (Alzheimer’s Research UK, 2017). This is calculated by dividing the number of people reported in national health statistics as being diagnosed with dementia by the total estimated number of people living with dementia. These numbers have reduced across the UK as a result of the COVID-19 pandemic (NHS England, 2021).

As the diagnosis rate is low, to avoid preventing potential participants from taking part in settings providing general care services, staff were asked to identify participants with dementia based on their professional judgment rather than a formal diagnosis. Participants were required to acknowledge they have, or potentially have, dementia to take part. This is because questions were asked about relationships and dementia, and if a participant does not accept that they have a memory problem then it may have caused upset or distress. To minimise the potential of this occurring while also taking into consideration the fact that a formal diagnosis of dementia may not have been made, the term ‘memory problem’ was used during data collection instead of ‘dementia’.

Ability to communicate verbally:

A main criteria of participation in the interview and focus group stage of the research was the ability to communicate verbally in English or Welsh, therefore no translation and interpreters were used. The decision to exclude those unable to communicate verbally (in English or Welsh) is to ensure participants were able to engage with the interviewer in a meaningful way, to ensure contribution to the research. The inability to communicate verbally or understand verbal explanations would have greatly limited the efficacy of both interviews and focus groups as a data collection method.

For the observation phase of the research, the researcher observed day-to-day interactions with as little influence on the case study environment as possible. Participants were observed interacting and communicating with other participants (staff and service users) as they usually do, therefore not requiring a translator or interpreter. In the case of direct observations, interaction and communication were not necessarily verbal, and included physical interactions and body language.

Welsh language:

To ensure this project complies with the Welsh Language Act, the researcher ensured that for participants who required it, the opportunity to participate in Welsh was offered. The manager at each case study site was consulted regarding the Welsh language use by residents and staff, as geographically across Wales the use of the Welsh language can vary greatly. Out of the two sites, one site supported potential participants who communicate bilingually in Welsh and English. Each potential participant will be asked their preferred language for information provision and while a small number of participants were fluent in Welsh, all participants chose to conduct their interviews in English, and English was the predominant language spoken during observations. Welsh was used sporadically and tended to be commonly used words or phrases interspersed amongst English, for example, ‘cwtch’ was used to describe a cuddle or hug.

Gender: Participants of any gender will be invited to take part in the research.

4.7 Consent and mental capacity

The main ethical and legal issue arising from this study was the involvement (or potential involvement) of people with dementia who lack the capacity to consent to participation, or people for whom the capacity to consent may fluctuate or deteriorate throughout the study. Participants were both staff and residents in settings providing care for people with dementia. Residents had a diagnosis of dementia, or if no formal diagnosis, presented with symptoms of dementia or memory problems. This was particularly relevant for participants in the mid to later stages of dementia, as cognitive ability usually declines as the dementia progresses. However, this was also of relevance to participants in the earlier stages of dementia who at the start of the research process might have capacity to consent to participation, but this capacity might have changed. Capacity for people with dementia can fluctuate on a day-to-day basis, as well as potentially decline throughout the case study and can vary from decision to decision.

The MCA 2005 stipulates rules for research with individuals lacking the capacity to consent to participation. The case study method used in this research project is defined as intrusive as participants will be both observed and asked to take part in recorded interviews. Therefore, for the research to be lawful ethics approval was sought through an approved body, therefore Ethical Approval through IRAS was gained before commencing data collection in addition to gaining approval from the Swansea University Research Ethics Committee. The MCA also requires there must be ‘*reasonable grounds for believing that research of comparable effectiveness cannot be carried out if the project has to be confined to or relate only to, persons who have* *the capacity to consent to taking part in it'* (MCA 2005 31(4)).

This study specifically aims to explore relationship-centred practice for people living with dementia, and a key feature of dementia is cognitive decline, increasing the likelihood that participants will lack the capacity to meaningfully consent to participation. Therefore, limiting the project to people with capacity would have had a significant impact on both the number of participants, but also the integrity of the findings. Section 31(5) (b) stipulates that the research must be intended to provide knowledge of the causes, treatments or care of persons affected by the same or similar conditions.

This project specifically sought to explore relationship-centred care of people living with dementia, with the aim of improving practice and policy, thus meeting these criteria for lawful research. The research was planned to be minimally invasive, with great care taken not to impose unduly on people with dementia, professionals, or the care environment. Section 31(5) (b) stipulates that the research must be intended to provide knowledge of the causes, treatments or care of persons affected by the same or a similar condition.

4.7.1 Process for participants who do not have the capacity to consent

According to the Mental Capacity Act (MCA) 2005, a person is defined as lacking the capacity to make a decision if they are unable to understand information relevant to the decision, retain that information, use it as part of the decision-making process or communicate their decision (verbally or through another means). Protocols were put in place to ensure that participants without the capacity to consent remain willing to participate and can withdraw from participation based on both verbal and non-verbal indications.

Through discussion with staff engaged in caring for each potential participant, a joint decision was made on whether a participant had the capacity to consent. On
The decision was guided by the informed knowledge of staff based on previous

capacity assessments and knowledge of the individual. This knowledge was used in combination with my own previous experience as a qualified social worker and working directly in a user involvement role with people with dementia to decide whether informed consent was sought, or whether procedures in place for supporting individuals without the capacity to consent were followed. This collaborative approach minimised the risk of including a participant who lacked the capacity to consent without following the legally outlined processes. On one occasion, staff indicated that a potential participant was able to consent, however, it became clear on explaining the research process and the study aims that the participant did not have the capacity to consent specifically to being a participant. The process was halted, and instead, carers consulted to enable the person to participate.

The distinction between the capacity to consent and the capacity to take part in the study lies primarily in the understanding and decision-making abilities of the participant. Capacity to consent refers to the potential participant’s ability to comprehend the research process, its aims, risks, and benefits, and to make an informed, voluntary decision to participate. However, the capacity to take part in the study refers to the potential participant’s ability to engage with the study's observations and interviews, regardless of their understanding of the consent process. For example, a person might not fully grasp the consent information due to their dementia, yet still be able to meaningfully participate in the interviews with appropriate support. This distinction ensures that ethical guidelines were followed while enabling participation from individuals who may otherwise have been excluded. The participants who did not have the capacity to consent but opted to participate in the interview were supported by staff members to understand the process, and I was able to use my skills to support their meaningful engagement.

In the case of participants who lacked the capacity to consent at the outset of the project, carers were consulted to determine whether the person should take part and whether, in the opinion of the carer, the person’s wishes and feelings about taking part would likely have been if they had capacity in relation to the decision. This process is set out in Section 32 of the MCA 2005 and was adhered to throughout data collection. This was a consultation process, and not ‘proxy consent’.

In line with the MCA 2005, a carer in this instance is a person who is engaged in caring for the potential participant or has an interest in their welfare. They were not paid for providing that care and have no connection with the project. Reasonable steps were taken to identify such an individual. If the identified person had the potential participant’s power of attorney, this would not have prevented them from being consulted. If the carer felt the potential participant would not agree to take part, or cannot be contacted, then that potential participant was not included in the project.

Following meetings at each identified site, consultation with carers would be conducted through the management at each location. Tailored information sheets were sent out, with identified persons asked to sign to confirm whether they believe the potential participant would, or would not, wish to take part. Stamped addressed envelopes were included, and one follow-up phone call would serve as a reminder if written confirmation was not returned within a specified timeframe.

If no confirmation (positive or negative) was received following this process, the individual concerned was not included in the study. If the participant's condition changed and it was deemed necessary to consult the carer or named person, contact would be made again. However, this was not an issue during the data collection of this research. If once the research had commenced, a participant without the capacity to consent appeared distressed or unwilling to participate, this was recorded, and their participation was withdrawn.

The following steps were taken to ensure nothing was done to which participants objected:

- Ensure any discussions/interviews were paced to give appropriate time for participants to formulate responses.
- Interview participants were reminded of their ability to withdraw from the research process at any point.
- The research would halt or stop the interview process if deemed appropriate, or if the participant was displaying nonverbal signs of withdrawing consent, even if not verbally withdrawing.
- Remain sensitive to potentially emotive subjects and participant emotions. If a

participant became upset, allowed space or time for the individual. Sought support of professionals on-site if appropriate.

4.7.2 Process for participants with the capacity to consent

The method put forward by Dewing (2007) for obtaining informed consent from individuals with a diagnosis of dementia, for whom the capacity to consent is potentially limited, was used. Having previously worked in a user involvement role within a dementia organisation, I was familiar with using this method when supporting people living with dementia to participate in activities. It has proved successful in ensuring participants are able to consent, not only before commencing, but are able to consent throughout the research process. This is vital, with one aspect of dementia being fluctuating capacity. Not only can capacity fluctuate day to day, but also within the same day.

To ensure that participants were thoroughly informed and protected throughout the research process, the following steps were taken:

- Permission to access an individual with dementia was gained from staff, relatives or another named person, if appropriate. Permission for access is not proxy consent. The purpose of involvement was clarified with both the person with dementia and others who are of significance to that person.
- A basis for the capacity to consent was established. If required, an adapted consent process was taken into consideration the individual’s usual self-presentation, how a decrease in this may have been triggered, how a decrease in well-being could be recognised and how the individual usually consents to activities and procedures in their everyday life. This also took into consideration whether an individual’s capacity was likely to fluctuate throughout the day, for example, if that person was more likely to have the capacity to consent in the morning as opposed to later in the day.
- Initial consent was sought. Information about the research project was provided clearly and concisely, both through an Information Sheet and

verbally, depending on the individual's preferred method of taking on information. This was sought again before arranging the interview and focus group and was monitored on an ongoing basis.

- Ongoing consent monitoring. The initial consent was revisited and re-established at each meeting, and if deemed necessary throughout the same meeting, to ensure their feelings regarding participation had not changed. Both verbal and non-verbal cues was observed while carrying out the case study. If a participant appeared upset or agitated, the observation or interview was halted.
- Written information provided was clear, concise, and provided in a non-patronising manner.

Information sheets were provided to all participants. Separate participant information sheets were provided to people living with dementia and social care professionals to reflect the different needs of participants and different subjects discussed in interviews. The risks and benefits of participation in the research were clearly outlined and explained, along with the intended purpose of the findings. Each information sheet provided clear information on how data collected will be used and stored. The option of reviewing interview transcripts was provided to each interview participant.

Withdrawal criteria were determined as follows:

- The participant verbally states they no longer wish to participate.
- The participant appears distressed.
- The participant appears unwilling to participate (based on observations or nonverbal cues).
- The participant is no longer able to communicate verbally (Interview and focus group only – no requirement to verbally communicate for observation).

4.8 Analysing the data

The data collected through the case study approach detailed above was transcribed, mostly in written form with the inclusion of images taken during the documentation gathering phase. The data collected was qualitative, through unstructured observations and semi-structured interviews consisting of open-ended questions. Thus, the approach best suited to analyse this data is qualitative content analysis.

4.8.1 Qualitative content analysis

Content analysis can be used on all forms of written text, regardless of the source of the material (Bengtsson, 2016). It is also well suited to analyse qualitative data expressed in words, where the researcher is unable to use statistical analysis to add meaning and context to the data, beyond just counting words (Bengtsson, 2016; Weber, 1990). Qualitative content analysis examines language in a high level of detail intending to analyse, classify, and theorise large amounts of text into efficient and representative categories, or themes, that represent similar meanings (Hsieh & Shannon, 2005; Weber, 1990).

Qualitative content analysis was chosen over other qualitative data analysis methods, such as phenomenology and grounded theory, as it focuses on the characteristics of language as communication, paying attention to the content and contextual meaning of the text (Hsieh & Shannon, 2005). This method is particularly suited for capturing nuanced aspects of communication within textual data. Unlike phenomenology, which explores subjective experiences and meanings from individual perspectives, or grounded theory, which aims to develop theories grounded in data, qualitative content analysis allows for a systematic examination of the content within texts.

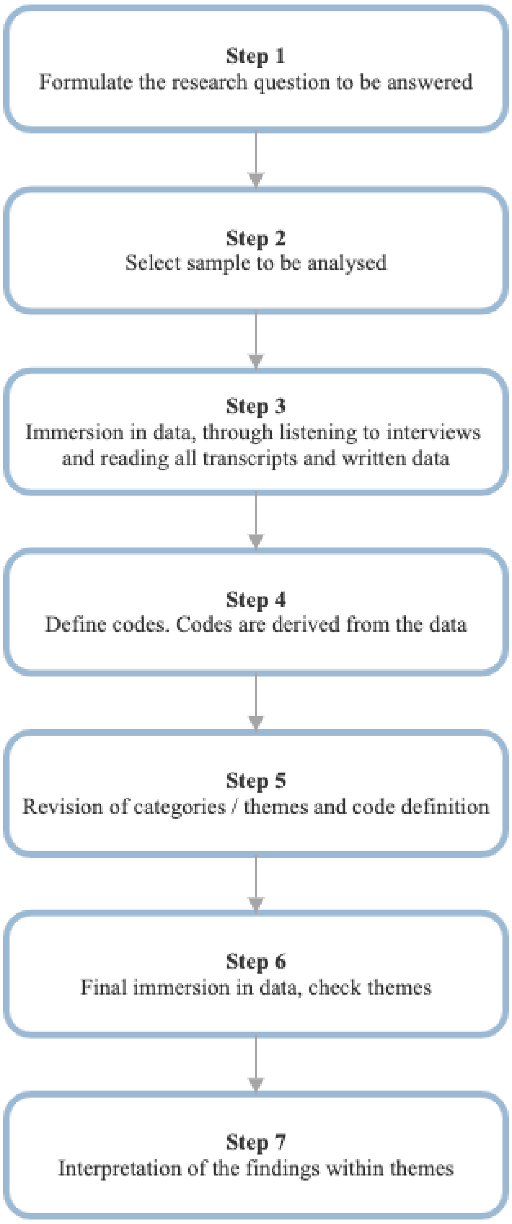
Qualitative content analysis offers flexibility in identifying themes and patterns, making it adaptable to diverse research contexts where understanding the intricacies of language use and contextual meanings is paramount (Hsieh & Shannon, 2005).

Thus, the method was deemed more appropriate for this study due to its rigorous yet flexible approach to uncovering the rich layers of communication.

When conducting qualitative content analysis, researchers avoid using preconceived categories, instead allowing the categories, or themes, to flow from the data (Hsieh & Shannon, 2005). The data analysis starts with thoroughly reading all available data, to achieve immersion and a full sense of the data. All qualitative approaches to content analysis require a similar analytical process, involving a process of steps from formulating the research question, to interpretation of the final findings.

The steps taken to analyse the findings in this thesis were based on Hsieh and Shannon's (2005) steps for conventional qualitative content analysis, as the codes in this research were defined after immersion in the data, as opposed to beginning the data analysis with a predefined set of codes identified from the literature. The steps are outlined in the flowchart in Figure 3:

Figure 3 - *Qualitative Content Analysis Flowchart*



Note: Adapted from *Three approaches to qualitative content analysis,* by Hsieh, H-F. and Shannon, S. E., 2005. (https://doi.org/10.1177/1049732305276687)

4.8.2 Coding and analysing

Following data collection, the initial results were analysed by utilising NVIVO software. The interviews were transcribed, along with the direct observations and copies of the documentation gathered during the initial phase of the research. The written data was then imported into NVIVO and were assigned case attributes according to the table below:

Table 3 - *NVIVO Case Attributes*

Case Attribute	Value
Participant Number	<Insert>
Is the participant a resident?	Yes No
Is the participant a social care professional?	Yes No
Case Study Site	Site 1 Site 2

The next phase of the research involved coding the interviews, documentation, and observations. This was undertaken in three separate phases: interviews, observations, and documents. The data collected was different enough to warrant separate coding and analysis strategies, with the view to bringing the findings back together for comparison during the discussion chapter. Analysis was undertaken using NVivo software of 17 interviews conducted across two venues. The interviews were conducted with 4 members of staff, 13 residents and 1 carer (who accompanied a resident at their request, the carer was the resident’s daughter).

Two residents did not have the capacity to consent, their next of kin were contacted and consultee forms were completed. Additionally, 4 observations of 2 hours each were completed and analysed, along with publicly available literature. These took place across 2 sites on four separate dates. The interviews and observations were coded using ‘nodes’ using the NVIVO software package. Data was coded using themes that emerged during the process of data immersion. The approach taken to coding in this study is an inductive one, due to the almost ethnographic nature of the case study approach taken this method allowed themes to emerge during the analysis process (Yin, 2018). The themes were coded by highlighting responses, passages or phrases relevant to the research topic and applying nodes such as ‘relationships’ and ‘loneliness’.

4.8.3 Analysis through an ethics of care lens

Once all the data had been thoroughly reviewed and coded, the notes were then combined into common groups, or themes, that began to emerge. Eight final themes, or categories of discourse, were found to exist and formed the basis for the discussion of the results. As outlined earlier in this chapter, the research has been framed by an understanding of the ethics of care. The study aims were to understand how relationships are experienced by residents and staff in residential social care and use this knowledge to examine professional boundaries and make recommendations for changes to improve care for those living in such settings. Understanding care provision, power imbalances, and the needs of those receiving care from their perspectives are key to both this thesis and the ethics of care literature (Brannelly, 2018; Edwards & Brannelly, 2017; Tronto, 1993, 2013). As Tronto (1993, 2013) explains, careful research practices are guided, analysed, and evaluated through the ‘*integrity of care’*.

Feminist ethics of care promotes a research approach involving attention to relationships and responsibilities within a specific context (Edwards & Brannelly, 2017). When analysing the findings in this thesis, the concept behind this approach was returned. Knowledge of the concept of roles and the recognition that people will respond from the multiple identities and positions they hold in their lives was also essential when conducting the analysis (Berger & Luckmann, 1991; Brannelly, 2018). Understanding the context, roles, and status of the interview participants, as both ‘caregiver’ and ‘cared for’ helped to contextualise their responses and actions during the interviews. In interpreting the data, the ethics of care framework provides a valuable lens through which to understand and contextualise the responses and actions of interview participants. Central to the ethics of care is the recognition of relationships, empathy, and understanding of context, which are crucial in qualitative research involving interpersonal dynamics such as caregiving.

By understanding the roles and statuses of interview participants, both as caregivers and recipients of care, it becomes possible to appreciate the nuances in their responses. Participants' dual roles can shape their perspectives, emotions, and the information they choose to disclose during interviews. For instance, a member of staff may share insights based on their professional experience and responsibilities, while someone receiving care might provide perspectives influenced by their dependency and personal experiences of receiving support. Understanding that the participants were coming from different positions of power and the impact this might have on their emotions, their views, and what they chose to share was essential in understanding how the findings could be used to understand their relationships.

4.9 Conclusion

This chapter has set out the insights and conceptual tools used in the upcoming analysis chapters. Regarding methodology, these insights and concepts shaped the research structure and guided the researcher in both the practical approach and framing the analysis. The analysis chapters which follow have been separated into three distinct chapters to represent the three distinct phases of data collection: documentation (chapter 4), observation (chapter 5), and interviews (chapter 6). The aim of this thesis, beyond simply answering the research questions, was to produce knowledge that could be applied in a tangible and meaningful way to hopefully support positive change in social care practice for older people with dementia.

As Tronto (1993) highlighted, not everything called care is good care. When conducting the research laid out in this thesis, the researcher was privileged to have access to information and resources through which change can be initiated; a point made by Brannelly (2018) when putting forward an argument for an approach to research from an ethics of care standpoint. It is hoped through analysis focused on centralising experience, contextualising the participants’ lives, and remaining mindful of the privileged access to knowledge gained as a researcher that this thesis can initiate change through an improved understanding of relationship-based practice (Brannelly, 2018).

Chapter 5 Content Analysis of Available Documentation

5.1 Introduction

This chapter, and the following two chapters, will present the analysis of the three forms of data collected across two residential care settings. The three data collection methods were identified to answer the question ‘How do people living with dementia and social care staff experience relationships in residential social care homes?’ To gain as holistic as possible understanding of how relationships are experienced within the residential care settings, the first two phases of data collection comprised conducting an analysis of the available documentation for each residential care setting and conducting direct observations of care in practice. The purpose of this document analysis was to gain valuable insights into the mission statements, values, and philosophies of these residential facilities. This analysis reveals the extent to which relationship-centred approaches are prioritised and communicated by the settings. Examining the descriptions of services, programmes, and amenities provided on these websites enabled a nuanced exploration of how the settings portray their relationships, practices, and overall ethos.

This first analysis chapter will discuss the first phase of the case studies conducted; documentation analysis. The analysis was performed on publicly available documentation, available both physically and online on the public-facing website of the parent company that owns the sites visited for data collection. Physically available documentation included any literature or imagery available in person, in the public-facing areas at each research site. This included:

- Parent company website (digital)
- Webpages of individual residential care settings (digital)
- Posters (physical)
- Leaflets (physical)
- Brochures (physical)
- Copies of reports (physical)
- Copies of inspections (physical)

Not included in this content analysis was personal information within residents' files, medical records or any documentation intended for internal use by members of staff. The data was collected from the two residential settings, owned by the same parent company, and analysed as one entity, to construct an understanding of what a visitor to the residential settings (either in person or online) might reasonably be able to deduct from the consumption of the available literature.

5.2 Content placement

Most of the analysed documentation was placed in public areas of the residential care sites, or online under each care home's individual page on the website. For example, in research site 1 several posters and leaflets were placed in the reception area near the entrance, where several chairs were placed for people to sit while waiting to be seen either by a member of staff or before being taken through to the residential areas of the site. This means the literature was placed in such a way that anyone would be drawn to it upon entering the site. When undertaking the analysis of the documents the purpose of it being displayed is a key feature. The images and literature placed in public areas can be thought of as a form of marketing, or advertisement, for the residential care settings. Theoretically, residential care settings engage in advertising and marketing to improve awareness of services offered in a particular market, and to signal high quality services (Kash & Miller, 2009).

Residential care homes need to attract potential customers, and to do so will ensure the publicly available literature will show the settings in a positive light. Marketing and advertising do vary, and marketing is defined as a process involving research, planning and development of effective and relevant tools to achieve strategic goals, whereas the main purpose of advertising is customer or public relations and direct sales (Kash & Miller, 2009). Without knowing the intention behind the publicly available literature, whether the material is marketing or advertising cannot be determined, however, throughout this chapter, it will be referred to as marketing material.

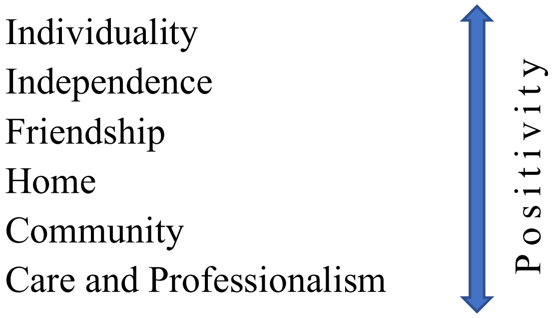
The literature was produced by the parent company (who own several residential care settings in the local area) and as such was branded. The written literature, throughout each document source, was nearly always accompanied by photographic images. These photographs tended to depict older people presumed to be, or to represent, residents. These older people were usually smiling and usually with another older person or a member of staff. The posters and leaflets appeared well produced, with easy-to-read fonts and a mainly blue colour palette that both felt easy to read and tied in with the parent company's brand colours.

The data available online was of a similar style, with some being a direct replication of what was available physically – the online information contained several identical photos and quotes. The online information is linked to more information-heavy sites, including recent inspection reports. The overall themes were similar, which felt strategic with a coherence of both theme and language across the various locations. The messages the publicly available literature was putting out mainly focussed on the care provision offered within the residential sites and describing the positive aspects of the sites themselves.

5.3 The content themes

The available documentation was analysed using the content analysis method outlined in the methodology chapter, allowing the researcher to organise the information into themes. Based on the content analysis six themes were identified with a seventh, overarching theme that permeated throughout all the available documentation, as depicted in Figure 4 below:

Figure 4 - *Documentation Content Themes*



Initially, a greater number of themes were coded. Themes were then grouped with similar themes, for example, ‘togetherness’ and ‘community within the care home’ were combined to the overarching theme of ‘community’, pulling together the common threads of meaning behind the data. This pulling together of coded categories to express a common, underlying meaning behind the information is used when conducting a content analysis of qualitative data to enable the interpretation of the data.

5.3.1 Positivity

When reviewing the publicly available brochures, posters and web-based material, an overarching theme became clear almost immediately. That theme was positivity. The language used to describe the residential sites can be interpreted as entirely positive. It focussed on the highlights of the care provision, the services, and facilities available and images were of smiling and happy residents and staff. These are analysed over the remainder of this chapter within their separate themes; however, the overarching theme of positivity was pulled out of the remaining content analysis as this pervading, positive lens by which each subsequent theme is viewed warrants standalone discussion.

Positivity was portrayed not only through the language used but also through imagery and colours. The descriptors focused on professionalism, promoting independence, on supporting people to live the lives they want to live while the imagery focused on people who look happy; they are smiling, the colours are warm, and many photos show multiple people looking happy and positive together. The images, and accompanying reassuring and positive language, are effectively used to provide a visual backup to the written words. For example, an image from the public-facing website provides an overview of one of the residential settings and depicts what is presumed to be a female resident, smiling.

While this positive use of imagery and language is noted, the context of who was responsible for the production of the literature and what the purpose of the literature remains crucial. The concept of marketing within adult care services is an aspect of managerialism that has been described as marketisation. Across social work and social care, although particularly evident in adult services, there has been a shift from social services directly providing care to commissioning care from external organisations. This is often referred to as the marketisation of social work and social care, as detailed in the literature review chapter 3. Rogowski (2012b) defines this as the development of competition in the provision of welfare services as a way of imitating market relationships. Chapter 3 discussed how marketisation has been cited as one of the reasons practice shifted away from a relationship-based focus. Therefore, it is of interest that positive relationships between professionals and residents are now being used as a key feature of marketing and advertising, within a social care market.

The literature and data analysed were produced by the residential care settings themselves and placed in public-facing physical settings and easily accessed online settings. For example, when using Google (the most popular online search engine) to search the names of the residential care settings, the parent company website is the first result returned. The literature's purpose could be easily considered as a form of marketing and advertising to potential residents and their family members. The online data would be available to anyone searching for potential places for themselves or loved ones to live in, while the physical data is placed in locations where anyone visiting a potential site with a view to moving there could read it. Inevitably, a company that requires the fees of residents to run as a business would focus heavily on the positive aspects of their sites and use the literature as advertising to those who, despite being residents are also customers – whether paying privately or through health and social care funding.

Throughout the remaining theme discussions, this overarching theme of positivity and the potential reasons behind it will not be directly referred to, however, it must be kept in mind when considering the integrity or intention behind the documents.

5.3.2 Individuality

One of the first themes that began to emerge from the data was that of individuality. The language used to discuss both care provision and those in receipt of care focussed heavily on the concepts of individuality and independence. Individuality is defined by the Oxford English Dictionary as

> *'The sum of the attributes which distinguish a person or thing from others of the same kind; individual character or quality'* (Oxford English Dictionary [OED], 2023: online).

Independence, meanwhile, is defined as:

> *'The condition or quality of being independent; the fact of not depending on another (with various shades of meaning: see the adjective); exemption from external control or support; freedom from subjection, or the influence of others; individual liberty of thought or action.'* (Oxford English Dictionary [OED], 2021).

Despite the overlap in the meaning of the concepts, the decision was taken to separate the themes, as individuality and independence are distinct enough to warrant this. Independence, particularly in the context of the setting this research was conducted in, namely residential care, is a loaded term. The very fact that a person is required to move into a residential care setting denotes a loss of independence, in at least one form, as the person moves into a managed and controlled environment. It is worth noting at this point that individuality, like other 'buzzword' topics discussed throughout the remainder of this chapter, is included in the care home literature in the absence of any clear definition. Individuality is referred to throughout the literature analysed here as a positive descriptor without any reference to, or acknowledgement of, the intricacies of such a nuanced concept.

The publicly available literature repeatedly emphasised the individuality of the people in receipt of their services, using the phrase 'individuals' to refer to people, as exemplified in the following quotes taken from the public-facing website of the parent company of the residential settings:

> *'Individuals are at the centre of their service and inform everything we do'*

And

> *'We are focused on the individual'*

The data immersion phase highlighted uses of language around individuality that deviated from simply overt use of the term 'individual', but also encompassed terms with similar meanings such as 'unique', and focused on the fact that people in receipt of services will have wishes and needs unique to them as an individual. For example, in the following quote taken from a brochure at case study site 2:

> *'We understand that everyone is unique'*

Terms that were used in the publicly available data to discuss individuality also included choice, control, and co-production. Analysis of the documentation identified these concepts being used to describe how the residential settings regard people in receipt of services as experts in their own care, and requiring support and services tailored to their individual needs and wants. The language of choice and control promotes the idea that people who choose to live in the residential care settings will continue to exert their individual wishes and choices in their lives. The focus is on the individual needs and wants. However, as previously discussed in this chapter, it often appeared that buzzwords were used in the absence of clear definitions, or explanations of how these concepts were realised in day-to-day life in the settings. For example, the following quotes taken from public-facing websites describe how care is tailored to reflect the individual:

> '[PARENT COMPANY] *provides innovative, high-quality support that builds on the strengths of individuals to enable them to live the life they want, in the home they choose'*

> *'The care is tailored to meet individual needs and wishes of each resident that comes to live at* [RESEARCH SITE 2]*'*

> *'Colleagues provide tailored support… to each and every individual, depending on their needs'*

Assessment and delivery of resident preferences for their everyday lives and care provision is one mechanism that research has found works effectively towards making residents feel at home and is described as a fundamental step in the provision of quality care in long-term care facilities (Bangert et al., 2016). Through focusing on individuality and reassuring potential residents that their wishes will be considered and acted on, the literature attempts to communicate to the reader that these residential sites will be able to deliver good quality care. This concept of tailoring support to meet each individual's needs and wishes is taken further in some of the documentation analysed via the idea of co-production of service planning and delivery, as seen in the following quote:

> *'We approach service planning through co-production, ensuring that people have full control of their homes and lives…'*

This takes the concept of control further through the implication that residents are involved at every stage of the services they receive, with the quote going as far as to describe the control offered to residents as 'full control'. The implication through the use of the word 'full' is that residents have a complete say in how their homes and lives are managed, which is at odds with the way residential care is often viewed. Coproduction is a concept described by the Social Care Institute of Excellence (SCIE) as working in partnership through the sharing of power between those in receipt of care, carers, families and citizens (SCIE, 2022). The description of co-production processes within the residential settings on the public-facing website fosters the idea that residents will have input into the running of the sites and be part of management's decision making processes. Again, however, statements are brief and do not include any detail regarding how the often complex process of co-production is actualised.

The documents discussing care and service delivery also focus on individual needs, looking at it from a right-based perspective. The language used refers to equality between all citizens, and again uses the term 'individual' to refer to people's contributions to society. As a continuation of the theme of independence, people in receipt of services are referred to as experts of their own needs and wishes. This is exemplified in the following excerpts taken from the physical brochure and the public-facing website:

> *'We regard the people we support as experts'*

And

> *'We champion the right of everyone to be equal and valued citizens… celebrate every individual's contribution to our society'*

The focus in the available documents on individuality is interesting considering this thesis aims to explore relationship-based practice, which has emerged in research and practice arenas in response to the shift in focus on individualisation in recent decades. Practice seeking to encourage independence and discourse around empowerment and a strength's perspective became increasingly common throughout the 1990s with citizens reminded of their personal responsibility (Gray, 2010; Stepney, 2006). The shift towards a practice focused on relationships in a response to increasingly risk-centric and bureaucratic social work policies and practices over recent decades, yet here the material put out into the public domain has a significant yet curious focus on strengths, individuality and independence.

5.3.3 Independence

As previously discussed, despite an element of overlap the decision was taken to maintain a separation between the two emergent themes of individuality and independence. While there is overlap in the meaning particularly within the context of residential care, dementia and ageing, the term independence takes on meaning beyond the concept of making individual and personal decisions and strays into the territory of physical independence and disability. Within the physically available brochure, and online within the publicly available website, language referred to the concept of independence of the individual rather than independence of the residential care setting or company delivering the services.

The quotes taken from the documents that referred to the theme of independence focussed on how residents could maintain their independence. This was in addition to describing amenities that were felt to align with independence and the concept that even once a person becomes a resident of the setting, they will be provided with the tools to maintain a desirable level of independence. For example, one site listed the availability of a 'licenced bar, daily clubs, Wi-Fi access, ensuite rooms'. Listing these amenities could be viewed as contributing to the narrative of maintained independence by alleviating concerns that a person might become more disconnected (WIFI access), or that they would suddenly lose access to things such as bars or even personal toilets.

The following quote is taken from the public-facing website describing residential site 2. It is felt to embody the concept of independence being a positive aspect that potential residents could be reassured of:

> *'We support people to live positive, independent lives'*

The language used is direct in telling the reader that residents are supported to be independent and that this will have a positive impact on their lives. The following quote again indirectly addresses potential concerns that moving into a residential setting could mean that a person loses their independence, and loses the ability to engage in activities they previously enjoyed:

> *'We believe people should be able to continue to do the things they enjoy….'*

A lot of the language around independence is strengths-based; focussing on the strengths of the people accessing services irrespective of any potential disabilities they are experiencing. This is embodied by the below quotes taken from digitally available documentation:

> '[RESIDENTS ARE] *experts in their own needs and aspirations… and in regard to the disability or difficulties they face'*

And

> *'[SUPPORT] builds on the strengths of individuals to enable them to live the life they want….'*

The focus on strength overlaps with the concept of independence. The language used focuses on continuing to promote independence, even when external factors such as declining physical and cognitive abilities may inhibit that independence. The limitations people who receive services may face are acknowledged but through the lens of focussing on what can be done, and the importance of maintaining as much independence as possible. For example, the following quotes were extracted from a mix of physically and digitally available literature:

> *'We do this by offering support and encouragement to maintain independence and live actively'*

And

> *'Our staff…understand the importance of enabling people to keep control of their lives.'*

5.3.4 Friendship

A theme which predominantly emerged from the available imagery was that of friendship. Multiple photos depicted people, whether residents, staff or a combination of the two, engaged in activities or simply looking happy with each other. People are photographed engaging in activities, laughing and depicting positive relationships. Beyond just portraying people looking happy and having fun with each other, the use of language and imagery depicting friendship could imply that people living and working within these settings enjoy good levels of physical and mental health. Research literature describes positive social relationships were associated with better health in later life and suggests that fostering relationships between older people has the potential to have a positive impact on both physical and mental health (Chang, Wray and Lin, 2014).

Key images that depict friendship include an image depicting two women, presumed to be residents, engaged in a game while seated, both are laughing and look to be playing the game with, or against each other. This image was particularly interesting as it depicts the residents engaged in an activity and having fun whilst remaining seated, demonstrating to a person viewing the image that fun can still be had if a person lacks mobility.

Another image was one viewed in person during the data collection phase of the research. This was available in the public-facing reception area of the residential site and was part of branded poster imagery. This image depicted two male residents sitting down and smiling while they appeared to be dancing in their chairs. This image, again of residents enjoying themselves while sitting down, also portrays the message that people who live within these settings can be engaged in communal activities and/or friendships even if their mobility restricts them to chair-based activities. A further image retrieved online depicts two men, presumed to be residents, holding pool cues and a pint. Both are laughing, and it can be assumed are in the middle of playing a game with each other. Another online image retrieved depicts two members of the kitchen staff, with their arms around each other while engaged in their work. Both appear to be laughing and enjoying themselves. Finally,

Another image which continued the theme of friendship was accompanied by a quote which was accessed via the publicly available information online. It depicts a staff member doing a manicure for a resident, with the quote '*Staff are marvellous. They're more like friends to me'.* The use of language and imagery depicting friendship is meaningful in the context of professional care, as it implies that the caring relationships in these settings go beyond perfunctory, task-centred care provision and into the realm of friendship. The inclusion of a quote alongside an image of a resident and member of staff further embeds the concept that staff are more than care providers, by showing an image of a staff member engaging in an activity that would not necessarily be deemed as care provision.

The use of a quotation also adds weight to the idea that the imagery is trying to persuade – that staff are more than staff, and instead, there is something akin to friendship that exists between staff and residents. The concept of friendship between residents and staff being important is backed up by research, such as the study conducted by Beresford, Croft and Adshead (2008). The authors found that friendship with the social care professionals was highly valued when receiving care, with service users wanting caring relationships to be a two-way, more reciprocal process. They pointed out that during their research, no participant stated the professional was ‘too friendly’.

A further image retrieved from the parent company’s website appears to depict a resident holding hands and dancing with a member of staff. It again gives the impression of friendship and happiness. There is friendly, physical contact between the two main people in the image, while the resident facing the camera has a large and warm smile. She appears to be happy and having fun. Previous research describes an indicator of quality care provision as the quality of the caring relationships (McGilton & Boscart, 2007). McGilton and Boscart (2007, p. 2152) described the ability to ‘*joke*’ or ‘*laugh around’* with the care provider being a key factor in relationship quality. By including imagery and language fostering the idea of positive relationships and friendship between residents and care providers, it lends itself to the idea that quality care is provided through positive caring relationships.

The images described above were all downloaded from the publicly available website and while depicting different scenarios, all showed companions engaged with each other happily. The images portrayed warmth and friendship by showing people happy and engaged in an activity with each other. The publicly available images showed an interesting balance of friendships. They depict the following:

- Friendships between female residents
- Friendships between male residents
- Friendships between staff/colleagues
- Friendships between residents and staff
- Friendships between residents who perhaps lack mobility

This means that these pictures could appeal to the widest audience possible, as by covering a variety of relationships, genders, and abilities more people can identify with the individuals depicted in the images. If a person was confined to a wheelchair or seat due to their lack of mobility, they would be less likely to identify with images solely of people engaged in activities or friendships while standing. If men were to view only images of women, or vice versa, they would be less likely to identify.

The inclusion of images of two staff together further embeds the concept of friendship. Not only are residents friends with each other, but the staff are also friends. This portrays the image that the residential care setting is a friendly place to be, conjuring images of laughing and happy staff which consequently would mean the setting is a nice and happy place to be. The implication of friendship between staff and residents is more implicit, with the use of an image of a member of staff and resident alongside the quote describing staff as being ‘more like friends’. This again further embeds the concept of friendship, of positive relationships between all people within the care settings.

5.3.5 Home

A further theme which emerged from the data immersion phase was that of ‘home’. The residential care setting was described as home multiple times throughout the publicly available literature. Although the quotes pulled from the publicly available data do not explicitly discuss the concept that the residential setting is considered a ‘home’ for the residents, using the term home embeds the concept throughout, even when it isn’t being directly discussed or implied in the text or images. One of the main images, that was used with the quote ‘This already feels like home’ was used in publicly available data available online and physically within the care home settings on leaflets. The online version is of a woman, presumably a resident, broadly smiling and looking happy. The use of this image alongside the quite powerful quote, describing the residential care setting, is effective in portraying the message that these settings are home to the residents and that they are happy about that.

The image and the quote complement each other, with the combined message feeling more powerful than its parts. The quote alone evoked feelings of warmth and homeliness. The image seeks to send the message that residents are happy. The combination of the two, however, feels reassuring and comforting. It would be reasonable to assume that the intended audience of the publicly available data, potential residents and their families, would be nervous about the possibility of moving into a residential care setting. The reassurance provided by this combined quote and image feels intentional and obvious, while the fact the words are placed as a direct quote further legitimises the concept that the residential setting feels like home.

The notion that the settings are home to those that live within them was further embedded through language that describes how residents are provided with ‘home cooked meals’, or in terms of discussing friends visiting residents in their home. For example:

> *‘Friends are welcome to pop in for tea or to join you for a meal’*

The use of the word ‘pop in’ also denotes a degree of informality and spontaneity. The use of such language appears deliberate, to put any potential residents (or customers, depending on which way you view residents) at ease, to ensure they feel that moving from their current home into the site would feel like moving into a new ‘home’, over a more institutional care provision setting. This description of the settings as ‘home’ was used both explicitly to describe how residents felt about the settings, and more casually in sentences when describing what residents can do within the setting, for example:

> *‘So they can continue to have enjoyable breaks away from home’*

More explicit references to the settings as ‘homes’ are made in the context of describing control and independence. The following quotes have been chosen to illustrate this concept as they appear to deliberately use the phrasing ‘their own homes’ when discussing the support given to residents:

> *‘[RESIDENTS HAVE] full control of their homes’*

And

> *‘We support people in their own homes to live the lives they want’*

This choice of language feels striking, as the intended audience of the publicly available data would likely understand that the residential care settings being described are not strictly the residents' 'own home', but the language used appears to reassure potential residents that the settings can be considered their homes and that they will not lose independence or control by moving in. The second quote included above refers to how people will be supported to live the lives they want within their own homes, again reinforcing the notion that people's independence and individuality can be maintained, suggesting their lives will be minimally impacted by moving from their current home.

The settings described throughout the analysed documentation are referred to as simply 'home' throughout yet could alternatively have been described as 'residential care home', 'residential site' or even 'care home'. Descriptors which are arguably more accurate. The decision to use the term 'home' throughout both the physically and digitally available data, which while not describing the setting as accurately as other possible terms, implies that the settings are thought of as home for residents. This further implies they are more informal than a setting that delivers care, or a service, which would have the potential of making residents feel alienated or less 'at home'. By referring to the settings as home, it also potentially minimises, or even removes, the professional and service delivery element of the settings. This could be interpreted as addressing the power imbalance between residents and staff, and that instead of being service users they are instead residents in their own home being supported by visiting staff.

5.3.6 Community

Moving beyond the concept of home, and to the communities homes sit within, the next theme to emerge from the data was community. Community, in the context of this content analysis, refers to both the community of people within the residential care settings in addition to how the residential care settings sit within, and contribute to, their wider surrounding place-based community. The language used in the literature available physically within the residential settings and digitally online both placed importance on the concept of community. Documents analysed contained lists of nearby amenities and referred to the residential care settings being centrally located, both geographically and socially, placing them firmly within the surrounding local communities. This concept is exemplified by the following quote:

> *'Located in the heart of [LOCAL AREA]'*

The above extract was taken from the publicly available information available online regarding research site 1, describing the residential care home as being in the 'heart' of the local area. This particular use of language implies the setting is not only geographically located centrally within the local area but also that the site is socially situated centrally within the surrounding community. The use of the word heart is particularly interesting. The term heart is often associated with love, friendship, and family. It evoked feelings of warmth and life; a beating heart within a community. This effective use of language implies the residential care home is vibrant and full of life, engaged with the surrounding area and geographically conveniently situated too. This concept is taken further by the following excerpt taken from publicly available data online:

> *'[Residential home name] plays an integral role in the [LOCAL AREA] community… we are close to public amenities including local shops, pubs, library and leisure centre'*

This quote explicitly centres the residential home both geographically and centrally within the surrounding community. Listing the local amenities the residential home is close to fosters the idea that residents would be able to access these amenities easily. The amenities listed, shops, pubs, library and leisure centre, all focus on independence and leisure. It implies that resident's lives will remain connected to their community, that friendships and existing ways of daily living can be maintained, and that they can continue in their leisure pursuits with minimal impact. The use of the word integral places importance on the residential home, it implies that it is both well integrated within the surrounding community and plays an important role in contributing to the area. This concept is described in the literature as a model of care homes as 'community hubs', described as the sharing of residential care facilities with the wider members of local communities and providing increased social options for residents (Ashcroft et al., 2014; Evans et al., 2017; Mason, 2012).

5.3.7 Quality and professionalism

The final theme that emerged from the content analysis was that of quality care and professionalism. The language used to describe the care provided was again positive but spoken of in terms of professionalism and quality, seemingly appearing to reassure the reader of the level of care provision within these residential settings. Similar to the overarching theme of ‘positivity’, the concept of quality and professionalism was woven throughout most of the documentation analysed. The settings and care provided were described positively and used language that fostered the idea of quality through the happy images portrayed, the description of professional practices and the listing of practical amenities. However, the decision was taken to leave ‘quality and professionalism’ as a standalone theme because, in addition to the concept being implied throughout the documentation, it was also referred to explicitly. For example, in one document, when describing how the company involves residents in decision-making processes, the parent company refers to themselves as ‘market-leaders’.

