# Doing What Makes Sense:

# Locating Knowledge about Person-Centred Care in the

# Everyday Logics of Long-Term Care

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# ABSTRACT

Addressing criticisms of the routine-driven, task-oriented, depersonalising nature of conventional services, and reflecting a broader trend across health and social care, *person-centred care* has become the watchword for quality in long-term care for older people in recent years. Person-centred care requires recognising the unique personhood of each individual regardless of their physical or mental capacity. Efforts to realise this approach depend largely on the non-professional nursing staff who deliver the majority of direct care in this context. However, little is known about how new knowledge, including ideas and evidence about person-centred care, translates into the daily practices of this cadre of staff, who have little formal training, low job status, and limited access to traditional forms of research dissemination and knowledge exchange.

Building on the existing knowledge-translation literature, therefore, the aim of this study was to explore the mechanisms of knowledge translation about person-centred care among care assistants in long-term care. The objectives were to examine how these staff develop their understanding of person-centred care; identify the personal and contextual factors involved; and explore what can be learned about person-centred care from their current practices. The study used ethnographic methods, including 500 hours of participant observation, in-depth interviews, and document analysis, to conduct case studies of two private nursing homes located in the East Midlands and the north-eastern United States. Without claiming to demonstrate causality, extending the research across two policy settings did facilitate the identification of pertinent issues within and beyond each individual facility. Data analysis was informed by *practice theory*, which provided an alternative to the individualist assumptions which characterise popular representations of long-term care, on the one hand, and, on the other, structural explanations that renounce individual agency altogether.

From this theoretical perspective, drawing in particular on Bourdieu's theory of *practical logic* and the neo-institutional concept of *institutional logics*, this study identified how the interconnection of particular practices within each setting produced different situated understandings and implementation of person-centred care. A key finding was that care

assistants' individualised knowledge about each resident, obtained through their direct daily care, represented an important form of symbolic capital in this field. Their willingness or reluctance to share such knowledge, consequently, corresponded to the extent to which other practices, including communication and teamwork, supported or threatened this limited source of power. The second, related finding was that care assistants derived from this individualised knowledge a certain amount of autonomy, or discretion, over the organisation and delivery of daily care. This discretion, together with the agency that care assistants exercised in navigating different institutional logics in this context of care − which was the third main finding − signified a potential nexus of practice change. Conversely, new knowledge or ideas that undermined this limited discretion and agency tended to engender denial or resistance.

As the population ages, demand for long-term care for older people is increasing exponentially, prompting concerns about the capacity and sustainability of this sector. One significant area of concern is workforce recruitment, retention, and competence. This study, located at the intersection of research on long-term care and knowledge translation, contributes to efforts to address these concerns by identifying opportunities for intervention in education, training, and support, in order to build a workforce that is equipped to provide high-quality, evidence-based, person-centred care for older people throughout the years ahead.

# ACKNOWLEDGEMENTS

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## ABBREVIATIONS

ADLs                    Activities of Daily Living, which include bathing, dressing, eating, and toilet care

CQC                     Care Quality Commission (UK)

CMS                     Centers for Medicare and Medicaid (US)

CNA                     Certified Nursing Assistant (US)

IADLs                   Instrumental Activities of Daily Living, such as finances, transportation, housework, and communications

IOM                     Institute of Medicine (US)

KT                      Knowledge Translation

LPN                     Licensed Practical Nurse (US)

MDS                     Minimum Data Set (US)

NHS                     National Health Service (UK)

NICE                    National Institute for Health and Clinical Excellence (UK)

NIHR                    National Institute for Health Research (UK)

LTC                     Long-Term Care

OBRA-87                 1987 Omnibus Budget Reconciliation Act (US)

OECD                    Organisation for Economic Co-operation and Development

PCC                     Person-Centred Care

RAI                     Resident Assessment Instrument (US)

RN                      Registered Nurse

SCIE                    Social Care Institute for Excellence (UK)