Another extract describes how the parent company works with ‘local authority and health partners’ to provide ‘specialist support to people with dementia’. In three separate extracts, staff are described as ‘highly trained’ while in another, they are described as ‘our professional, dedicated colleagues’. The language almost commands the reader to understand that the care provided is of high quality, and amongst the best available in the sector through the use of overtly positive and confidence inspiring descriptors, such as ‘market leaders’ and ‘professional and dedicated’. The following quotes taken from the documentation available online highlight this:

> *‘[PARENT COMPANY] provides innovative high-quality support….’*

And

> *'[PARENT COMPANY] are committed to providing sector-leading person-centred care…'*

This attempt to put themselves forward as leaders in the care provision arena is further exemplified by one extract describing how the company are 'proud' to have been runner-up in a 'Best Care Home' category of a charity award. Although the use of such language and information serves to reassure the reader of the quality of care provided by the settings, in a similar manner to the overarching theme of positivity, the purpose and intended audience of the published information are key when considering the data for analysis. The documents are likely published online and placed in public-facing areas of the residential settings with the main intention of being used as marketing and advertising material. Again, this means that the positive examples of care are going to be highlighted with the view to either reassuring potential residents of the level of care they can expect or perhaps more cynically to persuade people to move to the settings to generate further income for the settings.

5.4 Conclusion

The content of the publicly available documentation analyses in this chapter depicts relationships in an almost conflicting manner. The images selected for display are of smiling, happy people often engaged together in a way that insinuates the existence of a close relationship. Yet, at the same time the language used focuses heavily on independence and individuality, concepts not necessarily aligned with the prioritising of relationships. Another interesting focus in the language use, which is also at odds with the images depicting friendship and warmth, is the language used to describe the care provided at each setting. The focus of language describing care provision is on quality and professionalism, described in an almost clinical manner. This is in direct conflict with simultaneous attempts to depict the residential settings as 'home' for their residents. The discord in language and 'feel' of the literature is potentially confusing to the reader, at times coming across as an attempt to shoehorn in as many social care buzz words.

The contrast between warm imagery that suggests close relationships and more clinical language emphasising independence and individuality in the public documentation about residential care could shape how the public perceives and expects care. The warm imagery implies a nurturing, familial environment where residents feel deeply cared for, while some of the language used suggests a structured, professional approach focused on maintaining autonomy and meeting medical needs.

This difference might influence perceptions of the care environment, expectations of staff interactions, and assumptions about residents' overall quality of life. It also potentially impacts the trust, reputation, and recruitment strategies of the residential care facilities, highlighting the importance of aligning messaging with the actual care provided to effectively manage expectations. Understanding these influences is crucial for residential care facilities to effectively manage expectations, build trust, and provide a supportive environment that meets residents' differing needs.

Throughout this content analysis, although the positive framing has been discussed, the publicly available information must be taken at face value. Without being privy to the planning that goes into the creation of such marketing information, it is not possible to infer with any accuracy what the intentions behind the selection of particular quotes or information were. However, it is important to consider the context as well as the content. Future chapters will undertake further content analysis of observation and interview transcripts. The comparison of this data to the analysis of the public-facing marketing documentation will be interesting, particularly around the focus on what residents and staff most value in care provision in comparison to what the parent company felt best to market the settings.

The next chapter will provide a qualitative content analysis of the direct observation data. This provides observational data of residents and staff in practice, intending to add context and depth to answer the research question how relationships are experienced by social care staff and residents with dementia in residential care.

Chapter 6 Direct Observation Analysis

6.1 Introduction

To explore effective relationship-based practices within residential care settings, I conducted direct observations across two sites in South Wales. These observations aimed to gather rich data that would support answering this question thoroughly. The direct observations were undertaken before the interviews, following the evidence gathering for the content analysis phase of the research. The initial plan has been to undertake three sessions at each residential setting, lasting two hours per session. However, the data collection period for this thesis was planned for December 2019 to June 2020 and unfortunately had to cease earlier than planned due to the COVID-19 pandemic and consequent lockdowns. As a result, three observation sessions were conducted at site one, and one was conducted at site two. Therefore, the following analysis is based on eight hours of observations, across two residential settings.

The observations were conducted in the open-plan living areas of both sites and at times planned around points in the day where more residents would be present, for example, the period around mealtimes. The physical settings are described in greater detail later in this chapter. Across all observations, 28 participants were observed of which 11 were staff members and 17 were residents. Staff members identified 5 residents as not having the capacity to consent to participation. By following the process laid out in Chapter 4, with the support of key staff members and engaging with consultees, this study was able to include these residents. All participants were White British and spoke English with each other throughout the observations, meaning no Welsh translation was required.

The analysis takes a narrative form and is taken directly from contemporaneous notes, including direct quotes where it is deemed appropriate. Participants' permission was sought before commencing the observation sessions, and the researcher's role was explained thoroughly to both residents and staff. As a result, the interpretation of the data needs to consider that participants were aware of the research and that their behaviour may have been impacted. The data collection for the study was approached through a social constructionist theoretical lens. Therefore, it is important to recognise that my presence as a researcher may influence the behaviour of both staff and residents, as they are aware that their actions are being observed. Staff may have performed their duties more conscientiously, and residents might behave differently, knowing they are under scrutiny. This might have led to data that reflect how people want to be perceived rather than their typical behaviour. Also important is that scenarios were interpreted in situ and recorded based on what I deemed relevant and appropriate; therefore, there will always be a degree of subjectivity. Social constructionism emphasises that knowledge and meaning are co-constructed. My own biases and background will have shaped what I noticed and how I interpreted behaviours and interactions.

A thematic content analysis was conducted on the transcriptions of the contemporaneous notes. Through immersion in the direct observation date, four themes were identified. The themes are:

- Touch
- Laughter
- Familiarity
- Occupation

The observations from both sites will be categorised into the themes above and will be discussed further in this chapter. The physical environment within which the observations occurred will be detailed first, providing context. This is taken directly from the contemporaneous notes and includes digitised hand-drawn diagrams to replicate the original sketches as closely as possible. While not to scale, it is hoped their inclusion will provide a visual accompaniment to the written description.

6.2 The Sites

6.2.1 Site one

Site one was a residential unit situated within a larger residential care setting. The residential care setting was run by a branch of a not-for-profit organisation. Within site one, there were eighteen residents, of which twelve were female and six were male. The main entrance to the unit was accessed by entering the main building via a reception area and walking through the communal areas on the ground floor. The unit was signposted clearly throughout the communal areas of the residential setting, and staff at reception accompanied the first visit. Visitors to the residential setting are required to sign in and carry a visitor's pass. The entrance to the residential unit is locked, requiring a key card to both enter and leave.

On entrance, there was a door to the immediate left which opened into a large cupboard/storage room. The door into this storage room was also locked. The room contained a computer and all the resident's physical files, medication, and space where staff kept their personal belongings. The door itself opened immediately into an open plan living, dining and kitchen area. The kitchen was to the right, and completely open plan and accessible. Three dining tables were set out from the kitchen area and up to a window. The room opened to the left, into a living area. This looked out over the countryside and had several upright chairs around the perimeter of the room, facing inwards or towards a television on the rear wall. The television was not on unless a resident was sitting in the room, although a radio was playing in the dining/kitchen area. The contemporaneous notes stated this area felt:

> '*Homely, with lots of plants'*

The notes described the kitchen and dining area as follows:

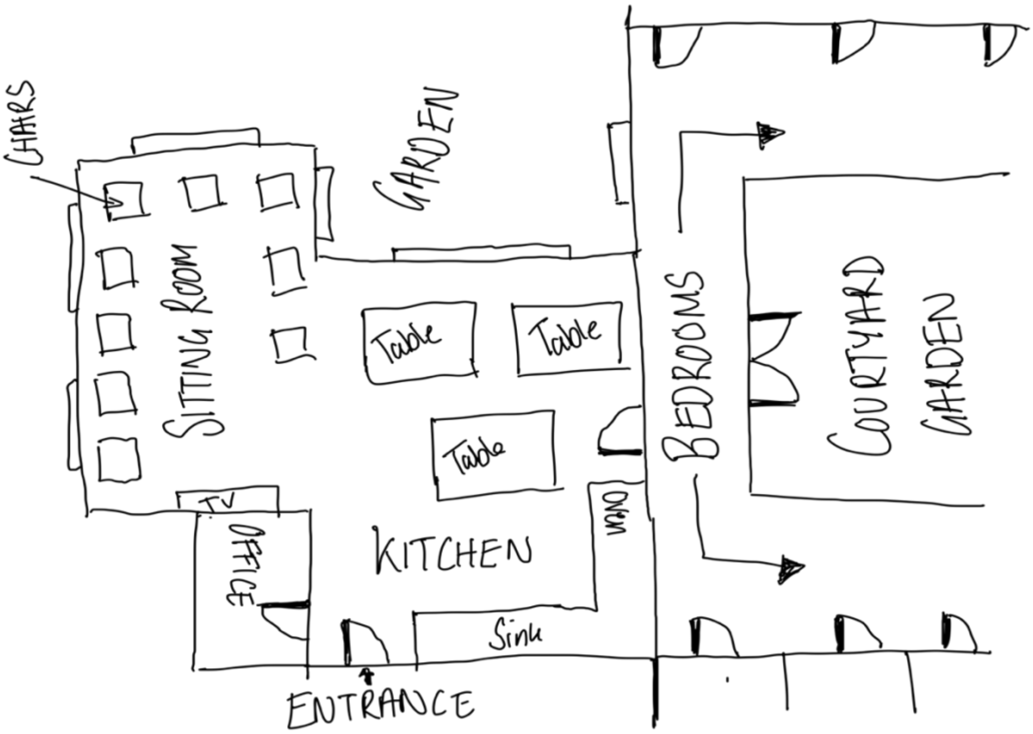
> '*A small, open plan kitchen similar to one you would expect to find in a [FAMILY] home……. feels very informal with bright lighting, lamps and plenty of large open windows'*

Walking between the dining tables led to a single door on the right-hand side of the room that opened into a large hallway. The hallway extended in a large loop around a courtyard, with residents' bedrooms accessed from the outer walls. The residents' bedrooms were numbered and had identical wooden doors. Noted within the contemporaneous notes was the following:

> *'…walking through the hallway is reminiscent of walking through the hallway of a chain hotel.'*

Some residents had their doors open, while others remained closed based on their personal preference. It was noted that many residents opted to stay in their rooms, but those who chose to keep their doors open often had their chairs facing out and would wave or call out as people walked past.

Figure 5 - *Site One Layout*



Note: Adapted from contemporaneous sketch, Site 1

6.2.2 Site two

Site two was another residential unit situated within a larger residential care setting. The residential care setting was owned by the same not-for-profit parent company and was built and decorated in a similar style to the first site. As with site one, the residential unit was accessed through the main entrance reception, although the unit was located on the first floor of the two-storey building. The first floor was accessed via a lift and similarly signposted with large, clear signage. As with site one, visitors were required to sign in and carry a visitor's pass before entering the building. The residential unit was again accessed via a locked door, unlocked with a key card. Each staff member carried the key card in a lanyard around their neck with their staff identification card.

On entrance to the unit, the door again opened directly into an open plan kitchen, living and dining area. This was slightly smaller than site one, with one large dining table surrounded by a kitchen area along the right-hand side wall. To the left, there was a seating area, consisting of several upright chairs around the periphery of the room, facing inwards and slightly towards a television on a television unit in the back left-hand corner of the room. The contemporaneous notes taken noted

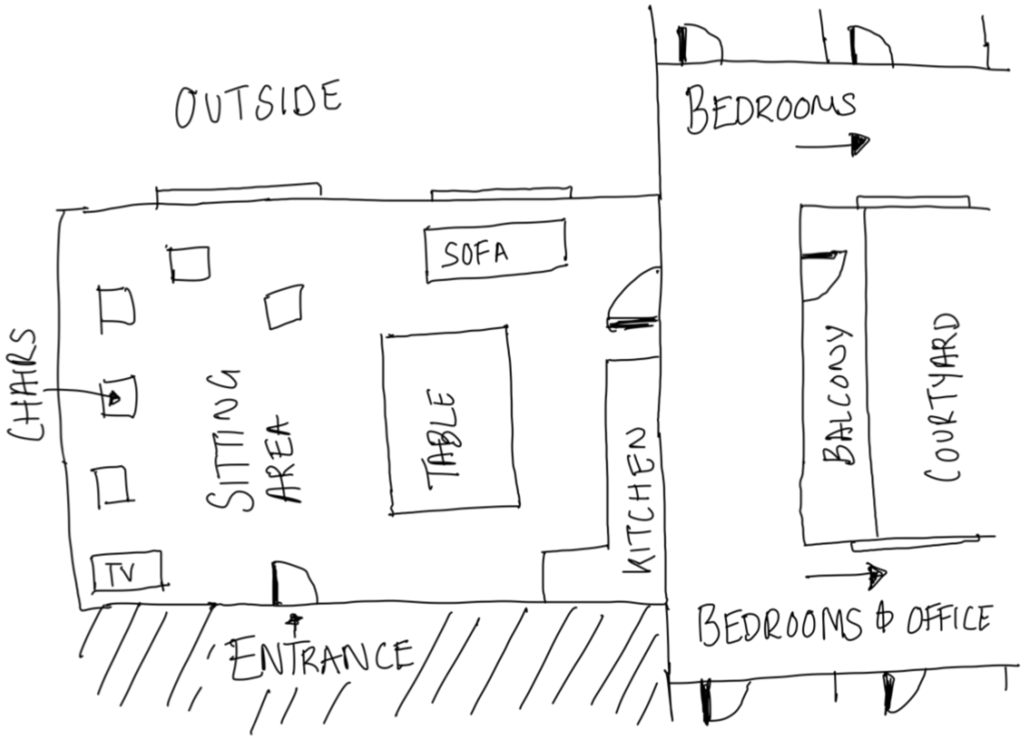
> *'[THE]room is colourful / brightly decorated in modern/simplistic style, art is on walls and framed plus ornaments on small tables. Feels homely'*

There was an additional sofa that was facing towards the window within the dining room. The room had 3 large windows along the wall opposite the entrance, facing in the same direction which was out towards an open grassy area on an industrial estate. Notes taken during the observation stated:

> '*The kitchen/dining area is lit by small lamps… feels dark but cosy for a winter morning.'*

To the right of the room was a door that entered into a hallway that led to residents' bedrooms and an office. Similar in design to site one, this hallway wrapped around a courtyard but due to this unit being located on the first floor, the external door opened onto a small outdoor balcony with seating. The remainder of the hallway had windows looking into the courtyard garden. Residents' bedrooms had identical doors along the outer walls, and each had a plaque on the wall next to the door denoting the room number. The hallway was described in the notes as darker than the previous setting, but the weather was noted to be overcast and the time of the observation was early to mid-morning in late February.

Figure 6 - *Site Two Layout*



Note: Adapted from contemporaneous sketch, Site 2

6.3 The direct observation themes

6.3.1 Touch

The first theme identified through the eight hours of observations undertaken was touch. Touch was observed being used to communicate and to comfort, informally and often it appeared to be instinctive. Touch was observed primarily in the staff–resident interactions, however instances of touch occurred in resident–resident and staff–staff interactions. Observations were unstructured, meaning that the frequency of interactions was not recorded in a structured manner. However, the notes taken highlighted that the majority of interactions observed during the observation window were between residents and staff. The following quote was noted during direct observation one at site one, conducted over two hours within which breakfast was served to residents. Two staff members were stood in the kitchen preparing breakfast and hot drinks for residents while residents were entering the dining area from the hallway one at a time, of their own accord after being offered breakfast by a third staff member who was not present while the observation was happening:

> ‘*[Staff] greeted [resident] placing their hand on the resident’s shoulder / back “how you feeling this morning [RESIDENT NAME]? Better?”. Opened informal dialogue between [resident] and the two staff members, conversation continued on topic, [resident] had bad day yesterday. Staff guided resident to seat continuing conversation. Touch looked caring but also used to support / guide [resident].’* (Site 1, Direct Observation 1)

The contemporaneous notes provided observed context for the above quote, rather than continuing to transcribe dialogue between the observation participants. The below excerpt taken from the direct observation explains:

> *‘Staff opening conversation and using questions to prompt interactions each time resident is entering room. Touch initiated by staff, comes across as natural/instinctive and responded with warmth by residents. Questions casual but open ... conversation between residents limited to seemingly ‘small talk’ conversation topics.*’ (Site 1, Direct Observation 1)

Direct observation three at site one was conducted over two hours mid to late morning. Contemporaneous notes included the following observations:

> *'Most interactions and conversation between staff and residents, staff approach residents, opening and continuing discussions. Touch initiated by staff. Staff grasping (?) / supporting under elbow/arm when resident is walking.'* (Site 1, Direct Observation 3)

As well as offering physical support, touch was observed between staff and residents that appeared to offer emotional support. Reassuring touch was observed being used in response to a resident who was upset, as detailed in the below excerpt from notes transcribed following direct observation one at site two:

> '*[Staff] approached [resident] who is crying. [Staff] asks in a soft/concerned way "What's up love?". [Resident] doesn't say why she is upset (seems unsure). [Staff] sits down at dining table next to her and holds her hand, offering a tissue. Resident seems comforted by staff member patting her hand, staff member reassures her verbally and physically and interaction lasts for approx. 2 minutes until resident seems to 'collect' herself. Staff member offers a 'cuppa' and gets up to carry on making it in the kitchen, still close by.' (*Site 2, Direct Observation 1)

Reassuring touch was also observed during a brief and informal interaction between a staff member and resident, during the second observation undertaken at site one. The resident sat at the dining table, although it was not lunchtime. The excerpt from the transcribed notes explains:

> '*[Resident] sat at table closest to kitchen, [Staff 1] and [Staff 2] milling about kitchen/office room following breakfast clean up. [Staff 2] explained before observation started [resident] has memory problems presenting similar to dementia but due to previous brain injury. Resident appeared anxious, starting conversations with two staff present and getting upset/frustrated and asking another unrelated question. Staff [both] responded to all questions gently, and when passing the resident [staff 1] responded verbally and placed her hand on*

> *the resident's forearm and stooping to her seated level to engage in the conversation. Comes across reassuringly….' (*Site 1, Observation 2)

Touch was also observed being used during humorous interactions. Humour was observed throughout all four direct observation sessions and is discussed later in this chapter. Touch was used between a resident and staff member, who were joking while the resident was sitting waiting for lunch to be served, and the staff member was busy. There was 'banter' between the two, and the touch observed was transcribed from the observation notes as follows:

> '*[Staff] responding to [resident] making [a] joke about wanting the staff to hurry up with their lunch by patting the resident on the shoulder and laughing loudly back. The interaction looked/felt familiar as if the relationship between resident and staff often included humour and banter type joking. Staff response natural/instinctive and resident responded by laughing even louder. Both smiling.' (*Site 1, Direct Observation 3)

During the observation, touch used when joking was observed again in the open-plan kitchen and dining area of site one. The resident was helping staff package up items previously made to be sold at the upcoming Christmas Fayre, to raise money. They were joking about how hard they were working and who was doing the better job.

> *'[Staff] made self-effacing joke that they weren't doing as well as resident who clearly has the "knack". [Resident] laughed and held/shook staff members hand and made joke that if they keep practising they might improve.' (*Site 1, Direct Observation 3)

The final example of touch used in humour during the direct observations was between two male residents while waiting for breakfast during observation one at site one. The transcribed notes taken explain:

> '*Two male residents sat at table closest to living room. Appears residents have 'usual' seats. Male residents joking when sat down, a lot of chatter between residents and staff during busiest period so while exact nature of joking not*

> *clear, both residents smiling, loudly laughing and one slaps the other on the back 'heartily' at joke he made. Atmosphere could be described as jovial/easy.' (*Site 1, Observation 1)

During observation three at site one, a member of staff was visiting on her day off to support preparations for the Christmas Fayre. The observation notes stated:

> '*[Staff] came in, made joke about it being her day off and was greeted warmly by two staff members working, and resident sat in dining/kitchen area. [Staff 1] came over and gave her a big hug in front of resident. Relationship seems friendly and genuine, natural.' (*Site 1, Direct Observation 3)

While touch was observed repeatedly, transcriptions of the observation notes also described how not all residents were treated the same by staff, in terms of the tone of voice used and how they interacted, both verbally and physically. The notes from the second observation at site one describe this state:

> *'Staff appear to have different relationships with different residents. Some residents are spoken to more softly, and more (formally? Seriously?), some are instinctively touched when being spoken to, while more physical space seems to exist between staff and other residents. Different relationship dynamics clear between staff and different residents.' (*Site 1, Observation 2)

6.3.2 Laughter

Laughter and humour were recorded in all four direct observations and were identified as a further theme when analysing the direct observation transcripts. Humour was present in almost every interpersonal interaction observed in the residential care settings. Some examples of laughter and joking were described in the observation notes often as 'banter', with the following example taken from the atmosphere description of observation one, site two:

> *'Lots of 'appropriate banter' in the background, laughter and joking….'* (Site 2, Observation 1)

The Oxford English Dictionary defines banter as:

> *'Mocking, humorous, or arch remarks made about people or things to expose their shortcomings and to make them appear laughable; humorous ridicule; (also) good-humoured teasing or raillery, witty or amusing repartee. Now usually: teasing, joking, or humorously mocking remarks exchanged playfully with another person or group, esp. among men; (also) an instance of such an exchange.'* (Oxford English Dictionary, 2021c)

The latter definition aligns with the use of the word banter throughout the direct observations. Banter describes the joking, often self-effacing, repeatedly observed in interactions. The frequent humour and joking affected the atmosphere of the residential setting during observation two at site one. The notes taken describe the atmosphere as follows:

> *'Jovial, a lot of laughter from both residents and members of staff. Chatter is continual, feels cheerful almost joyous. Hard to distinguish individual conversations from the short distance observation is being taken from due to volume but chatter providing a warm and friendly noise.'* (Site 1, Observation 2)

Laughter was also a key feature when describing the atmosphere of site one during observation one. The notes taken during the two-hour observation state:

> *'[Atmosphere is] …fairly quiet, but continual hubbub coming across as positive and upbeat. Lots of jokes heard, men talking and joking more than women present, feels relaxed despite people [Staff and residents] continually entering and leaving.'* **(**Site 1, Observation 1)

Conversations were observed between male residents while waiting to be served breakfast during observation one at site one. The observation notes stated:

> *‘Male residents engaging in ‘banter’. Loud joking, chat and jokes about the weather being bad but not as bad as it was last week. “Not so cold, not cold”.’* (Site 1, Observation 1)

As well as banter, laughter and joking were used when staff and residents spoke warmly to each other. This was mainly observed between female residents and staff. The use of the word ‘love’ was noted, and while the word love implies a deep relationship it was used in a light-hearted way. One example of this was found in observation two at site one:

> *‘The use of the word ‘love’ stands out. [Resident] said she loved a staff member who said it back to her. The resident said it in a way that felt humorous but still genuine, while the response from the member of staff also came across as warm and genuine. Exchanges with residents were similar in tone as between staff, friendly.*’ (Site 1, Observation 2)

The use of love was again noted, said with humour but again described in the notes taken as appearing to be based on a foundation of sincerity and a genuine warm relationship. The following excerpt is taken from the observation notes of observation one, site two:

> *‘Resident sat at dining table chatting to member of staff. Resident says” I love life, I do” and “we loves each other don’t we babes”. Directed to staff member, said while leaning back in her chair laughing ‘heartily’. Staff member agrees with resident, also laughing.*’ (Site 2, Observation 1)

In addition to laughter being used when joking or engaging with banter, it was also observed accompanying compliments. Residents and staff spoke fondly to each other, and positive interactions were often followed by laughter. The below example is taken from observation three at site one. Three residents and three staff members (one not officially working) were present working on wrapping jars of chilli jam. By the point of the below excerpt, three residents had joined in the work:

> *'Resident 1 to staff 'You're all marvellous aren't you'. All six present, three female residents and three members of staff [also all female] laugh in agreement. To observe feels like observing friends rather than a residents/staff divide when listening to the conversation, difference only apparent when [staff 2] is needed to help a resident with the activity. Warm, joking, laughing.'* (Site 1, Observation 3)

6.3.3 Familiarity

The third theme identified through analysis of the direct observation transcripts is familiarity. Familiarity is defined as:

> *'The state of being very friendly or intimate; friendly interaction; close friendship, intimacy (with a person).'*
>
> *Or*
>
> *'An instance of informal or friendly behaviour; something considered appropriate only amongst close friends.'* (Oxford English Dictionary, 2022c)

In this context, familiarity was chosen to reflect both these definitions of the word. It accurately describes the voluntary offering of intimate and personal information during exchanges between residents and staff. It was noted through the direct observations that topics that could be deemed of a personal nature were discussed openly and comfortably, during friendly interactions. Staff openly spoke to each other in the communal areas and the presence of residents, often discussing non work-related topics. Additionally, staff and residents conversed with each other, discussing relationships or links extending beyond the confines of the residential setting. Notes transcribed from observation two, site one states:

> *'[IT IS] apparent staff are known to some residents from local community. One resident taught a staff member's mother in nursery and [THEY ARE] reminiscing about it. Staff prompted resident to discuss points, evident this*

> *conversation had happened before and resident enjoying the discussion.'* (Site 1, Observation 2)

The staff member was happy to speak about her family and engaged with the resident, seeking to continue the conversation and encouraging her to reminisce. Residents and staff members again discussed the wider community and family members in the below excerpt from the observation notes taken from site two, observation one:

> *'Staff discussed seeing the resident at the local pub with her sister, staff member brought up and resident reacts warmly and pleased to discuss a recent visit with her sister. "Oh yes yes, last week, yes... I think". Both discussed being part of the same community and spoke about different places to go [resident] enthusiastic and responsive/engaged. Resident brought up how things had changed, staff member appears interested and discussion continued. Both smiling, staff member stopped her work and leaning in, prompting.'* (Site 2, Observation 2)

The staff member in this situation started the conversation, to which the resident responded warmly and was keen to discuss her recent day out in the community with her sister. The staff member appeared to use the personal information to prompt discussion about something the resident had enjoyed and made efforts to continue the conversation about the local area and community by prompting the resident who responded warmly and enthusiastically. In the below excerpt, a staff member similarly used personal information to start a friendly discussion, but this time the information was personal to a member of staff:

> "*What did you think about the news from [staff member]'s daughter?" [Staff] approached resident to ask whether she had heard about the news of her colleague's daughter's pregnancy. [Resident] responds by throwing her hands in the air (gleeful? Excited?) "Yes, wonderful! Yes".'* (Site 1, Observation 2)

The news of the pregnancy of a staff member's daughter had already been shared, and the casual way in which the question was asked of a resident suggests it is not unusual for positive, personal news to be shared by staff members with residents. This openness was seen again in the personal nature of discussions between staff members in the presence of residents. Friendly chatter was observed between staff members as they were going around their business. The following excerpt is taken from observation one, site one as staff prepared breakfast in the presence of residents:

> *'Staff appear to be friends with each other, in between short discussions/questions with residents and staff speaking to each other [are] conversations about personal ties and events, openly discussed. Also shopping, weekend plans and banking.'* (Site 1, Observation 1)

Residents were talking amongst themselves and to staff members while the staff chatted. The personal details were discussed naturally and openly, suggesting such discussions regularly occur in the presence of residents. This openness during discussions between staff and residents can again be seen in the excerpt below taken from observation three, site one. The observation describes the conversations happening while three residents and three staff members are working together to prepare for the upcoming Christmas Fayre:

> *'Resident scolding self for being forgetful, looks upset, frustrated? Two staff telling stories of their own bad memories and mistakes they've made recently. Both laughing at selves for mistakes, resident laughs too. Calms down. [Staff members] sharing personal info about own families and then ask questions [to] residents about their friends and family. Conversation continues, all laughing again, happy.'* (Site 1, Direct Observation 3)

The sharing of personal information in the above scenario appeared to be used as a tool to open conversation and encourage residents to continue talking about their own friends and family. The stories staff shared about their own mistakes due to forgetfulness diffused a situation where a resident appeared to begin getting distressed at their memory problem, and the subject was then changed through further sharing of personal information and encouraging the resident to join in. This interaction demonstrated staff used interpersonal skills seamlessly and naturally to prevent a resident from becoming distressed before changing the direction of the discussion. It was successful and handled well in this instance.

6.3.4 Occupation

The final theme identified from the transcripts of the four observations is occupation. There are multiple definitions of occupation, including those related to the occupation of land or countries however for this thesis, the meaning of occupation aligns with the below definition taken from the Oxford English Dictionary:

> *'The state of having one's time or attention occupied; what a person is engaged in; employment, business; work, toil.'* (Oxford English Dictionary, 2023).

Although it is to be expected the staff members observed would be engaged in work, it was noted throughout the eight hours of observations that residents were also regularly to be found engaging in 'work', or occupation. As the observations took place in the communal and open-plan dining, kitchen and living areas of the two residential units, personal care work undertaken by staff was not observed as this occurred within residents' private rooms. Instead, the work staff were observed engaging in the preparation and serving of food and drinks, along with social and emotional support. Throughout the observations, residents were frequently observed engaging in similar 'work' to staff. A good example of this was recorded during observation three at site one. As previously discussed during this chapter, three staff members and residents were engaged, side by side, in preparations for an upcoming Christmas Fayre. The observation notes state:

> *'Staff and residents working together to wrap chilli jam made in previous weeks. Discussing the prep of the jam together and plans to make marmalade together this weekend. Staff wonders if [another resident not present] will join in. Resident [2] jokes to [staff member 3] "all the delicacies, you make all the delicacies, don't you? You wants to go on dragon's den" ……. To observe feels like observing friends rather than a residents/staff divide when listening to the conversation, difference only apparent when [staff 2] is needed to help resident with the activity.'* (Site 1, Direct Observation 3)

A key point in this observation is how it felt like observing friends rather than observing a staff member and resident. The lack of an obvious divide between residents and staff describes how engaging in the same occupational activity alongside each other puts them on a more level playing field. All those present were undertaking the same activity, towards the same end goal. During mealtimes, the difference between staff and residents was clear, with residents sitting at the dining table or tables while staff prepped or served food. Breakfast was prepped in the small kitchens, while the lunch meals observed were delivered from a bigger kitchen elsewhere in the residential setting and then served to residents. However, outside of mealtimes, residents were encouraged to engage in occupation. The below excerpt from site one, observation two happened late morning before lunch was served:

> *'[Resident] said they "fancy a cuppa". Staff member clearing up in kitchen and said to [the resident to] come and give a hand. Resident goes over to kitchen area and obviously knows where mug is. Staff member pass[es] tea bags and sugar, resident boils kettle. Staff member only 'does for' when resident has finished making tea, [staff member] carries tea to living room.'* (Site 1, Direct Observation 2)

Similarly in the below excerpt from the observation at site two, a resident is encouraged to engage in work alongside a staff member:

> *'[Resident] finishes tea and carries cup to kitchen area where [staff] is clearing up from breakfast. "Come on then, give us a hand", resident puts cup by sink and picks up tea towel, starts drying plates. [Staff] complains about weather, conversation starts about cold weather and looking forward to the days getting longer soon. Quiet, slow but pleasant.'* (Site 2, Direct Observation 1)

This seemingly mundane interaction was observed to be quiet but pleasant. The staff member was busy doing the dishes and was close to finishing but inviting the resident to stand alongside and join in allowed for conversation and occupation. The alternative would have been the resident going to sit down alone; however, the resident was able to engage in activities of daily living that likely allowed for a sense of normality, again bridging the divide between the staff member and resident. The concept of roles being socially constructed and assigned is outlined in the methodology, with reference to the work of Berger and Luckmann (1991). The authors argue that through engaging in work, people can foster a sense of purpose and a sense of self. As Berger and Luckmann (1991, p. 91) explain, during a course of action there is a self-identification of the self, with the objective sense of action – the individual has been '*socially ascribed to that action'*. As discussed in the literature review chapters, dementia, ageing, and a move into a residential care setting are all events that can have a negative impact on a person's identity and sense of self (Clarke et al., 2010; Howe, 1998; Sabat, 2006; Ward, 2018). Supporting residents to engage in work alongside staff members may provide benefits beyond addressing power imbalances and creating opportunities for informal interactions. This practice could also support residents in fostering their sense of self.

6.4 Conclusion

The four observation sessions analysed in this chapter have provided rich, narrative data to support this thesis to answer the research question of how relationships are experiences by people living with dementia and social care staff in residential social care settings. Although the presence of a researcher may have influenced the data collected, over the eight hours of data collected there were many relaxed, informal, and positive interactions observed between residents and staff. Most notable was the informality and friendliness of many of the interactions, and the responsiveness of staff. Staff appeared well attuned to the needs of the residents in their care and interactions felt natural and instinctive; attributes that could only come through intimate knowledge of the residents' personal preferences and needs.

The inclusion of details of the physical environment provided additional context to understand how interactions, and thus relationships, are supported or inhibited by surroundings. Throughout the observations, it was clear the open-plan design of the small kitchen in both units allowed residents to work alongside staff members. Although information on the design process of the residential care settings was not available, the layout felt deliberate, especially when considering bigger meals were prepared in a larger, onsite kitchen elsewhere in the care home and delivered to the unit at mealtimes.

The themes identified were touch, laughter, familiarity, and occupation. Staff were observed using touch to comfort and engage with residents, who were observed responding warmly to the interactions. Laughter was pervasive throughout all the observation sessions and a large number of the interactions. The staff laughed with each other, residents laughed with each other and both groups of participants laughed together too. As a researcher, at times there were attempts to bring me into the laughter or involve me in a joke. The impact of this appeared to go beyond the individual interactions where the laughing and joking occurred and created an environment of laughter. Often individual conversations could not be discerned as there was so much chatter and laughter happening, and the result was a warm, welcoming, and almost joyous environment on occasion.

Laughter is also featured throughout the interactions themed together under occupation. The observations featuring staff and residents engaging and occupied alongside each other felt particularly significant in providing meaning to the lives of residents. Although the interactions observed in this study were only a snapshot of daily life in the residential settings, the inclusion of residents by staff appeared natural and as if they were regular occurrences. Laughter could be an important tool in relationship-based care as it fosters positive emotions and creates moments of joy and connection. It can also strengthen social bonds between residents and caregivers, enhancing the quality of their interactions. Engaging residents in meaningful activities tailored to their interests and abilities is integral to relationship-based care. Occupation provides opportunities for residents to feel productive, maintain skills, and experience a sense of accomplishment. Activities can range from simple tasks like folding laundry or gardening to more stimulating activities like art therapy or reminiscence sessions. Occupation not only stimulates cognitive functions but also promotes social interaction and a sense of purpose.

The theme of occupation links with the theme of familiarity. Staff were observed inviting residents who responded well to engaging in ‘work’ alongside them, indicating prior knowledge and familiarity with their preferences. This was also observed through the differing ways staff approached and responded to the individual residents; there was no ‘one size fits all’ approach. Staff appeared to know not only the needs and preferences of residents but also details about their wider social groups and their histories. This level of familiarity, and depth of relationship, is another way in which staff could support residents to strengthen their sense of self and identity within the care home. Physical touch, when used appropriately and respectfully, was observed to convey warmth, comfort, and security to residents with dementia. Touch can help establish a sense of connection or provide a way '*to offer comfort, promote healing, and demonstrate caring'* (Connor & Howett, 2009, p.127).

The data from these observations was synthesised, along with the initial phase of analysis of the documentation in the previous chapter. This was used to refine the interview questions before commencing the interview phase of this research. The observations add further context, meaning that the research does not need to rely on the recollections of participants to inform the understanding of how effective relationship-based care can be supported. This is particularly important when the residents involved in this research live in the residential settings observed due to problems concerning their memories. In the context of residential dementia care, these elements could contribute to relationship-based practice by focusing on the individual's emotional and social needs rather than just their medical or physical care. They create environments where residents feel valued, understood, and supported; crucial for maintaining their dignity and enhancing their overall quality of life. By incorporating touch, laughter, familiarity, and occupation into daily care routines, staff could foster meaningful connections with residents and promote positive experiences.

The next chapter provides a qualitative content analysis of the semi-structured interviews with participants, both residents and staff

Chapter 7 Interview Content Analysis

7.1 Introduction

Interviews were conducted with participants across two residential care sites, individually with both residents and staff. In total 17 interviews were conducted, amounting to close to nine hours of interview data[10]. 13 residents were interviewed across the two sites, with eight interviews conducted at site one and five conducted at site two. All residents were older adults (aged between 69 and 92 at the time of the interviews). All had either a diagnosis of dementia or were identified by staff as having memory problems. The ethnicity of the residents was White British, and all residents spoke English fluently. One resident interviewed was bilingual in Welsh and English but opted to conduct their interview in English. There was a close to even split in the gender of the residents, with six male and seven female participants. One female participant requested that her daughter, a daily visitor for her, be present at the interview. Consent was sought from the daughter, but she was not questioned directly. It must be noted that while the presence of the participant's carer did not appear to influence the participant's answers, the impact of her presence is unknown.

Eleven of the resident interview participants had the capacity to consent to the interview process, while two participants did not have the capacity to provide consent and instead the process for obtaining consultee approval was followed. The participants, while lacking the capacity to undergo the consent process were able to indicate their willingness to be interviewed. The interview questions for participants who lacked capacity to consent were the same, and as the interviewer I was able to draw on previous experience supporting people with dementia to ensure questions were understood, and that participants were able to answer and contribute meaningfully to the interview topics without pressure.

---

[10] The interviews were conducted with 4 members of staff, 13 residents and 1 carer (who accompanied a resident at their request, the carer was the resident's daughter).

Four members of staff were interviewed, all at site one. All staff interviewed were social care staff working in the unit's delivering day-to-day and personal care. The staff members all spoke English, although two also spoke Welsh fluently. The ethnicity of all staff members interviewed was White British, and they were all female.

The interviews at site two were conducted in early March 2020, shortly before nationwide lockdowns were introduced to control the spread of COVID-19. Data collection ceased immediately, before the desired number of interviews was reached, explaining the difference in interview numbers between the sites.

The data collection in this study was approached from a social constructionist standpoint, as outlined in Chapter 4. With this theoretical framework in mind, the impact of my presence as an interviewer must be considered. Participants may have tailored their responses to align with what they believe I expected or find acceptable. This is particularly pertinent in residential settings, where residents might respond according to perceived social norms rather than their authentic feelings. The relationship between myself and the participants has the potential to shape how comfortable and open the participants felt, impacting the depth and honesty of their responses. Additionally, power imbalances might have hindered participants' willingness to express negative experiences or dissenting opinions, thus affecting the authenticity of the data collected. Each participant was given the option of choosing where they felt most comfortable to conduct their interviews, and I spent time in each setting before conducting the interviews to allow both residents and staff the opportunity to get to know me, and the aims of the research. Recognising these influences is crucial when interpreting the data and understanding the constructed nature of the knowledge generated by this study.

An ethnographic approach was taken to analyse the content of the interviews, as outlined in the methodology chapter. Seven themes were identified and while each theme is discussed individually, it must be noted that there is a degree of overlap between themes. The themes identified via this content analysis, and explored in detail throughout this chapter, are as follows:

- Love and Friendship
- Humour and Laughter
- Trust and Reliability
- Time (or lack of)
- Acknowledgement of difference
- Touch and Boundaries
- Loss

Throughout immersion in the interview transcripts, one of the predominant themes that emerged from the data was that of ‘love and friendship’. When asked to think about what made a relationship between care professionals and residents positive, all of the staff interviewed, and over half of the residents, spoke about love and friendship. Relationships were spoken about in terms that alluded to them being beyond professional, task-driven relationships and instead were referred to both directly, and indirectly, in terms of warmth, friendship and love. The decision was taken to keep ‘love and friendship’ as a combined theme because frequently the descriptions of love and of friendship were used together, or interchangeably, when referring to the relationships between residents and staff. Humour and laughter were spoken about in a similar vein, and often alongside discussions around love and friendship, however, it was felt that humour and laughter were distinct enough to warrant their own theme. The decision to separate the themes was made to illustrate that not all interview participants referred to ‘humour and laughter’ alongside ‘love and friendship’ as the key to positive relationships. Grouping them together would have misrepresented a key difference between respondents.

The themes ‘Trust and Reliability’ and ‘Time (or lack of)’ are another example where interview participants often responded with answers that could be grouped under both themes due to inherent similarities. However, the decision was again taken that the two areas were distinct enough to be separated into two different themes. The two themes referred both directly and indirectly to the concept of being trustworthy and reliable as core to the development of positive and effective working relationships. When time was discussed, both residents and members of staff acknowledged the impact the availability of time has on the ability to be reliable and to build trust. This distinction was felt to be important as interview respondents indicated that time is a key factor in the development of trust, and therefore effective professional relationships. It was not, however, the only factor identified required when establishing trust.

The themes ‘Touch and Boundaries’ and ‘Acknowledgement of Differences’ are linked by the common theme of the concept of autonomy, and of personal choice. The decision was made to separate the themes, as while it is clear that responses from both staff and residents placed a high degree of importance of knowing, and respecting, the differences between individuals, there were enough responses that framed this through the lens of touch and professional boundaries to warrant the separation of themes. Touch and boundaries were often spoken of together, and predominantly by members of staff, with cautious and often negative responses to the existence of professional boundaries.

The final theme discussed in this chapter is ‘loss’. Responses from both staff and residents discussed the concept of loss, however the majority of responses came from residents where discussion of loss, and the management of loss, was woven throughout nearly every resident’s interview. The loss discussed included loss of autonomy, loss of independence, loss of physical ability and loss of relationships.

7.2 The interview themes

7.2.1 Love and friendship

The first theme being explored in this chapter is ‘love and friendship’. Friendship, in particular, was a recurrent theme when participants, both residents and staff, were asked about what they felt was important to the development of positive relationships between the two groups. Friendship, or being friendly, was spoken of as a key feature of positive working relationships and was often one of the first descriptions offered in response to the question. For example:

> *'Friendly... They're all friendly. That's the main thing, friendly, isn't it?'* (Participant 16, resident)

Another resident gave a similar response when asked what made relationships with staff positive:

> *'Friendship. Getting on in harmony. And getting to know the people who work here, in the first instance.'* (Participant 10, resident)

Friendship being an important part of positive relationships was something staff communicated too:

> *'Friendship and building a good bond with ... people and you know, yeah relationships is a good bond with people, and you know…'* (Participant 3, staff)

The concept of residents and staff 'getting on' with each other, and being in harmony, was one echoed throughout a number of interviews, even if not being referenced explicitly. Relationships being reciprocal, and fondness and friendship existing between both individuals in relationships was also discussed. For example, a resident described being 'liked' going both ways in the relationship when asked the same question *'they, like me and I like them. You know…'* (Participant 17, Resident).

This concept of reciprocity was taken further through the acknowledgement that it was felt important that staff and residents felt comfortable sharing personal information and anecdotes about their own lives. Relationships were framed positively when interview participants touched on this concept of confidence in being open with each other and feeling able to share details of their personal lives and histories. For example, when asked about their relationship with members of staff, a resident responded:

> *'I find them great, you know. Uhh…. I Have conversations with them about their family and uhh…. you know their children, the older one's grandchildren, and uhh you know... we have a chat about anything you know, that suits them…. Their holidays or whatever. Like [STAFF NAME] out here now... I mean she's got a five year old child. My great grandchild is a couple of days*

> *different to her little boy, you know. We talk about that... I always ask her nearly every day "how is [CHILD'S NAME]" and she tells me every day "oh great now".'* (Participant 18, Resident)

This excerpt exemplifies the concept of reciprocity between residents and staff. This resident spoke fondly of the parallels between her own family and the member of staff, and it enables the resident to speak about her own history, family and identity. By having a conversation starter about something personal it provides the resident with an opportunity to meaningfully connect with the staff member and provide a subject on which to build a positive relationship on.