## PREFACE

On a sunny afternoon in July 2010, less than six months after starting this research project, I received a telephone call from my aunt. "It's your dad," she said in a wavering voice, "he's okay but … he's had a stroke." That was just the first in a series of strokes that were caused, we later learned, by fragments of a tumour that had been quietly growing in the left atrium of his heart. A year later, life-saving surgery removed the tumour and significantly reduced the risk of further strokes. However, the physical and mental damage had already been done. Just before that first stroke, my father had been healthy and active, still working long hours during the week and covering centuries on his bicycle most weekends. Today, despite gains achieved through countless hours of intensive therapy, he remains in institutional care, requires considerable daily assistance, and struggles with basic movements and communication.

My dad has lost so much in terms of capacity, independence, and autonomy. But there is much that endures: his calm and capable presence, his boundless generosity, his silly sense of humour, his appreciation of simple pleasures, his stubborn will, his ready smile and strong (left-handed, now) handshake. He also understands much more than he can express, especially when addressed clearly and directly and monitored for signs of comprehension or confusion. All of this is eminently clear (and important) to me, but not necessarily to those who did not know him previously; strangers might see just another confused old man with a cane who cannot care for himself.

As I have followed my dad's journey through the acute medical system and into long-term care (LTC), I have come to understand person-centred care (PCC) as more than policy jargon or a buzzword for practice. Person-centred care provides the discursive resources (and some practical tools) to bring my dad back into the frame as an individual, rather than anonymising him as an undifferentiated recipient of care. He is *not* just an old man with a cane. Neither is that other resident just an old lady in a wheelchair, or that one "a dementia". Every older person living in LTC has a back story, just like my dad. Once, they did not live in a care home, and now they do. Their health and circumstances may have changed but their personhood – that complex constellation of memories, personality, relationships, moods and emotions, talents and flaws that makes every person unique – persists. Person-centred care aims to recognise and support personhood as the basis on which to develop care that is appropriate and acceptable to each individual, and which promotes, to the extent possible, opportunities for independence, meaningful interaction, and reciprocity.

After taking six months' leave to support my parents, I returned to my nascent research project with a new, deeply personal appreciation of the importance but also the immense challenges of implementing PCC. How can care be person-centred when those on the receiving end cannot express themselves or advocate for their own needs, due to cognitive or communicative impairments? Can care be person-centred in a routine-driven institutional setting, given the obvious pressures on time and resources? Does PCC even *make sense* to those who are required to implement it? With these questions in mind, I put on my care assistant's uniform, laced up my sensible shoes, and went into the field in search of answers.

## CHAPTER 1: INTRODUCTION

*When I went over to the east wing, Yolanda said again (as she'd said at supper when I'd asked her about doing an interview): "It'll be like, you know that book, 'The Help'!" When the others laughed, she said "I don't know why you're all laughing!" and Rianna called out, "yeah, we can call it 'The Aide'!"*

(Fieldnote, Richardson's, Shift 24)

## 1.1    Aim and objectives of the research

This doctoral research project uses ethnographic methods to explore how person-centred care (PCC) translates into practice in long-term residential care settings for older people. The research builds on an ethnographic study of dementia care in the National Health Service (NHS) that was funded by the National Institute for Health Research (NIHR) in 2008/2009 (Schneider et al., 2010). In that study, which included conducting participant observation as a health-care assistant in a large teaching hospital, I became interested in the situated and embodied knowledge and skills practised by this large – but largely unrecognised – group of staff. I concluded the study with lingering questions about how these auxiliary workers develop their expertise, and with what implications for the implementation of new ideas, evidence, and practices, which I decided to explore further in the long-term care (LTC) context.

I was fortunate to be supported in this ambition by the Collaboration for Leadership in Applied Health Research and Care for Nottinghamshire, Derbyshire, and Lincolnshire

(CLAHRC-NDL), which was one of nine CLAHRCs throughout England that were funded by the NIHR to foster the translation of evidence into practice in health and social care. CLAHRC-NDL adopted an organisational-learning approach, recognising the situated, social nature of learning, with the aim of co-producing evidence within the specific context(s) of its proposed implementation (Rowley et al., 2012). This represents the backdrop against which the current study was developed.