When analysing participant responses to questions regarding their established relationships between residents and professionals, those responses often indicated they felt relationships went beyond a perfunctory and task-oriented care giving relationship. Some participants spoke about the relationship being a friendship, and about how that element of friendship 'has to be there' for a relationship to be positive and effective. The 'social' element of the professional relationship was referred to, and how this can bridge the divide between professionals and residents. For example:

> *'it's a combination of a professional level and… a social level. It's got to be that way, you can't be purely, sort of, them and us, we've got to have a friendship as well with them. It's got to be there; it's got to be there.'* (Participant 18, Resident)

This resident, when referring to 'us and them', clearly communicates how the development of a social element to the professional relationship helps to address the power imbalance inherent in a staff–resident relationship. By avoiding the 'us and them', it unites the two groups and enables residents to feel more equal to the people providing their care. The importance of kindness and responsiveness to emotions, over task-oriented communication, was also relayed by another participant who stated:

> *'And of course, I do get my ... uhh sad moments, and of course they there to help you. And… uhh… they come and comfort you and they say if there's*

> *anything you want to talk about, we'll come and we'll have a little chat and they're very good at that. Marvellous, yes.'* (Participant 17, Resident)

Similarly, the social element to relationships was discussed in terms of residents' location in wider social relationships, outside of the confines of the care home setting. The participant stated:

> *'Because when the ladies here now, she said… she said to me "you was talking to my mother last week in town", she said. And I said, "oh I don't know your mother", "Oh yes, she was talking to you, she knew you." Oh, everybody knows me [LAUGHS].'* (Participant 16, Resident)

The residential care setting this participant resided in was part of a fairly small community, and it was clear that she found a sense of pride in being a part of a community where people knew her. It also provides the resident with a sense of her own identity, and again somewhat addresses the power imbalance by humanising the professionals and providing a thread of commonality outside of the residential setting. This concept has been explored in social work and social care literature and is referred to as 'dual relationships' and is particularly common in smaller communities where paid professionals are likely to have community and social links with the people they work with, as discussed in chapter two of the literature review (Alexander & Charles, 2009; NASW, 2017). It is of note in this situation that it is the professional who brings up the dual aspect of their relationship which could be used to establish trust and rapport with the resident, in addition to fostering a social or friendly element to their professional relationship. It is clear that the staff member feels confident enough in their position to divulge personal links and information with the resident.

The establishment of a relationship that goes beyond the professional was discussed by one resident (Participant 17), who spoke fondly of staff members at her previous residential home and how they still contact her from time to time via social media. The resident stated:

> *'Friends and family... [Contact me on Facebook] yes… yes... and of course, sometimes, the girls… uh... in the home, that I was in before uhh… they, they… text me now.'* (Participant 17, Resident).

As in the previous example, this resident spoke with a sense of pride that the professionals in her previous residential setting still sought contact with her and continued to check in with her. Although not stated explicitly, it can be assumed from the resident's response that the staff members were either connecting with her through social media or their phones meaning that these details were exchanged. This again implies that the relationship went beyond the realm of perfunctory and professional, and towards a lasting relationship that ventures into the realms of friendship.

A number of participants, that included both residents and professionals, took the concept of friendship further and spoke in terms of 'love' when asked about what features were key to positive professional relationships. Love was spoken about both directly, but also indirectly through referring to each other as being equivalent to 'family'. The word family infers aspects of trust and love, and unbreakable familial bond. Thus, to refer to another person as 'being like family' insinuates the relationship between those individuals goes beyond the professional, and perhaps beyond even friendship, and contains long lasting bonds and elements of love. Residents spoke of staff members being 'like a daughter' or 'like family', implying that the care in this professional caring relationship is not one directional, and is instead reciprocated by the resident. Participant 15 (Resident) stated:

> *'With all them, and I don't mean this in a romantic way, there's got to be a love there……. There's got to be that little bit more than friendship… umm…. How can I explain it, a warmth with these people… staff as well. … they're almost like family. And that's the way I want it to be. You know, I'm comfortable with that'*

Participant 15 was explicit in his requirements of effective professional relationships requiring more than the staff member performing tasks and even more than friendship. He implies that the people providing his care need to demonstrate love towards him in a familial way, and that warmth is a key feature of the relationship. This concept of love and family is echoed by Participant 17 (Resident) who stated:

> *'Well… love. Kindness… Happiness. [PAUSE] You know?.... They're very friendly…… I call this my home. Which everybody does... you know. And… ummm. Well, they're like a family.'*

What is interesting in this response is how Participant 17 refers to themselves and 'everybody' calling the residential setting their 'home'. The idea of everybody living in one home further extends the concept of family, as the word home is defined by the Oxford English Dictionary as:

> *'[A] place where one lives permanently, especially as a member of a family or household'* (Oxford English Dictionary [OED], 2016: online).

In response to a later question about what contributes to developing positive relationships, Participant 17 (Resident) again refers to concepts of family, stating:

> *'Sometimes, they're uhh... I treat them as if they were my daughters, you know. And they're very helpful…'*

Similarly, Participant 6 (Resident) responded:

> *'They're here to talk to, you know. Umm... They care for you. I got multiple problems so umm... you know each one is… what can I say, it's different from day to day. But if I get, I get down or whatever I can have a chat with the staff here, you know, it's not a problem. They're like a family.'*

While Participant 17 and Participant 6 have different responses, the conclusion is the same. Both of these excerpts conclude with the same phrase, similar to Participant 15, that the professionals are 'like a family'. Participants 15 and 17 spoke of kindness, happiness, warmth and friendliness, while Participant 6 referred to professionals being able to have a chat and professionals being aware of their day-to-day problems. The difference in what each resident defines as being 'like family' exemplifies the difficulty in defining what constitutes a ‘familial like’, and also highlights the difference in personal needs and preferences. Interestingly, there is almost a caring and maternal element felt in the relationship between Participant 17 (Resident) and the staff providing her care, with the care in those relationships flowing both ways. Conversely, Participant 16 responded to a question about their relationship with professionals in the care home stating:

> *‘Well, you can’t say it’s like families, because… like, you know, like, I got a family, but I don’t see them often.’* (Participant 16, Resident)

This response highlights that while comparing relationships between staff and residents to familial relationships is frequently a positive comparison, for this individual it can be concluded from their response that such a comparison is not necessarily positive to them. Not all family relationships are positive, and not all families value seeing each other frequently.

While residents spoke quite freely of the love, friendship and familial elements of their professional relationships with staff, it was interesting that while staff acknowledged feelings of love towards residents, they were more reticent when doing so. The professionals interviewed reflected on how feelings of love and friendship could be deemed wrong, or against guidelines. It appeared that some members of staff felt conflicted about the fact they developed feelings of love towards the people in their care. One such example is clear from the following excerpt of Participant 13’s (Staff) response:

> *‘You get really attached to people and you love people, you know, rightly or wrongly you love people.’*

The conflicted feelings around love and developing closeness in relationships in residential care homes are further explored later in this chapter, in the identified theme of ‘touch and boundaries’. It must also be noted that while several responses indicated that close relationships were valued, this was not universal. Some residents indicated they preferred to maintain distance, while staff acknowledged that the closeness of their relationships with staff needed to reflect the individual preferences of the residents they work with. The next theme to be discussed is 'humour and laughter', which although often referred to alongside the concept of friendship, warrants its distinct theme and discussion.

7.2.2 Humour and laughter

A further notable theme in the supportive relationships was the use of humour in a way that reflected the depth of the relationship. Both staff and residents referred to humour as a vital element of a positive relationship, both directly and indirectly through humorous responses, as illustrated by the following quotes. In response to being asked what they felt was important in relationships between residents and staff, Participant 9 (Resident) answered:

> *'Conversation. Uhhh… Having a laugh, yeah…'*

While, similarly, Participant 6 (Resident) explained the importance of being able to have a laugh, and having a sense of humour:

> *'Oh, goody good. You've got to have a laugh. It is important, you know. You've got to have a bit of a sense of humour. You know… it's the way I like it.'*

Participant 8 (Resident) also spoke about their sense of humour and staff 'having a laugh' with them, in effusive terms. She stated:

> *'Oh marvellous. They're comical [LAUGHS]. They are, they're a laugh a minute, honest…. They comical. You know... They got a laugh a minute and… they so happy all of them, from early in the morning, you know. They are fabulous.'*

Similarly, Participant 9 (Resident) explained:

> *'Oh, I think it's uhh... very uhh... amicable, you know. I don't... yeah… we have a laugh. Uhhh… Having a laugh, yeah…. And some people are more, uhhh, easily amused than other people. But on the whole, they're all excellent really.'*

Participants often responded to the interview questions with humour. Perhaps demonstrating the importance of humour to them, however, the joking responses could also be a reaction to the participants being nervous about being interviewed. For example, when asked about what they felt contributed to positive relationships between residents and staff, Participant 11 (Resident) joked:

> *'They don't nag you like, you know. [LAUGHS]'*

While Participant 6 (Resident) laughed while explaining, after speaking positively about relationships with staff:

> *'I haven't been coached to say good things [LAUGHS]. It's genuine here.'*

This nervous, jokey and almost self-deprecating way of responding to questions was not limited to residents. Participant 13 (Staff) also joked when responding to the question of what they felt was important in relationships between residents and staff:

> *'Well, I think to be totally bonkers is.'*

However, despite the humorous responses, the self-deprecating comments made by some residents hint at an underlying level of anxiety in the relationships, perhaps linked to the power imbalance inherent in a professional service-user relationship. Responses indicated a degree of questioning whether staff members truly like them, and that they 'put up' with them. For example, Participant 17 (Resident) made the following comment in a tone that implied they were joking, yet the content of what they stated communicates a degree of insecurity in their relationships with staff:

> *'Well if they like me, they must like me otherwise they wouldn't come back and have a good chat.'* (Participant 17, Resident)

Similarly, while complimenting staff, Participant 16 (Resident) joked that they have to 'put up' with her, explaining:

> *'Oh well, I said... well they're all good. They're good as gold [NAME] and all of them. And they all ask me what I want, and... they are good to me, mind. They got to put up with me haven't they [LAUGHS].'* (Participant 16, Resident)

Although laughter and humour were a thread that connected a lot of the responses in this theme, a number of the responses hint at the use of humour to mask underlying anxiety or lack of confidence. It is important to consider that participants may have felt nervous being interviewed and recorded by an unfamiliar person. This discomfort and uncertainty could explain some instances of nervous laughter and self-deprecating jokes.

7.2.3 Trust and reliability

Trust and reliability were initially two separate themes identified during the analysis of the interview transcripts. The decision was made to condense the two themes into one overarching theme due to the inextricable links between trust and reliability, evident even in the definitions of the words. According to the Oxford English Dictionary, trust is 'the firm belief in the reliability, truth or ability of someone or something' (Oxford English Dictionary [OED], 2016: online). The definition of reliability, meanwhile, is 'the quality of being trustworthy, or of performing consistently well' (Oxford English Dictionary [OED], 2016: online). Participants themselves attempted to define what trust means to them in responses, with one participant stating:

> *'Trust. If you say something in confidence… they stay in confidence.' (*Participant 6, Resident)

The concept of trust being related to confidence and privacy was echoed by a member of staff interviewed, who responded:

> *'Yeah, they need somebody to talk to, and you not going to tell everybody. And respect they privacy and things.'* (Participant 12, Staff)

Being trustworthy in the context of positive professional relationships was founded on staff being relied upon to maintain the confidence of those in their care, residents want to be able to talk to others with the trust that what they share is not shared further. This is of note, in the context of adult protection, and how professional boundaries can encapsulate what is seen as fundamental to developing trust while still maintaining awareness of safeguarding.

The concept of trust was also communicated through participants' responses when they spoke of feeling comfortable enough with staff to be able to communicate openly and honestly, even if what was being communicated was negative. A member of staff explained:

> *'Making them feel comfortable with me. Making them that they can ask me anything or say anything they want. Umm... not to be afraid of a person.'* (Participant 12, Staff)

The ability to be comfortable enough in the relationship with staff to communicate openly and freely was also communicated by residents. One resident responded to a question of what they felt was important in a positive relationship with staff by stating:

> *'A positive relationship would be where. You feel comfortable to complain if things are not good. And at the same time, you feel comfortable in telling them if things are working well. It's got to be that relationship where I'm getting satisfaction and then telling when things are bad and they're responding. At the same time, me saying things that I think are working particularly is giving*

> *them feedback that they're on the right track as well. It's got to be that way. Yes... yes...'* (Participant 15, Resident)

Upon closer examination of participant responses, it is evident that both residents and staff highlighted trust and reliability as crucial elements of positive relationships. Although these aspects were less explicitly mentioned than friendship and love, the language used underscored the importance of staff members demonstrating care through dependability, reliability, and exceeding their expected roles.

Participants' responses suggest that emphasising the performative aspects of the caregiving role and being reliable in executing that role creates a foundation for building deeper relationships. The following response spoke of the importance of reliability and dependability in staff:

> *'She's… ummm… um… what can I say. She has a heart of gold you know. If I need anything done, it's done. Loud but... good as gold.'* (Participant 6, Resident)

The concept of being reliable was communicated, although not directly, through explaining that if the resident needs anything done, it's done. The term 'good as gold' is an interesting one in this context too. The phrase is one usually reserved to describe the behaviour of a child, as being obedient and behaving as expected (HarperCollins, 2019). In the context of Participant's 6 response, they used the phrase warmly and almost maternally, as they spoke of a specific member of staff who despite not being 'young' or a child, was several decades younger than the resident in question. Talking of the resident having a heart of gold, and being as good as gold, really communicated the resident's belief that the member of staff was trustworthy and had good intentions, behaving as expected in their role of professional caregiver. The concept of being reliable and trustworthy through performing caregiving tasks was echoed by another resident who stated:

> *'Well, you got to… what you call... friends... because they do help you a lot, see…. If you want anything, they... they're here for you, you know?'* (Participant 16, Resident)

Participant 16 referred to staff as being like ‘friends’ and described staff helping a lot as being a reason for that. The task-based element of the professional caring role is something that, while it might be thought of as a core element of being a professional caregiver, it is clear that residents still value in staff. Participant 16 qualifies this by explaining that it is the fact the staff members are always there if they need anything, which again means we can infer that the resident is talking about the concept of reliability. It is not that the staff member is performing tasks and ‘helping’, it is that they are doing it in such a manner that the residents feel they can rely upon the staff to perform these tasks. This concept is again echoed by another resident, who explained:

> *‘Well, they’re very friendly and if you ask them to do something they will, you know, They’re very nice, yeah. Yeah… I dunno, just chat like. Chat about something, that’s all.’* (Participant 7, Resident)

Again, here the resident speaks of staff being friendly, but the key takeaway from this response to what is important in relationships with staff is again the concept of staff being reliable when they are performing the task-oriented aspects of their role. When they are asked to do something, they do it. Functional relationships focus on tasks, while supportive relationships are characterised by a sense of trust (Wiersma & Pedlar, 2008).

The concept of caring being part of the professional role is touched upon directly by Participant 18, a resident, who responded:

> *‘Well, they’re carers really, aren’t they? And they do care…. They’re very kind. Over and above what they got to do. They pick up things in the shops on their way...’* (Participant 18, Resident)

The resident's remark that the staff are ‘carers’ and genuinely care suggests that care extends beyond performative tasks to include emotional investment in the people they work with. The Oxford Dictionary defines care, as a noun, to mean the provision of what is necessary for the health, welfare or maintenance of something. However, when defined as a verb, care can be defined as to feel concern or interest, or attach importance to something (Oxford English Dictionary [OED], 2016: online). Participant 18 seems to infer the duality in the meaning behind care to explain that the staff develop positive relationships by going beyond what is expected of them and showing they really ‘do care’. Staff going above and beyond in performing tasks, and picking things up for residents was again referenced by a resident who stated the following:

> *‘If I want anything I ask [STAFF NAME] to get it. Yeah, because she…. Because [STAFF NAME] gets everything for me now.’* (Participant 11, Resident)

Going above and beyond what residents expected of their carers was a recurrent theme in responses to what residents felt was important to positive relationships with staff. Another resident stated:

> *‘These girls... they’re marvellous uh… they say now, we going over Morrison’s, is there anything you want. And they’re very good.’* (Participant 11, Resident)

And similarly, Participant 16, a resident, responded:

> *‘If you want anything, they... they here for you, you know?’* (Participant 16, Resident)

Interestingly, while the interviews emphasised the emotional aspects of the caring relationship over task-based care, residents also valued staff performing practical tasks, particularly when these tasks went beyond basic care. Importance was placed on staff responding to requests and performing tasks reliably, gaining the trust and respect of the residents in their care. It is relevant to note, that in this vein, Participant 12’s (Staff) interview was conducted in the residential setting on what was supposed to be her day off. The participant was present on a non-working day as she wanted to support residents and staff in preparation for their Christmas Fayre the following week. Staff supported residents in making crafts and preparing chilli jam and marmalade to raise money. Participant 12 (Staff) explained:

> *'I don't come here just 'cause I got to earn money. I come in again, next, cause I'm not in until a week Friday but I want to get all the things done for the fete. So, I've got the time to do it, innit? Ahh right...'* (Participant 12, Staff)

A further element of trust and reliability was considered when undertaking the analysis of participants' responses, and that was of the nature of the professional caring role and what trust and reliability mean in the context of caregiving. Staff in residential care homes, such as the two sites where these observations and interviews were conducted, are employed in what can be viewed as a functional and task-oriented role. Participant 18 (Resident) eloquently communicated respect for what the caring role entails, and the trust inherently placed in staff, whilst expressing shock at what staff were paid, explaining:

> *'I'm amazed really, that you know, it's only that it came to my notice that they are paid the minimum wage. And I think it's a job which... and they give out medicines, you know... really... really umm... well, all sorts of medicines, you know. And they have to care for people dying, and you know... it's not... it's not the same as being a cleaner, you know. You've got responsibilities, and care and all that sort of thing. Yes... indeed. And some of them are really really nice;* (Participant 18, Resident)

Trust was communicated by both the residents and staff interviewed as being key to the development of positive working relationships. Participant 13 (staff) stated:

> *'Trust, always with residents. Trust I think is a big thing. Because they trust you to be able to look after them, to be able to move them from one place to the other. I think you see it with new starters sometimes, when they're like 'oh, can they move me'. So, trust is a massive thing, you build up relationships on trust.... Yeah, I think trust is a massive thing, here, because they're entrusting you to give them you know, a high standard of care, in washing, in giving the right medications, you know, it's a massive thing, I think trust.'* (Participant 13, Staff)

Participant 13 here communicates the trust that residents have in the professional capabilities of the staff providing their care, describing being entrusted to give a high standard of care, washing and medications as being ‘a massive thing’. The residents are placing trust in the ability of the staff. This opinion was echoed by Participant 3, another member of staff who responded:

> *‘Well, I think if you’ve got a good relationship with residents, they do a lot more with you and you can do a lot more with them, and you know, they humour you and. you know, and the families will trust you as well….’* (Participant 13, Staff)

This member of staff related the development of trust between themselves and residents by opening up the relationship, allowing it to become deeper. Trust will enable the staff to do more with residents, and those residents will engage better with staff. This member of staff highlighted the importance of developing trust between staff and the families of those in their care by focusing not solely on the individual, but on their wider relationship networks. Participants' responses indicate that relationships are viewed more positively when they extend beyond functional interactions to become deeper and more supportive. However, both staff and residents mentioned that time constraints negatively impact their ability to form such relationships. Time is a key element in developing positive relationships and is explored in more detail in the next theme discussion.

7.2.4 Time (or lack of)

Time, framed both positively and negatively, was another theme that emerged through the content analysis of participants’ responses. As discussed previously, time was acknowledged by both staff and residents as vital to enabling the development of trust and reliability. Through spending time with residents, staff felt enabled to get to know them, their interests, their individual and varied needs and, importantly, their preferences around personal boundaries. It also enables staff to develop an understanding of the residents’ social context, with sufficient time enabling conversations about residents’ histories and their situation outside of the confines of the residential setting. Participant 12 (Staff) responded to a question on what they felt was important in developing positive relationships with residents, stating:

> *'They just want reassurance, they all forgetful, they forget about they [SIC] family and they want to know you and you need the time to sit... time is a big thing, mind.'* (Participant 12, Staff)

While another staff member responded:

> *'Well, spend time with them, sit with them, do activities with them and you know, um and... well just spend time with them, 1:1, yeah one to one.'* (Participant 3, Staff)

In both responses, staff members refer to unstructured time that would allow them to sit and get to know the residents on a one-to-one basis, without the need to perform caregiving duties and tasks. The need for unstructured time to get to know each other was echoed by residents too. For example, Participant 17 (Resident) acknowledged that the time taken by staff to demonstrate that they cared, and were interested in their lives, was important to them:

> *'And… uhh… they come and comfort you and they say if there's anything you want to talk about, we'll come and we'll have a little chat and they're very good at that. Marvellous, yes.'* (Participant 17, Resident)

Participant 2 (Staff) also spoke of the importance of time in getting to know residents:

> *'They get use to you, they know you. In a residential they know you; they know your face... and you know, you kind of... I care a lot, I do… and I always say good morning to them when they come, and you go in their rooms to have a chat and that's the way.'* (Participant 2, Staff)

Another member of staff spoke of the length of time she had been working in the setting:

> *'I'm older than some of the residents here, it frightens me in some ways, but I know I know them well, I been here longer than anyone living here has. I should be finishing soon but… I don't know, I enjoys it'* (Participant 13, Staff)

The predominant focus of participants' responses were the positive elements of the professional caring relationship, however, when participants did focus on the barriers to forming effective relationships, time was most frequently referred to. Lack of time was highlighted as a key barrier to developing meaningful, positive relationships with every staff member interviewed referring to a lack of time. For example, a member of staff stated:

> *'Sometimes… it's such a rush then. It's too much. Too much rushing and you not giving them enough time.'* (Participant 12, Staff)

This sentiment of staff being too busy to dedicate enough time to residents was echoed in the responses from residents themselves. During interviews, some residents expressed uncertainty about whether staff had the time to talk to them or if they were too busy. A noticeable tone of hesitancy was present when residents discussed this, almost as if they were reluctant to bring up negative aspects of the care provision. When discussing the lack of time staff had to respond to their requests, residents were quick to explain this away and acknowledge potential reasons why. For example, Participant 4 (Resident) responded:

> *'The only thing though, in the morning I know they're short staffed but, but uhh, hour and a half I waited for breakfast this morning and we were all just sitting there. And sitting there and we were hungry.'* (Participant 4, Resident)

In quite a justified complaint about themselves and other residents having to wait for half an hour, while hungry, to be provided with breakfast they immediately prefaced the negative statement with the acknowledgement that the residential home was short-staffed. Similarly, another resident explained:

> *'And sometimes the people are too busy to uhh... to bother or, like this morning, you know, it's been all, I don't know, some kind of emergency, I don't go into it.'* (Participant 11, Resident)

Participant 17 (Resident) when asked if there was anything that they felt could improve the relationships between residents and staff responded similarly. Initially, they stated there was nothing that they would change, before hesitating and discussing the fact the residential home was currently short-staffed:

> *'No, not anything... at the moment, they're a bit short-staffed. Like anywhere else.'* (Participant 17, Resident)

Their responses, while making it clear they felt that a lack of time had a negative impact on their relationships with staff, demonstrated an element of insecurity and vulnerability in the relationships, perhaps due to the power imbalance inherent in a professional-service user relationship. The residents spoke of sitting and passively waiting whilst hungry, or staff being 'too busy to bother'. Participants' uncertainty as to whether the staff had time did not promote the creation of positive relationships, and their reluctance to criticise adds credence to the possibility that residents were worried about being negative towards those providing their care.

The discussion of the downsides of being short-staffed, and the implications that has on care provision, was not limited to residents. Participant 12 (Staff) explained:

> *'I don't like it when we short staffed, I find that very hard. Very hard, you have not got the time, you running around like idiots. Umm. Apart from that…. I do like my job.'* (Participant 12, Staff)

In addition to time being an immediate barrier to effective relationship building, time also appears to be a key factor in developing positive relationships in the longer term. Staff and residents both acknowledged the importance of building relationships over a period of time, and this was reflected in the discussion around staff continuity and the impact this has on professional caring relationships. The importance of taking time to gradually develop relationships to create cohesion was explained by Participant 10

(Resident), who stated:

> *'As I say, you get to know them gradually and everybody seems to be, you know, work together, in all fairness.'* (Participant 10, Resident)

The ability to take time to form relationships was attributed to higher levels of continuity amongst staff members. For example, Participant 13 (Staff) explains:

> *'We're lucky, we've got continuity of care, and because we are here all day every day for three days a week, I think they do recognise you, and you can say things or remember and they'll pick up little things...'* (Participant 13, Staff)

Participant 13 placed value on being able to provide a continuity of care when supporting residents who have memory problems, and how it enables residents to remember, and recognise, the members of staff. This participant also highlighted the fact this works both ways through the statement 'you can say things, or remember...'. In the context of what this participant was saying, the meaning is felt to be that continuity enables staff to develop a more in-depth knowledge of that person as an individual, allowing them to reminisce with residents. The importance of continuity of care was not only communicated by staff. Participant 9 (Resident) responded:

> *'Well, you get to know carers the longer you've been here. Very seldom do you have new carers, the people are here when I started, when I came here first you know. It's nice to have the same carers, who know your needs rather than… they have to have some from other suites you know, here, and then you've got to explain the things you know, And uhh. Some carers like to have their own methods, and they try to keep to have your own, you know. It's much preferable to have people… regular people then.'* (Participant 9, Resident)

The practical importance of continuity of care is communicated by this participant. The resident spoke almost uncomfortably about needing to explain elements of personal care to staff they did not know, and how they get used to one member of staff's ways of performing such tasks. The same sentiment was shared by staff, as a staff member explained:

> *'Every one of these are different, that's why I don't like working on a different suite if I can help it, because have I got that time to read every care plan?'* (Participant 12, Staff)

Participant 12's response encapsulates the importance of time and continuity of care in effectively meeting care needs. This staff member's response suggests that greater continuity of care enables staff to become more familiar with individual care needs. Also implicit in their response is that lack of time leads to staff providing poorer quality of care, as it results in less time to familiarise themselves with care plans.

Time was also discussed as a requirement for managing relationship difficulties with residents. One staff member interviewed reflected on the time required to navigate a difficult relationship:

> *'I think you do try and respect that issue but then you do try and make an effort to become, you know, because if there's someone that you don't really get on, you know, they don't like you and you don't like them maybe you keep your distance to a certain extent, but then I think you just try and build up a bit of trust and build up a bit of, maybe a one to one thing at a distance, play dominoes or do something that interests them and um…. And then hopefully you can get something that they like and then you can play on that... and… sort of build up and form a relationship.'* (Participant 12, Staff)

This excerpt emphasises the importance of time in allowing trust to develop where perhaps the relationship does not develop easily. Through taking the time to make small steps towards establishing trust and finding common ground, this staff member explains how it allows effective relationships to form. Participant 13 (Staff) also explained the need for continuity of care, and ensuring residents know the staff working with them, in relation to the specific needs of working with residents with memory problems, or dementia, explaining:

> *'Because I think they will still remember you. You know, even if it's… I suppose when it's advanced dementia… but you know, we not really dealing with advanced dementia, but they do recognise you. Yes, they might not know your name, but they know... who you are...'* (Participant 13, Staff)

Time, or a lack of time, and the positive and negative impacts this has on the ability of staff and residents to develop positive and meaningful relationships, could be thought of as foundational to all the themes explored in this chapter. Relationship-based practice models emphasise the importance of building meaningful relationships between professionals and the people they provide care for, grounded in empathy, trust, and understanding (Dix et al., 2019; Ruch et al., 2018). By focusing on building strong relationships between staff and residents, relationship-based practice has the potential to support staff to make the most of the time they do have. Even brief but meaningful interactions can positively impact on residents' well-being and sense of connection, as seen in the data gathered in this study.

As the responses highlight, the presence of time allows relationships to deepen and friendships to form, and it enables staff to familiarise themselves with the individual needs and preferences of the residents they work with. These individual preferences, and the importance of recognising the differences, are further explored in the next theme discussion.

7.2.5 Acknowledgement of difference

Across the interviews conducted with both staff and residents, several similarities and common strands emerged when discussing what is important to developing positive professional relationships. However, what was also clear from the responses is that knowing the differences between individuals is equally important. Both staff and residents placed importance on the ability of staff to be aware of the residents and the ability to respond accordingly. What also emerged was the acknowledgement that not all individuals were able to, or importantly, willing to establish relationships. In contrast to the previous discussion around touch, love, and friendship in the development of positive, professional relationships, a number of residents interviewed were clear in the desire to maintain a distance between themselves and the staff providing their care. For example, Participant 5 (Resident) responded:

> *'I think they're alright you know? You can, you know. Not to get too close to – you know what I mean. I prefer it that way… Well, I like uhh people to be close, but not that close you know. You know, like 'how are you today?' you know all that like you know, stuff like that. But I don't like to be too close.'* (Participant 5, Resident)

This participant acknowledged that while they felt that staff members were 'alright', they clearly expressed that they prefer not to get too close. This concept of maintaining distance when appropriate was articulated clearly by Participant 13 (Staff) who explained:

> *'Well if there's somebody that you don't, they don't, you know, that there's sort of like an issue with, I think you do try and respect that issue but then you do try and make an effort to become, you know, because if there's someone that you don't really get on, you know, they don't like you and you don't like them maybe you keep your distance to a certain extent.'* (Participant 13, Staff)

Participants also referred to the differences between residents and how that impacts the day-to-day life within the care home. Friendships between residents were not a focus of this research but were a feature in participants' responses. Residents spoke of their peers in terms of friendships, but also in terms of barriers they face in developing relationships. This is seen in the below quote taken from an interview with a resident:

> *'As I've previously said, with other residents... there are some residents who... can be a little… crotchety on occasions. Like most people... yes, like, isn't it? We all have our moments. When I have my moments it's in private… as I said, we're all different. Some residents... they like to show that they're crotchety, only on occasions but if they're feeling bad about something the world's got to know about it. And so be it. But... overall... good.'* (Participant 15, Resident)

Staff also highlighted the importance of taking the time to find out the tastes of residents, enabling them to tailor support accordingly. This links back to the previous theme of having enough time to develop positive relationships between residents and staff. The following quote from Participant 12 (staff) also acknowledges the additional need to respect residents' rights not to engage in a relationship with them, if that is their preference. They state:

> *'I want them to feel confident when I'm with them. I want them to feel that I'm not invading they space or making them do things they really don't want to do. Umm. I... try to... we always try to find out what they like, what they don't like. Not everyone likes being touched and things. Everybody got they little ways.'* (Participant 12, Staff)

This particular excerpt of Participant 12's response also references the previous theme of touch and comfort but from the opposite side of the spectrum. The member of staff acknowledges that not every resident will want to be touched, or to have their 'space invaded'. While again referring to the requirement of time to establish an effective relationship, in the context of this excerpt, the emphasis is placed on using that time to develop the knowledge of how to provide effective care. 'Everybody's got they little ways' neatly sums up how, although care provision as a whole has a lot of similarities, each individual receiving that care will have differences in their preferences and will need to be approached and responded to accordingly. This was echoed by Participant 13 (Staff) who responded:

> *'Well, obviously you know the person well enough to understand where they are, their boundaries. You wouldn't disrespect somebodies personal space by hugging them and things, but then some people you just do… 'cause you know that they ... they want... not that they want it, you know, my ... me and [NAME] it's like, oh my god, I haven't seen you, where you been?' you know, and I'm like 'Oh come here', but other people they wouldn't like it, they like to be called 'Mrs so-and-so' and you respect that, they're entitled to it… they're entitled to have that opinion and if they don't want people touching and hugging and… sort of, then that's fine, that's.. it's not a problem.'* (Participant 13, Staff)

When analysing the interview data, the emergent theme of difference and the impact difference has on relationships, was taken beyond literal references to differences between individuals to include the concepts of choice and autonomy. This decision was taken as choice is core to respecting the different preferences individuals have; care provision is not a ‘one size fits all’ practice. Autonomy takes this concept of choice somewhat further, meaning the ability of a person to adequately self-govern their beliefs and actions. The concepts of choice, autonomy and respecting the choices of individuals, were discussed as key to positive professional relationships in responses. Participant 13 (Staff) spoke about this through the lens of person-centred care, explaining that preferences will vary from resident to resident:

> *‘I would say, it’s got to be more person-centred... It’s got to be... not ‘one massive umbrella’. It’s got to be individualised to that person and to that staff member. It can’t be one rule for all. It’s got to be individualised and it’s got to be assessed and safeguarded and... everything’s got to be protected, but then you can’t… say one for one, you know, for everybody. And I think it’s from a person... other resident... you know, individual it’s got to be individual to the person.’* (Participant 13, Staff)

The concept of choice was frequently discussed in the context of participation in structured and organised activities. Such activities are a focus of daily life in the residential settings in this study. Residents and staff alike gave examples of leisure opportunities and seemed to place value on being offered the choice of whether to participate. These also provided opportunities for residents to interact with each other in a social setting. For example, Participant 18 (Resident) replied:

> *‘Well, I don’t go to everything, you know. They have an amazing Welsh choir comes here, half ladies and half gentlemen, and one of them is a resident. Yes... I really enjoyed that, it all depends, you know? What it is... You have the choice.* (Participant 18, Resident)

This resident spoke positively of the environment of the care home, and of being given the option to participate in organised activities while also having their right not to participate in everything respected. Participant 15 (Resident) echoed the appreciation for choice when speaking positively about leisure opportunities:

> *'The choice is always, whether you want to participa... participate.'* (Participant 15, Resident)

The value of being offered choice was discussed by another resident, Participant 17, who spoke of outings and trips being offered. They spoke of not usually wanting to go, but when referencing the fact that they were always given the opportunity they spoke warmly and appreciatively, which is perhaps not clear solely from the quote itself, but when listened to in the context of the wider interview is apparent:

> *'Well, I'm a person who likes to keep to myself. But if I wants to go anywhere, they asks you anyway. We got so and so on; would you like to go?'* (Participant 17, Resident)

The concept of not making residents do something they don't want to do is again discussed in the following quote from the previously used excerpt of Participant 12's (Staff) response:

> *'I want them to feel that I'm not invading they space or making them do things they really don't want to do.'* (Participant 12, Staff)

Participant 13 (Staff) made a more explicit reference to the concept of choice, and the importance of enabling residents to make those choices:

> *'We've got choices, no matter how small, no matter what decision they got to make, it's got to be made... it's empowering them...'* (Participant 13, Staff)

Participant 13 (Staff) speaks of empowering residents by supporting them to make choices. By supporting residents to make choices, 'no matter how small', this member of staff appears to see the value this has on addressing the power imbalance between staff members and residents, and that continued choice over day-to-day lives is linked to continued autonomy and empowerment. The importance of individual choice while also encouraging participation was elaborated on:

> *'They will not, and they got that choice not to come out. The encouragement is there…. But yeah, they have got choices, but sometimes you've got to try and encourage that choice to change but if they don't want to, they don't want to and that's it. You don't think, oh I don't want to come, you try and say there's a lovely singer in the lounge, you'll really enjoy it and they come then but a lot of ladies they won't come.'* (Participant 13, Staff)

Participant 12 (Staff) discussed the same dilemma, of trying to encourage residents to participate, but ultimately respecting their decision even if it did not align with what the staff felt might be in their best interests. She explained:

> *'The choices of, umm, if we gonna do something in our lounge, we ask them to come and join in. Some say no, you can encourage them to come. We got two ladies who constantly stay in their bedrooms, and they would be fantastic if they would come out, but we can't get 'em.'* (Participant 12, Staff)

The need to acknowledge and respect people's differences, and what their different preferences might be when it comes to relationship development were spoken about in terms of both relationships between staff and residents, and between residents themselves. For example, Participant 15 (Resident) stated:

> *'I get on well with all of them, uhh... there are some that I have to respect that some residents don't want that closeness. Ummm… and in that respect, I'm polite to them umm… but no more than that. I ... I don't try and push myself towards because I accept the fact no no… I'm not their cup of tea, which is fair enough. Perhaps there'd be an occasion again with staff they're not my cup of tea. At this moment in time, it's not there, but if it were… that's it. [PAUSE].'* (Participant 15, Resident)

The importance of getting to know individual preferences and differences, and using that knowledge to build meaningful relationships is key to all iterations of relationships, between peers and relationships between staff and residents. The next theme discussion builds upon this concept through the lens of touch and individual preferences around touch. However, where these discussions differed was in reference to the professional boundaries put in place that govern touch in staff–resident relationships.

7.2.6 Touch and boundaries

Touch and boundaries were two themes often referred to together, and primarily by staff. Touch was acknowledged to be a core part of positive relationship building for a lot of (but not all) residents, however, staff spoke in quite cautious and somewhat negative terms about the professional boundaries in place to regulate touch between staff and residents. One member of staff (Participant 13) elaborated on the topic of touch when asked. They spoke of the importance of touch and affection for the people in their care, while simultaneously expressing concerns about the implications this might have professionally:

> *'I think because, if, they're telling us on courses that you can't touch and the CIW and things... then I think it's… it's a touching job. Like, you know, inappropriate touching absolutely no, but... you have to touch, you know, even... it's what we do... you know, you wouldn't go touching somebodies, you know, but... you'd hug and you'd touch and it's not overly…. it doesn't happen all the time every day, but if somebody's upset, you touch people, don't you? You know, you can verbalise and touch them that way, yes, but… people like to be touched. You know, cwtched... if they're in a relationship all their lives, with their children or whatever and they haven't got that close contact they... like, like [RESIDENT]'s a widower. You go happy birthday and give him a cwtch, and he's like oh... he needed that. It weren't sexual, it weren't inappropriate. It was just something, you know… you feel... you what you feel then, you know. It's empathy. If we haven't got that then... you know, it's going to be a sad day for the job. [PAUSE] But I respect the professional boundaries,*

> *absolutely… it's there for a reason... when there's naughty people and to deter but… absolutely, but no... it's not um... [PAUSE]'* (Participant 13, Staff)

It is clear from Participant 13's response that they placed value on both the physical and emotional aspects of the relationship yet acknowledged and communicated boundaries and limits to this. The participant demonstrates an intrinsic knowledge of the lines that must not be crossed within a professional caring relationship. The participant spoke passionately about the importance of the 'softer' elements of the caring relationship, yet paused and the tone of her voice changed to be firmer and almost cold when stating that she respected the professional boundaries while acknowledging the reason for their existence as 'when there's naughty people', yet hesitantly refers to it being a 'sad day for the job' when discussing the need for empathy, before tailing off. It appeared from Participant's 13 response that there is an element of fear that aspects of the professional boundaries may have implications on the staff's ability to use empathy and touch and what this might mean for the profession.

The topic of professional boundaries, and specifically the boundaries that exist around touch between members of staff and residents was touched upon in the response of another member of staff, Participant 12:

> *'So, with this new course, it has made me wary, but it's very difficult to follow and… sometimes... you not following because you reaction is to, if they're upset to… I like a cuddle or a cwtch, it just makes you feel better sometimes. If staff here are down or something, and it is nice... but I don't know. I am wary of it now, and I am watching what I'm doing. I do understand why it's there, but it's sad.'* (Participant 12, Staff)

Participant 2 (Staff) did not go into as much detail as Participant 12 and Participant 13, but when asked about boundaries was cautious in their response stating:

> *'Umm yeah, you've got to be careful you know, you've got to be careful, you know.'* (Participant 2, Staff)

Their response was similar, in that they expressed sadness about the professional boundaries in place and how they are now ‘wary’ around touch. When asked to explain what they felt was different now, and why they were more ‘wary’ now, Participant 12 responded:

> *‘No, I think the way we are... were with them... was a better relationship. You know…. You might be walking with somebody, and they give you a kiss on the cheek. I could never say ‘don’t do that!’ I could never, I could never. I’m glad in a way that I’ll be finishing, ‘cause I find things…. [PAUSE] things have gone out of hand, probably with people abusing…. Um… residents, I don’t know. I don’t know what to say. I just find it’s gone... I don’t like it very much, this way anymore. But as I say I got to accept what it is.’* (Participant 12, Staff)

Participant 13 (Staff) again expressed concern about policies that she felt indicated that you should not touch residents, stating:

> *‘I think at the moment, but I think if they gonna go any further with, you know, the sort of no-touch policy and things like that I think... very slippery road.’* (Participant 13, Staff)

Interestingly, both Participant 12 and Participant 13 expressed concern about the future of professional boundaries and what that meant for people in their care. They both acknowledged the reasons why they felt professional boundaries were needed, to prevent abuse and protect residents from ‘naughty’ people, but discussed how they did not like it and did not like why they felt such boundaries were heading.

They also both spoke about how the reaction to offer a comforting touch to the people in their care is instinctual, stating that:

> *‘[IT IS] your reaction…. if they’re upset is to… cuddle or cwtch’* (Participant 12, Staff)

And

> *‘But if somebody’s upset, you touch them don’t you’* (Participant 13, Staff)

The members of staff spoke about their instinctual and human response to another person's emotions in a passionate yet matter-of-fact way, before communicating a sense of fear that this response could have implications on their role. The staff equated the residents' need for human touch to their own, as members of staff, on bad days. This common human need appears to bridge any divide between the residents and members of staff, yet the professional boundaries in place to protect residents were spoken of as almost a barrier put up between the two groups. They communicated that they understood why professional boundaries exist but simultaneously expressed sadness about it.

The very human and emotional response both members of staff had, followed by a reticent and more formal acknowledgement of the rules around touch, were in stark contrast to each other. This contrast was not only in the language used but also in the tone of voice and emotion behind it. Participant 12 (Staff) again, in response to another question brought up this topic about boundaries going against their natural reaction, alongside the fear of losing their job, stating:

> *'I heard it, he said if the inspector walked in and you were... you'd be sacked right away 'cause you natural reaction is to comfort somebody. You comfort, the same with disabled children you can't comfort, it's so sad. That it's getting all… it's all sexual now gone. It's bad. [PAUSE]'* (Participant 12, Staff)

Another commonality between the two members of staff response is the use of the word 'cwtch'. This Welsh word is commonly used by people in Wales, even if not able to fluently speak the Welsh language. The word has no literal English translation, yet loosely means 'hug' or 'cuddle'. 'Cwtch' is also used to describe a cosy, safe and homely place or snug. However, these definitions are not conclusive as they do not accurately communicate the true meaning behind the word, which speaks of comfort, with a nostalgic nod back to childhood and safety. Participant 13 further acknowledges that these residents will likely have lost those in their lives who previously would have provided those 'cwtches'. The recognition by staff that residents need a 'cwtch' when they are sad communicates the existence of a clear caring and emotional quality to the relationship, often taking the place of relationships residents have lost. Loss of relationships, along with other forms of loss, are further explored in the discussion of the next theme.

7.2.7 Loss

While autonomy and freedom of choice were common themes when reflecting on the elements of positive relationships, a common barrier to effective relationships discussed by residents was the loss of autonomy. While this was not necessarily discussed overtly as a barrier, the semi-structured interview method provided participants with the opportunity to talk about the topics being questioned. The findings highlighted themes of loss and managing loss.

The verbal and non-verbal expressions of participants suggested residents were navigating difficult changes in their relationships and wider lives, underscored by various forms of loss. Loss of autonomy, loss of independence, loss of physical ability and loss of relationships. Residents referred to their own physical health and disabilities as factors contributing to their inability to form relationships with other residents and staff. The findings highlighted residents' reluctance to engage with peers who exhibited behavioural symptoms of dementia. The physical limitations and health conditions of residents were also acknowledged as hindering the development of relationships with peers and staff.

When talking about relationships, many residents reflected on the loss of different types of relationships in their lives. For example, Participant 7 (Resident) explained:

> *'Well, a lot of my old friends have died over the years... I've lost, I've lost a lot of my good friends.'* (Participant 7, Resident)

Residents appeared to conflate ageing with a loss of relationships. When discussing how relationships had changed as the participants got older, Participant 15 (Resident) stated:

> *'As you get older some drift off, and some stay. I got some friends I've had for donkey's years, and they'll be there for life. There are some... drift in and out. But that's the way life is. You know... for everyone.'* (Participant 15, Resident)

Participant 14 (Resident) explained age as the potential reason she felt she chose not to 'bother' developing relationships with her peers, explaining:

> *'Maybe because we are getting older, you know, uhh but I don't bother with anybody much except [resident name], now [PAUSE].'* (Participant 14, Resident)

While Participant 16 (Resident) explained sadly, and almost hesitantly:

> *'I do phone 'em... of course, they got family... and then, uhh... they're alright but... it's not the same when they can... when we were all friends when we were younger... cause I'm in here now, I do phone 'em, you know... and they do come in, they do come and see me... when it's my birthday and all that.. [PAUSE]'.* (Participant 16, Resident)

Residents who were in the later stages of dementia, or those who had more advanced physical disabilities, were discussed in terms of loneliness and isolation. Also highlighted was the impact of dementia and ageing itself on the ability to create and maintain relationships, often resulting in weak and short-lived relationships as residents' health deteriorates and the time spent in their rooms increases. A recurrent theme was that of being confined to their room. When asked about how relationships had changed as she got older, Participant 4 (Resident) discussed how her friendship with a neighbouring resident had become more difficult:

> *'Yeah, she's confined to her bedroom. She's 96.' (*Participant 4, Resident)

Participant 17 (Resident) also spoke of how a peer's memory loss had a negative impact on their relationship, and how she now often is required to support her when she is confused, explaining:

> *'Umm…. sometimes… if she goes to sleep in the afternoon, she can't remember where she is, so she walks down to me.; (*Participant 17, Resident)

Similarly, Participant 7 (Resident) spoke of her neighbour's memory problems as a barrier to forming a relationship with her, while also referencing her own memory problems:

> *'Yeah, she's... [NAME] she's nice, she comes up, but she's gone mentally you know… everything she says I got to take with a pinch of salt. She's nice mind [LAUGHS] but she thinks her mother's coming to see her and, you know, things like that. Hmm... I'm not that way, it's just that I forget. Names I can't remember, I'm terrible with names.'* (Participant 7, Resident)

Participant 17 (Resident) explained the barriers she felt in forming relationships with her peers:

> *'There's uhh... [NAME] next door, she's in bed all the time. And of course, uhh… [NAME] this side, she's in bed.'* (Participant 17, Resident)

Participant 16 (Resident) similarly explained that she had found it difficult to bond with her peers in the residential home, as people preferred to go back to their room meaning this often left them with nobody to talk to:

> *'Oh, they're all right, but… uh… they always go back to their room and I got nobody to talk to then. Then I say, I likes to... in the summer I sit in the garden. And then I can sit in the garden, and I do a lot of reading. But… otherwise, they go back, I don't see 'em, they back to their room, you know.'* (Participant 16, Resident)

While some residents spoke sadly of other residents staying in their rooms as a barrier to relationship development, some residents discussed their own reasons for staying in. Participant 14 (Resident) explained how her choice to return to her room left little time to engage with her peers outside of mealtimes, stating:

> *'They... I see 'em lunchtime. I see 'em in them all at the table but I don't see 'em after because I comes to my room then.'* (Participant 14, Resident)

Participant 7 (Resident) explained she no longer went into the social areas of the residential home, instead choosing to stay in her room, as a result of her increasing physical problems:

> *' I don't go down to the sitting room or the dining room, I have my food here because uhh... my spine is crumbling…. And… I get panic attacks, so I don't know… I'm gone now, a couple of years I can't get my breath so… uhhh one of my doctors said, he thinks it's my heart, but I don't know mind, but the time I walk down there I can't get my breath so it's better for me to stay by here.'* (Participant 7, Resident)

Participant 8 (Resident) communicated similar reasons why she felt unable to leave her room and socialise in the common areas of the residential home. Again, this participant explained the physical barriers to building relationships, stating:

> *'Well, I don't go out much. I must admit it, and they do keep on why don't I go out more. My legs are terrible, my knees…. I don't have close relationships with them because I'm disabled really, with my knees you know. So, I don't go out...'* (Participant 8, Resident)

Participant 8 (Resident) again, later in her interview, related her lack of close relationships with her peers to her loss of physical ability, explaining:

> *'I don't have close relationships with them because I'm disabled really, with my knees you know. So, I don't go out, I got to have the zimmer even to go to the toilet so there you are. But I'm lucky in a lot of ways because good job I can get out with the zimmer after what I've seen down here, you know.'* (Participant 8, Resident)

While Participant 8 (Resident) explained this sadly, initially, earlier on in the interview she had referred to the fact she was unable to participate in many activities in an almost joking, self-deprecating way:

> *'Well, I'm 91 you see, so I can't do much. And I got bad legs. The knees are gone… well what can you expect, 91 years on the same pins [LAUGHS]'* (Participant 8, Resident)

It is interesting, that had we not explored the topic of relationships deeper, at face value it might have been assumed that this participant was not too bothered by her loss of abilities and was instead making light of it. Similar to the loss of physical ability was one resident's explanation of how his loss of hearing had a direct impact on his ability to develop relationships with both peers and care home staff. Participant 9 (Resident) explained:

> *'Uhhh... well... you need quite a lot of patience with some people… uhh like myself, I got a hearing aid now, which I didn't have before and it was very uncomfortable for everybody and uhh… quite a lot of strain, you know, getting in through to me.'* (Participant 9, Resident)

Loss, again, featured when Participant 11 (Resident) explained how he is now unable to drive, and spoke of the impact this had on his independence. He explained how he was no longer able to drive to horseracing:

> *'I suggested if I want to go anywhere, I just jump in the car. But I can't do that anymore. Because I don't drive anymore…. Well... It takes my independence away. Yeah...'* (Participant 11, Resident)

The theme of loss of autonomy and connections to her previous life was continued by one resident's discussion of having to sell her property to fund her place in the residential home. She discussed how she and her husband had worked all their lives and expressed deep regret at not being able to choose where their earnings went:

> *'Yes, I think it's awful. I wanted to leave it, I've got no family and I wanted to leave everything to my friend and her husband, they've been so kind to me for years. They are the ones who do my business, and I couldn't leave it to them. It's all had to go.'* (Participant 9, Resident)

7.3 Conclusion

The themes identified and discussed in this chapter highlight both the variety of factors that contribute to building positive relationships, but also the commonalities. It is important to recognise the nuance in responses; that what some residents and staff value in their relationships did not reflect the preferences of all participants. These differences highlight the nuanced nature inherent in social care, and more broadly in all relationships. Staff must remain sensitive to individual preferences. In ethics of care, this involves understanding and respecting the unique needs and desires of each person involved, fostering relationships that are responsive and attuned to these individual nuances. This approach acknowledges that residential care is not a one-size-fits-all endeavour but requires a tailored, empathetic response that honours the complexities of human interaction in the context of the residential care setting.

Love and friendship were found to be key features of positive relationships for both staff and residents. Staff, however, spoke of 'loving' the people in their care even though they felt this was going against the professional boundaries in place. Some residents spoke of the importance of staff members being similar to family members, being 'like family', or treating them as if they were their 'daughter' with one resident describing this family-like relationship as being 'more than friendship'. This implies that for both staff and residents, the depth of the relationships developed goes beyond professional, and possibly even beyond friendship to something that more resembles a familial relationship.

This evolution towards familial-like relationships can be understood through the lens of the ethics of care, a framework that emphasises empathy, responsiveness, and mutual concern in caregiving relationships. When staff and residents develop relationships that resemble familial bonds, it reflects a deepening of care that goes beyond professional obligation. This perspective recognises the importance of emotional connections and reciprocal responsibilities in fostering a supportive and nurturing environment, where both staff and residents feel valued and understood. From a social constructionist perspective, the idea that relationships between staff and residents can transcend the professional reflects how social roles and expectations are not fixed, but instead constructed through interactions and shared meanings. In this context, staff and residents may naturally evolve their interactions beyond the professional due to shared experiences, shaping their roles into something akin to familial bonds. This shift can be seen as a mutual construction where both parties have negotiated and redefined their roles based on their emotional and practical needs.

Like the previous analysis chapters, humour and laughter were identified in the interview responses as being a key feature of a positive relationship in the residential settings studied. However, it was noted that a number of humorous responses during the interview appeared to mask nerves, or humour was used in a self-deprecating manner by participants. Trust and reliability were further identified as key features contributing towards positive working relationships. Trust in particular was identified by a staff member as being what '*you build up relationships on'*. This concept was reflected across responses which acknowledged that the development of trust enabled relationships to become more open and deeper, and supported residents to better engage with staff. From a social constructionist perspective, the development of trust between staff and residents in care settings signifies an ongoing process of mutual negotiation and the construction of meanings within their interactions. Trust emerges as staff and residents engage over time, navigating their roles and expectations through shared experiences and communication. This mutual trust is not inherent but constructed through continuous interactions, where both parties contribute to shaping the relational dynamics based on their respective roles.

Having sufficient time was identified as a positive factor in the building of effective working relationships. Having the time to get to know each other enabled residents to feel they could rely upon staff and for staff to develop knowledge and understanding of residents' histories. However, a key barrier to building positive relationships was identified as a lack of time. If this barrier was removed, sufficient time would create environments that enable staff and residents to build relationships based on the key positive features discussed. Staff would have time to deepen relationships; getting to know individual residents, their histories, and preferences. A further barrier highlighted by the analysis of interview responses was concerns about professional boundaries and the implications this had on staff. Some staff interviewed expressed concern that regulations impede their ability to build positive relationships and are having a detrimental impact on the social care profession.

In residential care settings, staff members often engage with residents in ways that go beyond just physical care. They provide emotional support, companionship, and a sense of security, and spend significant time with residents daily, assisting with personal care, meals, activities, and social interactions. Over time, this consistent presence appears to allow the development of trust and familiarity between staff and residents. Beyond the basic caregiving tasks, staff often become attuned to residents' emotional needs, fears, and preferences, as described by a staff member '*obviously you know the person well enough to understand where they are, their boundaries'*. They offer comfort, reassurance, and empathy, which can deepen the emotional bond, as one resident explained '*they come and comfort you and they say if there's anything you want to talk about, we'll come and we'll have a little chat'*.

While these relationships are beneficial, and caution is expressed by staff about their perceptions of the professional boundaries in place, the boundaries exist to ensure the well-being and safety of both staff and residents. While deep, familial-like relationships can naturally develop between staff and residents in residential care settings, it's crucial to navigate these relationships with sensitivity and adherence to the elements of the professional boundaries that exist to support both residents and staff. This ensures that the care provided remains ethical, respectful, and supportive of residents' needs, with staff remaining mindful of the inherent power dynamics in the relationships.

The ability to build positive relationships is asserted by proponents of relationship-based practice to be central to achieving the goals of social work (Ruch, 2005). Relationship-based practice argues human relationships are crucial and should be at the core of all good social work and social care practice. How working practices might change to promote the aspects of care that allow relationships to flourish, while limiting the relationship impeding aspects of care, will be explored throughout the discussion chapters. The themes across all three of the analysis chapters, this one and the two that preceded it, will be synthesised to produce a picture of relationship-based practice in residential care with the aim of developing an understanding of how this might influence professional boundaries.

Chapter 8 Relationship-based Practice, in Practice

8.1 Introduction

The introduction of this thesis presented the challenges faced by the social care sector in delivering effective relationship-based care in residential settings. It highlighted the importance of contextualising this against a background of adult social work and the emerging practice focus of relationship-based practice in child and family social work. The research questions developed to explore these challenges were:

- How do people living with dementia and social care staff experience relationships in residential social care homes?
- How could knowledge of how effective relationship-based care is delivered in residential settings shape professional boundaries?
- How might residential care's culture and practice need to evolve to support relationship-based practice?

This discussion will draw on the findings from the qualitative content analyses laid out in the three results chapters: documentation analysis, observations, and interviews. The focus will be on interpreting the data to develop an understanding of relationship-based practice through the experiences of the residents and staff who participated.

The three analysis chapters, while all analysed using qualitative content analysis, cannot be synthesised as three equal documents. The analysis needs to be interpreted with an understanding of the context of the data sources. Observation data and interview data are differentiated throughout the discussion chapter, although it must be noted that direct quotes taken from both observation and interview are used. Rather than referring to each quote by participant number, quotes and excerpts from transcripts will be identified throughout the discussion by whether they were interview participants or observation participants, and whether they were a resident or member of staff.

8.1.1 The discussion themes

To answer the question of how relationships are experienced by residents living with dementia and social care staff in residential settings, the findings from the qualitative content analysis of the interviews and observations were synthesised. Set against the context of the current literature, themes were identified that will be discussed over the ensuing paragraphs.

As discussed in Chapter 4, the ethics of care framework provides a framework to understand the value and necessity of the labour of caring, emphasising the importance of empathy, sensitivity and trust while also being aware of interdependency and relationship-based ethics (Graham, 2007; Held, 2010). This perspective places a strong emphasis on the quality of relationships, recognising that effective care is grounded in genuine, empathetic relationships (Tronto 1993, 2013; Edwards & Brannelly, 2017). By synthesising the findings from documentation, interviews, and observations through this lens, it is possible to appreciate better how staff's emotional engagement, attentiveness, and responsiveness to residents' needs can contribute to effective practice. This perspective highlights that the relational aspects of care are as crucial as the physical aspects.

The main discussion points in answering this research question are:

- Connectedness
- Time
- Loss
- Autonomy
- Fear and Risk

These areas will be discussed in relation to the research topic, ensuring the voice of the participants is heard, and they are placed fully at the centre.

8.2 Connectedness

Connectedness, closely intertwined with notions of familiarity and friendship, was identified as a key feature of effective relationship-based practice. The definition of connectedness in this context is as follows:

> *'The state or quality of being connected.'* (Oxford English Dictionary, 2018)

The definition of connected, meanwhile, for the purpose of this thesis closely aligns with the definitions given in the Oxford English Dictionary below:

> *'To unite (a person)* with *others (by ties of intimacy, common aims, or family relationship).'*
>
> Or
>
> *'To state or establish relationship with.'* (Oxford English Dictionary, 2022d)

A number of themes which sit under the overarching theme of 'connectedness' emerged during the qualitative content analysis of the data and were split into sub-categories for discussion below. These consist of:

- Friendship and belonging
- Dual relationships
- Familiarity
- Touch
- Humour

While enough difference exists between the themes to warrant them being discussed under separate subheadings, there is a clear link between them. All contain elements inherent in relationships, and of the threads that unite people within them. Each of the themes above relates to participants developing and seeking connection with the people around them.

8.2.1 Friendship and belonging

> *'They, like me and I like them. You know…'* (Interview Participant, Resident)

The move into a residential care setting is one often fraught with challenges in navigating the change and loss that accompanies it. It follows that as residents move into their new home, they want to get to know the people they will be sharing that home with, both staff and fellow residents. As discussed during the literature review chapter, people usually move into residential settings because their care needs exceed those which can be managed independently (Funk & Outcalt, 2019). This is now happening at later and more dependent stages. As such, it is often the case that residents require support with multiple aspects of their care. It is therefore unsurprising that residents place high importance on getting to know the staff who will be supporting them with personal tasks and is a motivating factor in wanting to develop strong relationships with staff.

The needs of people with dementia in residential settings go beyond basic care needs; people need friendships and to feel part of their community. The community for the participants in this study is the community within the residential setting. This was identified as a further factor contributing to the desire to get to know staff well, the basic human need of belonging. Chapter 3, the second part of this thesis' literature review, explored the concept of belonging and its link to a desire for connectedness. Baumeister and Leary (1995) use the term 'belonging' to describe the desire for interconnectedness, stating:

> *'Human beings have a pervasive drive to form and maintain at least a minimum quantity of lasting, positive, and significant interpersonal relationships.'* (Baumeister & Leary, 1995, p. 497)

Belonging also features as one of the basic human requirements in Maslow's (1943) hierarchy of needs, a motivational psychology theory depicting human needs.

Schölzel-Dorenbos et al. (2010) translated Maslow's hierarchy into a hierarchy of consequences of unmet needs for people with dementia, depicted below in Fig. 14:

Figure 7 – *Model of consequences of unmet needs in dementia*

Note: Retrieved from Schölzel-Dorenbos et al. (2010, p. 117)

Belonging and love are needs which, Schölzel-Dorenbos et al. (2010) argue, when unmet increase the burden on caregivers. This suggests there is perhaps a motivational factor for staff as caregivers in this to foster interpersonal connections with residents. Building close relationships with the people they care for would not only meet their desire to belong but may also make their day-to-day role easier. There is arguably a practical motivation for staff to foster close relationships with residents. Some staff spoke of the importance of knowing how residents preferred to be cared for, both to ensure residents' well-being and to ensure their working day ran smoothly, for example by reducing their need to consult care plans. This narrative of focussing on the more pragmatic benefits of relationship-based practice could be thought of as at odds with an ethics of care framework.

Through getting to know residents' needs, staff spoke of not being required to take extra time to read through their care plans. Staff also spoke of their preference to stay working within the same unit in the residential home for this purpose, highlighting the extra time required when working with new residents and not knowing how they 'like things to be done'. In line with an ethics of care approach, the participants interviewed (both residents and staff) value placed on growth and supporting the residents in the context of their self-defined needs (Edwards & Brannelly, 2017). The ethics of care approach is inherently relational and focuses on the moral significance of caring and the context-specific needs of people receiving care. This means recognising that each resident has unique preferences, desires, and requirements for care that must be respected. The participants valued an approach that does not impose a one-size-fits-all model of care but rather adapted to their specific needs and wishes. As the staff interviewed noted, this involved actively listening to residents and being attentive to their expressed needs and unspoken cues.

Some residents spoke of staff being carers who 'do actually care', beyond the expected requirements of their role to something more closely resembling friendship. Jansson et al. (2001) suggest the phrase to 'care for' is frequently used to convey a sense of the bonds that tie us to people. Residents spoke of building bonds with staff, of being liked, and of getting to know staff on a more personal level. As one resident stated:

> *'We've got to have a friendship as well with them. It's got to be there; it's got to be there.'* (Interview Participant, Resident)

Residents reflected on the importance of staff knowing them well during interviews and were observed responding positively to staff demonstrating intimate knowledge of their histories and preferences during observations. Residents spoke of the important role friendship and love play in their relationships with staff, with the need for a depth of relationship that goes beyond friendship being spoken of. An example of this is evidenced in the below interview excerpt from one resident:

> *'With all them, and I don't mean this in a romantic way, there's got to be a love there……. There's got to be that little bit more than friendship… umm….'* (Interview Participant, Resident)

While friendship and love would be expected to be a core feature of personal relationships, it could be argued that they are not expectations for relationships between staff and residents. Previous research discussed in Chapter 3 has highlighted the importance of interpersonal connections and relationships between residents and staff in care settings in ensuring a positive transition into residential care from home (Fitzpatrick & Tzouvara, 2018). Friendship, and reciprocity in the professional relationship were identified by Beresford et al. (2008) as being key to successful interventions in palliative social work with older people. The identification of friendship and love being a key feature of positive relationships in residential care practice is likely related to the innate human drive to foster positive interpersonal relationships to promote a sense of belonging (Baumeister & Leary, 1995; Schölzel-Dorenbos et al., 2010). This was backed up by the data collected in this study. Participants valued connections between staff and residents that went beyond basic, task-based caring.

Residents also spoke of the importance of there not being an ‘us and them’. This desire to bridge the gaps between residents and staff was also reflected in the ways residents referred to staff members as being ‘like family’ or using endearing terms such as ‘the girls’ or referring to staff as being like their daughter. This again could be linked to the need to belong, through redressing the power imbalance in the working relationships it could enable residents to feel a greater sense of belonging, with staff as their equals rather than the ones holding power. When viewed through an ethics of care perspective, attempts to balance power can be understood considering the inherent power imbalance that exists in caring relationships (Tronto, 2013). In residential care settings, staff typically hold more power due to their roles, responsibilities, and abilities to make decisions on behalf of the residents. This power dynamic can lead to situations where the needs and preferences of residents are overshadowed by institutional routines or staff convenience. The ethics of care approach emphasises the moral responsibility of caregivers to recognise and address these imbalances by fostering practices that prioritise the voices of residents.

8.2.2 Dual relationships

> *'"You was talking to my mother last week in town", she [STAFF MEMBER] said.'* (Interview Participant, Resident)

The breaking down of the 'us and them' divide between residents and staff can also be observed through the concept of dual relationships. Dual relationships occur in professional practice when, in this context, paid carers can relate to residents in more than one relationship meaning dual or multiple relationships are occurring simultaneously. Dual relationships are discussed in the literature in terms of workers navigating boundary issues and facing possible conflicts of interest, covered in Chapter 2 of this thesis (Reamer, 2003). Within social work practice, professionals are advised against dual relationships within the ethical code of practice, although the code acknowledges they can be unavoidable in some scenarios (BASW, 2021). The social care code of practice also advises social care workers against forming 'inappropriate relationships', although what constitutes inappropriate is not defined (Social Care Wales, 2022a).

In this study, it was found that both residents and staff used interpersonal connections from outside of the residential setting, or dual relationships, to their benefit. The concept of dual relationships, particularly in relation to professional boundaries, was picked up during the literature review chapters in this thesis. However, the value placed on connections between residents and staff that went beyond the bounds of the residential setting was an unexpected finding of this study. Staff spoke openly and unprompted about the wider community and the links they have with residents. Residents responded with warmth to staff bringing up scenarios from outside of the residential setting to reminisce about, and communication about dual relationships was not just open, but spoken about with a sense of pride. The residential care settings that took part in this study were both situated in small town communities in South Wales, which is perhaps a contributing factor in this. It is acknowledged that dual relationships are especially unavoidable in smaller communities where people live and work in the same place (Pugh, 2007).

As discussed in the literature review, research suggests community connections raise complex issues about how people conduct themselves both in work and their communities while they navigate the multiple facets of their relationships (Pugh, 2007; Reamer, 2003). However, during this study, the use of dual relationships was observed in fostering warmth, connection, and strengthening bonds between staff and residents. Through talking about mutual connections and placing themselves within their wider geographical community, staff and residents were observed gaining satisfaction and joy from the conversation. Perhaps too, the need to relate with each other based on interpersonal connections going beyond the bounds of the residential home could be attributed to a desire to feel a sense of belonging, for both staff and residents.

8.2.3 Familiarity

> *'I Have conversations with them about their family and uhh…. you know their children…. I always ask her nearly every day.'* (Interview Participant, Resident)

The sharing of personal information and anecdotes was not confined to dual relationships. Staff and residents were also observed talking about their own family and friends and identified the importance of talking about their families and sharing stories during interviews. It is referred to here as familiarity due to the personal nature of conversation topics conveying a sense of familiarity and intimacy. The anecdotes gave a sense that residents and staff knew each other well, and that the relationship could almost be described as a friendship. Both staff and residents spoke of conversations about their own families and friends being important, and conversations on these topics were frequently witnessed during observations. Familiarity was a standalone theme in the qualitative content analysis of the direct observation data,

Staff used personal anecdotes as a tool to open conversation and encourage residents to engage. One staff member appeared to use the personal information to prompt discussion about something the resident had enjoyed and made efforts to continue the conversation about the local area and community by prompting the resident who responded warmly and enthusiastically. One staff member was observed sharing about their own mistakes due to forgetfulness diffused a situation where a resident appeared to begin getting distressed at their memory problem. This interaction demonstrated staff used interpersonal skills seamlessly and naturally to prevent a resident from becoming distressed, before changing the direction of the discussion.

Ruch (2005) highlights the importance of not marginalising the social aspects of people's lives and emphasises the value of understanding life experiences. This is especially important when working with people with dementia, to understand their relationship history when providing support (Youell et al., 2016). Through knowing and understanding residents' backgrounds, staff can promote the continuation of valued relationships for residents beyond the care setting, even if that continuation is through the means of reminiscing. Formal reminiscence therapy has been found to create improvements for people with dementia living in residential care settings (Woods et al., 2005). While the motivations behind staff's encouragement of reminiscing are unknown in this study, and it was not formally done, by fostering bonds and relationships it appeared that staff were able to identify which residents respond well to reminiscing and use that knowledge as a tool to encourage engagement.

Staff referred to the different approaches to different residents during their interviews, stating that:

> '*I get on well with all of them, uhh... there are some that I have to respect that some residents don't want that closeness.'* (Interview Participant, Staff)

Knowledge of resident's personal preferences can only come through familiarity. Using that knowledge to build meaningful relationships that meet individual residents' individual needs was found to be important. Knowing each other well and developing strong interpersonal bonds allowed staff to respond to residents in ways tailored to each resident. Not all residents will need, or want, the same relationship with every member of staff. As one staff member put it:

> '*I accept the fact no, no… I'm not their cup of tea, which is fair enough.'* (Interview Participant, Staff)

Understanding the nuances of closeness between staff and residents is crucial in these settings. While familiarity and close relationships were valued by some participants, it's essential to recognise that not all residents will desire or benefit from the same level of closeness with every staff member. Some residents' responses suggested they prefer a more formal or professional interaction, appreciating respectful distance while still feeling cared for. Others appeared to thrive on deeper, more personal connections, seeking companionship and emotional support from staff members they feel particularly close to. These differences highlight the importance of staff sensitivity and flexibility in adapting their approach to meet each resident's unique preferences and needs when delivering relationship-based care.

8.2.4 Humour

> *'They['RE] comical. You know... They got a laugh a minute and… they so happy all of them, from early in the morning, you know. They are fabulous.'* (Interview Participant, Resident)

Humour and laughter were themes identified throughout all three analysis chapters. The observation notes highlighted the positive impact frequent laughter had on the atmosphere. There is a longstanding interest in understanding the meaning behind humour within sociology, and its use in working relationships has been explored in research (Fogarty & Elliot, 2020; Gleibs et al., 2011; Tanay et al., 2013; Williams, 2009). Humour was found to be used in many ways throughout this study; it was used as banter, it was used by both residents and staff in a self-deprecating way, and it was observed being used light-heartedly between staff when going about their daily tasks. Not only was laughter and humour observed, but residents and staff identified it during interview as a key component of positive relationships in the residential home.

Humour was observed being used by staff differently with different residents. It is assumed that through developing strong bonds and understanding the personalities and preferences of individual residents, staff were able to appropriately tailor their approach and humour. The requirement of strong interpersonal bonds when using humour in caring relationships is backed up by research. Fogarty and Elliot (2020) acknowledge that the use of humour can be risky, as it has the potential to result in negative outcomes. When used as a strategy in caring, staff run the risk of appearing contrived or inauthentic, which could undermine instead of supporting the development of relationships between staff and residents.

To be emotionally supportive and caring, humour needs sympathy and positive feeling. Tanay et al. (2013) conducted research into the use of humour between nurses and patients in an adult cancer setting and found both groups of participants highlighted the requirement for ongoing reflection and assessment of the relationship when using humour, remaining sensitive to the patients' needs. Fogarty and Elliot (2020) note the importance of allowing humour to arise naturally, something that can only happen when staff and residents have had sufficient opportunity to develop interpersonal relationships with space continued reflection and assessment (Fogarty & Eliot, 2020; Tanay et al, 2013).

Humour was witnessed in almost every interpersonal interaction during the observation phase of this study. 'Banter', usually used to describe joking and often self-effacing humour, was observed between all residents but was particularly notable as the humour used between male residents:

> *'Lots of jokes heard, men talking and joking more than women present… Male residents engaging in 'banter'.'* (Site 1, Observation 1)

The link between the use of humour and men's gender identity was explored by Gleibs et al. (2011) who explained for most of men's lives they are in a privileged social and economic position in relation to women, which changes as they age. Although this study involved a relatively small cohort of residents; 15 interviews and 18 individuals throughout the observations, approximately three-quarters of the participating residents were female. This gender gap is reflected in the care home population across the UK. Although a breakdown of the latest (2021) census data by gender is not available, in 2011 there were around 2.8 women for each man aged 65 and over (ONS, 2014). This is compared to a ratio of 3.3 women for each man in 2001, so while the gender gap in care settings is closing the proportion of men to women still differs to the proportions residents will have experienced in their lives before moving into residential care.

Men become a minority as they age and transition into residential care, which may be of particular concern to men living in these settings. This is generally perceived as challenging and having a negative impact on a person's sense of self and Gleibs et al. (2011) argue this may be a particular concern to men in these settings and impact on the way they use humour. The use of banter is suggested to be a way to divert attention from their sense of vulnerability as men and involves striving to take risks to be the funniest, or most transgressive (Gleibs et al., 2011). Research into fathers' use of humour by Williams (2009) reflected this use of humour amongst men. Williams (2009) found that humour was important to fathers' gender identity, and a key aspect of their social connectedness with other men. Williams also identified humour being frequently used to reduce tension and hide embarrassment; a use of humour also identified in this study, amongst both men and women.

The use of humour to reduce tension and create a comfortable atmosphere was identified in the analysis of both observation and interview data. Humour was used in situations of vulnerability in a self-deprecating manner. Participants often joked about themselves in a way which came across as self-deprecating and light-hearted while simultaneously hinting at feelings of vulnerability. Participants joked about whether staff liked them, and whether they were causing a hindrance to staff. This use of humour observed between residents and staff was observed being used similarly by researchers looking at care between patients and nursing staff in adult cancer care (Tanay et al., 2013). The researchers found humour was used by patients to alleviate the stress of the nurses working with them, shifting the power balance in the relationship back towards the patients, for the benefit of both patients and staff. Translated to this study, it could be argued that the residents were using humour to joke about the staff having a difficult and busy job, to both lighten to mood but also acknowledge the staff's support in a way that does not require thanking them and expressing direct gratitude, which would reinforce the resident's 'cared for' role. Joking with staff places them on a more similar, social level. This use of humour demonstrates the residents' agency in navigating their social environment and subtly redressing the power imbalance inherent in the caregiver-resident dynamic. By engaging in humour, residents assert their individuality, potentially challenging and reshaping the traditional care relationship.

Humour was being utilised by participants during the interviews to broach subjects with the interviewer which they might have otherwise found difficult, particularly around loss and needs. Exposing their internal vulnerabilities and concerns through humorous interactions lightens the mood while still addressing the topics. For example, one resident that the staff must like her 'otherwise they wouldn't keep coming back.'. While this was said humorously, it perhaps communicated her underlying anxiety about wanting to be liked by the staff.

Studies have shown humour being used to broach controversial and difficult subjects in a light-hearted way (Fogarty & Elliot, 2020). Similarly, staff were observed joking with each other while working and spoke of the importance of 'having a laugh' and the need to be 'totally bonkers' while working during the interviews. Humour in the workplace has been shown in research to be used as a coping mechanism for people working across a range of caring professions (Jordan, 2017; Fogarty & Elliot, 2020; Tanay et al., 2013). It has been found to aid in coping with day-to-day tasks, particularly when being faced with emotionally difficult scenarios is a regular occurrence, sometimes being referred to as 'gallows' humour (Jordan, 2017; Tanay et al., 2013).

Evidence linking humour to physical health is still inconclusive but is acknowledged to be a fundamentally social behaviour that can strengthen interpersonal bonds and support people to preserve hope and dignity in otherwise disempowering situations (Martin & Ford, 2018). Humour increases positive emotions and reduces negative ones, so can help reinterpret stressful situations from a less threatening perspective (Martin & Ford, 2018). When viewed in this context, the use of laughter and humour in residential care makes sense for both staff and residents. Loss is an inherent part of life in residential care, a topic discussed later in this chapter, and care work is often difficult and low-paid (Block et al., 2018; King-Dejardin, 2019; Naue & Kroll, 2008). Yet, the atmosphere was overwhelmingly positive, and described as 'almost joyous'. A testament, perhaps, to the pervasive use of laughter in the residential settings in this study.

8.3 Time and trust

> *'I don't like it when we short staffed, I find that very hard. Very hard, you have not got the time, you running around like idiots.'* (Interview Participant, Staff)

The themes which come under intimacy have a common requirement for their fulfilment, time. Time, framed both positively and negatively, emerged through the content analysis of participants' interview responses, being acknowledged by both staff and residents as vital to enabling the development of trust and reliability. There needs to be enough time to develop meaningful relationships that will allow staff and residents to know each other intimately. To effectively use humour and touch and get to know residents' histories, preferences and personalities, staff need to have time to develop interpersonal bonds. The impact of time, and the barriers to finding it, are discussed in the ensuing paragraphs. As Ruch explains:

> *'However, to facilitate the development of relationship-based approaches, which embrace a holistic understanding of clients, of practitioners and the nature and contexts of social work practice, there is a need for practitioners to be afforded the time and space to respond thoughtfully– reflectively – to the unique, complex, and dynamic situations they encounter.'* (Ruch, 2005, p 121).

Staff highlighted the importance of being able to take time to find out residents' tastes and allowing them to tailor support accordingly, as seen below:

> *'We're lucky, we've got continuity of care, and because we are here all day every day for three days a week I think they do recognise you, and you can say*

> *things or remember and they'll pick up little things.'* (Interview Participant, Staff)

Sufficient time enables staff to develop an understanding of the residents' social context, enabling conversations about residents' histories and their situation outside of the confines of the residential setting. Strengthening bonds with staff based on shared social and geographical context enables residents to feel a sense of belonging and enables staff to meet more than just residents' basic care needs (Baumeister & Leary, 1995).

A further key theme identified during the qualitative content analysis of interview data was trust. Residents and staff identified trust as being key to forming effective relationships within residential care. Trust, like other aspects of relationships, requires time to establish. Not just in terms of the period it takes to develop a trusting relationship, but also due to staff needing time and space in their days to sit down and get to know residents. Staff members spoke of the importance of unstructured time to sit and get to know the residents on a one-to-one basis, without the need to be performing caring duties and tasks. While functional relationships focus simply on tasks, effective and supportive relationships are characterised by a sense of trust (Wiersma and Pedlar, 2008).

Being trustworthy in the context of positive professional relationships means building a foundation on which staff can be relied on to keep their confidence but also maintain reliability (Wiersma & Pedlar, 2008). Trust was evidenced through participants' responses about feeling comfortable enough with staff to be able to communicate openly, even when discussing negative topics. Language used by residents emphasised the value they placed in staff showing they care through being reliable and dependable, and going above and beyond their role. Aspects of a relationship all that take time to develop.

Continuity of staff members emerged as a key feature of developing trust. The development of trusting and intimate relationships between staff and residents was attributed to the high level of staff retention in the residential units in this study. Staff turnover in the units was said to be low, although no data was available on the actual turnover rate at the sites. This contrasts with social care across the UK, where data identifies a turnover rate of 29% in the sector in 2021/22 which has been referred to as a staffing crisis (Skills for Care, 2022b). The importance of continuity of care and low turnover lies not only in providing the time for staff and residents to establish strong interpersonal bonds in the longer term but also frees up time in the shorter term. The practical importance is communicated by a resident, who explained they ‘get used to’ the way one member of staff performs tasks and spoke uncomfortably of the occasions they have been required to explain elements of personal care to staff they did not know well.

McLeod (2007) investigated issues of power in relationships between young people and social workers. Although a different cohort of service users, McLeod’s findings highlighted the value placed on workers staying a long time and was hindered by high caseloads. The high caseloads of social workers in McLeod’s study are similar to the issue of the high workload identified by residents and staff in this study.

Staff acknowledged and spoke of how busy they often were, and residents raised uncertainties over knowing whether staff would have enough time to speak with them and worried about whether staff were too busy. The lack of time in these circumstances added insecurity to the relationship, where residents spoke almost nervously about the response staff might have. Staff being too busy to spend one-on-one time with residents is a barrier to effective relationship-based practice, not only due to reduced time to develop and strengthen interpersonal bonds but also due to the way their ‘busyness’ is perceived by residents. Residents’ concerns about approaching busy staff and feeling like a burden are not conducive to forming effective relationships.

8.4 Loss and loneliness

> *‘They always go back to their room, and I got nobody to talk to then.’* (Interview Participant, Resident)

A key theme which emerged from the analysis of interview data was loss and its impact on residents' lives. Residents spoke of the loss of relationships, the loss of their homes, the loss of routine, and the loss of their health. Discussion of loss was accompanied by discussion of loneliness and isolation for residents, even within the busy confines of the residential setting residents spoke of feeling alone. They spoke of feeling unable to leave their rooms, of the impact of other residents staying in their own rooms, and of missing aspects of the life they had before their move into residential care. Loss, in its different guises, and its impact on the relationship between staff and residents is discussed below.

Any move into residential care will feature loss, as residents navigate the transition from their previous home and community. This sense of loss will likely be compounded by the loss of independence which so frequently is the reason for the move. As Funk and Outcalt (2019) highlight, changes in health and social care have resulted in adults entering residential care settings later, and at a point where they are more dependent. Residents spoke of choosing to stay in their rooms due to the loss of their physical abilities, rather than going into communal areas where the opportunities to socialise took place. The impact of losing the ability to drive was discussed by another resident, who lamented the loss of freedom this had caused.

Residents spoke of not only losing their physical abilities but also of the loss of relationships. One resident told of how she had *'lost a lot of my good friends'*. Zizzo et al. (2020) conducted research into loss and the transition into residential care, with their findings suggesting that the transition may result in unresolved and complicated grief with the potential to negatively impact health and well-being. Staff in this study spoke of recognising the loss of previous relationships, by acknowledging that residents will likely have lost those in their lives who previously would have provided those 'cwtches'. It is important to consider, however, that these relationships might sometimes function as substitutes for familial or close personal connections that may now be missing from residents' lives. Staff now try to provide those cwtches, linking back to the previous discussion about recognising residents' need for touch and familiarity in their relationships with staff to foster deeper interpersonal bonds and a sense of belonging. Staff not only provide essential care but also, as identified, they develop meaningful bonds. These bonds can mitigate the sense of isolation and loneliness experienced by older people and this potential filling of gaps left by other relationships highlights the complex and multifaceted nature of providing care within residential settings.

Residents also spoke of being unable to form relationships due to their fellow residents being unable to socialise due to poor health and spoke with sadness of their isolation and being in bed ‘all the time’. The loss of cognitive ability due to dementia was also referred to as a contributor to the isolation of other residents, and residents spoke of being unable to form friendships with neighbouring residents due to their more advanced dementia. Harris (2013) found that the stigma surrounding dementia has an impact on relationships, and upon friendships. It is interesting that participants in this research also had dementia yet spoke of their reluctance to engage with peers with more advanced dementia. The hesitation observed could be due to barriers posed by dementia symptoms affecting communication, but it might also involve an element of fear causing this reluctance.

The findings indicated residents can be reticent about engaging with peers exhibiting behavioural symptoms, *‘describing them as “crazy” and undesirable friends’* (Bonifas et al., 2014, p 1332). Additionally, connections between residents are often superficial in nature, meaning residents feel lonely and isolated from their external community. Individuals’ own health conditions and limitations were also found the hinder the development of peer relationships. The residents are likely aware of the progressive nature of dementia, and spending time with peers in more advanced stages of dementia could be distressing. To translate these findings into an understanding of how effective relationship-based practice might be supported, it is important to frame residents’ experiences of loss within the wider context of their histories. Again, by allowing interpersonal bonds to develop over time and by finding time to get to know residents intimately the staff can strengthen the relationship.

Through a strong relationship, staff can support residents to navigate their feelings of loss and help them better engage with their wider social environment. John and Trevithick (2012:76) suggest those experiencing high levels of social and systematic disadvantages are less likely to be engaged in shaping their external worlds. By working alongside residents, staff can find solutions to help address the residents' disadvantages caused by loss. Through a strong working relationship staff can support residents to improve their resilience and better engage in their external world, the residential home.

8.5 Choice and interdependence

Autonomy is closely linked with notions of independence and discourse around power imbalances. It is a key focus in the literature on risk management and personalisation in the care of older people as seen throughout chapter 2 and chapter 3 of this thesis. Autonomy, as a reminder, for this thesis is defined as:

> *'[THE] liberty to follow one's will; control over one's own affairs; freedom from external influence, personal independence.'* (Oxford English Dictionary, 2022b)

Autonomy will be discussed throughout the remainder of this section in relation to choice and individualism, and independence and interdependence. The notion of being autonomous and independent is then discussed with reference to occupation; a method of involving residents noted during the observation stage of this study that has potentially interesting links to the concepts of autonomy and interdependence.

8.5.1 Choice and individualism

> *'We've got choices, no matter how small, no matter what decision they got to make, it's got to be made... it's empowering them...'* (Interview Participant, Staff)

Providing people receiving care with increased choice and control of their service provision was done with the idea this would enable people to retain their autonomy and redress the power imbalance in professional relationships (Brookes et al., 2015). In this study, the concept of choice was frequently discussed in the context of participation in structured and organised activities. Participants spoke of being offered both a choice of activity and the choice of whether to participate. As seen in the below response:

> *'The choice is always, whether you want to participa... participate.'* (Interview Participant, Resident)

Staff responses demonstrated the value placed on offering residents choices in their daily activities. However, interestingly this is the extent of choice discussed in responses. There were no interview questions asking what participants felt about choice, or what choices they had, so this study is unable to give a definitive answer on the area's residents can input into decisions. However, the question was posed about what mattered to people and what they valued. The value for participants appeared to exist in exercising choice in the small, daily decisions of life in the residential settings. Nolan's Senses Framework can support an understanding of how these choices align with residents' preferences, autonomy, and rights. It provides a comprehensive approach to supporting people with dementia to participate meaningfully and maintain a sense of control over their daily lives (Nolan et al., 2006). Navigating the individual preferences of residents who prefer solitude and decline group activities requires a nuanced approach that respects autonomy while also considering the benefits of social interaction and community engagement within the framework of relationship-based care, striking a balance between respecting individual preferences and recognising the benefits of social interaction.

Interestingly, choice and individuality were key themes that emerged during the content analysis of the available documentation in the residential settings. As pointed out in the introduction to this chapter, the documentation was published and placed (either online or physically in public areas on the sites) by the not-for-profit company that owned both sites. The language used focussed heavily on choice for residents, as the below examples demonstrate:

- *‘Individuals are at the centre of their service and inform everything we do’*
- *‘We are focused on the individual’*
- *‘We understand that everyone is unique’*
- *‘Our staff…. understand the importance of enabling people to keep control of their lives’*

This focus on the individual is notable, and although photos accompanying the quotes and statements often depicted images suggesting happiness and friendship, this was not the focus of the written content. It can be assumed the purpose of the literature is to advertise the settings, as the literature highlights is a necessity for residential settings to ensure their financial viability (Kash & Miller, 2009). It could therefore be interpreted that the residential care settings are working on the assumption that people considering a move into a care setting want to retain choice and control, as this is what is being ‘advertised’.

Houska and Loučka (2019) explored the dominant definition of autonomy as the capacity of individuals to make independent rational choices, concluding it might not be suitable for those receiving end-of-life care. The authors suggest there is a need for more nuanced perspectives on autonomy in such cases. Fernández-Ballesteros et al. highlight that:

> *‘Although the promotion of autonomy is intrinsically right, it may be adjusted to the individual baseline characteristics, taking into consideration that a very high level of autonomy demand could overcome the individual baseline, producing anxiety, and suffering.’* (Fernández-Ballesteros et al., 2019, p. 1460)

This is an opinion echoed by McNally and Lahey (2015) who caution that while the informed choice process is intended to uphold autonomy, it can inadvertently become burdensome for individuals and their families. This perspective highlights the complexities involved in decision-making within healthcare and social care settings, where the emphasis on autonomy may sometimes lead to overwhelming choices or responsibilities. McNally and Lahey suggest that the process of making informed choices, while important for respecting individuals' preferences and values, can sometimes overwhelm individuals and their families with the weight of decision-making. This burden may arise from the complexity of the information provided, the emotional impact of decisions, or the practical challenges associated with implementing choices.

This is particularly interesting when set against the absence of discussion over control for residents in this study, beyond minor daily choices. Although not explicitly explored during this research, asking questions about the boundaries of control residents seek or desire would provide interesting knowledge and context to this discussion. Residents may place value on different aspects upon transitioning into care home environments. Younger adults, accustomed to independence and autonomy, may hold different values and priorities compared to older adults who may be more dependent on others to meet their needs. These concepts will be further explored in the concluding discussion in the next chapter.

Understanding residents through the context of their histories, their losses, and their level of dependency aids in the exploration of the boundaries of choice and control. Residents will have experienced loss in many forms during their transition into residential care. This is likely to have a considerable impact on residents’ mental health, and their care needs should reflect this. As previously discussed, residents often spoke of exercising their choice to stay in their own rooms. However, residents also spoke of staying in their rooms due to physical barriers related to a loss of physical abilities or spoke of their neighbours having to stay in their rooms. They spoke of the isolation and loneliness this caused. Loneliness and isolation are both linked to negative psychological outcomes (Mushtaq, 2014). Simultaneously, low mood and psychological disorders such as depression, often result in low mood and reduced motivation (NHS, 2019). It is therefore not unreasonable to suggest that a cycle of isolation and low mood might impact residents’ willingness to leave their rooms.

Pushing autonomy and choice unquestioningly may not always be in the best interests of residents in these cases. The Mental Capacity Act 2005 protects the right of adults with the capacity to make unwise choices, and in most instances observed in this study, residents had the capacity to participate in day-to-day decision-making. However, staff spoke of trying to change decisions when they felt it was in the interests of residents. Through developing strong relationships with residents and getting to know their individual preferences and capacity capabilities, staff can support residents to engage and promote change through the medium of the relationship. This can be seen in the below excerpt taken from a staff member’s interview response:

> ‘*They have got choices, but sometimes you’ve got to try and encourage that choice to change.’* (Interview Participant, Staff)

This member of staff succinctly describes how she navigates the dilemma of promoting choice and autonomy while trying to promote good outcomes for the residents in her care. The question of whether autonomy and choice are always in the best interest of people has been explored in previous research in the context of direct payments and personalisation for people who lack capacity, by Williams et al. (2017). The authors highlighted that it was often unclear whether people who lack capacity can benefit from choice and control in the same way as people with capacity. A point highlighted in the findings of this study is the question of whether taking a resident's choice at face value is always the best and only course of action. Only through knowing residents well and developing strong interpersonal bonds can a member of staff use their judgment to decide when to encourage a change in that choice.

8.5.2 Interdependence and independence

The interplay between independence and interdependence is explored here as a continuation of the discussion points on choice and autonomy above. Independence and interdependence are defined in the preceding literature review chapters, however as a brief reminder independence is a condition of not being dependent on one another, while interdependence is the condition of depending on each other (Oxford English

Dictionary, 2021a, 2021b). Interdependence is a concept that underlies all social interactions, yet people rarely have objective awareness or knowledge of that interdependence (Gerpott et al., 2018). Independence, related to concepts of autonomy and choice, differs in that it stems from the ideology of self-reliance. As Leece and Peace (2009) explain, care literature tends to define independence in terms of the extent of the absence of dependence. Although absent from the data collected during the observation and interview phase, independence was a predominant feature of the documentation produced by the care home, as seen in the below quotes:

- *'We support people to live positive, independent lives.'*

- *'We do this by offering support and encouragement to maintain independence and live actively.'*

Leece and Peace (2009) suggest the contested nature of the term 'independent' can result in a lack of clarity of whether it refers to people's ability to exert independence through decision-making, or their ability to self-care. Although elsewhere the documentation analysed spoke about supporting residents to exert choice and control over their lives, the use of the word independent here is unclear. It is an interesting choice given the move to a residential setting often occurs due to a person's loss of independence, indicating that residents no longer live independent lives. Additionally, it is notable that the quote describes an independent life as 'positive,' implying that a dependent life might not be considered a positive one.

Mackenzie and Stoljar (2000) suggest frailty and dependence are not something that should be avoided or feared. The authors discuss interdependence, or dependence on one another, in terms of 'relational autonomy'. They explain that relational autonomy comes from the stance that everyone is interdependent and embedded socially within the structural, social cultural contexts within which they live. The responses in the interviews suggest that residents and staff embraced emotions that came with being socially embedded, including the below excerpts:

- *'You get really attached to people and you love people, you know, rightly or wrongly you love people.'* (Interview Participant, Staff)

- *'They're like a family'.* (Interview Participant, Resident)

Interdependence is closely linked with the human need to belong, a concept discussed previously in this chapter. This desire for interconnectedness is described in terms of an ongoing tension between independence and interdependence by Orehek and Kruglanksi (2018), who described the puzzle in human behaviour as readiness to give up their individual needs for social cooperation to connect with groups, a need Baumeister and Leary (1995) refer to as belonging. Ethics of care also places emphasis on interdependence, as Tronto states when discussing how care needs to change:

> *'We will need to rethink our conceptions of human nature to shift from the dilemma of autonomy or dependency to a more sophisticated sense of human interdependence.'* (Tronto, 1993, p. 101)

Approaching residential care through an ethics of care perspective involves considering the roles of interdependence, connection, and mutuality in relationships between residents and staff. Interdependence acknowledges that both residents and caregivers rely on each other in various ways, creating a dynamic where both parties contribute to and benefit from the relationship. Connection emphasises the importance of building strong, empathetic bonds that foster understanding and trust while mutuality recognises that effective care is not a one-way street; it involves reciprocal relationships where the needs, preferences, and well-being of both residents and staff are valued and supported.

McCabe et al. (2021) explored choice in care provision and activities of daily living and found a significant correlation with resident quality of life. However, they found neither of these variables contributed significantly to quality of life when the staff-resident relationship was included in the model. The findings of this study are particularly interesting when considering relationship-based practice, as they suggest that the relationship between staff and residents has a much more significant impact on the quality of life of residents than the types of choice being discussed. This suggests that it is interdependence that provides greater quality of life, over independence.

Although residents and staff spoke about the importance of choice in day-to-day tasks, overwhelmingly more apparent was the desire of residents and staff to achieve a sense of belonging in the residential setting. Care was spoken about in terms of feelings, as seen in the below excerpt:

> *'Well, they're carers really, aren't they? And they do care…. They're very kind. Over and above what they got to do.'* (Interview Participant, Resident)

And

> *'Well, you got to… what you call... friends... because they do help you a lot, see…. If you want anything, they... they're here for you, you know?'* (Interview Participant, Resident)

Gómez-Vírseda et al. (2019) describe relational autonomy as a rich and complex concept, coming from a variety of diverse philosophical sources but caution it has emerged more as a 'reaction against' the individualistic interpretation of autonomy. This is interesting when the parallels with relationship-based practice are considered, given it is acknowledged that relationship-based approaches have re-emerged in reaction to individualistic and managerialist practice. Houska and Loučka (2019) stress the importance of relational autonomy, and the importance of social relationships and interdependence as a medium through which such autonomy can be shaped instead of being reduced to simple decision-making for 'passive recipients of care'.

However, choice and autonomy were discussed previously in this chapter in relation to the value placed by staff, residents, and the owners of residential care settings on supporting residents in decision-making. It may be easier to discuss, measure, and define choice than relationships. Alternatively, the historical emphasis on personalisation, autonomy, control, and choice may have entrenched these concepts as the predominant language within care homes.

8.5.3 Occupation and interdependence

Occupation was a theme that featured heavily in the observation data. Staff and residents were frequently observed working side by side on craft and cooking projects, and staff encouraged residents to join them in preparing drinks and washing up. Each unit had an open plan living, dining and kitchen area that was conducive to this, enabling residents and staff to both access and use the facilities. It was noted that observing staff and residents engaged in activity, or occupation, side by side was similar to observing friends. While working together, the conversation was observed flowing freely, with residents and staff laughing and chatting alongside each other.

Theurer et al. (2015) explored the concept of occupation, proposing that practices focussing on entertainment and distraction in residential care should be replaced by an approach centred on resident contribution and support. The researchers found residents lacked meaning in their lives, with limited opportunities and frustration with paternalistic approaches by staff, resulting in unmet needs including lack of autonomy and belonging (Theurer et al., 2015). The findings of this study agree with their findings. Residents working alongside staff to prepare items for an upcoming Christmas fayre reflected positively on the time spent preparing and cooking some of the items they were then wrapping and were looking forward to selling them the following week to raise money for charity. They were engaged, animated and positive. Not only was the preparation itself a source of occupation, but the time spent working alongside each other also allowed for unstructured chat.

Panthi (2022) explored the impact of participation in meaningful activity for care home residents providing connection with peers and staff, highlighting that their findings indicated such participation provided connection and combatted loneliness. Panthi attributes this to the activity allowing participants to maintain and develop a sense of autonomy and independence. However, when considering the concept of interdependence and the observations taken during this study, it could be suggested the benefits come from allowing the residents and staff to strengthen their bond and develop a sense of interdependence.

In this setting, the concept of interdependence reflects the mutual reliance and interconnectedness between staff and residents. Unlike more transactional models of care, which focus primarily on meeting basic needs, relationship-based care acknowledges that both parties contribute to, and benefit from, the caregiving dynamic. Interdependence recognises that residents rely on caregivers for support, assistance, and companionship, while caregivers depend on residents for their unique perspectives, experiences, and contributions to the caregiving community. From a social constructionist perspective, this interdependence highlights the significance of continuous dialogue, negotiation of meanings, and shared understanding between staff and residents. This reflects the evolving nature of caregiving relationships and the impact of social contexts on shaping these interactions, by acknowledging the fluidity of roles and the importance of cultural and social factors in their relationships.

It must be noted that the preparations witnessed during the observation were for an annual event, and it is unclear if there are regular events that residents could support the preparation of. However, the suggested benefits make it worth exploring opportunities for residents to engage and prepare in meaningful ways, rather than just entertainment or crafts that lack purpose. Nolan et al. (2006) put forward a framework for a relationship-based approach to practice with older people called the Senses framework. Within this framework, the authors suggest that a sense of purpose and a sense of fulfilment are prerequisites for positive and effective relationships in care provision. They describe a sense of fulfilment for older people as:

> *'To feel recognised and valued as a person of worth, that one's actions and existence is of importance, that you 'matter'. '(*Nolan et al., 2006, p. 22)

A sense of purpose for older people is described as:

> *'Opportunities to engage in purposeful activity, the constructive passage of time, to be able to pursue goals and challenging pursuits.'* (Nolan et al., 2006, p. 22)

According to Nolan et al.'s (2018) senses framework, involving care home residents in activities like dishwashing and tea-making serves to empower them with a sense of agency and independence. These tasks not only fulfil practical needs but can also nurture emotional well-being through the fostering of social connections and affirming residents’ values and purpose within their community. Engaging in these activities allows residents to feel actively involved in daily life, promoting a sense of purpose and accomplishment that might contribute to their overall well-being. This approach underscores Nolan’s framework's emphasis on holistic care that respects residents' dignity and supports their sense of purpose through meaningful engagement in everyday activities.

For most of their lives before moving into residential care, residents will have engaged in meaningful activity and contributed to the upkeep of their surroundings. Providing residents with a sense of purpose not only has the potential to enhance their lives but also to enrich their community by tapping into their wealth of experience and wisdom. It recognises their agency and power to contribute meaningfully, redressing power imbalances. The ethics of care approach emphasises the importance of supporting people in finding and pursuing meaningful activities and roles, suggesting that empowering older residents with purpose can cultivate mutual respect and reciprocity between staff and recipients of care.

For residents to move into the residential setting and be expected to be passive recipients of care does not make sense. The observation data supported the idea that residents responded positively to being invited to contribute and that working alongside staff appeared to breach the staff-resident divide. Ruch's model for relationship-based practice emphasises the importance of genuine and empathetic interactions (Ruch, 2005). Understanding activities such as dishwashing and tea-making through Ruch’s framework might view them as opportunities for relational engagement, where staff can build trust, understand individual preferences, and promote residents' autonomy and self-worth through personalised interactions.

The emphasis of the approach is on interdependence, connection and mutuality, and there is considerable overlap between the approach and models for relationship-based practice (Hollinrake, 2019; Ruch et al., 2018; Tronto, 1993). As Hollinrake states:

> *'Both reject the notion of the autonomous, independent human being and stress interdependence, with the elements.'* (Hollinrake, 2019, p. 17)

Ethics of care as a research approach offers opportunities for researchers to use their relative position of power to engage with participants to conduct research that values, as Brannelly states:

> *'[VALUES] above all, the lived experience and real-life change that improves the conditions of life by addressing what matters to people.'* (Brannelly, 2018, p. 373)

Parton discusses vulnerability and care, stating:

> *'Receiving [CARE] makes one aware of one's vulnerability and vulnerability is not only an issue for children and elders but is something which we all—at different times and in different ways— experience.'* (Parton, 2003, p. 11)

Vulnerability, when explored through an ethics of care, has been related to interdependence, and the universal need, at some point in our lives, for care (Miller, 2020). This perspective emphasises that no individual is entirely self-sufficient; all individuals encounter periods where reliance on others for support is necessary, whether due to illness, ageing, or other life circumstances. The ethics of care framework highlights that recognising and addressing these vulnerabilities is crucial for fostering a compassionate society, suggesting that care should not be seen as a burden, but instead, as a fundamental aspect of human relationships, underscoring the moral significance of caregiving roles and the societal structures that support or undermine them (Miller, 2020).

Despite the focus on promoting and valuing independence in the care home documentation and current policy approaches, what was observed within this study is that not all interpretations of independence are achievable for all residents. For example, some residents observed within this study were dependent on support from staff to participate in activities of daily living due to their physical needs, or due to needs associated with dementia. While the degree of dependency experienced varied between participants, to some extent, all residents were dependent on staff as their caregivers. Participants did not shy away from this dependence, nor was it spoken about in especially negative terms. Instead, residents spoke about wanting relationships with the staff, they spoke of the importance of forming close bonds and of laughing alongside them. Dependency and vulnerability were found to be significant experiences for the residents in this study. This is potentially a situation that is feared by those who do not yet find themselves dependent on others for their care.

8.6 Fear

> *'I heard it…, he said if the inspector walked in, and you were.. you'd be sacked right away... 'cause you natural reaction is to comfort somebody.'* (Interview Participant, Staff)

Fear was a main theme amongst responses from staff during interviews. Staff spoke about fear of touching residents, fear of being perceived as going against 'the rules', and fear of those rules becoming stricter. Staff members discussed fear when they considered how their experience of professional boundaries impacts their roles as social care workers in relationships with residents.

Fear is discussed in Chapter 3 in relation to risk management. Altheide and Michalowski describe fear permeating throughout the news media, with danger and risk as a core component, stating that as a society:

> *'We increasingly share understandings about what to fear and how to avoid it.'* (Michalowski, 1999, p. 476)

The concept of fear was explored by Furedi (2009), who suggests that the UK press has reinforced the idea that devious adults exist everywhere, which has resulted in society exacerbating suspicions against *all* adults. These findings were observed in research undertaken by Brown et al. (2018) with residential childcare workers, who also expressed concerns and fear around touch with the residents, who were in this case, children. Piper and Stronach (2008) suggest fears surrounding touch satisfy the requirements of a moral panic, resulting in the distancing of adults from children and protecting adults from the potential of any allegations being made. As the authors state:

> *'A contemporary common attitude towards touch is one of helplessness, where workers sometimes feel they must 'break away' from what they assume to be policy to best meet the needs of the child, fear has led to the suspicion that adults are likely to have 'ulterior, negative motives'.'* (Piper & Stronach, 2008, p.4)

As outlined in Chapter 3, when the public is mobilised by fear or anger, the government feels the need to respond to placate society (Altheide, 2013). This pressure encourages the government to draft reactionary or 'knee-jerk' legislation to demonstrate that they are serious about preventing similar situations from occurring again (Munro, 2011) which has the potential to contribute to the current risk-averse policy landscape.

Although Furedi's and Piper and Stronach's work both consider the risk adults pose to children, it follows that the same concepts would also apply to 'vulnerable' older adults. This is evident in the sentiments expressed by the below participant when discussing her feelings towards the residents she cares for potentially being thought of as 'wrong':

> *'You get really attached to people and you love people, you know, rightly or wrongly you love people.*' (Interview Participant, Staff)

The above quote succinctly describes the feelings communicated throughout the staff interviews. One member of staff spoke of the human, instinctive response to respond to residents' emotions with feelings, love, and touch, while simultaneously referring to boundaries as stifling their instinct to comfort. Similar responses were frequently followed by an expression of concern, or a sense of fear, that reacting in this way might have implications for their role. Staff spoke of understanding the need for the 'rules' to protect residents against ‘naughty’ people, but described professional boundaries as a barrier put up between themselves and residents and expressed sadness that they exist. Piper and Stronach suggest:

> *‘Perhaps a society that makes certain words taboo or ‘naughty’ (and touch appears now to be one such word) ensures that adults will have inappropriate responses.’* (Piper & Stronach, 2008, p.8)

Although Piper and Stronach discuss adults' concerns about touch in relation to children, it is interesting that the constant fear of touch towards residents in their care causes staff to continually worry about how they interact with residents. This concern appeared to make the staff interviewed in this study experience anxiety towards providing comfort and relating through touch. In this context, the dilemma for staff is whether it is more inappropriate to place a comforting hand on an upset resident or to fear touch, step back, and avoid comforting a person in distress.

One member of staff spoke of fear of losing her job for following her instincts. Whatever the professional boundaries for the staff interviewed state, the interpretation of the boundaries as an infringement on their ability to work with residents in the way they would prefer was unanimous amongst the staff interviewed. Fear can be argued to be part of the reason that professional boundaries exist in the first place, as they are established as part of risk management policies to protect both vulnerable individuals and professionals from potential harm. However, these boundaries also cause fear in the staff interviewed. This is seen in the interview excerpt quoted at the beginning of this section from a staff member relaying what a manager had told her; that she could get sacked if an inspector saw her hugging a resident.

Brown et al. (2008) researched the impact of fear in residential childcare in Northern Ireland, finding that the impact of a culture of fear is amplified by the low status of care workers. The low status of care workers in this study could have similar implications. Care work is low-paid and low status, and any job loss would have negative consequences and financial implications (Brown et al., 2008). Staff spoke of engaging with residents between the cracks of the professional boundaries, the concern for their jobs is likely to negatively influence both the way they work and the way they feel about their work. This is evident in the following quote from a staff member discussing a recent course she attended on professional boundaries and touch in the workplace:

> *' I don't know. I am wary of it now, and I am watching what I'm doing… I just find it's gone... I don't like it very much, this way anymore. But, as I say I got to accept what it is.' (*Interview Participant, Staff)

A lot of the fear around people with dementia is linked to the perception that they are particularly at risk of harm (Manthorpe, 2015). Dementia, and more broadly, old age is often defined through stereotypes of being frail and weak and in need of protection (McNally & Lahey, 2015). The concerns raised by staff in this research reflect findings in previous research about the tensions in health and social care between taking and avoiding risks, and the need to focus on balancing possible harm with the possible benefits (Postle, 2002; Quinn, 2010).

The concept of being 'too close' to residents was not just confined to the physical but extended also to being emotionally close. However, the findings of this study highlighted staff and residents' positive attitudes towards comforting touch, as seen in the below quote.

> *'If somebody's upset, you touch people don't you'* (Interview Participant, Staff)

When discussing physical touch between staff and residents, however, it is important to acknowledge subtlety and differences in preferences. While touch can be a powerful tool for comfort and connection, it's crucial to recognise that not all residents will desire or be comfortable with the same level or type of physical contact. Some residents may appreciate gentle touches or hugs as a form of reassurance and affection, while others may prefer minimal physical contact or may have cultural or personal boundaries that dictate their comfort level with touch. Respecting these differences is key to building trust and rapport with residents. Staff members should be attuned to individual preferences and always seek consent before initiating any physical contact.

Stalker (2003) highlights, that the constant presence of danger has contributed to the tendency to regulate professionals and their decision-making to minimise risk. Social care's challenge in developing effective relationship-based practice is how to address this. If thought is given to how to allow staff the space to use their own judgement and instincts, to respond to residents sensitively, to build strong relationships and to foster a sense of belonging in their lives, then social care could reap the benefits.

However, it is important to note, as Quinn does that:

> *'What people with dementia fear for themselves and what others fear on their behalf may differ greatly.'* (Quinn, 2010, p.6)

8.7 Conclusion

This chapter sought to answer the question of how residentials and staff experience relationships in residential social care settings for people with dementia. This was achieved through the synthesis of the findings of the three qualitative analysis chapters. The data collected throughout the two case studies suggests that positive relationships between residents and staff might assist in improving both residents' and staff's experience in the care home. Residents and staff spoke of friendship being a core feature of an effective practice, valuing genuine feelings within the caring relationship. The findings suggest residents value reliability and trust in the staff supporting them. Touch was another key feature of effective relationship-based practice. Touch was observed being used to comfort residents, and staff utilised touch instinctively and responsively which demonstrated how attuned they were to residents' needs.

Integrating key elements like trust, touch, knowledge of residents' histories, and the balance between choice and guidance within existing frameworks of relationship-based practice, such as Ruch et al.'s (2018) approach and the IDEAS model by Dix et al. (2019), highlights their potential roles in enhancing care in residential settings. Ruch et al.'s framework for relationship-based social work emphasises the importance of relational competencies, which include qualities like empathy, emotional intelligence, and reflective practice among staff. Trust is foundational in this approach, as it fosters a supportive environment where residents feel secure and valued. Staff build trust through consistent and empathetic interactions, respecting residents' autonomy while offering guidance based on their individual needs and preferences. Touch, within ethical boundaries and with sensitivity, can convey reassurance and comfort, contributing to a nurturing relationship. Knowledge of residents' histories enriches caregiving by personalising interactions, and understanding their preferences, life experiences, and values.

A further model for applying a relationship-based approach to adult social work practice was put forward by Dix et al. (2019). The authors suggest a framework entitled 'IDEAS', which focuses on a strengths-based approach to practice, building on and widening the approach taken by Ruch et al. (2018) to ensure applicability to practice with adults. IDEAS stands for '*Influence, Delivery, Expertise, Alliance, and Support'* (Dix & Meade, 2019, p. 47). While focused on social work with adults, this strengths-based approach to relationship-based practice provides a framework for social work professionals to successfully develop relationships with the people they support. Where the findings of this study align with the IDEAS model for practice is the focus on support for the staff to practice effectively with residents. The findings suggest staff in residential settings might benefit from additional support in navigating and engaging with professional boundaries, particularly the fear felt when appropriately utilising professional knowledge and skills around touch and comfort.

Also required to answer the research question is an understanding of what might need to change in the current practice culture and context to better support staff to enable effective relationship-based practice. A key barrier to effective relationship-based practice was identified as time. The data suggests residents feel reluctant to ask for the support they need when they perceive staff as being busy or not having enough time. Staff identified time as a key enabling feature of effective relationship-based practice. Sufficient time allowed staff to spend one-on-one time with residents, 'chatting' and getting to know them. The knowledge gained through getting to know each other was used to strengthen their interpersonal bonds. Staff and residents spoke passionately and warmly about their shared connections that extended beyond the confines of the residential home. It was clear that in some cases, residents and staff shared mutual friends or knew family members. Staff were observed bringing up these personal anecdotes, openly sharing parts of themselves and engaging with the people they care for.

Effective practice was observed through knowledge of residents’ histories and backgrounds being used to support residents emotionally. The data highlighted a common theme amongst residents was loss. Loss was associated with ageing for many participants of this study, who spoke of the loss of their previous lives, and homes, and of losing important relationships. Staff spoke of giving ‘cwtches’ to residents, acknowledging the loss of relationships with those who would have cwtched them before they moved into residential care. Through developing an understanding of residents’ social and wider histories, staff were well placed to provide support to help them navigate the loss associated with the transition into residential care.

The findings of this study highlight that residents placed value on their abilities to make choices in day-to-day activities. The findings also suggest that residents’ choices can be influenced by anxieties around the loss of their physical abilities, and staff spoke of encouraging residents to ‘change their choice’ on occasion. Through a strong relationship, staff can understand when a resident’s choice might not be in their best interests and know when to gently push them but also when to stop.

An understanding of how relationship-based practice is important for staff as well as residents, as it forms the foundation for compassionate and effective caregiving. By prioritising meaningful connections and understanding the individual needs and preferences of residents, staff can create a supportive environment that enhances the quality of life for the residents in their care. It also has the potential to contribute to job satisfaction and professional fulfilment for staff. By forming meaningful connections with residents, caregivers can experience a profound sense of purpose and impact in their roles. Building trust and rapport allows staff to better understand residents' needs and preferences, leading to more effective care delivery and outcomes while seeing the positive impact of their efforts on residents' lives can be deeply rewarding.

Independence was mentioned frequently in the care home literature; however, the findings of this study suggest that independence is not as much of a priority to residents. Instead, residents spoke of the importance they placed on their relationships with staff and the findings suggest residents prioritise belonging over autonomy. Occupation was a tool observed to support residents to feel a sense of belonging. Through working alongside staff in purposeful activities, residents were witnessed being treated as equals and contributing in a meaningful way.

The next chapter will explore the final two research questions. This will be done against the context of all three analysis chapters, including the qualitative content analysis of the documentation. The data will be interpreted to explore how it might shape or influence professional boundaries, and what might be required to change in current practice culture and context.

Chapter 9 Practice Implications

9.1 Introduction

This chapter will explore the practical implications of the study's findings within the context of the current policy landscape and practice culture outlined previously in Chapter Three. Each theme analysed in the previous chapter will be discussed regarding its potential impact on practice in residential care for people with dementia, including professional boundaries. The implications of these findings for professional boundaries will also be examined, alongside an exploration of how the theoretical foundations of this study can aid in understanding their practical implications.

Drawing on the findings from the three qualitative content analysis chapters, key aspects of effective practice were highlighted. By understanding what effective practice entails, the chapter will delve into the necessary support mechanisms that need to be established to facilitate staff in delivering such care. This discussion will address the following research questions:

- How could knowledge of how effective relationship-based care is delivered in residential settings shape professional boundaries?
- How might residential care's culture and practice need to evolve to support relationship-based practice?

To explore how this acquired knowledge might impact practice and professional boundaries, the chapter has been structured into distinct areas of discussion. The first part will explore the insights gained that could influence the implementation of relationship-centred care in residential social care settings, drawing on the previous chapter's exploration of themes such as loss, occupation, interdependence, and connectedness. This will help elucidate how effective relationship-based practice might be supported and enabled within the residential social care environment.

Subsequently, the chapter will examine the changes required in current practices and contexts to support the adoption of these insights. This section will draw upon themes discussed earlier, such as trust, humour, and time, to explore how staff and residents can be better supported in implementing effective relationship-based practices in residential care. The theoretical underpinnings of this study, particularly social construction and ethics of care frameworks, will be referenced to discuss how these can guide the integration of relationship-based care into practice, including its impact on professional identity.

Finally, the chapter will discuss the implications of these findings for professional boundaries in residential care settings. It will focus on how the study's findings shape our understanding of what professional boundaries should be in a setting that adopts relationship-based social care. Consideration will be given to balancing the support needed for staff to develop and maintain relationships with the imperative to protect the well-being of residents.

9.2 Practice implications

The findings of this study have the potential to feed into the understanding of how relationship-centred care could be implemented in residential care settings for people with dementia. Good relationship-based practice was found when good relationships were allowed to grow. The findings suggest that having time to develop meaningful relationships with staff is important, allowing residents to foster a sense of belonging to their new communities. Choice in day-to-day decision-making was found to be important, but promoting autonomy through independence was only suggested to be important in the documentation produced by the setting, rather than residents themselves. Residents instead focused on the importance of friendship and meaningful bonds with the staff providing their care. Value was also found in the provision of meaningful activity that allowed residents to contribute to daily life in the settings and enabled them to work alongside staff as equals.

Chapter 8 explored how themes of loss identified from the data could inform relationship-based practice in residential care by highlighting the need for empathy, understanding, and personalised support. Residents were often found to have experienced significant losses, such as the death of loved ones, diminished physical capabilities, or the loss of their home and independence. Recognising these losses during daily practice and understanding the impact such losses might have on residents would enable care staff to approach residents with compassion and patience, fostering a sense of trust and emotional safety. This awareness can guide staff in creating a supportive environment where residents feel valued and understood.

The importance of offering opportunities for residents to engage in meaningful occupation was highlighted as an important finding in the Chapter 8 discussion. Occupation, in this context, refers to the activities and roles that give individuals a sense of purpose and identity. Recognising the value of occupation helps care staff design and implement activities that align with residents' interests, histories, and abilities. This could be through ensuring residents are given the opportunity to help in day-to-day activities, such as food and drink preparation, or through engaging residents in planning and delivering activities based on their interests. This approach not only supports residents' mental and physical well-being but also fosters a sense of accomplishment and self-worth. Approaching practice in this way would align with Nolan's Senses framework, particularly in how it acknowledges the importance of ensuring that care practices uphold dignity, privacy, choice, safety, and inclusion (Nolan et al., 2006). By integrating meaningful occupation into residents’ care, staff can better meet their needs and promote effective relationship-based practice.

Choice was found to be important to residents. How residents and staff spoke about the importance of choice was found to contrast with the way it was spoken about in the care home documentation analysed. Residents were found to value having a say in day-to-day decisions in the residential setting. They spoke of being offered a choice in activity and choice about whether to participate in activities on offer. The literature analyses, however, focussed heavily on independence for residents moving into the settings. Independence was not a focus in participant responses. Participants instead spoke candidly and in a matter-of-fact way about their loss of independence.

Instead, throughout the responses residents spoke of the importance of meaning in their relationships. Legislation, policy, and the care home literature all place a high value on independence. While this might be the case for many people receiving social care support, the findings of this study bring into question whether the same degree of value is placed on independence for people living in residential settings.

As discussed in the previous chapter, the findings indicate people in residential care acknowledge their dependence on the staff providing their care. Social work and social care need to explore what is important to these people, for whom interdependence is more highly valued. Frailty, vulnerability, and dependence are features of old age and dementia that seem to be feared by society (Leece & Peace, 2009; McNally & Lahey, 2015). If independence continues to be defined as the absence of dependency this will continue to be the case.

These findings suggest that while those running the residential settings may feel independence is what people moving into residential care value, what the residents who participated instead appear to value is interdependence. Interdependence was identified as another theme which could shape relationship-based practice by underscoring the importance of mutual reliance and shared responsibility among residents and staff. This is related to the suggestions of ensuring residents are provided with opportunities to engage in meaningful occupation, however, the concept of interdependence takes this further. Recognising interdependence would involve understanding that both residents and staff contribute to, and benefit from, their relationships with one another. This perspective encourages a shift from a purely care-receiver and caregiver dynamic to one where residents are seen as active participants in their care, capable of contributing to the community.

By fostering an environment of interdependence, care staff can promote collaboration, where residents are encouraged to assist one another and engage in activities that utilise their skills and strengths. Staff could provide residents with opportunities to feed back into the running of their residential setting, while staff members could be supported to feel secure and confident enough in their role that they are able to understand and acknowledge the benefits they too receive from the caring relationship. It will be important to develop an understanding of how effective relationship-based practice and interdependence can be supported in residential care.

Connectedness was identified as a further theme that emerged from the data as being key to an effective relationship-based practice in residential care. By recognising the importance of fostering strong, reciprocal relationships amongst residents and staff, care staff could be encouraged to create an environment where social bonds are nurtured through promoting mutual support and shared experiences. This might be achieved through the development of strong support networks for both residents and staff, encouraging an open dialogue where everyone feels heard and valued.

In a residential care setting, relationship-based practice centres on fostering strong, trusting relationships between care staff and residents. This approach emphasises personalised care, where staff members take the time to understand each resident's individual needs, preferences, and history. Ethics of care writers highlight that ‘not all care is good care’, and good care places value within relationships (Tronto, 1993). Approaches grounded in an ethics of care value growth and advocate for supporting those being ‘cared for’ to develop within the context of their self-defined needs (Edwards & Brannelly, 2017; Gilligan, 1982). The findings of this study align with this, placing value on the relationship through which care is delivered. By building genuine connections, staff can hopefully provide emotional support, create a sense of belonging, and promote residents' well-being. Activities should be tailored to residents' interests, and their input should be actively sought in decision-making processes. Consistency in staffing would help in maintaining these bonds, and ensuring continuity of care would enable both staff and residents to feel secure and valued.

9.3 What would need to change

Next, this chapter will examine what may need to be different in current practices and contexts to facilitate the implementation of the sorts of practices discussed above. It will explore how staff and residents could receive improved support to effectively implement relationship-based practices in residential care, referencing the study's theoretical foundations: social construction and ethics of care.

Staff could be effectively supported in implementing relationship-based practice in a residential setting through the development of specific training that would focus on enhancing relational skills and effective communication strategies. Ongoing and reflective practice sessions would be essential in ensuring staff feel supported, both by management but also as a team. This is discussed in greater detail in the coming paragraphs. Leadership would play a pivotal role in this process by modelling effective relational skills, providing guidance, and reinforcing the organisation's commitment to relationship-based care. This would give staff the confidence they currently lack in approaching care in a relationship-based way, even though they often already have the skills.

The staff community within residential settings will play an important role in implementing effective relationship-based practice, by creating an environment that enables strong relationships between care staff and care managers. A cohesive staff community could provide a platform for sharing insights, discussing ethical dilemmas, and collectively enhancing skills in communication and empathy. Managers within the care community should both guide staff but also allow staff professional autonomy in decision making when navigating professional boundaries with residents. How staff might be supported in their decision making is discussed in the following paragraphs.

9.3.1 Support for social care staff

A key feature in enabling social care staff to navigate professional boundaries in a way which supports relationship-based practice will be enabling the use of professional judgement when making decisions. As evident by participants' responses throughout this study, residential care staff are also required to make decisions throughout their working day to support the people they work with. The construction of professional boundaries in social care is helpful in managing tasks effectively. Such boundaries can help staff clarify their roles and responsibilities, ensuring they can prioritise their workload and use resources wisely to deliver effective care, while supporting staff to develop a sense of professional autonomy if constructed carefully.

Both-Nwabuwe et al. (2020) put forward a theoretical framework through which the benefits of professional autonomy can be understood. The authors, approaching the framework from a nursing perspective define professional autonomy as:

> *'The freedom to act on one's knowledge base without the need for permission of some authority.'* (Both-Nwabuwe et al., 2020, p. 107)

Taking this understanding of professional autonomy, the social care staff in this study did not appear to have the freedom to act on their experience. Two members of staff who were interviewed for this study had experience that amounted to decades of practicing in social care. The findings of this study suggest that the staff's need for a sense of security was unmet, one of the key requirements for effective relationship-based practice identified in Nolan et al.'s (2006) framework. A sense of security is defined as:

> *'To feel free from physical threat, rebuke or censure. To have secure conditions of employment. To have the emotional demand of work recognised and to work within a supportive culture.'* (Nolan et al., 2006, p. 22)

While the decisions they make might be more focused on the day-to-day care of residents, as highlighted by the responses in this study, for the residents these decisions are the ones that matter. The decisions around how to deliver this care are also a source of concern and anxiety for staff, who reported their wariness of engaging in care in ways that felt instinctive to them. By supporting staff to work within the code of practice in a way that enables them to exert professional judgement without fear when making decisions about residents' care, their ability to develop a strong basis for relationship-based practice will likely improve.

The IDEAS model is a framework for relationship-based social work with adults put forward by Hollinrake (2019). While aimed at social workers, the framework can provide sound learning for a model for practice in social care. The 'S' in the model stands for support. Dix and Meade (2019) explain that support needs to be provided at all management levels to improve resilience in practice. The authors suggest improved resilience will mean workers feel able to take risks without feeling they are at risk of punitive measures, a fear clearly expressed by participants in this study. To support the development of effective relationships with colleagues, Ward (2018, p. 74) notes a strong sense of self, particularly in relation to others, is needed. In the model put forward for relationship-based practice by Ruch who states:

> *'Holistic reflective practice enables practitioners to engage with the complexities of the self in professional practice and avoid the temptation (and risk) of resorting to a 'safe' reductionist position.'* (Ruch, 2005, p. 119)

Supporting staff to develop professional autonomy in a residential care setting might involve the provision of training and development opportunities. Fostering a culture of trust and empowerment is crucial. Staff should be encouraged to take initiative and make autonomous decisions, allowing flexibility for professional judgment based on individual resident needs. As discussed previously in this chapter, supervisory sessions would be key. This could provide opportunities for staff to discuss their interactions with residents, receive constructive feedback, and reflect on their approaches. Encouraging staff to reflexively evaluate their practice and learn from their experiences promotes continuous improvement in relationship-based practice. These should not only provide feedback but also encourage staff to reflect on their practice, discuss ethical dilemmas, and seek guidance when needed. This could be achieved through supporting staff to develop their sense of professional identity, as explored below.

Professional identity is a concept discussed in literature exploring social work and social care, often linked with discussion around workers' reliance and quality of life (Silarova et al., 2022; Wiles, 2017). Although there is a definitive definition of professional identity, Wiles explored the understanding of what professional identity is, finding:

> *'[SOCIAL WORK STUDENTS] constructed their professional identity in relation to desired traits, or through developing a sense of shared identity with other social workers; alternatively, it was portrayed as a process of individual development'* (Wiles, 2017, p.42)

Social constructionism provides a valuable framework for understanding professional identity in social care by emphasising how identities and roles are socially constructed through interactions, language, and shared meanings within a specific cultural context. In the context of social care, from a social constructionism perspective, professional identities are not fixed or inherent, but instead shaped through ongoing interactions and negotiations between staff and residents. As staff engage in the process of identity development, they could draw on shared experiences with each other to refine their understanding of their role and the potential impact they could have on residents' lives.

Professional identity is also a topic discussed in relation to professional boundaries and professionalism, as Wiles states:

> *‘Professional identity, when linked with the concept of ‘professionalism’, has become bound up with the regulation of practitioners and the avoidance of ‘unprofessional’ behaviour.’* (Wiles, 2017, p. 35)

The senses framework is a model for effective relationship-based practice with older people, put forward by Nolan et al. (2006). The authors suggest that for staff to be able to form positive and effective relationships, they must feel a sense of significance and a sense of belonging. The requirements for feeling a sense of significance and belonging are outlined below:

> *‘Significance: to feel that gerontological practice is valued and important, that your work and efforts ‘matter’. ‘*
>
> *‘Belonging: To feel part of a team with a recognised contribution, to belong to a peer group, a community of gerontological practitioners.’* (Nolan et al., 2006, p. 22)

The requirements outlined are similar to the requirements for developing a strong sense of personal identity, as outlined by Wiles (2017) above. Silarova et al. (2022) explored the quality of life for adult social care workers, finding that a key component of a good quality of life in these settings is having a strong sense of professional identity. This research is backed up by Graham and Shier (2010), whose small-scale qualitative study found that identity formation and a positive connection with work can contribute to happiness. If staff can be successfully supported to find their practice valuable and important and are encouraged to feel part of a team with their contribution recognised, it follows that they will be able to develop a strong sense of professional identity and according to the studies above, improve their quality of life. Through this strong sense of professional identity, Nolan et al.'s (2006) framework suggests staff will also be supported in their ability to deliver effective relationship-based practice.

9.3.2 Barriers to the implementation of relationship-based practice in residential social care

Identifying the barriers is crucial, considering the potential benefits of supporting staff to develop an effective relationship-based practice. As discussed in Chapter 3, social care work is widely acknowledged to be a low-status and low-paid role (Block et al., 2018). The rate of staff turnover is high (Skills for Care, 2022a) and social care workers are not currently required to register (Social Care Wales, 2017). Lymbery (1998) argued that the reduction in the role of the social worker following increases in managerialism led to a negative impact on professional identity. These political factors, and the perception of care homes, have also had an impact on how the residential social care sector is recognised and impacting research processes and knowledge generation on issues affecting care homes (Toms et al., 2020).

Social care is already an undervalued and underpaid sector; however, austerity has contained social care pay whilst simultaneously negatively impacting the working environment (King-Dejardin, 2019). The social care workforce has a turnover rate of 29%, set against a national workforce average of 15% (Skills for Care, 2022b). A low turnover rate contributing to good relationship-based practice was one of the findings of this study. Currently, care workers with five years of experience receive only 7p more per hour than a worker with less than one year of experience (Skills for Care, 2022b). Social care workers in the sector need to have their experience and skills better valued if retention of staff is to be improved. An issue only exacerbated when understood in the wider socioeconomic environment of austerity and the cost-of-living crisis. This high turnover means staff do not have time to develop skills and will have limited the ability of staff to form bonds with their wider team. Social care staff need to be supported to develop a stronger sense of professional identity, that would provide a strong base from which they can develop an effective relationship-based practice. While relationship-based practice offers many benefits, it requires time, commitment, and training for caregivers. Developing genuine relationships can be challenging in settings with high turnover or when faced with complex resident needs.

Social Care Wales released a workforce strategy for 2021 onwards (Social Care Wales, 2020). The strategy acknowledges:

> *'The people who provide health and social care are highly valued, not just for their dedication and commitment to the health and care system, but as members of local communities, they contribute greatly to the wider socio-economic prosperity and sustainability of Wales.'* (Social Care Wales, 2020, p. 2).

The strategy set out 32 actions, due for review in 2023, that attempt to address the fact that staff do not feel valued or supported. This is reflected in the findings of this study, which identified staff practising in fear regarding professional boundaries and lacking support in interpreting them and applying them to their own practice. Staff were observed as having the expertise needed to develop and sustain supportive relationships with the people in their care but communicated that they felt this was stifled by professional boundaries. The strategy acknowledges these issues, acknowledging the need for '*better alignment and integration across professional boundaries which too often get in the way of doing the right thing for the people at the centre of our service'* (Social Care Wales, 2020, p. 9). The strategy in Wales seeks to address these issues, and hopefully reduce staff turnover, by achieving:

- *'Healthy working arrangements and environments.*
- *Exemplar employment practices with a clear focus on equality and diversity, employee voice and collective representation.*
- *Work-life balance.*

- *Fair rewards and recognition, including addressing pay gaps across the protected characteristics.*
- *Flexible career opportunities to meet changing needs.'* (Social Care Wales, 2020, p. 19)

If this strategy can meet these ambitious but fair goals for the sector, then it would address several of the workforce issues identified in this thesis. Staff need to feel supported to work within professional boundaries that enable them to use their valuable skills and expertise to provide the best care possible for people.

Over 80% of the people who work in social care are women, and it was the case in this study that every member of staff observed and interviewed was female. The only male member of staff encountered was the manager of one site. If the status of care work was addressed and people were paid appropriately for the level of skill and work they do, then the high turnover that leads to poor continuity of care might be able to be addressed. If care work was afforded higher status, staff could receive better support to develop a professional identity. With a stronger sense of professional identity, staff might feel more confident in exercising professional autonomy and applying their expertise when making decisions about supporting those in their care, without the fear of losing their job.

The undervaluation and underpayment of social care work exacerbate these challenges, perpetuating a cycle of high turnover and low job satisfaction. Addressing these systemic issues requires a societal recognition of the importance and complexity of care work, accompanied by policies that improve pay, working conditions, and opportunities for career development. By elevating the status of care work and investing in staff retention through better compensation and support, social care workers might be enabled to develop a stronger professional identity. This would have the potential to improve the staff's ability to engage in relationship-based practice with confidence and empathy.

9.4 How findings could shape professional boundaries

How the findings of this study, and the suggestions for implementing them in practice, might mean for professional boundaries in residential care will be explored over the ensuing paragraphs. In Wales, social care workers are not currently required to register to practice. They are, however, expected to follow the code of practice set out by Social Care Wales (Social Care Wales, 2022a). For registered care managers and registered social workers, the code must be followed, however for social care workers the language used is ‘should follow’. as registration is not currently compulsory. Places of employment will also have their own codes of conduct for social care workers to adhere to. While nowhere in the code does it state social care workers are not allowed to touch the people they work with, it cautions staff not to:

> *‘Form inappropriate personal relationships with individuals, their families or carers.’* (Social Care Wales, 2022a, p. 14)

Regardless of what the code of practice states, the staff interviewed in this study have interpreted it to mean they are not allowed to touch residents or to form emotional bonds with them. Staff also referred to being warned by their manager that they could lose their job should an inspector see them hugging residents. Such an interpretation is likely to have a detrimental effect on developing an effective relationship-based practice.

Unlike previous managerial approaches that often emphasise procedure and risk management, a relationship-based model would prioritise the building of meaningful connections and understanding between staff and recipients of care. The findings of this study lend themselves to the suggestion that professional boundaries should become more nuanced and flexible. Rather than rigidly defined rules governing interactions, boundaries supporting a relationship-based approach may instead focus on fostering empathy, understanding personal contexts, and adapting support strategies to meet individual needs. This approach might encourage social care workers to engage more authentically with clients, potentially blurring traditional boundaries to better meet emotional and relational needs.

However, a more nuanced approach would be needed for social care workers when compared to social work, particularly considering Twigg et al.'s (2011) work on 'body work' in social care. Social care staff must navigate a delicate balance between providing necessary physical and intimate care within professional boundaries. This highlights the nuanced nature of bodily closeness in professional caregiving relationships. While physical touch is essential for providing compassionate and dignified care, it must be performed sensitively and respectfully. Professional boundaries that support a relationship-based approach to social care could enable staff to build trusting relationships with residents while negotiating boundaries of emotional support and personal space.

Findings in this study highlight that staff and residents did not fear intimacy in their relationships with each other. Intimacy in this case refers to feelings of friendship and affection between each other. Staff and residents both spoke of and were observed, engaging in laughter, touch, and divulging personal information. Both participant groups spoke of love for each other. Neither participant group shied away from sharing information about their families, or from acknowledging the fact they had connections that went beyond the bounds of the residential unit, often referred to as dual relationships. What was found, however, was that staff feared the rules they interpreted as preventing this level of relationship. Staff feared repercussions of being seen 'cwtching' residents, and felt the professional boundaries require distance. They spoke of 'rightly or wrongly' loving the people they worked with, and of understanding the rules were there to protect them from 'naughty people'. Whether the professional boundaries are being interpreted correctly or incorrectly is irrelevant, this is how they are interpreted. The impact of this on staff's confidence in their decision-making and ability to exercise professional judgement was unclear, but staff spoke about it being 'sad' for the profession.

The *Social Care Code of Practice* advises social care workers against forming 'inappropriate relationships', although what constitutes inappropriate is not defined (Social Care Wales, 2022a). Despite suggesting that professional boundaries are more nuanced and flexible, perhaps providing greater detail of what an inappropriate relationship entails could promote social care workers' confidence to use appropriate touch and develop emotional bonds. As it stands, the vague descriptions in the code of practice have allowed the staff interviewed in this study to ‘read between the lines’. They have developed the belief that their current, relationship-based approach to practice is ‘wrong’.

Balancing relationship-based practices involving closeness and touch in residential care with the protection of both residents and care workers is a delicate but essential task. Alongside the benefits a relationship-based practice brings, come significant ethical considerations and potential risks. People living in residential are still at risk of abuse or exploitation, making it crucial to establish boundaries and guidelines for appropriate relationships. Additionally, the protection of care workers themselves is important. In environments where physical closeness is part of caregiving, there is a risk of allegations of misconduct. Social care staff must be able to recognise signs of discomfort or distress and respect residents' autonomy. This might involve taking into consideration cultural differences, individual preferences, and past experiences that may influence residents' attitudes towards touch. Professional boundaries must reflect this need for nuance, and balance to need to protect people receiving care with the need to move away from risk averse practice.

How to successfully balance risk and autonomy has long been a challenge for social care, but relationship-based practice takes this challenge further. The challenge lies in how the residential care sector can support older people with dementia to develop and maintain relationships with those providing their intimate and physical care, and whether the long upheld ‘ideals’ of autonomy and independence are the ‘right’ ideals for those living in residential care.

9.5 Conclusion

Professional boundaries have been discussed in this chapter with reference to what might need to change to support a relationship-based practice in social care. Staff in this study spoke of the negative impact they felt professional boundaries had on their ability to build relationships with residents, particularly around touch. Staff spoke of knowing what the ‘rules’ were while admitting they went around them and acted instinctively towards residents anyway. They spoke of this acknowledging concerns and fears of the implications if they were caught. The challenge for social care workers is less what the professional boundaries say, and more to do with the context they practice within. Staff were aware of the risks, and understood why boundaries were in place, but feared repercussions for using their professional judgement and their practice expertise in decision-making processes.

Effectively navigating professional boundaries in social care relies on empowering staff to exercise judgement. Supporting staff to develop this autonomy is crucial for prioritising tasks, allocating resources efficiently, and delivering effective care. However, challenges in the sector, like low status, inadequate pay, and high turnover, hinder the development of a strong professional identity. These issues contribute to instability and high turnover, limiting time and resources for staff to build essential relationships with residents, crucial for effective practice.

The findings of this study offer insight into how professional boundaries might need to change to support good relationship-based practice, and what might need to change in current practice and culture. Care, as a profession, needs to be better valued, with staff better supported to use their professional knowledge and skills. What is evident is that good relationship-based practice exists, but staff are afraid to admit it. The culture of fear around touch and vulnerability needs to be addressed, to avoid risk-averse practice and embrace the need to form emotional bonds with residents despite their vulnerabilities.

Finally, there needs to be a shift in the way dependency is framed. What residents in care homes say that want is not 'autonomy' and 'independence'. They are fully aware of their limitations and that independence is often unachievable. However, what they want is to embrace their interdependency, develop a sense of belonging and build meaningful relationships with staff. Residents want care that cares about them. As Miller states:

> ‘*The most foundational component of our human existence is not our vulnerability, but rather, our dependency. When we are injured and when we*

> *are needy, we require the same thing: care. It is our interdependence that provides that care.'* (Miller, 2020, p. 659)

The next chapter will summarise the findings of this study in relation to their contribution to knowledge. It will also discuss recommendations for further research in addition to acknowledging the limitations of this study.

Chapter 10 Conclusion

10.1 Introduction

This chapter will first review the key findings of this study in relation to the research questions outlined in Chapter 1. It will then discuss the study's potential contributions to the literature, followed by an examination of its limitations. Finally, suggestions for further research will be outlined.

This thesis explored perspectives on relationship-based practice within the context of residential care for people living with dementia. Using a case study approach across two settings in South Wales, it identified principles of effective practice through the analysis of documentation, direct observations, and interviews with staff and residents. Content analysis, incorporating an ethics of care perspective, was used to uncover findings that suggested laughter, touch, and closeness were vital elements of effective relationships for many.

Residents did not require a diagnosis of dementia to participate, however were defined as having ‘memory problems’ or presented with symptoms of dementia. Residents both with and without the capacity to consent were invited to participate, with different approaches to involvement laid out in the methodology chapter of this thesis. This was done to ensure the voices of older people in the later stages of dementia could be included, as Dewing states:

> *‘For persons with a dementia, informed consent becomes increasingly redundant and consequently exclusionary to them as persons.’* (Dewing, 2007, p. 11)

As a researcher, I felt it was important to be able to offer the opportunity of participation for all residents in the setting. When approaching research from an ethics of care perspective, I acknowledged that I had the opportunity to be able to use my relative position of power to enable often unheard voices to be heard (Brannelly, 2017). This meant that the effort of undertaking additional steps in line with the Mental Capacity Act 2005 and seeking NHS ethics approval processes was non-negotiable to me.

10.2 The key findings

10.2.1 How do people living with dementia and social care staff experience relationships in residential social care homes?

The first research question explored how people living with dementia and social care staff experience relationships within residential care settings. This small-scale qualitative study found that such practice occurs when staff develop meaningful connections with residents. These connections often include affection and even love. Effective relationship-based practice involves staff knowing residents’ personalities and histories well enough to respond instinctively to their needs, including the appropriate use of touch and 'cwtches.' It is present when staff feel confident encouraging residents to participate in activities and can work and laugh alongside them. Staff described this practice as working around their interpretation of the ‘rules’ and emphasised the need for time and continuity.

The study highlighted the importance of belonging, a key feature of good relationship-based practice, aligning with theories of interdependency or relational autonomy within the ethics of care framework. The basic human need to belong was strongly felt in the residential care settings, where residents, despite their multifaceted losses, acknowledged the positive effects of strong bonds with staff. They valued laughter, friendships, and meaningful relationships, describing these bonds as love, friendship, and being 'like family,' extending beyond typical professional relationships.

For people with dementia in residential settings, the staff providing daily care are the ones they form relationships with. This highlights the need to explore how a relationship-based approach can be applied in the social care sector. The literature review examined the Senses framework by Nolan et al. (2006), which outlines six prerequisites for developing positive and effective relationships between staff and people with dementia. This study found alignment with Nolan et al.’s framework, with both residents and staff emphasising the importance of meeting the needs outlined, especially the sense of belonging.

The residents moving into residential care consider it their new home. It makes sense that they wish to feel belonging in their new home and their new community, with the people who spend so much time with them. The findings of this study suggest an effective relationship-based practice in social care might be achieved by ensuring staff have the time to get to know residents well and develop strong interpersonal bonds. Through these bonds, residents could be supported to engage with their new community, the residential home.

Staff and residents spoke of the importance of continuity of care. The study found residents valued not having to explain personal care preferences to new staff and feeling comfortable addressing concerns. Staff valued continuity of care for its familiarity with residents' needs and care plans, saving time and allowing personalised responses. Staff knew when to encourage residents to leave their rooms, who appreciated comforting touch, and who preferred personal space. Both staff and residents emphasised the significance of understanding personalities, histories, and preferences.

Time in the short term was identified as being important; time in each day to be able to ‘have a chat and a cuppa’. However, time in the long term was also found to be key in delivering good relationship-based practice. Time pressures have become significant in the context of staff retention issues and the wider implications of austerity in the UK. A further finding in this study was the value provided by enabling residents to participate in meaningful activities. What was observed appearing to provide value and a sense of belonging were opportunities for residents to engage meaningfully alongside staff. Chapter 9 discussed how these findings could be applied in practice by offering increased support and supervision for staff, promoting professional identity and autonomy, and developing professional boundaries that reflect the nuances of practice while providing clarity on appropriate relationships.

10.2.2 How could knowledge of how effective relationship-based care is delivered in residential settings shape professional boundaries?

The second question this thesis set out to answer was how an understanding of how effective relationship-based practice is delivered might influence or help shape professional boundaries. The findings in this study indicate that staff fear professional boundaries and the perceived repercussions, particularly around developing relationships with the people they care for. To support staff to engage in good relationship-based practice, professional boundaries need to be something that is not feared. Staff have a lot of experience and skill in responding appropriately and effectively to the people in their care. Their ability to do this is at risk of being stifled by a fear of professional boundaries.

In addition to developing an understanding of how staff might be better supported to engage with professional boundaries, the findings of this study offer suggestions on how professional boundaries could better reflect a relationship-based approach to practice. The findings indicate many staff and residents value closeness and touch, and while this thesis offers suggestions of how this can be reflected in professional boundaries, further exploration is needed. It is important to note that not all participants valued close relationships. Some residents preferred to keep their distance, while staff recognised the need for the closeness of their relationships with residents to reflect individual preferences.

10.2.3 How might residential care's culture and practice need to evolve to support relationship-based practice?

The third and final research question examined what changes are needed in current practice culture and context to enable an effective relationship-based approach to care. Chapter 9 discussed the current policy context, austerity measures, and the status of care work. It emphasised that navigating professional boundaries in social care effectively relies on empowering staff to make informed decisions and prioritise tasks.

However, challenges such as low status, inadequate pay, and high turnover rates impede the development of a strong professional identity among social care workers.

To address these issues, the discussion highlighted the importance of increased training and supervision, as well as fostering positive staff and management cultures within care homes. Better recognition, improved compensation, and enhanced support for staff are crucial steps towards creating a more stable workforce. Such measures would enable social care workers to consistently deliver compassionate and relationship-based care.

10.3 Contribution

The findings of this study have the potential to enrich the body of research by providing a detailed dataset that captures the experiences and relationships of the participants involved. While these findings cannot be generalised, they offer valuable insights into the nuanced details of residents' and staff members' lived experiences. Semi-structured interviews were instrumental in allowing participants to narrate their experiences comprehensively, addressing key research questions while retaining flexibility for participants to explore relevant topics. This approach, although more time-intensive for conducting, transcribing, and analysing interviews, proved advantageous in uncovering themes and issues that might have been overlooked in a more rigidly structured interview format.

The findings of this study explore the experiences and relationships of people often overlooked in research: people with dementia residing in social care settings. By giving a voice to both residents and staff within these settings, this study enriches understanding of the complex dimensions of their everyday lives. Through this research, valuable insights are gained into the nuanced realities and challenges faced by people living in care homes, ultimately contributing to broader knowledge and potentially informing more effective care practices and policies.

This research yielded valuable insights because the participants, both residents living with dementia and staff members, were incredibly open and willing to share their experiences. This openness offered a valuable window into their lives, allowing this study to gain a deep understanding of their perspectives and challenges. Staff were candid, discussing their fears and being frank about the professional boundaries they navigate. This honesty offered crucial insights into the complex dynamics of caregiving within social care settings. My previous experience in the social care and social work sectors perhaps contributed to my ability to conduct this research as staff knew of our shared experiences, and I was able to relate to them uniquely as both a researcher and a previous social care worker. Additionally, drawing on my previous experience and skill set in working with people with dementia, I was able to successfully explore the feelings and thoughts of residents with dementia. This direct input from residents further enriched the data, offering an invaluable firsthand account of their lived experiences and preferences.

10.4 Limitations

This study has limitations regarding its small sample size. Therefore, any discussion of these findings in terms of the wider practice context must be done so with caution. The sample covered two residential care settings in the South Wales area, and the sample was limited to the people who resided and worked within them. Although the sample was representative of the populations within which the study took place, the participant sample is not representative of the wider picture of residential care settings in the UK. The ethnicity of all residents was ‘White British’, and all participants spoke English as their first language, although some were bilingual Welsh speakers. This means that the study only offers limited insight into the experiences of people with the same ethnic and language backgrounds. Findings for people with different cultural backgrounds or different language needs might have differed. The same issue applies to the backgrounds of the staff participants. All staff interviewed were ‘White British’. Data suggests that 13% of the social care workforce are ‘non-UK’ migrant workers (Skills for Care, 2022c), and their absence from this data means their voices and experiences were not heard.

Another limitation common across qualitative research methods is the potential for the researcher to influence findings (Erickson, 2018). In this study, I was responsible for observing relationships and interactions in practice and conducting semi-structured interviews. Therefore, the collection and interpretation of data relied on my skills, inevitably introducing personal biases. Despite efforts to maintain objectivity, complete impartiality is unattainable in practice. My background in social work and experience with people living with dementia undoubtedly influenced how I perceived and interpreted the findings. While this background and experience enhanced the success of data collection, it also represents a limitation due to its potential impact on my ability to remain fully objective. The theoretical framework of social constructionism supports understanding of this limitation, asserting that knowledge and meaning are shaped by social interactions and contexts rather than being absolute truths.

My presence will also have an impact on the participants. The observations were conducted openly and with the consent of all participants. In an attempt to mitigate the influence of my presence, multiple two hour long observations were conducted to enable those present to settle and become accustomed to my presence. I was also able to build up a degree of rapport during the observation phase before conducting interviews. Initially, concerns were raised by residents that I was there to inspect, but through building up rapport in these initial phases, when it came to conducting interviews, it was hoped residents and staff felt more comfortable and able to participate in the interviews freely and openly. My previous experience was used to the benefit of the study here, as I was able to communicate well with residents and put staff at ease through a shared understanding of the social care role.

Another limitation of the sample in this case study research was the gender of the participants. Again, this was limited by the population of the residential settings. The breakdown of gender was representative of the wider UK gender split in residential care settings. For example, the latest available census breakdown showed female residents over 65 made up approximately 73% of the care home population (Office for National Statistics, 2023). The resident sample size in this study was approximately 50% female for interviews, although that increased to 67% female for participants across both observations and interviews.

In Wales, female staff make up 81% of the social care workforce (Social Care Wales, 2022). However, in this study 100% of the staff interviewed were female, and 100%

of the staff working in the two settings during the observation periods were also female. The manager of Site One was male at the time, however, did not provide any of the day-to-day care in the units studied and was not interviewed. This means that not only is the voice of the male social care worker missing from the data but also any differences that might be created by the presence of a male carer are missing from the data. As there were only female staff employed on the two units studied, this means that the residents only spoke of relationships developed with female staff members. Whether the presence of male staff members would have had any impact on the findings is unknown and must be noted as a limitation of this study.

A further limitation is the lack of a control group for this study. The residents of the two sites that participated in this study were all deemed to have ‘memory problems’ or had a diagnosis of dementia. Without a control group of participants who did not have memory problems, it is not possible to differentiate what features of a relationship-based practice were important specifically to people with dementia, and what is important for older people. Without this comparison, it is difficult to ascertain whether the findings are representative of older people with dementia, or to the generic lived experiences of older people requiring residential care. However, as highlighted in the introduction of this thesis, it is estimated that 70% of residents have either a diagnosis of dementia or a severe memory problem (Wittenberg et al., 2019). Therefore, it could be argued that these findings are representative of most care home residents regarding dementia and severe memory problems.

This study faced further limitations due to the COVID-19 pandemic, which necessitated an abrupt cessation of data collection in March 2020. As the pandemic escalated, it became unsafe and impractical to continue in-person interactions essential for gathering the data. This interruption resulted in a smaller sample size, limiting the depth and breadth of the study's findings. The inability to conduct follow-up focus groups also restricted the insights and opportunities for people with dementia to contribute, that were initially intended. Consequently, the pandemic's impact on the data collection must be considered when interpreting the results.

An additional limitation related to the COVID-19 pandemic is that all data collection for this study occurred before the nationwide lockdowns. COVID-19 significantly affected older people in the UK, especially those in residential care, as discussed in Chapter 3. Although the results still offer valuable insights into relationship-based practice in residential care, the pandemic's impact on the participants is not explored, and the data does not reflect the environments and experiences in residential care settings post-COVID-19.

The inclusion of people with dementia or severe memory problems who were deemed to lack the capacity to consent posed a methodological issue in terms of the reliability of their memories and insights during the interview phase of the research. It was important to include their voices in the research, particularly when considering this study through the lens of an ethic of care. It is important to support all people’s voices to be heard in research, particularly when they lack power (Edwards & Brannelly, 2013). The theoretical underpinning of this thesis is social constructionism, which is concerned with understanding the subjective world as experienced by the participants. Therefore, it would neither be ethical nor useful to fact-check responses or discount them based on any issues with memory or understanding. The responses of people who lacked capacity were treated equally to those who had capacity, with no differentiation in the findings. Additionally, the inclusion of an observation phase meant that interactions and relationships were observed and interpreted in person adding a further layer of reliability to findings.

10.5 Further research

The contributions to the literature and social care knowledge discussed above address previously neglected questions, but they also highlight additional areas for future research. Specifically, studying the experiences of residents and staff from diverse ethnic and cultural backgrounds will enhance understanding of how different groups experience relationships, independence, and care.

Further research should also seek to understand the experiences of male staff, in addition to the impact staff gender might have on relationships with both male and female residents. Again, with relation to gender, the gender of participants was noted however the different experiences of male and female residents were not explored. In taking a broader focus, this thesis may have neglected a more directed study into the impact resident gender has on the relationships residents form with staff, their preferences and their emotional needs.

The suggestions made concerning practice implications are tentative, given the small-scale nature of this study. To further understand relationship-based approaches to practice in residential care, it could be beneficial to explore relationship-based approaches with other models of care delivery, to pinpoint their respective strengths, weaknesses, and areas for enhancement. Evaluating outcomes such as quality of life, caregiver/staff stress, or any changes in the cost of care delivery might provide insights into the effectiveness and applicability of relationship-based practice on a broader scale across social care settings.

Future research focusing on relationship-centred practice for staff working with people with dementia could explore any impact of ongoing support and supervision, a recommendation outlined in the study. This might include examining how increased support could influence staff's professional identity, job satisfaction, and the quality of relationships they establish with residents.

10.6 Conclusion

This study has contributed to the knowledge base and literature on relationship-based practice in residential social care by exploring the perspectives of both residents and staff. This has enabled findings to be explained in the context of their lived experiences in residential care, and in the context of their experiences of forming relationships in this setting.

Staff described their experiences of working with people with dementia in residential care and the value placed on being able to respond intuitively and emotionally to the people in their care. Staff demonstrated knowledge and expertise in developing supportive relationships yet expressed fear about the implications of professional boundaries and rules they felt sought to prevent emotions and touch. The study identified concerns around professional boundaries and areas in which staff can be better supported to engage with the boundaries while being able to confidently employ their professional skills and experience. The study highlights the importance of adopting a nuanced approach to professional boundaries within residential social care, considering the complex emotional and relational dynamics involved. Overly rigid interpretations of professional guidelines run the risk of diminishing the intuitive and empathetic responses crucial for delivering effective support. It is important to recognise that factors beyond the care home setting, such as staffing stability and wider austerity issues have the potential to significantly influence internal dynamics and relationships. By providing comprehensive and continuous support, staff could be empowered to navigate these boundaries thoughtfully, enabling them to use their expertise and cultivate a strong professional identity and autonomy.

Residents described the value they placed on being able to form meaningful bonds with the people providing their care, and the importance of finding a sense of belonging in the residential care environment. Residents and staff were observed gaining benefit from working side by side in ways that supported residents to contribute to the day-to-day activities of the residential setting and enabled them to interact more as equals. The study revealed how residents and staff can be supported to engage in positive relationship-based practice, through humour, emotional connections, and responsive care that is tailored to the preferences and needs of each resident. However, this study also highlighted the challenges in maintaining relationship-based practices within the current context of residential social care in the UK. Issues such as staff turnover, time constraints, and current interpretations of professional boundaries can sometimes inhibit the continuity and depth of these connections. Addressing these barriers requires a concerted effort to prioritise relationship building so that residents' emotional and social needs remain central to care.

Reference List

Abendstern, M., Tucker, S., Wilberforce, M., Jasper, R., Brand, C., & Challis, D. (2016). Social workers as members of community mental health teams for older people: What is the added value? *British Journal of Social Work*, *46*(1), 63–80. https://doi.org/10.1093/bjsw/bcu122

Age UK (2022). *Types of care homes.* Accessed May 2023. https://www.ageuk.org.uk/information-advice/care/arranging-care/care-homes/type-of-care-home/

Alexander, C., & Charles, G. (2009). Caring, mutuality and reciprocity in social worker-client relationships. *Journal of Social Work*, *9*(1), 5–22. https://doi.org/10.1177/1468017308098420

Alford, J. (1997) 'Towards a new public management model: Beyond ''managerialism'' and its critics', in Considine, M. and Painter, M. (eds), *Managerialism: The Great Debate*, Melbourne, Melbourne University Press, pp. 152–72.

Alm, A. K., Hellzen, O., & Norbergh, K. G. (2014). Experiences of family relationships when a family member has dementia. *Open Journal of Nursing*, *04*(07), 520–527. https://doi.org/10.4236/ojn.2014.47055

Altheide, D. L. (2013). Media logic, social control, and Fear. *Communication Theory*, *23*(3), 223–238. https://doi.org/10.1111/comt.12017

Altheide, D. L., & Michalowski, R. S. (1999). Fear in the news: A discourse of control. *The Sociological Quarterly*, *40*(3), 475–503. https://doi.org/10.1111/j.1533-8525.1999.tb01730.x

Alzheimer's Disease International. (2019). *Adi - Dementia Facts & Figures*. Alzheimer's Disease International (ADI). (n.d.). Retrieved April 15, 2023, from https://www.alzint.org/about/dementia-facts-figures/

Alzheimer’s Disease International, Guerchet, M., Prince M., & Prina, M. (2020). *Numbers of people with dementia worldwide: An update to the estimates in the World Alzheimer Report 2015.* Retrieved May 2023, from https://www.alzint.org/u/numbers-people-with-dementia-2017.pdf.

Alzheimer’s Research UK. (2022). *Prevalence and incidence of dementia.* Retrieved May 2023, from https://dementiastatistics.org/about-dementia/prevalence-and-incidence/.

Alzheimer's Society. (2023). *Risk factors for dementia.* Retrieved April 5, 2024, from https://www.alzheimers.org.uk/about-dementia/managing-the-risk-of-dementia/risk-factors-for-dementia

Alzheimer's Society. (2023). *What is dementia? symptoms, causes and treatments*. Retrieved April 15, 2023, from https://www.alzheimers.org.uk/about-dementia/types-dementia/what-is-dementia

Andrews, T. (2012). What is social constructionism? *The Grounded Theory Review, 11*(1), 39-46. https://groundedtheoryreview.com/2012/06/01/what-is-social-constructionism/

Association of Palliative Care Social Works (APCSW). (2017). *The role of a palliative care social worker*. Accessed: May 2023. https://www.apcsw.org.uk/social-worker-role/

Ayre, P. (2001). Child protection and the media: Lessons from the last three decades. *British Journal of Social Work*, *31*(6), 887–901. https://doi.org/10.1093/bjsw/31.6.887

Baghramian, M., Petherbridge, D., & Stout, R. (2020). Vulnerability and trust: An introduction. *International Journal of Philosophical Studies*, *28*(5), 575–582. https://doi.org/10.1080/09672559.2020.1855814

Ballard, C. G., Solis, M., Gahir, M., Cullen, P., George, S., Oyebode, F., & Wilcock, G. (1997). Sexual relationships in married dementia sufferers. *International Journal of Geriatric Psychiatry*, *12*(4), 447–451.

https://doi.org/10.1002/(sici)1099-1166(199704)12:4<447::aid-gps491>3.0.co;2-5

Bartlett, R., & O'Connor, D. (2010). *Broadening the dementia debate: Towards social citizenship*. Policy Press.

Bastian, B., & Haslam, N. (2010). Excluded from humanity: The dehumanizing effects of social ostracism. *Journal of Experimental Social Psychology*, *46*(1), 107–113. https://doi.org/10.1016/j.jesp.2009.06.022

Baumeister, R. F., & Leary, M. R. (1995). The need to belong: Desire for interpersonal attachments as a fundamental human motivation. *Psychological Bulletin, 117(3),* 57–89. https://doi.org/10.1037/0033-2909.117.3.497

Baumeister, R. F., & Leary, M. R. (1997). Writing narrative literature reviews. *Review of General Psychology*, *1*(3), 311–320. https://doi.org/10.1037/1089-2680.1.3.311

Bell, M. (2002). Promoting children's rights through the use of relationship. *Child & Family Social Work*, *7*(1), 1–11. https://doi.org/10.1046/j.1365-2206.2002.00225.x

Bengtsson, M. (2016). How to plan and perform a qualitative study using content analysis. *NursingPlus Open*, *2*, 8–14. https://doi.org/10.1016/j.npls.2016.01.001

Bennett, B., Redfern, H., & Zubrzycki, J. (2017). Cultural responsiveness in action: Co-constructing Social Work Curriculum Resources with aboriginal communities. *The British Journal of Social Work*, *48*(3), 808–825. https://doi.org/10.1093/bjsw/bcx053

Bennett, B., Zubrzycki, J., & Bacon, V. (2011). What do we know? the experiences of social workers working alongside Aboriginal people. *Australian Social Work*, *64*(1), 20–37. https://doi.org/10.1080/0312407x.2010.511677

Beresford, P., Croft, S., & Adshead, L. (2008). 'We don't see her as a social worker': A service user case study of the importance of the social worker's relationship and humanity. *British Journal of Social Work*, *38*(7), 1388–1407. https://doi.org/10.1093/bjsw/bcm043

Berger, P., & Luckmann, T. (1991). *The Social Construction of Reality: A treatise in the Sociology of Knowledge*. Penguin.

Block, K., Croft, A., & Schmader, T. (2018). Worth less?: Why men (and women) devalue care-oriented careers. *Frontiers in Psychology*, *9*. https://doi.org/10.3389/fpsyg.2018.01353

Block, K., Croft, A., De Souza, L., & Schmader, T. (2019). Do people care if men don't care about caring? the asymmetry in support for changing gender roles. *Journal of Experimental Social Psychology*, *83*, 112–131. https://doi.org/10.1016/j.jesp.2019.03.013

Bottery, S. and Mallorie, S. (2024). *Social Care 360.* The King’s Fund. https://assets.kingsfund.org.uk/f/256914/x/10453129ad/social_care_360_2024.pdf

Bonifas, R. P., Simons, K., Biel, B., & Kramer, C. (2014). Aging and place in long-term care settings. *Journal of Aging and Health*, *26*(8), 1320–1339. https://doi.org/10.1177/0898264314535632

Bosco, A., Schneider, J., Coleston-Shields, D. M., Higgs, P., & Orrell, M. (2019). The social construction of dementia: Systematic review and metacognitive model of Enculturation. *Maturitas*, *120*, 12–22. https://doi.org/10.1016/j.maturitas.2018.11.009

Both-Nwabuwe, J. M. C., Lips-Wiersma, M., Dijkstra, M. T. M., & Beersma, B. (2020). Understanding the autonomy–meaningful work relationship in nursing: A theoretical framework. *Nursing Outlook*, *68*(1), 104–113. https://doi.org/10.1016/j.outlook.2019.05.008

Botsford, J., Clarke, C. L., & Gibb, C. E. (2011). Dementia and relationships: Experiences of partners in Minority Ethnic Communities. *Journal of Advanced Nursing*, *68*(10), 2207–2217. https://doi.org/10.1111/j.1365-2648.2011.05905.x

Bowers H., Clark A., Crosby G., Easterbrook L., Macadam A., MacDonald R., Macfarlane A., Maclean M., Patel M., Runnicles D., Oshinaike T. and Smith C. (2009). *Older People's Vision for Long-term Care.* Joseph Rowntree Foundation, York, UK

Brannelly, T., 2018. An Ethics of Care Research Manifesto. *International Journal of Care and Caring,* 2 (3), 367-378. https://doi.org/10.1332/239788218X15351944886756

British Association of Social Workers. (2021). *The BASW code of ethics for social work.* https://www.basw.co.uk/system/files/resources/basw_code_of_ethics_-_2021.pdf

Brooker, D. (2003). What is person-centred care in dementia? *Reviews in Clinical Gerontology*, *13*(3), 215–222. https://doi.org/10.1017/s095925980400108x

Brookes, N., Callaghan, L., Netten, A., & Fox, D. (2013). Personalisation and innovation in a cold financial climate. *British Journal of Social Work*, *45*(1), 86–103. https://doi.org/10.1093/bjsw/bct104

Brown, T., Winter, K., & Carr, N. (2018). Residential Child Care Workers: Relationship based practice in a culture of fear. *Child & Family Social Work*, *23*(4), 657–665. https://doi.org/10.1111/cfs.12461

Bryman, A. (2016). *Social Research Methods* (5th ed.). London: Oxford University Press.

Cairns, R., Brown, P., Grant-Peterkin, H., Owen, G. S., Richardson, G., Szmukler, G., & Hotopf, M. (2011). Mired in confusion: Making sense of the deprivation of Liberty Safeguards. *Medicine, Science and the Law*, *51*(4), 228–236. https://doi.org/10.1258/msl.2011.010122

Carehome.co.uk (2022). *Care home stats: Number of settings, population and workforce.* Accessed May 2023. https://www.carehome.co.uk/advice/care-home-stats-number-of-settings-population-workforce

Carey, G., Crammond, B., & Malbon, E. (2019). Personalisation schemes in Social Care and inequality: Review of the evidence and early theorising. *International Journal for Equity in Health*, *18*(1). https://doi.org/10.1186/s12939-019-1075-2

Carey, M. (2015) "The fragmentation of social work and social care: Some ramifications and a critique," *British Journal of Social Work*, 45(8), pp. 2406–2422. Available at: https://doi.org/10.1093/bjsw/bcu088.

Carpenter, J., Langan, J., Patsios, D. and Jepson, M. (2014). Deprivation of Liberty Safeguards: What determines the judgements of Best Interests Assessors? *Journal of Social Work* 2014. 14(6): 576–593. https://doi.org/10.1177/146801731350418

Carter, J., Zawalski, S., Sminkey, P., Christopherson, B. (2015). Assessing the whole person: Case managers take a holistic approach to physical and mental health. *Professional Case Management,* 20(3), 140-146. DOI: 10.1097/NCM.0000000000000087

Celdrán, M., Triadó, C., & Villar, F. (2009). Learning from the disease: Lessons drawn from adolescents having a grandparent suffering dementia. *The International Journal of Aging and Human Development*, *68*(3), 243–259. https://doi.org/10.2190/ag.68.3.d

Chatzidakis, A., Hakim, J., Littler, J., Rottenberg, C and Segal, L. (The Care Collective) (2020). *The Care Manifesto: The Politics of Interdependence.* London: Verso Books.

Chang, P.-J., Wray, L., & Lin, Y. (2014). Social relationships, leisure activity, and health in older adults. *Health Psychology*, *33*(6), 516–523. https://doi.org/10.1037/hea0000051

Clare, L., Rowlands, J., Bruce, E., Surr, C., & Downs, M. (2008). The experience of living with dementia in residential care: an interpretative phenomenological analysis. *The Gerontologist*, *48*(6), 711–720. https://doi.org/10.1093/geront/48.6.711

Clark, C. (2006). Moral character in social work. *British Journal of Social Work*, *36*(1), 75–89. https://doi.org/10.1093/bjsw/bch364

Clarke, C. L., Keady, J., Wilkinson, H., Gibb, C. E., Luce, A., Cook, A., & Williams, L. (2010). Dementia and risk: Contested territories of Everyday Life. *Journal of Nursing and Healthcare of Chronic Illness*, *2*(2), 102–112. https://doi.org/10.1111/j.1752-9824.2010.01040.x

Coady, P. (2015) Relationship boundaries in residential child care: connection and safety in group care relationships. *Research, Policy and Planning,* 31(2), 79-91 . http://ssrg.org.uk/wp-content/uploads/2015/09/Coady_v2.pdf

Collins, C., & McCartney, G. (2011). The impact of neoliberal "political attack" on health: The case of the "Scottish effect." *International Journal of Health Services*, *41*(3), 501–523. https://doi.org/10.2190/hs.41.3.f

Connor, A., & Howett, M. (2009). A conceptual model of intentional comfort touch. *Journal of Holistic Nursing, 27*(2), 127-135. https://doi.org/10.1177/0898010109333337

Cook, C., Henrickson, M., Atefi, N., Schouten, V., & Mcdonald, S. (2021). Iatrogenic loneliness and loss of intimacy in residential care. *Nursing Ethics*, *28*(6), 911–923. https://doi.org/10.1177/0969733020983394

Cooper, F. (2012). *Professional boundaries in Social Work and social care a practical guide to understanding, maintaining and managing your professional boundaries*. Jessica Kingsley.

Cooper, J., Meyer, J., & Holman, C. (2013). Advancing knowledge on practice change: Linking facilitation to the senses framework. *Journal of Clinical Nursing, 22*(11-12), 1729-1737. https://doi.org/10.1111/jocn.12054

Cortis, N. (2011). Overlooked and under-served? promoting service use and engagement among ‘hard-to-reach’ populations. *International Journal of Social Welfare*, *21*(4), 351–360. https://doi.org/10.1111/j.1468-2397.2011.00825.x

Cox, C. B. (2007). *Dementia and social work practice: Research and interventions*. Springer.

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Dabiriyan Tehrani, H., & Yamini, S. (2022). Gender differences concerning the horizontal and vertical individualism and collectivism: A meta-analysis. *Psychological Studies*, *67*(1), 11–27. https://doi.org/10.1007/s12646-022-00638-x

Daly, L., McCarron, M., Higgins, A., & McCallion, P. (2012). ‘Sustaining place’ - a grounded theory of how informal carers of people with dementia manage alterations to relationships within their Social Worlds. *Journal of Clinical Nursing*, *22*(3-4), 501–512. https://doi.org/10.1111/jocn.12003

Daly, M. (2020). COVID -19 and Care Homes in England: What happened and why? *Social Policy & Administration*, *54*(7), 985–998. https://doi.org/10.1111/spol.12645

Davies, J., & Gregory, D. (2007). Entering the dialogue: Marriage biographies and dementia care. *Dementia*, *6*(4), 481–488. https://doi.org/10.1177/1471301207084366

Dearden, J. (2004). Resilience: A study of risk and protective factors from the perspective of young people with experience of Local Authority Care. *Support for Learning*, *19*(4), 187–193. https://doi.org/10.1111/j.0268-2141.2004.00346.x

Denscombe, M. (2010) *The Good Research Guide for small-scale social research projects,* 3rd edition, Maidenhead: OUP/McGraw-Hill Education

Department of Health (DOH). (2005). Mental Capacity Act. London: HMSO.

Dewing, J. (2007). Participatory research: A method for process consent with persons who have dementia. *Dementia*, *6*(1), 11–25. https://doi.org/10.1177/1471301207075625

Dimes, M. (2019). Relationship-based social work with older people, in Dix, H., Hollinrake, S., & Meade, J. (Eds.) *Relationship-based social work with adults,* Critical Publishing, p. 59-76.

Dix, H. & Meade, J. (2019). The IDEAS model, in Dix, H., Hollinrake, S., & Meade, J. (Eds.). *Relationship-based social work with adults,* Critical Publishing, p. 47 – 55.

Dodsworth, E. and Oung, C. Who organises and funds social care? *Nuffield Trust*. Retrieved July 2024, from https://www.nuffieldtrust.org.uk/news-item/who-organises-and-funds-social-care-1

Doel, M., Allmark, P., Conway, P., Cowburn, M., Flynn, M., Nelson, P., & Tod, A. (2010). Professional boundaries: Crossing a line or entering the shadows? *British Journal of Social Work*, *40*(6), 1866–1889. https://doi.org/10.1093/bjsw/bcp106

Dominelli, L. (1996). Deprofessionalizing Social Work: Anti-oppressive practice, competencies and Postmodernism. *British Journal of Social Work*, *26*(2), 153–175. https://doi.org/10.1093/oxfordjournals.bjsw.a011077

Eagly, A. H., & Wood, W. (2012). Social role theory. In P. Van Lange, A. Kruglanski, & E. Higgins (Eds.), *Handbook of theories of social psychology* (pp. 458–476). Thousand Oaks, CA: Sage.

Edwards, R., & Brannelly, T. (2017). Approaches to democratising qualitative research methods. *Qualitative Research, 17*(3), 271–277. https://doi.org/10.1177/1468794117706869

Ellis, K. (2014). Professional discretion and adult social work: Exploring its nature and scope on the front line of personalisation. *British Journal of Social Work, 44*(8), 2272–2289. https://doi.org/10.1093/bjsw/bct076

Elo S. & Kyngas H. (2008) The qualitative content analysis process. *Journal of Advanced Nursing*. 62(1), 107–115. doi: 10.1111/j.1365-2648.2007.04569.x

Erickson, F. (2018) 'A history of qualitative inquiry in social and educational research', in Denzin, N. and Lincoln, Y. (eds), *The SAGE handbook of qualitative research,* 43 - 58. Thousand Oaks, CA: Sage.

Eynon, T., & Conroy, S. (2017). The state of social care: the reality of a fragmented system. *The British journal of general practice : the journal of the Royal College of General Practitioners, 67*(658), 200–201. https://doi.org/10.3399/bjgp17X690593

Faulkner, A. (2012). The Right to Take Risks: Service Users' Views of Risk in Adult Social Care. *Joseph Rowntree Foundation, York, UK. https://www.jrf.org*.uk/sites/default/files/jrf/migrated/files/right-to-take-risks-faulkner.pdf

Ferguson, H., Warwick, L., Disney, T., Leigh, J., Cooner, T. S., & Beddoe, L. (2020). Relationship-based practice and the creation of therapeutic change in long-term work: Social work as a holding relationship. *Social Work Education*, *41*(2), 209–227. https://doi.org/10.1080/02615479.2020.1837105

Fernández-Ballesteros, R., Sánchez-Izquierdo, M., Olmos, R., Huici, C., Ribera Casado, J. M., & Cruz Jentoft, A. (2019). Paternalism vs. autonomy: Are they alternative types of formal care? *Frontiers in Psychology*, *10*. https://doi.org/10.3389/fpsyg.2019.01460

Fitzpatrick, J. M., & Tzouvara, V. (2018). Facilitators and inhibitors of transition for older people who have relocated to a long-term Care Facility: A systematic review. *Health & Social Care in the Community*, *27*(3). https://doi.org/10.1111/hsc.12647

Fitzpatrick, K., & Grace, M. (2019). Dementia patients' transition to residential aged care: Carers' and Social Workers' experiences. *Australian Social Work*, *72*(3), 287–298. https://doi.org/10.1080/0312407x.2018.1536155

Fogarty, M., & Elliot, D. L. (2020). The role of humour in the Social Care Professions: An exploratory study. *The British Journal of Social Work*, *50*(3), 778–796. https://doi.org/10.1093/bjsw/bcz027

Forbes (2022). Bracing for the Silver Tsunami. Accessed May 2023. https://www.forbes.com/sites/deborahwince-smith/2022/02/25/bracing-for-the-silver-tsunami/?sh=52fb17d833e4

France, A., Freiberg, K., & Homel, R. (2010). Beyond risk factors: Towards a holistic prevention paradigm for children and young people. *British Journal of Social Work*, *40*(4), 1192–1210. https://doi.org/10.1093/bjsw/bcq010

Funk, L. M., & Outcalt, L. (2019). Maintaining the 'caring self' and working relationships: A critically informed analysis of meaning-construction among paid companions in long-term residential care. *Ageing and Society*, *40*(7), 1511–1528. https://doi.org/10.1017/s0144686x19000138

Furedi, F. (2006). *Culture of fear revisited: Risk-taking and the morality of low expectation*. Continuum.

Furedi, F. (2009). *Socialisation as Behaviour Management and the Ascendancy of Expert Authority.* Amsterdam: Amsterdam University Press.

Gardner, W., Gabriel, S., & Lee, A. (1999). "I" value freedom, but "we" value relationships: Self- construal priming mirrors cultural differences in judgment. *Psychological Science, 10*, 321–326. https://doi.org/10.1111/1467-9280.00162

Garrett, P. M. (2014). Re-enchanting social work? the emerging 'spirit' of social work in an age of economic crisis. *British Journal of Social Work*, *44*(3), 503–521. https://doi.org/10.1093/bjsw/bcs146

Gergen. K. (1995). Relational Theory And The Discourses Of Power, in *Hosking, D., Dachler, H., & Gergen, K. (eds.) Management And Organization: Relational Alternatives To Individualism*. 29-50, London: Avebury.

Gerpott, F. H., Balliet, D., Columbus, S., Molho, C., & de Vries, R. E. (2018). How do people think about interdependence? A multidimensional model of subjective outcome interdependence. *Journal of Personality and Social Psychology*, *115*(4), 716–742. https://doi.org/10.1037/pspp0000166

Gibson, M. (2016). Social Worker or social administrator? findings from a qualitative case study of a Child Protection Social Work Team. *Child & Family Social Work*, *22*(3), 1187–1196. https://doi.org/10.1111/cfs.12335

Gilburt, H., Rose, D., & Slade, M. (2008). The importance of relationships in mental health care: A qualitative study of service users' experiences of psychiatric hospital admission in the UK. *BMC Health Services Research*, *8*(1). https://doi.org/10.1186/1472-6963-8-92

Gilliard, J., Means, R., Beattie, A., & Daker-White, G. (2005). Dementia care in England and the social model of disability: Lessons and issues. *Dementia, 4*(4), 571-586. https://doi.org/10.1177/1471301205058312

Gilligan, C. *(*1982*). In a different voice: Psychological theory and women's development*. Cambridge, MA: Harvard University Press.

Gilligan, R. (2000). The key role of social workers in promoting the well-being of children in state care ? A neglected dimension in reforming policies. *Children & Society*, *14*(4), 267–276. https://doi.org/10.1002/1099-0860(200009)14:4<267::aid-chi629>3.0.co;2-e

Given, L. M. (2008). *The SAGE encyclopedia of qualitative research methods.* Thousand Oaks, CA: Sage.

Glasby, J., Zhang, Y., Bennett, M. R., & Hall, P. (2021). A lost decade? A renewed case for adult social care reform in England. *Journal of Social Policy, 50*(2), 406-437. https://doi.org/10.1017/S0047279420000288

Gleibs, I. H., Haslam, C., Jones, J. M., Alexander Haslam, S., McNeill, J., & Connolly, H. (2011). No Country for Old Men? the role of a 'gentlemen's club' in promoting social engagement and psychological well-being in residential care. *Aging & Mental Health*, *15*(4), 456–466. https://doi.org/10.1080/13607863.2010.536137

Gómez-Vírseda, C., de Maeseneer, Y., & Gastmans, C. (2019). Relational autonomy: What does it mean and how is it used in end-of-life care? A systematic review of argument-based ethics literature. *BMC Medical Ethics, 20*(1). https://doi.org/10.1186/s12910-019-0417-3)\

Graham, J. R., & Shier, M. L. (2010). The social work profession and subjective well-being: The impact of a profession on overall subjective well-being. *British Journal of Social Work*, *40*(5), 1553–1572. https://doi.org/10.1093/bjsw/bcp049

Graham, K., Stevens, M., Norrie, C., Manthorpe, J., Moriarty, J., & Hussein, S. (2016). Models of safeguarding in England: Identifying important models and variables influencing the operation of adult safeguarding. *Journal of Social Work*, *17*(3), 255–276. https://doi.org/10.1177/1468017316640071

Graham, M. (2007). The ethics of care, black women and the social professions: Implications of a new analysis. *Ethics and Social Welfare*, *1*(2), 194–206. https://doi.org/10.1080/17496530701450372

Gray, M. (2011). Back to basics: A critique of the strengths perspective in Social Work. *Families in Society: The Journal of Contemporary Social Services*, *92*(1), 5–11. https://doi.org/10.1606/1044-3894.4054

Green, D. (2007). Risk and social work practice. *Australian Social Work*, *60*(4), 395–409. https://doi.org/10.1080/03124070701671131

Green, B. N., Johnson, C. D., & Adams, A. (2006). Writing narrative literature reviews for peer-reviewed journals: Secrets of the Trade. *Journal of Chiropractic Medicine*, *5*(3), 101–117. https://doi.org/10.1016/s0899-3467(07)60142-6

Groot, B. C., Vink, M., Haveman, A., Huberts, M., Schout, G., & Abma, T. A. (2018). Ethics of care in Participatory Health Research: Mutual Responsibility in collaboration with co-researchers. *Educational Action Research*, *27*(2), 286–302. https://doi.org/10.1080/09650792.2018.1450771

Guba, E. G., & Lincoln, Y. S. (2018). Paradigmatic Controversies, Contradictions, and Emerging Confluences. In N. K. Denzin & Y. S. Lincoln (eds.), *The Sage handbook of qualitative research*, 191–215. Thousand Oaks, CA: Sage.

Hallberg, I. R., & Kristensson, J. (2004). Preventive home care of frail older people: A review of recent Case Management Studies. *Journal of Clinical Nursing*, *13*(s2), 112–120. https://doi.org/10.1111/j.1365-2702.2004.01054.x

Hankivsky, O., Grace, D., Hunting, G., Giesbrecht, M., Fridkin, A., Rudrum, S., Ferlatte, O., & Clark, N. (2014). An intersectionality-based Policy Analysis Framework: Critical Reflections on a methodology for Advancing Equity. *International Journal for Equity in Health*, *13*(1). https://doi.org/10.1186/s12939-014-0119-x

Harkey, J. (2017). Case management at the intersection of social work and health care. *Social Work Today,* 17(1), 20. Accessed 20 April 2024 from https://www.socialworktoday.com/archive/011917p20.shtml

Harington, P. R. J., & Beddoe, L. (2013). Civic Practice: A new professional paradigm for Social Work. *Journal of Social Work*, *14*(2), 147–164. https://doi.org/10.1177/1468017313477316

Harris, J. (2008). State social work: Constructing the present from moments in the past. *British Journal of Social Work*, *38*(4), 662–679. https://doi.org/10.1093/bjsw/bcn024

Harris, P. B. (2011). Maintaining friendships in early stage dementia: Factors to consider. *Dementia,* *11*(3), 305–314. https://doi.org/10.1177/1471301211421066

Harris, P. B. (2013). Dementia and friendship: The quality and nature of the relationships that remain. *The International Journal of Aging and Human Development, 76*(2), 141–164. https://doi.org/10.2190/ag.76.2.c

HarperCollins (2019). *HarperCollins English Dictionary [Online].* 'Good as Gold'. Retrieved June 2023: https://www.collinsdictionary.com/dictionary/english/as-good-as-gold

Haunch, K., Downs, M., & Oyebode, J. (2023). 'Making the most of time during personal care': nursing home staff experiences of meaningful engagement with residents with advanced dementia. *Aging & Mental Health, 27*(12), 2346–2354. https://doi.org/10.1080/13607863.2023.2177254

Held, V. (2010). Can the ethics of care handle violence? *Ethics and Social Welfare, 4*(2), 115–129. https://doi.org/10.1080/17496535.2010.484256

Heu, L. C., van Zomeren, M., & Hansen, N. (2018). Lonely alone or lonely together? A cultural-psychological examination of individualism–collectivism and loneliness in five European countries. *Personality and Social Psychology Bulletin, 45*(5), 780–793. https://doi.org/10.1177/0146167218796793

Higgs, A. and Hafford-Letchfield, T. 2018. 'At what cost? the impact of UK long-term care funding policies on social work practice with older people': a literature review. *Ethics and Social Welfare.* 12 (3), pp. 229-243. https://doi.org/10.1080/17496535.2018.1505931

Hingley-Jones, H., & Ruch, G. (2016). 'Stumbling through'? Relationship-based Social Work Practice in austere times. *Journal of Social Work Practice*, *30*(3), 235–248. https://doi.org/10.1080/02650533.2016.1215975

Hojer, S., & Forkby, T. (2011). Care for sale: The Influence of New Public Management in child protection in Sweden. *British Journal of Social Work*, *41*(1), 93–110. https://doi.org/10.1093/bjsw/bcq053

Hollinrake, S. (2019). Theoretical perspectives for relationship-based practice with adults in Dix, H., Hollinrake, S., & Meade, J. (Eds.). *Relationship-based social work with adults,* 7 – 25. Critical Publishing

Hollis, F. (1964). *Casework: A psychosocial therapy*. Random House.

Horlick-Jones, T. (2005). On 'risk work': Professional discourse, accountability, and everyday action. *Health, Risk & Society*, *7*(3), 293–307. https://doi.org/10.1080/13698570500229820

House of Commons Committee of Public Accounts (2024). *Reforming adult social care in England: Twenty-second report of session 2023–24*. UK Parliament. https://committees.parliament.uk/publications/43918/documents/217743/default/

Houska, A., & Loučka, M. (2019). Patients' autonomy at the end of Life: A Critical review. *Journal of Pain and Symptom Management*, *57*(4), 835–845. https://doi.org/10.1016/j.jpainsymman.2018.12.339

Houston, B. (1990). Caring and Exploitation. *Hypatia*, *5*(1), 115–119. https://doi.org/10.1111/j.1527-2001.1990.tb00395.x

Howe, D. (1994). Modernity, postmodernity and social work. *The British Journal of Social Work*. https://doi.org/10.1093/oxfordjournals.bjsw.a056103

Howe, D. (1998). Relationship-based thinking and practice in Social Work. *Journal of Social Work Practice*, *12*(1), 45–56. https://doi.org/10.1080/02650539808415131

Hsieh, H.-F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, *15*(9), 1277–1288. https://doi.org/10.1177/1049732305276687

Huby, G., Harris, F. M., Powell, A. E., Kielman, T., Sheikh, A., Williams, S., & Pinnock, H. (2014). Beyond professional boundaries: Relationships and resources in Health Services' Modernisation in England and Wales. *Sociology of Health & Illness*, *36*(3), 400–415. https://doi.org/10.1111/1467-9566.12067

Hussein, S., & Manthorpe, J. (2011). The Dementia Social Care Workforce in england: Secondary analysis of a national workforce dataset. *Aging & Mental Health*, *16*(1), 110–118. https://doi.org/10.1080/13607863.2011.596808

Jacobs, S., Abell, J., Stevens, M., Wilberforce, M., Challis, D., Manthorpe, J., Fernandez, J.-L., Glendinning, C., Jones, K., Knapp, M., Moran, N., & Netten, A. (2011). The personalization of care services and the early impact on staff activity patterns. *Journal of Social Work*, *13*(2), 141–163. https://doi.org/10.1177/1468017311410681

Jansson, W., Nordberg, G., & Grafström, M. (2001). Patterns of elderly spousal caregiving in dementia care: An observational study. *Journal of Advanced Nursing*, *34*(6), 804–812. https://doi.org/10.1046/j.1365-2648.2001.01811.x

John, M. and Trevithick, P. (2012). *Psychosocial practice in social work, in Social Work Models, Methods and Theories*, eds P. Stepney and D. Ford, 2nd edn, Lyme Regis: Russell House.

Johnson, E. K. (2022). Dirt, decency and the symbolic boundaries of caregiving in residential homes for older people. *The Sociological Review*, *71*(3), 679–695. https://doi.org/10.1177/00380261221140240

Johnson, I. G., Morgan, M. Z., & Jones, R. J. (2022). Oral Care, loss of personal identity and dignity in residential care homes. *Gerontology*, *40*(2), 200–206. https://doi.org/10.1111/ger.12633

Jones, R. (2007) A journey through the years: Ageing and social care. *Ageing Horizons*. 6(1), 42–51. https://www.ageing.ox.ac.uk/files/Ageing%20Horizons%206%20%20Jones.pdf

Jordan, S. (2017). Relationship based social work practice: The case for considering the centrality of humour in creating and maintaining relationships. *Journal of*

Social Work Practice, *31*(1), 95–110. https://doi.org/10.1080/02650533.2016.1189405

Kash, B., & Miller, T. (2009). The relationship between advertising, price, and nursing home quality. *Health Care Management Review, 34*(3), 242-250. DOI: 10.1097/HMR.0b013e3181a16ce0

Kales, H. C., Gitlin, L. N., & Lyketsos, C. G. (2015). Assessment and management of behavioral and psychological symptoms of dementia. *BMJ*, *350*. https://doi.org/10.1136/bmj.h369

Kaplan, D. B., & Berkman, B. (2011). Dementia care: A global concern and social work challenge. *International Social Work, 54*(3), 361–373. https://doi.org/10.1177/0020872810396255

Keeling, J., & van Wormer, K. (2011). Social worker interventions in situations of domestic violence: What we can learn from survivors' personal narratives? *British Journal of Social Work*, *42*(7), 1354–1370. https://doi.org/10.1093/bjsw/bcr137

King-Dejardin, A. (2019) *The Social Construction of Migrant Care Work. At the Intersection of Care, Migration and Gender, Geneva: International Labour Office.* https://englishbulletin.adapt.it/wp-content/uploads/2019/03/wcms_674622.pdf

Kitwood, T. *(*1997*). Dementia reconsidered: The person comes first.* Buckingham: Open University Press.

Kitwood, T. (2013). in G. Jones, & B. Miesen (Eds.). *The concept of personhood and its relevance for a new culture of dementia care, in care-giving in dementia.* New York: Routledge.

Kor, K., Fernandez, E., Spangaro, J. (2022). Relationship-Based Practice in Therapeutic Residential Care: A Double-Edged Sword. *The British Journal of Social Work, 52*(2), 663-681. https://doi.org/10.1093/bjsw/bcab018

Krys, K., Zelenski, J. M., Capaldi, C. A., Park, J., Tilburg, W., Osch, Y., Haas, B. W., Bond, M. H., Dominguez-Espinoza, A., Xing, C., Igbokwe, D. O., Kwiatkowska, A., Luzniak-Piecha, M., Nader, M., Rizwan, M., Zhu, Z., & Uchida, Y. (2019). Putting the "we" into well-being: Using collectivism-themed measures of Well-being attenuates well-being's association with individualism. *Asian Journal of Social Psychology*, *22*(3), 256–267. https://doi.org/10.1111/ajsp.12364

La Fontaine, J., & Oyebode, J. (2014). Family relationships and dementia: A synthesis of qualitative research including the person with dementia. *Ageing and Society*, *34*(7), 1243–1272. https://doi.org/10.1017/s0144686x13000056

Leece, J., & Leece, D. (2010). Personalisation: Perceptions of the role of social work in a world of brokers and budgets. *British Journal of Social Work*, *41*(2), 204–223. https://doi.org/10.1093/bjsw/bcq087

Leece, J., & Peace, S. (2009). Developing new understandings of Independence and autonomy in the personalised relationship. *British Journal of Social Work*, *40*(6), 1847–1865. https://doi.org/10.1093/bjsw/bcp105

Leigh, J. T. (2013). The process of professionalisation: Exploring the identities of Child Protection Social Workers. *Journal of Social Work*, *14*(6), 625–644. https://doi.org/10.1177/1468017313504380

Liberati, E. G., Gorli, M., & Scaratti, G. (2016). Invisible walls within multidisciplinary teams: Disciplinary boundaries and their effects on Integrated Care. *Social Science & Medicine*, *150*, 31–39. https://doi.org/10.1016/j.socscimed.2015.12.002

Liedtka, J. M. (1996). Feminist morality and competitive reality: A role for an ethic of care? *Business Ethics Quarterly*, *6*(2), 179–200. https://doi.org/10.2307/3857622

Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (2018). Paradigmatic controversies, contradictions, and emerging confluences revisited. In N. K. Denzin & Y. S.

Lincoln (Eds.), *The Sage handbook of qualitative research*, 97-128. Thousand Oaks, CA: Sage.

Littlechild, B. (2008) Child protection social work: Risks of fears and fears of risks - impossible tasks from impossible goals?, *Social Policy & Administration*, 42(6), pp. 662–675. https://doi.org/10.1111/j.1467-9515.2008.00630.x.

Livingston, G., Huntley, J., Sommerlad, A., et al. (2020). Dementia prevention, intervention, and care: 2020 report of the Lancet Commission. *The Lancet,* 396(10248), 413-446. doi:10.1016/S0140-6736(20)30367-6

Lloyd, L., & Sullivan, M.-P. (2018). Ageing, ethics and Social Welfare: Contemporary Social Work and social care practices with older people. *Ethics and Social Welfare*, *12*(3), 201–203. https://doi.org/10.1080/17496535.2018.1537545

Lovatt, M. (2018). Becoming at home in residential care for older people: A material culture perspective. *Materialities of Care*, 123–135. https://doi.org/10.1002/9781119499749.ch10

Lupton, D. (1999) *Risk*. London: Routledge.

Lymbery, M. (1998). Care management and professional autonomy: The impact of Community Care Legislation on social work with older people. *British Journal of Social Work*, *28*(6), 863–878. https://doi.org/10.1093/oxfordjournals.bjsw.a011405

Lymbery, M., & Postle, K. (2010). Social work in the context of adult social care in England and the resultant implications for Social Work Education. *British Journal of Social Work*, *40*(8), 2502–2522. https://doi.org/10.1093/bjsw/bcq045

Lymbery, M., Lawson, J., MacCallum, H., McCoy, P., Pidgeon, J., & Ward, K. (2007). The social work role with older people. *Practice*, *19*(2), 97–113. https://doi.org/10.1080/09503150701393601

Macdonald, K., & Morgan, H. M. (2020). The impact of austerity on disabled, elderly and immigrants in the United Kingdom: A literature review. *Disability & Society*, *36*(7), 1125–1147. https://doi.org/10.1080/09687599.2020.1779036

Mackenzie, C. and Stoljar, N. (2000) *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self.* Oxford University Press

Manthorpe, J. (2015). The abuse, neglect and mistreatment of older people with dementia in care homes and hospitals in England: The potential for secondary data analysis: Innovative Practice. *Dementia*, *14*(2), 273–279. https://doi.org/10.1177/1471301214541177

Manthorpe, J., & Iliffe, S., 2005. Timely responses to dementia: Exploring the social work role. *Journal of Social Work, 5*(2), pp.191-203. https://doi.org/10.1177/1468017305054973

Manthorpe, J., & Martineau, S. (2016). Engaging with the new system of safeguarding adults reviews concerning care homes for older people. *British Journal of Social Work*. https://doi.org/10.1093/bjsw/bcw102

Manthorpe, J., & Samsi, K. (2013). 'Inherently risky?': Personal budgets for people with dementia and the risks of financial abuse: Findings from an interview-based study with adult safeguarding coordinators. *British Journal of Social Work*, *43*(5), 889–903. https://doi.org/10.1093/bjsw/bcs023

Manthorpe, J., Iliffe, S., & Eden, A. (2003). The implications of the early recognition of dementia for multiprofessional teamworking. *Dementia*, *2*(2), 163–179. https://doi.org/10.1177/1471301203002002003

Manthorpe, J., Moriarty, J., Rapaport, J., Clough, R., Cornes, M., Bright, L., & Iliffe, S. (2008). 'there are wonderful social workers but it's a lottery': Older people's views about social workers. *British Journal of Social Work*, *38*(6), 1132–1150. https://doi.org/10.1093/bjsw/bcl379

Manthorpe J., Stevens M., Rapaport J., Challis D., Jacobs S., Netten A., Glendinning C. (2010) Individual budgets and adult safeguarding: Parallel or converging tracks? Further findings from the evaluation of the Individual Budget pilots. *Journal of Social Work* 11(4): 422–438. https://doi.org/10.1177/146801731037945

Markus, H. R., & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological Review, 98*(2), 224–253. https://doi.org/10.1037/0033-295X.98.2.224

Martin, R. & Ford, T. (2018). *The psychology of humour: an integrative approach.* 2nd ed. London: Academic Press.

Maslow, A. (1943). A Theory of Human Motivation, *Psychological Review, 50(4),* 430-437. https:// https://doi.org/10.1037/h0054346

McAuliffe, D., Tilbury, C., Chenoweth, L., Stehlik, D., Struthers, K., & Aitchison, R. (2015). (Re)valuing relationships in child protection practice. *Journal of Social Work Practice*, *30*(4), 365–377. https://doi.org/10.1080/02650533.2015.1116437

McCabe, M., Byers, J., Busija, L., Mellor, D., Bennett, M., & Beattie, E. (2021). How important are choice, autonomy, and relationships in predicting the quality of life of nursing home residents? *Journal of Applied Gerontology*, *40*(12), 1743–1750. https://doi.org/10.1177/0733464820983972

McDonald, A. (2010). The impact of the 2005 Mental Capacity Act on Social Workers' decision making and approaches to the assessment of risk. *British Journal of Social Work*, *40*(4), 1229–1246. https://doi.org/10.1093/bjsw/bcq021

McGilton, K. S., & Boscart, V. M. (2007). Close care provider–resident relationships in long-term care environments. *Journal of Clinical Nursing, 16*(11), 2149–2157. https://doi.org/10.1111/j.1365-2702.2006.01636.x

McLaughlin, J. (2015). Social work in acute hospital settings in Northern Ireland: The Views of service users, carers and multi-disciplinary professionals. *Journal of Social Work*, *16*(2), 135–154. https://doi.org/10.1177/1468017314568843

McLeod, A. (2007). Whose agenda? issues of power and relationship when listening to looked-after young people. *Child & Family Social Work*, *12*(3), 278–286. https://doi.org/10.1111/j.1365-2206.2007.00493.x

McLeod, A. (2010). 'a friend and an equal': Do young people in care seek the impossible from their social workers? *British Journal of Social Work*, *40*(3), 772–788. https://doi.org/10.1093/bjsw/bcn143

McNally, M., & Lahey, W. (2015). Frailty's place in ethics and law: Some thoughts on equality and autonomy and on limits and possibilities for aging citizens. *Frailty in Aging*, 174–185. https://doi.org/10.1159/000381235

McNay, M., Clarke, J., & Lovelock, R. (2012). The journey towards professionalism in social work. *The Journal of Practice Teaching and Learning*, *9*(3), 72-91. https://doi.org/10.1921/jpts.v9i3.403

Means, R., Smith, R., & Richards, S. (2008). *Community care: Policy and practice*. Palgrave Macmillan.

Miller, S. C. (2020). From vulnerability to precariousness: Examining the moral foundations of care ethics. *International Journal of Philosophical Studies, 28*(5), 644-661. https://doi.org/10.1080/09672559.2020.1804239

Milne, A. (2011), "Living with dementia in a care home: capturing the experiences of residents", *Quality in Ageing and Older Adults*, Vol. 12 No. 2, pp. 76-85. https://doi.org/10.1108/14717791111144687

Morrison, T. (2007). Emotional intelligence, emotion and social work: Context, characteristics, complications and contribution. *British Journal of Social Work*, *37*(2), 245–263. https://doi.org/10.1093/bjsw/bcl016

Mortimer, J. T., & Moen, P. (2016). The changing social construction of age and the life course: Precarious identity and enactment of “early” and “encore” stages of adulthood. *Handbooks of Sociology and Social Research*, 111–129. https://doi.org/10.1007/978-3-319-20880-0_5

Munro, Eileen (*2011*) *The Munro review of child protection: final report, a child-centred system*. CM (8062). The Stationery Office, London.

Murphy, D., Duggan, M., & Joseph, S. (2013). Relationship-based social work and its compatibility with the person-centred approach: Principled versus instrumental perspectives. *British Journal of Social Work*, *43*(4), 703–719. https://doi.org/10.1093/bjsw/bcs003

Murphy, E., & Dingwall, R. (2007). Informed consent, anticipatory regulation and ethnographic practice. *Social Science & Medicine,* 65, 2223–2234. doi:10.1016/j.socscimed.2007.08.008

Murphy, E., Dingwall, R., Greatbatch, D., Parker, S., & Watson, P. (1998). Qualitative research methods in health technology assessment: a review of the literature. *Health technology assessment. 2*(16), 252–274. https://doi.org/10.3310/hta2160

Mushtaq, R. (2014). Relationship between loneliness, psychiatric disorders and physical health ? A review on the psychological aspects of loneliness. *JOURNAL OF CLINICAL AND DIAGNOSTIC RESEARCH*. https://doi.org/10.7860/jcdr/2014/10077.4828

National Association of Social Workers (NASW). (2017). *NASW code of ethics.* Retrieved: May 2023. https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

Naue, U., & Kroll, T. (2009). ‘The demented other’: Identity and difference in dementia. *Nursing Philosophy*, *10*(1), 26–33. https://doi.org/10.1111/j.1466-769x.2008.00379.x

NHS (National Health Service). (2019). *Symptoms – Clinical depression.* https://www.nhs.uk/mental-health/conditions/clinical-depression/symptoms/

NHS (National Health Service). (2021). *Help at home from a paid carer.* Accessed May 2023. https://www.nhs.uk/conditions/social-care-and-support-guide/care-services-equipment-and-care-homes/homecare/

NHS (National Health Service). (2023). *What is dementia.* Accessed May 2024. https://www.nhs.uk/conditions/dementia/about-dementia/what-is-dementia/

NHS England. (2021). *Recorded Dementia Diagnoses 2021*. Accessed May 2023. https://digital.nhs.uk/data-and-information/publications/statistical/recorded-dementia-diagnoses/january-2021

Noble, C. (2004). Postmodern thinking: Where is it taking social work? *Journal of Social Work*, *4*(3), 289–304. https://doi.org/10.1177/1468017304047747

Nolan, M. R., Brown, J., Davies, S., Nolan, J. and Keady, J. (2006). The Senses Framework: improving care for older people through a relationship-centred approach. Getting Research into Practice (GRiP) Report No 2. Project Report. University of Sheffield. https://core.ac.uk/download/pdf/99946.pdf

Nolan, M.R., Davies, S., & Grant, G. (Eds.). (2002). *Working with older people and their families: Key issues in policy and practice*. Buckingham: Open University Press.

Norton, M. C., Piercy, K. W., Rabins, P. V., Green, R. C., Breitner, J. C., Ostbye, T., Corcoran, C., Welsh-Bohmer, K. A., Lyketsos, C. G., & Tschanz, J. T. (2009). Caregiver-recipient closeness and symptom progression in alzheimer disease. The Cache County Dementia Progression Study. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *64B*(5), 560–568. https://doi.org/10.1093/geronb/gbp052

Nyashanu, M., Pfende, F., and Ekpenyong, M. S. (2020). Triggers of mental health problems among frontline healthcare workers during the COVID-19 pandemic in private care homes and domiciliary care agencies: Lived experiences of care workers in the Midlands region, UK. *Health & Social Care in the Community*, *30*(2). https://doi.org/10.1111/hsc.13204

O'Leary, P., Tsui, M.-S., & Ruch, G. (2012). The boundaries of the Social Work Relationship Revisited: Towards a connected, inclusive and dynamic conceptualisation. *British Journal of Social Work*, *43*(1), 135–153. https://doi.org/10.1093/bjsw/bcr181

Office for National Statistics. (2014). *Changes in the Older Resident Care Home Population between 2001 and 2011.* Accessed May 2023. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ageing/articles/changesintheolderresidentcarehomepopulationbetween2001and2011/2014-08-01#:~:text=and%20Wales%2C%202011-,The%20resident%20care%20home%20population%20is%20ageing%3A%20in%202011%2C%20people,65%20to%2074%20in%202011.

Office for National Statistics. (2022). *Deaths within the care sector involving COVID-19, England and Wales.* Accessed May 2023. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsinvolvingcovid19inthecaresectorenglandandwales

Office for National Statistics. (2023). *Profile of the older population living in England and Wales in 2021 and changes since 2011.* Accessed May 2023. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ageing/articles/profileoftheolderpopulationlivinginenglandandwalesin2021andchangessince2011/2023-04-03#:~:text=Census%202021%20results%20show%20the,from%2016.4%25%20to%2018.6%25.

Oliver, C., & Charles, G. (2015). Which strengths-based practice? reconciling strengths-based practice and mandated authority in child protection work. *Social Work*, *60*(2), 135–143. https://doi.org/10.1093/sw/swu058

Omori, M., Baker, C., Jayasuriya, J., Savvas, S., Gardner, A., Dow, B., & Scherer, S. (2019). Maintenance of professional boundaries and family involvement in residential aged care. *Qualitative Health Research*, *29*(11), 1611–1622. https://doi.org/10.1177/1049732319839363

Orehek, E., & Kruglanski, A. W. (2018). Personal failure makes society seem fonder: An inquiry into the roots of social interdependence. *PLOS ONE*, *13*(8). https://doi.org/10.1371/journal.pone.0201361

Orme, J. (2002). Social work: Gender, care and justice. *British Journal of Social Work*, *32*(6), 799–814. https://doi.org/10.1093/bjsw/32.6.799

Ormston, R., Spencer, L., Barnard, M. & Snape, D. (2014) ‘The foundations of qualitative research’ in Ritchie, J., Lewis, J., Nicholls, C. & Ormston, R. (eds), *Qualitative research practice: A guide for social science students and researchers,* 152–72. Thousand Oaks, CA: Sage.

Ostwald, S. K., Duggleby, W., & Hepburn, K. W. (2002). The stress of dementia: View from the inside. *American Journal of Alzheimer's Disease & Other Dementias*, *17*(5), 303–312. https://doi.org/10.1177/153331750201700511

Oxford English Dictionary [OED], (2022a). *Oxford English Dictionary.* (3rd edn). Oxford University Press. Retrieved: March 2023. https://www.oed.com/view/Entry/15312?rskey=AspKC4&result=1&isAdvanced=false#eid

Oxford English Dictionary [OED]. (2018). *Oxford English Dictionary.* (3rd edn). Oxford University Press. Retrieved: May 2023 https://www.oed.com/view/Entry/39331?redirectedFrom=connectedness#eid

Oxford English Dictionary [OED]. (2021a). *Oxford English Dictionary.* (3rd edn). Oxford University Press. Retrieved: March 2023. https://www.oed.com/view/Entry/94323?redirectedFrom=Independence#eid

Oxford English Dictionary [OED]. (2021b). *Oxford English Dictionary.* (3rd edn). Oxford University Press. Retrieved: March 2023. https://www.oed.com/view/Entry/97699?redirectedFrom=interdependence#eid

Oxford English Dictionary [OED]. (2021c). *Oxford English Dictionary.* (3rd edn). Oxford University Press. Retrieved: March 2023. https://www.oed.com/view/Entry/67960?redirectedFrom=familiarity&

Oxford English Dictionary [OED]. (2022b). *Oxford English Dictionary.* (3rd edn). Oxford University Press. Retrieved: March 2023. https://www.oed.com/view/Entry/13500?redirectedFrom=Autonomy#eid

Oxford English Dictionary [OED]. (2022c). *Oxford English Dictionary.* (3rd edn). Oxford University Press. Retrieved: March 2023.

Oxford English Dictionary [OED]. (2022d). *Oxford English Dictionary.* (3rd edn). Oxford University Press. Retrieved: June 2023.https://www.oed.com/view/Entry/39326?rskey=6FOvGc&result=1&isAdvanced=false#eid

Oxford English Dictionary [OED]. (2023). *Oxford English Dictionary.* (3rd edn). Oxford University Press. Retrieved: May 2023 https://www.oed.com/view/Entry/130181?redirectedFrom=occupation#eid2023.

Oyserman, D., & Lee, S. W. (2008). Does culture influence what and how we think? effects of priming individualism and collectivism. *Psychological Bulletin*, *134*(2), 311–342. https://doi.org/10.1037/0033-2909.134.2.311

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2013). Purposeful sampling for qualitative data collection and analysis in Mixed Method Implementation Research. *Administration and Policy in Mental Health and Mental Health Services Research*, *42*(5), 533–544. https://doi.org/10.1007/s10488-013-0528-y

Panthi, M. (2022). Loneliness and boredom in residential care. *Aotearoa New Zealand Social Work*, *34*(1), 88–99. https://doi.org/10.11157/anzswj-vol34iss1id846

Parton, N. (1996). Social work, risk and 'the blaming system' in Parton, N. (ed.) *Social Theory, Social Change and Social Work.* London: Routledge. P. 98 -114.

Parton, N. (2003). Rethinking professional practice: The contributions of social constructionism and the feminist 'ethics of care'. *British Journal of Social Work*, *33*(1), 1–16. https://doi.org/10.1093/bjsw/33.1.1

Parton, N. (2008). Changes in the form of knowledge in Social Work: From the 'social' to the 'informational'? *British Journal of Social Work*, *38*(2), 253–269. https://doi.org/10.1093/bjsw/bcl337

Payne, M. (1997). *Modern Social Work theory*. Bloomsbury Academic.

Pickard, L., King, D., & Knapp, M. (2016). The 'visibility' of unpaid care in England. *Journal of Social Work*, *16*(3), 263–282. https://doi.org/10.1177/1468017315569645

Piper, H. and Stronach, I. (2008). *Don't Touch! The Educational Story of a Panic.* Oxford: Routledge.

Pollack, S. (2008). Labelling clients 'risky': Social work and the neo-liberal welfare state. *British Journal of Social Work*, *40*(4), 1263–1278. https://doi.org/10.1093/bjsw/bcn079

Postle, K. (2001). 'The social work side is disappearing. I guess it started with us being called Care Managers'. *Practice*, *13*(1), 13–26. https://doi.org/10.1080/09503150108415468

Postle, K. (2002). Working 'between the idea and the reality': Ambiguities and tensions in Care Managers' work. *British Journal of Social Work*, *32*(3), 335–351. https://doi.org/10.1093/bjsw/32.3.335

Powell, A. E., & Davies, H. T. O. (2012). The struggle to improve patient care in the face of professional boundaries. *Social Science & Medicine*, *75*(5), 807–814. https://doi.org/10.1016/j.socscimed.2012.03.049

Prince M, Bryce R, Albanese E, Wimo A, Ribeiro W, Ferri CP (2013) The global prevalence of dementia: a systematic review and metaanalysis. *Alzheimers & Dementia* 9(1). 63–7. https://doi.org/10.1016/j.jalz.2012.11.007

Pugh, R. (2007). Dual relationships: Personal and professional boundaries in rural Social Work. *British Journal of Social Work*, *37*(8), 1405–1423. https://doi.org/10.1093/bjsw/bcl088

Puka, B. (1990). The liberation of caring; a different voice for Gilligan's "Different voice." *Hypatia*, *5*(1), 58–82. https://doi.org/10.1111/j.1527-2001.1990.tb00390.x

Quinn, C. (2010) Risk, rights and advocacy: some lessons from social work practice with people who have dementia. *Women in Welfare Education*, 9(1). Https://link.gale.com/apps/doc/A230867734/AONE?u=anon~23efa293&sid=googleScholar&xid=287afe4c

Quinn, C., Clare, L., McGuinness, T., & Woods, R. T. (2012). The impact of relationships, motivations, and meanings on dementia caregiving outcomes. *International Psychogeriatrics*, *24*(11), 1816–1826. https://doi.org/10.1017/s1041610212000889

Rainbird, H., Leeson, E., & Munro, A. (2011). Is regulation good for skill development? mediating actors and workplace practice in Adult Social Care in England. *The International Journal of Human Resource Management*, *22*(18), 3727–3741. https://doi.org/10.1080/09585192.2011.622921

Ray, M. and Phillips, J. (2012) *Social work with older people [5th ed.]*. Practical Social Work. Palgrave Macmillan.

Reamer, F. G. (2003). Boundary Issues in Social Work: Managing dual relationships. *Social Work*, *48*(1), 121–133. https://doi.org/10.1093/sw/48.1.121

Reamer, F. G. (2013). *Social work values and ethics* (4th ed.). Columbia University Press.

Richards, S. (2000). Bridging the divide: Elders and the assessment process. *British Journal of Social Work*, *30*(1), 37–49. https://doi.org/10.1093/bjsw/30.1.37

Ridge, P. G., Hoyt, K. B., Boehme, K., et al. (2017). Assessment of the genetic variance of late-onset Alzheimer's disease. *Neurobiology of Aging,* 70, 244.e9-244.e17. doi:10.1016/j.neurobiolaging.2018.07.014

Robinson, L., Hutchings, D., Corner, L., Finch, T., Hughes, J., Brittain, K., & Bond, J. (2007). Balancing rights and risks: Conflicting Perspectives in the management of wandering in dementia. *Health, Risk & Society*, *9*(4), 389–406. https://doi.org/10.1080/13698570701612774

Rogowski, S. (2010). *Social Work: The Rise and Fall of a Profession?*. Bristol: Policy Press.

Rogowski, S. (2011). Managers, managerialism and social work with children and families: The deformation of a profession? *Practice*, *23*(3), 157–167. https://doi.org/10.1080/09503153.2011.569970

Rogowski, S. (2012). Social work with children and families: Challenges and possibilities in the neo-liberal world. *British Journal of Social Work*, *42*(5), 921–940. https://doi.org/10.1093/bjsw/bcr129

Ruch, G. (2005). Relationship-based practice and reflective practice: Holistic approaches to Contemporary Child Care Social Work. *Child & Family Social Work*, *10*(2), 111–123. https://doi.org/10.1111/j.1365-2206.2005.00359.x

Ruch, G. (2018a). The contemporary context of relationship-based practice. In Ruch, G., Turney, D., Ward, A., & Howe, D. (eds.). *Relationship-based social work: Getting to the heart of practice*. 2nd Edn. Jessica Kingsley Publishers. P. 23-36.

Ruch, G. (2018b). Theoretical frameworks informing relationship-based practice. In Ruch, G., Turney, D., Ward, A., & Howe, D. (eds.). *Relationship-based social work: Getting to the heart of practice*. 2nd Edn. Jessica Kingsley Publishers. P. 37 – 54.

Ruch, G., Turney, D., Ward, A., & Howe, D. (2018). Introduction. In Ruch, G., Turney, D., Ward, A., & Howe, D. (eds.). *Relationship-based social work:*

Getting to the heart of practice. 2nd Edn. Jessica Kingsley Publishers. P. 13-18.

Rudebeck, C. E. (2019). Relationship based care – how general practice developed and why it is undermined within contemporary healthcare systems. *Scandinavian Journal of Primary Health Care*, *37*(3), 335–344. https://doi.org/10.1080/02813432.2019.1639909

Rummery, K. (2020). Gender equality and the governance of long-term care policy: New comparative models and paradigms. *Journal of International and Comparative Social Policy*, *37*(1), 16–33. https://doi.org/10.1017/ics.2020.16

Ryan, T., Nolan, M., Reid, D., & Enderby, P. (2008). Using the senses framework to achieve relationship-centred dementia care services. *Dementia*, *7*(1), 71–93. https://doi.org/10.1177/1471301207085368

Sabat, S. R. (2006). Implicit memory and people with alzheimer's disease: Implication for caregiving. *American Journal of Alzheimer's Disease & Other Dementias*, *21*(1), 11–14. https://doi.org/10.1177/153331750602100113

Sanders, S., Bullock, K., & Broussard, C. (2012). Exploring professional boundaries in end-of-life care: Considerations for Hospice Social Workers and other members of the team. *Journal of Social Work in End-Of-Life & Palliative Care*, *8*(1), 10–28. https://doi.org/10.1080/15524256.2012.650671

Savvas, S. M., Gibson, S. J., Rizakis, P., Vaughan, M. P., & Scherer, S. C. (2017). Testing the reliability and validity of a transition map for older adults in long term care settings. *Geriatric Nursing*, *38*(6), 551–558. https://doi.org/10.1016/j.gerinurse.2017.04.005

Sayer, T. (2008). *Critical practice in working with children*. Palgrave Macmillan.

Schölzel-Dorenbos, C. J. M., Meeuwsen, E. J., & Olde Rikkert, M. G. M. (2010). Integrating unmet needs into dementia health-related quality of life research and care: Introduction of the hierarchy model of needs in dementia. *Aging & Mental Health*, *14*(1), 113–119. https://doi.org/10.1080/13607860903046495

Schrack, J. A., Corkum, A. E., & Freedman, V. A. (2022). Covid-19 pandemic experiences of older adults with dementia in community and residential care settings: Results from a US national survey. *Alzheimer's & Dementia: Diagnosis, Assessment & Disease Monitoring*, *14*(1). https://doi.org/10.1002/dad2.12382

Schwandt, T. A., & Gates, E. F. (2018). Case Study Methodology. In N. K. Denzin, & Y. S. Lincoln (eds.), *The SAGE handbook of qualitative research*, 341-358. Thousand Oaks, CA: Sage.

Scourfield, J., & Welsh, I. (2003). Risk, reflexivity and Social Control in child protection: New times or same old story? *Critical Social Policy*, *23*(3), 398–420. https://doi.org/10.1177/02610183030233005

Sherwin, S., & Winsby, M. (2010). A relational perspective on autonomy for older adults residing in nursing homes. *Health Expectations*, *14*(2), 182–190. https://doi.org/10.1111/j.1369-7625.2010.00638.x

Sherwood-Johnson, F. (2014). A different kind of practice? meanings attached by practitioners to the idea of 'adult protection.' *Journal of Social Work*, *14*(5), 473–490. https://doi.org/10.1177/1468017313479857

Silarova, B., Brookes, N., Palmer, S., Towers, A. M., & Hussein, S. (2022). Understanding and measuring the work-related quality of life among those working in Adult Social Care: A scoping review. *Health & Social Care in the Community*, *30*(5), 1637–1664. https://doi.org/10.1111/hsc.13718

Sims, D. (2011). Achieving collaborative competence through Interprofessional Education. lessons learned from joint training in Learning Disability Nursing and social work. *Social Work Education*, 30(1), 98–112. https://doi.org/10.1080/02615471003748056.

Skills for Care. (2022a). *Headline social work information.* Accessed May 2023. https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/Topics/Social-work/Headline-social-work-information.aspx

Skills for Care. (2022b). *The state of the adult social care sector and workforce in England. Go to Our strategy 21-25.* Retrieved March 2023, from https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx

Skills for Care. (2022c). *Workforce nationality figures.* Accessed June 2023. https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/Topics/Workforce-nationality.aspx

Social Care Institute for Excellence (SCIE). (2011). *What is personalisation?*. Retrieved May 2023, from https://www.scie.org.uk/personalisation/introduction/what-is

Social Care Wales. (2017). *Code of Professional Practice for Social Care.* Retrieved May 2023, from https://socialcare.wales/cms-assets/documents/Code-of-Professional-Practice-for-Social-Care-web-version.pdf.

Social Care Wales. (2022). *Social care workforce report 2021.* Retrieved May 2023, from https://socialcare.wales/cms-assets/documents/Workforce_Report_2021_EN-final.pdf.

Social Care Wales. (2024). *Social Work Qualifiations.* Retrieved June 2024, from https://socialcare.wales/qualifications-funding/social-work-qualifications

Stake, R. E. (2018). Case Studies. In N. K. Denzin, & Y. S. Lincoln (Eds.), *The SAGE Handbook of Qualitative Research,* 435-453. Thousand Oaks, CA: Sage

Staniforth, B., Fouché, C., & O'Brien, M. (2011). Still doing what we do: Defining social work in the 21st Century. *Journal of Social Work*, *11*(2), 191–208. https://doi.org/10.1177/1468017310386697

Stanley, N. (1999). User-practitioner transactions in the New Culture of Community Care. *British Journal of Social Work, 29*(3), 417–435. https://doi.org/10.1093/oxfordjournals.bjsw.a011465

Stein, J., Löbner, M., Pabst, A., König, H.-H., & Riedel-Heller, S. G. (2020). Unmet care needs in the oldest old with social loss experiences: Results of a representative survey. *BMC Geriatrics*, *20*(1). https://doi.org/10.1186/s12877-020-01822-2

Stepney, P. (2005). Mission impossible? critical practice in social work. *British Journal of Social Work*, *36*(8), 1289–1307. https://doi.org/10.1093/bjsw/bch388

Stuckler, D., Reeves, A., Loopstra, R., Karanikolos, M., & McKee, M. (2017). Austerity and health: The impact in the UK and Europe. *European Journal of Public Health*, *27*(suppl_4), 18–21. https://doi.org/10.1093/eurpub/ckx167

Su R., Rounds J., Armstrong P. I. (2009). Men and things, women and people: A meta-analysis of sex differences in interests. *Psychological Bulletin*, 135, 859–884. https://doi.org/10.1037/a0017364

Suárez-González A, Livingston G, Low LF, Cahill S, Hennelly N, Dawson WD, Weidner W, Bocchetta M, Ferri CP, Matias-Guiu JA, Alladi S, Musyimi CW, Comas-Herrera A. (2020). *Impact and mortality of COVID-19 on people living with dementia: cross-country report*. LTCcovid.org, International Long-Term Care Policy Network, CPECLSE. https://ltccovid.org/2020/08/19/impact-and-mortality-of-covid-19-on-people-living-with-dementia-cross-country-report/

Sudbery, J. (2002). Key features of therapeutic social work: The use of relationship. *Journal of Social Work Practice*, *16*(2), 149–162. https://doi.org/10.1080/0265053022000033711

Sweeney, M. R., Boilson, A., White, C., Nevin, M., Casey, B., Boylan, P., & Staines, A. (2022). Experiences of residents, family members and staff in residential care settings for older people during COVID-19: A mixed methods study. *Journal of Nursing Management*, *30*(4), 872–882. https://doi.org/10.1111/jonm.13574

Tanay, M. A., Wiseman, T., Roberts, J., & Ream, E. (2013). A Time to weep and a time to laugh: Humour in the nurse–patient relationship in an adult cancer setting. *Supportive Care in Cancer*, *22*(5), 1295–1301. https://doi.org/10.1007/s00520-013-2084-0

Taylor, B. J. (2006). Risk management paradigms in health and Social Services for professional decision making on the long-term care of older people. *British Journal of Social Work*, *36*(8), 1411–1429. https://doi.org/10.1093/bjsw/bch406

Tellis, W. M. (1997). Introduction to Case Study. *The Qualitative Report,* 3(2), 1-14. https://doi.org/10.46743/2160-3715/1997.2024

The Guardian (2023). *Global 'silver tsunami' of older cancer patients is coming, experts warn.* Accessed June 2023. https://www.theguardian.com/society/2023/jun/05/global-silver-tsunami-of-older-cancer-patients-is-coming-experts-warn

The King's Fund (2023). *Social Care 360.* Accessed June 2024. https://www.kingsfund.org.uk/sites/default/files/2023-05/social_care-360_2023.pdf

Theurer, K., Mortenson, W. B., Stone, R., Suto, M., Timonen, V., & Rozanova, J. (2015). The need for a social revolution in residential care. *Journal of Aging Studies*, *35*, 201–210. https://doi.org/10.1016/j.jaging.2015.08.011

Todd, J. (2017). Relationship based practice: working with older people. In McColgan, M. & McMullin, C. (eds.) *Social work: A practical guide to building relationships and enabling change,* 90-102. London: Jessica Kingsley Publishers.

Tolo Heggestad,, A. K., Høy,, B., Sæteren,, B., Slettebø,, Å., Lillestø,, B., Rehnsfeldt,, A., Lindwall,, L., Lohne,, V., Råholm,, M.-B., & Aas, T. (2015). Dignity, dependence, and relational autonomy for older people living in nursing homes. *International Journal of Human Caring*, *19*(3), 42–46. https://doi.org/10.20467/1091-5710.19.3.42

Toms, G., Green, S., Orrell, A., & Verity, F. (2020). Building relational research capacity in care homes in the COVID-19 era: Applying recognition theory to the research agenda. *Quality in Ageing and Older Adults, 21*(4), 229-239.

Tresolini, C. P. (1994). *Health Professions Education and Relationship-centered Care*. Pew Health Professions Commission. Retrieved from https://idainstitute.com/fileadmin/user_upload/tx_tcfiledownload/RelationshipCentered_07.pdf

Trevithick, P. (2003). Effective relationship-based practice: A theoretical exploration. *Journal of Social Work Practice*, *17*(2), 163–176. https://doi.org/10.1080/026505302000145699

Trevithick, P. (2011) Understanding defences and defensive behaviour in social work, *Journal of Social Work Practice*, Vol. 25(4):. 389-412. https://doi.org/10.1080/02650533.2011.626642

Trevithick, P. (2014). Humanising managerialism: Reclaiming emotional reasoning, Intuition, the relationship, and knowledge and skills in Social Work. *Journal of Social Work Practice*, *28*(3), 287–311. https://doi.org/10.1080/02650533.2014.926868

Tronto, J. *(*1993*). Moral Boundaries: A Political Argument for an Ethic of Care*. New York: Routledge.

Tronto., J. (2013). *Caring Democracy: Markets, Equality, and Justice.* New York: New York University Press.

Tsui, M. and Chueng, F. (2004). Gone with the wind: The impacts of managerialism on human services. *British Journal of Social Work*, *34*(3), 437–442. https://doi.org/10.1093/bjsw/bch046

Turney, D. (2018). Sustaining Relationships: Working with Strong Feelings: Part III: Love and Positive Feelings. In Ruch, G., Turney, D., Ward, A., & Howe, D. (eds.). *Relationship-based social work: Getting to the heart of practice*. 2nd Edn. Jessica Kingsley Publishers. P.129-146.

Turnpenny, A., & Hussein, S. (2022). Migrant Home Care Workers in the UK: a Scoping Review of Outcomes and Sustainability and Implications in the Context of Brexit. *Journal of international migration and integration*, *23*(1), 23–42. https://doi.org/10.1007/s12134-021-00807-3

Twigg, J., Wolkowitz, C., Cohen, R. L., & Nettleton, S. (2011). Conceptualising body work in health and social care. *Sociology of health & illness*, *33*(2), 171–188. https://doi.org/10.1111/j.1467-9566.2010.01323.x

Vasterman, P., Yzermans, C. J., & Dirkzwager, A. J. (2005). The role of the media and media hypes in the aftermath of Disasters. *Epidemiologic Reviews*, *27*(1), 107–114. https://doi.org/10.1093/epirev/mxi002

Ward, A. (2018) *The use of self in relationship-based practice.* In Ruch, G., Turney, D., Ward, A., & Howe, D. (eds.). *Relationship-based social work: Getting to the heart of practice*. 2nd Edn. Jessica Kingsley Publishers. P 55-76.

Warner, J. (2013). Social Work, class politics and risk in the moral panic over baby P. *Health, Risk & Society*, *15*(3), 217–233. https://doi.org/10.1080/13698575.2013.776018

Warner, J. (2014). 'heads must roll'? emotional politics, the press and the death of baby P. *British Journal of Social Work*, *44*(6), 1637–1653. https://doi.org/10.1093/bjsw/bct039

Watt, R. G., Heilmann, A., Sabbah, W., Newton, T., Chandola, T., Aida, J., Sheiham, A., Marmot, M., Kawachi, I., & Tsakos, G. (2014). Social relationships and health related behaviors among older US adults. *BMC Public Health*, *14*(1). https://doi.org/10.1186/1471-2458-14-533

Waugh, F. (2010). Where does risk feature in community care practice with older people with dementia who live alone? *Dementia*, *8*(2), 205–222. https://doi.org/10.1177/1471301209103255

Weber, R. P. (1990). *Basic content analysis* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Welsh Government (2018). *Dementia action plan for Wales: 2018-2023*. Accessed March 2023. https://www.gov.wales/sites/default/files/publications/2019-04/dementia-action-plan-for-wales.pdf.

West, D., & Heath, D. (2011). Theoretical pathways to the future: Globalization, ICT and Social Work Theory and Practice. *Journal of Social Work*, *11*(2), 209–221. https://doi.org/10.1177/1468017310386835

West, D., & Heath, D. (2011). Theoretical pathways to the future: Globalization, ICT and Social Work Theory and Practice. *Journal of Social Work*, *11*(2), 209–221. https://doi.org/10.1177/1468017310386835

Wiersma, E.C. and Pedlar, A. (2008) The Nature of Relationships in Alternative Dementia Care Environments. *Canadian Journal on Aging,* 27, 101-108. http://dx.doi.org/10.3138/cja.27.1.101

Wiles, F. (2011). Blurring private–professional boundaries: Does it matter? issues in researching social work students' perceptions about professional regulation. *Ethics and Social Welfare, 5*(1), 36–51. https://doi.org/10.1080/17496535.2010.516114

Wiles, F. (2017). What is professional identity and how do social workers acquire it? In: Webb, Stephen A. (ed.) *Professional Identity and Social Work.* Routledge Academic, 35–50.

Williams, L., Ettelt, S., Perkins, M., Wittenberg, R., Lombard, D., Damant, J., & Mays, N. (2017). Will direct payments make adult residential care more personalized? Views and experiences of social care staff in the direct payments in Residential Care Trailblazers. *Social Policy & Administration*, *51*(7), 1060–1078. https://doi.org/10.1111/spol.12276

Williams, R. (2009). 'Having a laugh': Masculinities, health and humour. *Nursing Inquiry*, *16*(1), 74–81. https://doi.org/10.1111/j.1440-1800.2009.00437.x

Wilson, K, Ruch, G, Lymbery, M and Cooper, A (eds) (2011) *Social Work: An Introduction to Contemporary Practice* (2nd edn). Harlow: Pearson.

Winter, K. (2009). Relationships matter: The problems and prospects for social workers’ relationships with young children in care. *Child & Family Social Work*, *14*(4), 450–460. https://doi.org/10.1111/j.1365-2206.2009.00628.x

Witkin, S. L. (2012). An introduction to social constructions. In Witkins, S. L. (ed.) *Social Construction and social work practice: Interpretations and innovations*. Columbia University Press. P. 13 - 37

Wittenberg, R., Hu, B., Barraza-Araiza, L., & Rehill, A. (2019). *Projections of Older People with Dementia and Costs of Dementia Care in the United Kingdom, 2019– 2040*. Care Policy and Evaluation Centre, London School of Economics and Political Science.

Wong, J. 2001. The state of the profession. *Research on Social Work Practice*, 11(2): 217–222. https://doi.org/10.1177/104973150101100208

Woods, B., Spector, A. E., Jones, C. A., Orrell, M., & Davies, S. P. (2005). Reminiscence therapy for dementia. *Cochrane Database of Systematic Reviews*. https://doi.org/10.1002/14651858.cd001120.pub2

World Health Organization [WHO]. (2022). *Ageing and health.* Retrieved May 2023. https://www.who.int/news-room/fact-sheets/detail/ageing-and-health.

World Health Organization [WHO]. (2023). *Dementia*. Retrieved March 2024. https://www.who.int/news-room/fact-sheets/detail/dementia

Xie, C., Hughes, J., Chester, H., Sutcliffe, C., & Challis, D. (2014). Exploring the role of independent organisations in care coordination for older people in England. *Journal of Social Work*, *14*(4), 419–438. https://doi.org/10.1177/1468017313478330

Yang, K., & Girgus, J. S. (2018). Are women more likely than men are to care excessively about maintaining positive social relationships? A meta-analytic review of the gender difference in sociotropy. *Sex Roles*, *81*(3-4), 157–172. https://doi.org/10.1007/s11199-018-0980-y

Yin, R. (2018). *Case study research: Design and methods* (6th ed.). London: Sage.

Youell, J., Callaghan, J., & Buchanan, K. (2015). 'I don't know if you want to know this': Carers' understandings of intimacy in long-term relationships when one partner has dementia. *Ageing and Society, 36*(5), 946–967. https://doi.org/10.1017/s0144686x15000045

Zizzo, G., Mackenzie, C., Irizarry, C., & Goodwin-Smith, I. (2020). Loss and grief: The experience of transition to residential aged care. *Australian Journal of Social Issues*, *55*(4), 474–491. https://doi.org/10.1002/ajs4.105

Appendix A - Participant Information Sheets

A1: Consultee Information: Observations

PARTICIPANT INFORMATION SHEET: OBSERVATIONS

What does Relationship Based Care for People with Memory Problems look like in practice?

Information for Consultee

We feel your relative/friend is unable to decide for himself/herself whether to participate in this research.

To help decide if he/she should join the study, we'd like to ask your opinion whether or not they would want to be involved. We'd ask you to consider what you know of their wishes and feelings, and to consider their interests. Please let us know of any advance decisions they may have made about participating in research. These should take precedence.

If you decide your relative/friend would have no objection to taking part we will ask you to read and sign the consultee declaration on the last page of this information leaflet. We'll then give you a copy to keep. We will keep you fully informed during the study so you can let us know if you have any concerns or you think your relative/friend should be withdrawn.

If you decide that your friend/relative would not wish to take part it will not affect the standard of care they receive in any way.

If you are unsure about taking the role of consultee you may seek independent advice.

We will understand if you do not want to take on this responsibility.

The following information is the same as would have been provided to your relative/friend:

What is the purpose of the research?

We are conducting research on relationship-based practice for people with memory problems. The purpose of the study is to look more closely at the relationships between staff and people with memory problems to draw out exactly what makes a relationship a positive one, to look at the factors that contribute to positive relationships and how future guidelines and policy might incorporate these into practice. Your relative / friend's participation in this study will take approximately six hours, across three separate two hour visits.

Who is carrying out the research?

The data is being collected by Faye Grinter, from the Centre of Innovative Ageing within the College of Human and Health Sciences. The research has been approved by the College of Human and Health Sciences Research Ethics Committee and the NHS Research Ethics Committee.

What does participation involve?

The researcher will come to spend some time observing the day-to-day happenings at your relative / friend's residential home. They will not take part in any activities but will instead observe and record details of the practice that is taking place. Your relative / friend will not be asked to do anything other than continue with their day as usual. Additionally the researcher will ask for some background information including age, sex and if they have a diagnosis of dementia.

Are there any risks associated with taking part?

The research has been approved by the College of Human and Health Sciences Research Ethics Committee. There are no significant risks associated with participation.

Data Protection and Confidentiality

Your relative / friend's data will be processed in accordance with the Data Protection Act 2018 and the General Data Protection Regulation 2016 (GDPR). All information collected about your relative / friend will be kept strictly confidential. Their data will only be viewed by the researcher.

All electronic data will be stored on a password-protected computer file in Swansea University. All paper records will be stored in a locked filing cabinet at Swansea University. Your relative / friend's consent information will be kept separately from their responses to minimise risk in the event of a data breach.

Please note that the data we will collect for our study will be made anonymous, at the point of collection, thus it will not be possible to identify and remove data at a later date, should you decide to withdraw your relative / friend from the study.

What will happen to the information provided?

An analysis of the information will form part of our report at the end of the study and may be presented to interested parties and published in scientific journals and related media. *Note that all information presented in any reports or publications will be anonymous and unidentifiable*.

Is participation voluntary and what if I wish to later withdraw?

Participation is entirely voluntary. If you decide to agree to your relative / friend's participate, but later wish to withdraw from them from the study, then you are free to withdraw at any time, without giving a reason and without penalty. This will not affect their care in any way.

Data Protection Privacy Notice

The data controller for this project will be Swansea University. The University Data Protection Officer provides oversight of university activities involving the processing of personal data, and can be contacted at the Vice Chancellors Office.

Your relative / friend's personal data will be processed for the purposes outlined in this information sheet.

The legal basis that we will rely on to process your personal data will be processing is necessary for the performance of a task carried out in the public interest. This public interest justification is approved by the College of Human and Health Sciences Research Ethics Committee, Swansea University.

The legal basis that we will rely on to process special categories of data will be processing is necessary for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes.

How long will your relative / friend's information be held?

We will hold any personal data and special categories of data for four months, or until the completion of all data collection.

What are their rights?

Your relative / friend has a right to access their personal information, to object to the processing of their personal information, to rectify, to erase, to restrict and to port their personal information. Please visit the University Data Protection webpages for further information in relation to their rights.

Any requests or objections should be made in writing to the University Data Protection Officer:-

University Compliance Officer (FOI/DP)
Vice-Chancellor's Office
Swansea University
Singleton Park
Swansea
SA2 8PP
Email: dataprotection@swansea.ac.uk

How to make a complaint

If you are unhappy with the way in which your relative / friend's personal data has been processed you may in the first instance contact the head of the College of Human and Health Sciences at Swansea University:

Professor Ceri Phillips

College of Human and Health Sciences
First Floor, Vivian Tower,
Singleton Campus
Swansea
SA2 8PP
Email: [redacted]

If you remain dissatisfied, then you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at: -

Information Commissioner's Office,
Wycliffe House,
Water Lane,
Wilmslow,
Cheshire,
SK9 5AF
www.ico.org.uk

What if I have other questions?
If you have further questions about this study, please do not hesitate to contact us:

Faye Grinter College of Human and Health Sciences [redacted]	Prof. Fiona Verity College of Human and Health Sciences [redacted]

A2: Consultee Information: Interviews

PARTICIPANT INFORMATION SHEET: INTERVIEWS

What does Relationship Based Care for People with Memory Problems look like in practice?

Information for Consultee

We feel your relative/friend is unable to decide for himself/herself whether to participate in this research.

To help decide if he/she should join the study, we'd like to ask your opinion whether or not they would want to be involved. We'd ask you to consider what you know of their wishes and feelings, and to consider their interests. Please let us know of any advance decisions they may have made about participating in research. These should take precedence.

If you decide your relative/friend would have no objection to taking part we will ask you to read and sign the consultee declaration on the last page of this information leaflet. We'll then give you a copy to keep. We will keep you fully informed during the study so you can let us know if you have any concerns or you think your relative/friend should be withdrawn.

If you decide that your friend/relative would not wish to take part it will not affect the standard of care they receive in any way.

If you are unsure about taking the role of consultee you may seek independent advice.

We will understand if you do not want to take on this responsibility.

The following information is the same as would have been provided to your relative/friend:

What is the purpose of the research?

We are conducting research on relationship based practice for people with memory problems. The purpose of the study is to look more closely at the relationships between staff and people with memory problems to draw out exactly what makes a relationship a positive one, to look at the factors that contribute to positive relationships and how future guidelines and policy might incorporate these into practice. Your relative / friend’s participation in this study will take approximately six hours, across three separate two hour visits.

Who is carrying out the research?

The data is being collected by Faye Grinter, from the Centre of Innovative Ageing within the College of Human and Health Sciences. The research has been approved by the College of Human and Health Sciences Research Ethics Committee and the NHS Research Ethics Committee.

What does participation involve?

The researcher will conduct an informal interview with your friend / relative, which will take place in a location where they are comfortable and will also ensure their privacy. The researcher will ask questions, giving your friend /relative plenty of time to answer at their own pace. They do not have to answer every question and are free to pause or stop the interview at any time. The interview will be recorded using an audio recorder.

Are there any risks associated with taking part?

The research has been approved by the College of Human and Health Sciences Research Ethics Committee. There are no significant risks associated with participation.

Data Protection and Confidentiality

Your relative / friend’s data will be processed in accordance with the Data Protection Act 2018 and the General Data Protection Regulation 2016 (GDPR). All information collected about your relative / friend will be kept strictly confidential. Their data will only be viewed by the researcher.

All electronic data will be stored on a password-protected computer file in Swansea University. All paper records will be stored in a locked filing cabinet at Swansea University. Your relative / friend’s consent information will be kept separately from their responses to minimise risk in the event of a data breach.

Please note that the data we will collect for our study will be made anonymous, at the point of collection, thus it will not be possible to identify and remove data at a later date, should you decide to withdraw your relative / friend from the study.

What will happen to the information provided?

An analysis of the information will form part of our report at the end of the study and may be presented to interested parties and published in scientific journals and related media. *Note that all information presented in any reports or publications will be anonymous and unidentifiable*.

Is participation voluntary and what if I wish to later withdraw?

Participation is entirely voluntary. If you decide to agree to your relative / friend’s participate, but later wish to withdraw from them from the study, then you are free to withdraw at any time, without giving a reason and without penalty. This will not affect their care in any way.

Data Protection Privacy Notice

The data controller for this project will be Swansea University. The University Data Protection Officer provides oversight of university activities involving the processing of personal data, and can be contacted at the Vice Chancellors Office.

Your relative / friend’s personal data will be processed for the purposes outlined in this information sheet.

The legal basis that we will rely on to process your personal data will be processing is necessary for the performance of a task carried out in the public interest. This public interest justification is approved by the College of Human and Health Sciences Research Ethics Committee, Swansea University.

The legal basis that we will rely on to process special categories of data will be processing is necessary for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes.

How long will your relative / friend's information be held?

We will hold any personal data and special categories of data for four months, or until the completion of all data collection.

What are their rights?

Your relative / friend has a right to access their personal information, to object to the processing of their personal information, to rectify, to erase, to restrict and to port their personal information. Please visit the University Data Protection webpages for further information in relation to their rights.

Any requests or objections should be made in writing to the University Data Protection Officer:-

University Compliance Officer (FOI/DP)
Vice-Chancellor's Office
Swansea University
Singleton Park
Swansea
SA2 8PP
Email: dataprotection@swansea.ac.uk

How to make a complaint

If you are unhappy with the way in which your relative / friend's personal data has been processed you may in the first instance contact the head of the College of Human and Health Sciences at Swansea University:

Professor Ceri Phillips
College of Human and Health Sciences
First Floor, Vivian Tower,
Singleton Campus

Swansea
SA2 8PP
Email:[redacted]

If you remain dissatisfied then you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at: -

Information Commissioner’s Office,
Wycliffe House,
Water Lane,
Wilmslow,
Cheshire,
SK9 5AF
www.ico.org.uk

What if I have other questions?

If you have further questions about this study, please do not hesitate to contact us:

Faye Grinter	Prof. Fiona Verity
College of Human and Health Sciences	College of Human and Health Sciences
[redacted]	[redacted]

A3: Participant Information: Observations

PARTICIPANT INFORMATION SHEET: OBSERVATIONS

What does Relationship Based Care for People with Memory Problems look like in practice?

You are being invited to take part in some research. Before you decide whether or not to participate, it is important for you to understand why the research is being conducted and what it will involve. Please read the following information carefully.

What is the purpose of the research?

We are conducting research on relationship based practice for people with memory problems. The purpose of the study is to look more closely at the relationships between staff and people with memory problems to draw out exactly what makes a relationship a positive one, to look at the factors that contribute to positive relationships and how future guidelines and policy might incorporate these into practice. Your participation in this study will take approximately six hours, across three separate two hour visits.

Who is carrying out the research?

The data is being collected by Faye Grinter, from the Centre of Innovative Ageing within the College of Human and Health Sciences. The research has been approved by the College of Human and Health Sciences Research Ethics Committee and the NHS Research Ethics Committee.

What happens if I agree to take part?

The researcher will come to spend some time observing the day-to-day happenings at your residential home. They will not take part in any activities, but will instead observe and record details of the practice that is taking place. You will not be asked to do anything other than continue with your day as usual. Additionally the researcher will ask for some background information including your age, sex and if you have a diagnosis of dementia.

Are there any risks associated with taking part?

The research has been approved by the College of Human and Health Sciences Research Ethics Committee. There are no significant risks associated with participation.

Data Protection, Privacy Notice and Confidentially

Swansea University is the sponsor for this study based in the United Kingdom.
We will be using information from you in order to undertake this study and will act as the data controller for this study.

This means that we are responsible for looking after your information and using it properly. Swansea University will keep identifiable information about you for 3 months after the study has finished. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate.

If you withdraw from the study, we will keep the information about you that we have already obtained.To safeguard your rights, we will use the minimum personally-identifiable information possible. You can find out more about how we use your information at resgov@swansea.ac.uk

Please note that the data we will collect for our study will be made anonymous, at the point of collection, thus it will not be possible to identify and remove your data at a later date, should you decide to withdraw from the study. Therefore, if at the end of this research you decide to have your data withdrawn, please let us know before you leave. Research Data (non identifiable) will be kept for 4 years after the study has finished.

What will happen to the information I provide?

An analysis of the information will form part of our report at the end of the study and may be presented to interested parties and published in scientific journals and related media. *Note that all information presented in any reports or publications will be anonymous and unidentifiable.*

Is participation voluntary and what if I wish to later withdraw?

Your participation is entirely voluntary – you do not have to participate if you do not want to. If you decide to participate, but later wish to withdraw from the study, then you are free to withdraw at any time, without giving a reason and without penalty.

Data Protection Privacy Notice

The data controller for this project will be Swansea University. The University Data Protection Officer provides oversight of university activities involving the processing of personal data, and can be contacted at the Vice Chancellors Office.

Your personal data will be processed for the purposes outlined in this information sheet. Standard ethical procedures will involve you providing your consent to participate in this study by completing the consent form that has been provided to you.

The legal basis that we will rely on to process your personal data will be processing is necessary for the performance of a task carried out in the public interest. This public interest justification is approved by the College of Human and Health Sciences Research Ethics Committee, Swansea University.

The legal basis that we will rely on to process special categories of data will be processing is necessary for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes.

How long will your information be held?

We will hold any personal data and special categories of data for four months, or until the completion of all data collection.

What are your rights?

You have a right to access your personal information, to object to the processing of your personal information, to rectify, to erase, to restrict and to port your personal information. Please visit the University Data Protection webpages for further information in relation to your rights.

Any requests or objections should be made in writing to the University Data Protection Officer:-

University Compliance Officer (FOI/DP)
Vice-Chancellor’s Office
Swansea University
Singleton Park
Swansea
SA2 8PP
Email: dataprotection@swansea.ac.uk

How to make a complaint

If you are unhappy with the way in which your personal data has been processed you may in the first instance contact the University Data Protection Officer using the contact details above.

If you remain dissatisfied then you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at: -

Information Commissioner’s Office,
Wycliffe House,
Water Lane,
Wilmslow,
Cheshire,
SK9 5AF
www.ico.org.uk

If you have further questions about this study, please do not hesitate to contact us:

Faye Grinter	Prof. Fiona Verity
College of Human and Health Sciences	College of Human and Health Sciences
	[redacted]

A4: Participant Information: Interviews

PARTICIPANT INFORMATION SHEET: INTERVIEWS

What does Relationship Based Care for People with Memory Problems look like in practice?

You are being invited to take part in some research. Before you decide whether or not to participate, it is important for you to understand why the research is being conducted and what it will involve. Please read the following information carefully.

What is the purpose of the research?

We are conducting research on relationship based practice for people with memory problems. The purpose of the study is to look more closely at the relationships between staff and people with memory problems to draw out exactly what makes a relationship a positive one, to look at the factors that contribute to positive relationships and how future guidelines and policy might incorporate these into practice. Your participation in this study will take approximately 30 minutes.

Who is carrying out the research?

The data is being collected by Faye Grinter, from the Centre of Innovative Ageing within the College of Human and Health Sciences. The research has been approved by the College of Human and Health Sciences Research Ethics Committee and the NHS Research Ethics Committee.

What happens if I agree to take part?

The researcher will conduct an informal interview with you, which will take place in a location where you are comfortable and will also ensure your privacy. The researcher will ask questions, giving you plenty of time to answer at your own pace. You do not have to answer every question and are free to pause or stop the interview at any time. The interview will be recorded using an audio recorder.

Are there any risks associated with taking part?

The research has been approved by the College of Human and Health Sciences Research Ethics Committee. There are no significant risks associated with participation.

Data Protection, Privacy Notice and Confidentially

Swansea University is the sponsor for this study based in the United Kingdom.
We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Swansea University will keep identifiable information about you for 3 months after the study has finished. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate.

If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible. You can find out more about how we use your information at resgov@swansea.ac.uk

Please note that the data we will collect for our study will be made anonymous, at the point of collection, thus it will not be possible to identify and remove your data at a later date, should you decide to withdraw from the study. Therefore, if at the end of this research you decide to have your data withdrawn, please let us know before you leave. Research Data (non identifiable) will be kept for 4 years after the study has finished.

What will happen to the information I provide?

An analysis of the information will form part of our report at the end of the study and may be presented to interested parties and published in scientific journals and related media. *Note that all information presented in any reports or publications will be anonymous and unidentifiable*.

Is participation voluntary and what if I wish to later withdraw?

Your participation is entirely voluntary – you do not have to participate if you do not want to. If you decide to participate, but later wish to withdraw from the study, then you are free to withdraw at any time, without giving a reason and without penalty.

Data Protection Privacy Notice

The data controller for this project will be Swansea University. The University Data Protection Officer provides oversight of university activities involving the processing of personal data, and can be contacted at the Vice Chancellors Office.

Your personal data will be processed for the purposes outlined in this information sheet. Standard ethical procedures will involve you providing your consent to participate in this study by completing the consent form that has been provided to you.

The legal basis that we will rely on to process your personal data will be processing is necessary for the performance of a task carried out in the public interest. This public interest justification is approved by the College of Human and Health Sciences Research Ethics Committee, Swansea University.

The legal basis that we will rely on to process special categories of data will be processing is necessary for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes.

How long will your information be held?

We will hold any personal data and special categories of data for four months, or until the completion of all data collection.

What are your rights?

You have a right to access your personal information, to object to the processing of your personal information, to rectify, to erase, to restrict and to port your personal information. Please visit the University Data Protection webpages for further information in relation to your rights.

Any requests or objections should be made in writing to the University Data Protection Officer:-

University Compliance Officer (FOI/DP)
Vice-Chancellor's Office
Swansea University
Singleton Park
Swansea
SA2 8PP
Email: dataprotection@swansea.ac.uk

How to make a complaint

If you are unhappy with the way in which your personal data has been processed you may in the first instance contact the University Data Protection Officer using the contact details above.

If you remain dissatisfied then you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at: -

Information Commissioner's Office,
Wycliffe House,
Water Lane,
Wilmslow,
Cheshire,
SK9 5AF
www.ico.org.uk

What if I have other questions?

If you have further questions about this study, please do not hesitate to contact us:

Faye Grinter College of Human and Health Sciences	Prof. Fiona Verity College of Human and Health Sciences [redacted]

[redacted]

Appendix B – Participant Consent Form

Swansea University
Prifysgol Abertawe

Participant Consent Form

What does Relationship Based Care for People with Memory Problems look like in practice?

Name and Contact details of the principal researcher:

		Participant Initial
1.	I (the participant) confirm that I have read and understand the information sheet for the above study.	
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reasons.	
3.	I understand what my role will be in this research, and all my questions have been answered to my satisfaction.	
4.	I understand that I am free to ask any questions at any time before and during the study.	
5.	I have been informed that the information I provide will be safeguarded.	
6.	I am happy for the information I provide to be used (anonymously) in academic papers and other formal research outputs.	
7.	I am willing for my information to be audio recorded **(Interview and Focus Group Only)**	
8.	I have been provided with a copy of the Participant Information Sheet.	
9.	I agree to the researcher processing my personal data in accordance with the aims of the study described in the Participant Information Sheet.	

Thank you for your participation in this study. Your help is very much appreciated.

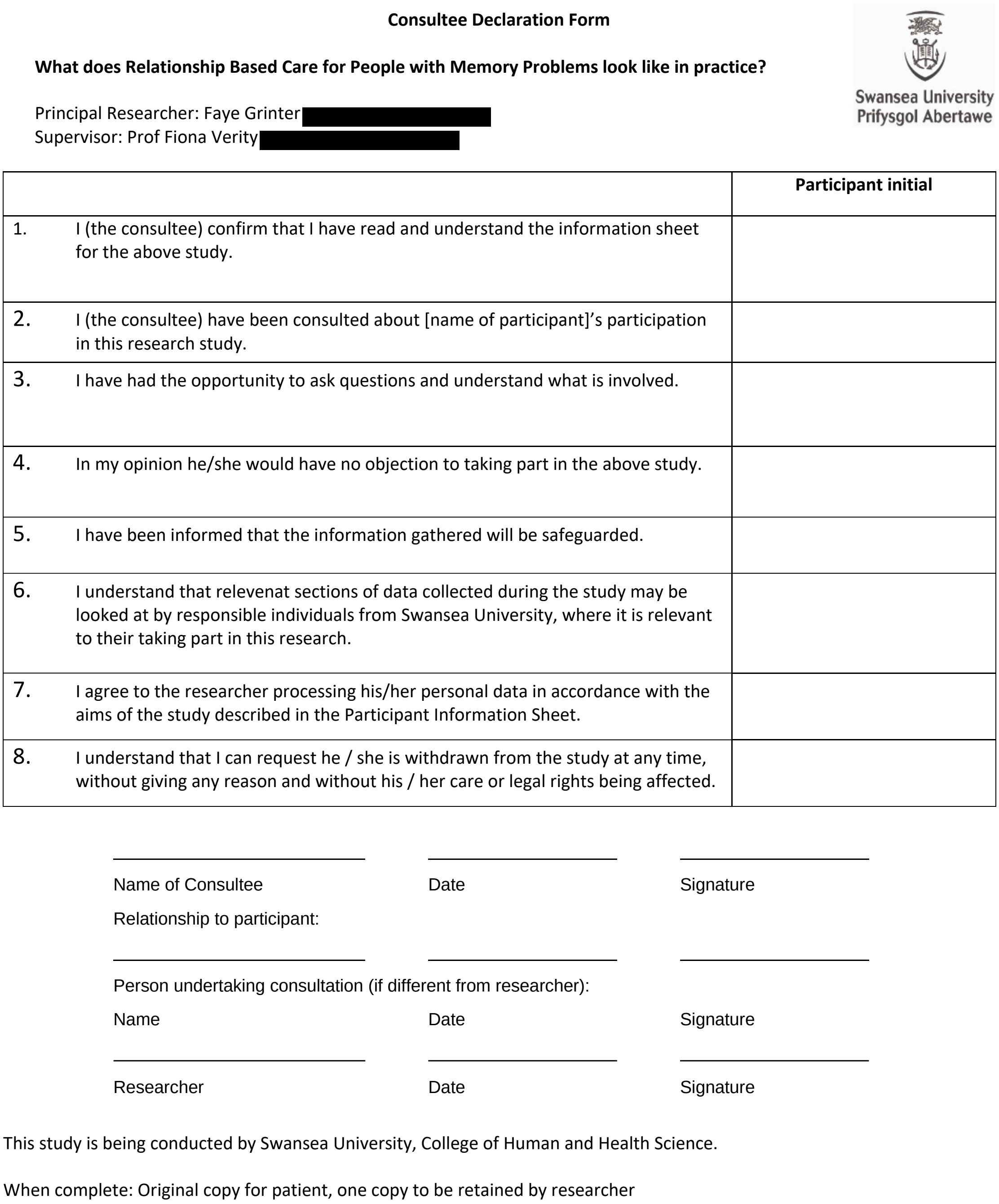
Print name of participant   Signature   Date

Print name of researcher   Signature   Date

This study is being conducted by Swansea University, College of Human and Health Science.

When complete: Original copy for patient, one copy to be retained by researcher

Appendix C – Consultee Declaration Form



Consultee Declaration Form

What does Relationship Based Care for People with Memory Problems look like in practice?

Principal Researcher: Faye Grinter [redacted]
Supervisor: Prof Fiona Verity [redacted]

Swansea University
Prifysgol Abertawe

		Participant initial
1.	I (the consultee) confirm that I have read and understand the information sheet for the above study.	
2.	I (the consultee) have been consulted about [name of participant]'s participation in this research study.	
3.	I have had the opportunity to ask questions and understand what is involved.	
4.	In my opinion he/she would have no objection to taking part in the above study.	
5.	I have been informed that the information gathered will be safeguarded.	
6.	I understand that relevenat sections of data collected during the study may be looked at by responsible individuals from Swansea University, where it is relevant to their taking part in this research.	
7.	I agree to the researcher processing his/her personal data in accordance with the aims of the study described in the Participant Information Sheet.	
8.	I understand that I can request he / she is withdrawn from the study at any time, without giving any reason and without his / her care or legal rights being affected.	

Name of Consultee — Date — Signature

Relationship to participant:

Person undertaking consultation (if different from researcher):

Name — Date — Signature

Researcher — Date — Signature

This study is being conducted by Swansea University, College of Human and Health Science.

When complete: Original copy for patient, one copy to be retained by researcher

Appendix D – Observation Template

Direct Observation Form

Setting *(1, 2 or 3)*	
People *(Number: xx, xx, xx).*	Number of service users, Number of support staff
Time	
Duration	
Event	
Setting *(details of physical environment eg. room size, décor, seating available, information on walls etc)*	
Atmosphere *(ambience, mood of participants, levels of noise etc.)*	
Observations *To Include:* - *Communications between residents* - *Communications between support workers* - *Non verbal communications* - *Touch* - *Conversation topics (task based only?)*	

Direct Observation Form

Observations (cont.)	
Further Notes	
Photos* Taken (Y/N)	* of publically displayed organisational information only (with permission). **Not** images of participants.

Appendix E – Interview Guides

E1: Interview Guide (People in receipt of services)

Introduction

Hello my name is Researcher Name and I'm a PhD Research Student with Swansea University.

I'm interviewing you as part of my PhD looking at relationship based practice with people with memory problems. I came _______ weeks ago to see what the day to day life here looks like and would like to ask you some questions to follow up my observations.

I hope to use what we talk about to get a better idea of what makes a relationship with support staff an effective one, and what effect any positive relationships have had on you.

Managing Risks, Rights and Responsibilities

How long have you been *living/staying* here? (*Dependant on setting)*

What is a typical day here like for you?

What types of opportunities do you get? (*eg activities, freedom of choice to participate)*

Relationships

I will be asking you some questions about the relationships you have with the people who work here – what comes to mind when you think about those relationships?

How do you get on with people here?

What about that relationship do you feel makes it positive / negative? *(Phrase depending on individual's response).*

What could that individual have done to make you feel more comfortable / cared for / valued etc.? *(Phrase depending on individual's response).*

What do you value in a relationship? *(With peers, support staff, family)*

Have you found relationships have changed as you have got older / developed problems with your memory?

Professional Boundaries

How do you feel support staff here interact with residents?

When thinking about relationships with support staff, is there anything you would like to change?

Closing

Is there anything else you would like to share with me?
Thank you very much for you time.

E2: Interview Guide (Staff providing support for people with dementia)

Introduction

Hello my name is Researcher Name and I'm a PhD Research Student with Swansea University.

I'm interviewing you as part of my PhD looking at relationship based practice with people with memory problems. I came _______ weeks ago to see what the day to day life here looks like and would like to ask you some questions to follow up my observations.

I hope to use what we talk about to get a better idea of what exactly makes working relationships between service users and staff effective and positive.

Relationships

What comes to mind when you think about relationships?

What do you value in relationships with service users?

What is important in making a relationship with service users positive and effective?

Are there any examples of difficult relationships with service users? How do you negotiate those relationships?(*if answered yes).*

Do you feel memory problems / dementia has an impact on caring relationships?

Managing Rights, Risks and Responsibilities

What is a typical working day like for you here?

How are service users encouraged to make decisions or choices?

How do you balance service users’ rights with managing risks?

Professional Boundaries

How do you manage boundaries in relationships with service users?

Do you feel professional boundaries support effective working relationships? (Yes/No response) How?

If you could make any changes to policy or guidelines around relationships with service users, what would those changes be?

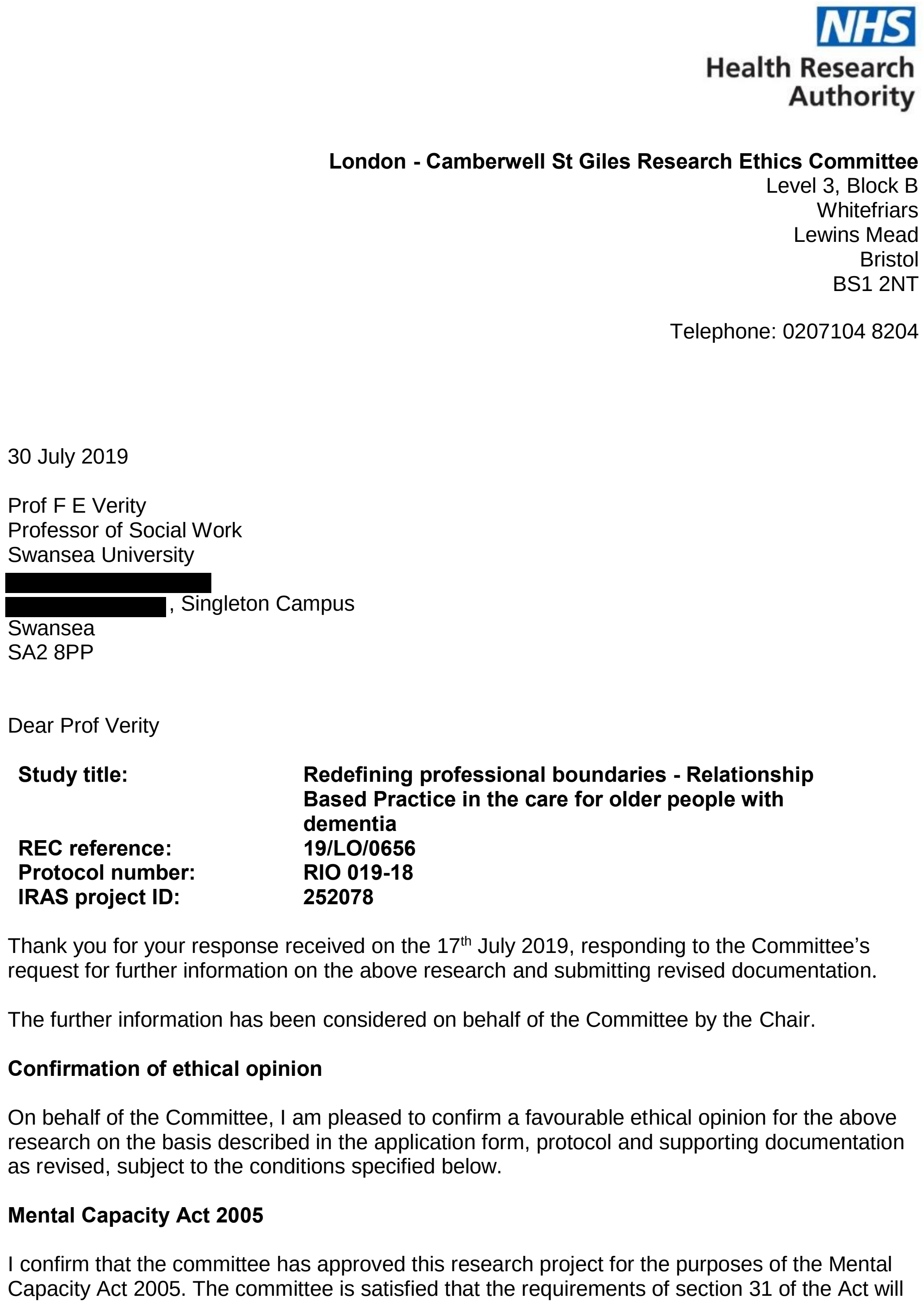
Closing

Is there anything else you would like to share with me?

Thank you very much for you time.

Appendix F – Ethical Approval

F1: NHS Health Research Authority ethical approval



NHS
Health Research
Authority

London - Camberwell St Giles Research Ethics Committee
Level 3, Block B
Whitefriars
Lewins Mead
Bristol
BS1 2NT

Telephone: 0207104 8204

30 July 2019

Prof F E Verity
Professor of Social Work
Swansea University
[redacted]
[redacted], Singleton Campus
Swansea
SA2 8PP

Dear Prof Verity

Study title:	**Redefining professional boundaries - Relationship Based Practice in the care for older people with dementia**
REC reference:	**19/LO/0656**
Protocol number:	**RIO 019-18**
IRAS project ID:	**252078**

Thank you for your response received on the 17th July 2019, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Mental Capacity Act 2005

I confirm that the committee has approved this research project for the purposes of the Mental Capacity Act 2005. The committee is satisfied that the requirements of section 31 of the Act will be met in relation to research carried out as part of this project on, or in relation to, a person who lacks capacity to consent to taking part in the project.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

It is a condition of the REC favourable opinion that all clinical trials are registered on a publicly accessible database. For this purpose, clinical trials are defined as the first four project categories in IRAS project filter question 2. For clinical trials of investigational medicinal products (CTIMPs), other than adult phase I trials, registration is a legal requirement.

Registration should take place as early as possible and within six weeks of recruiting the first research participant at the latest. Failure to register is a breach of these approval conditions, unless a deferral has been agreed by or on behalf of the Research Ethics Committee (see here for more information on requesting a deferral: https://www.hra.nhs.uk/planning-and-improving-research/research-planning/research-registration-research-project-identifiers/

As set out in the UK Policy Framework, research sponsors are responsible for making information about research publicly available before it starts e.g. by registering the research project on a publicly accessible register. Further guidance on registration is available at: https://www.hra.nhs.uk/planning-and-improving-research/research-planning/transparency-responsibilities/

You should notify the REC of the registration details. We will audit these as part of the annual progress reporting process.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

After ethical review: Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study, including early termination of the study
- Final report

The latest guidance on these topics can be found at https://www.hra.nhs.uk/approvals-amendments/managing-your-approval/.

Ethical review of research sites

NHS/HSC sites

The favourable opinion applies to all NHS/HSC sites listed in the application subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor Insurance Confirmation]		23 January 2019
Interview schedules or topic guides for participants [Observation Template]	2	11 March 2019
Interview schedules or topic guides for participants [Interview Guide]	2	11 March 2019
IRAS Checklist XML [Checklist_17072019]		17 July 2019
Letter from funder [Funder Letter]		07 December 2018
Letters of invitation to participant [Consultee Letter]	1	11 March 2019
Letters of invitation to participant [Participant Letter]	1	11 March 2019
Other [Student CV]	1	10 April 2019
Other [Assurance Letter]	1	06 July 2019
Other [Training Evidence]	1	19 December 2018
Other [Training Evidence]	1	10 July 2019
Other [Applicant Responses to REC]	1	10 July 2019
Participant consent form [Consultee Declaration Form]	2	11 March 2019
Participant information sheet (PIS) [PIS Direct Observation]	4	11 July 2019
Participant information sheet (PIS) [PIS Direct Observation (tracked version)]	4	17 July 2019
Participant information sheet (PIS) [PIS Interviews (tracked version)]	1	17 July 2019
Participant information sheet (PIS) [PIS Focus Groups (tracked version)]	1	17 July 2019

Participant information sheet (PIS) [PIS Interviews]	4	11 July 2019
Participant information sheet (PIS) [PIS Focus Groups]	4	11 July 2019
REC Application Form [SC_Form_25032019]		25 March 2019
Research protocol or project proposal [Case Study Protocol]	2	11 March 2019
Summary CV for Chief Investigator (CI) [CI / Supervisor CV]		10 April 2019

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improving-research/learning/

19/LO/0656	**Please quote this number on all correspondence**

With the Committee’s best wishes for the success of this project.

Yours sincerely
[redacted]
Pp

Mr John Richardson
Chair

Enclosures: “After ethical review – guidance for researchers”
Copy to: Dr Sherrill Snelgrove