The aim of this study was to investigate how non-professional nursing staff in LTC facilities for older people engage in knowledge translation (KT) about PCC. Three specific objectives were developed to address this aim:

1. To describe how/by what means non-professional nursing staff in LTC develop their understanding of PCC.
2. To identify and assess the significance of personal and contextual factors on the process of KT among these staff.
3. To analyse what can be learned from their practices about PCC in LTC.

In order to explore these objectives, and building on the precedent of the previous study on inpatient dementia care, I developed an ethnographic design for this study. Specifically, taking a loosely comparative approach, I conducted participant observation and in-depth interviews in two care homes which have explicitly adopted PCC as a new model of care. One facility, which I have called Richardson's, is located in New York State, while the other, Forest Lodge, is located in the East Midlands of England. They are both medium-sized skilled nursing facilities located in small towns, and the client base for both is predominantly

white and relatively affluent. Both are privately owned, although Richardson's is a long-established family business while Forest Lodge is the fairly recent acquisition of a large international care-home operator. Both are highly rated facilities which, in their commitment to providing PCC, welcomed my investigation and the insights that it might yield.

It should be noted that, following the tenets of ethnographic research, I did not attempt consecutively or systematically to "answer" the questions implicit in the research aim and objectives; such an intention might have prematurely restricted my observations and predetermined the structure of my analysis. Rather, the aim and objectives served to *orient* my research, by highlighting key issues for consideration. The findings presented here thus reflect this broad orientation but are organised according to the themes that emerged through analytical engagement with the data.

The next section will explicate the three main concepts identified in the aim and objectives. First, however, it is important to make a brief note about terminology. A plethora of terms is used, both across and within national contexts, to describe LTC and its workforce. In the United States, the official title for non-professional nursing staff in LTC is "certified nursing assistant" or "certified nurses' aide" (CNA); in shorthand, this becomes "NAs" or "aides". In the United Kingdom, the terms "care assistants" and "carers" are more commonly used. More generally, this cadre of staff is also known as direct-care workers, nonqualified staff, and auxiliary or ancillary care workers. They work alongside registered nurses (RNs) in both countries and, in the United States, an intermediary band called licensed practical nurses (LPNs). Throughout this document, the term "CNA" or "aide" is used when referring specifically to staff in the United States, and "care assistant" or "carer" for the United

Kingdom. When referring to the workforce more broadly, "carer" is used interchangeably with any of the other general terms listed.

Although on a lesser scale, there is similar diversity in the terms used to describe LTC. Here, the term "nursing home" is used to describe skilled nursing facilities (SNFs, or "sniffs") providing long-term residential care for older people in the United States, and "care homes" to describe the similar grade of facility in the United Kingdom; non-specific terms such as "facility" and "institution" are also used throughout. These terms are not intended to encompass residential care *without* nursing, since that type of service provision was not included in the research. Finally, the term "resident" is used to describe the people who live in LTC, as a compromise between the outdated (but not entirely obsolete) "patient" and the person-centred (but not widely adopted) "elder".

## 1.2    Three acronyms under investigation: KT, LTC, and PCC

As evident in the research aim and objectives, this study weaves together three strands of inquiry, the first of which is *knowledge translation* (KT). Policymakers and practitioners across most, if not all, domains of health and social care are now expected to work within the evidence-based practice paradigm, justifying their actions according to the "current best evidence" derived from research (Sackett et al., 1996, p. 71). However, it has long been recognised that new ideas are never simply applied to practice in straightforward or predictable ways. Building on this recognition, KT and related research (in fields such as implementation science and research utilisation) highlight the messy, complex, and contextualised ways that evidence is *translated* and *transformed* in practice. At the heart of

this research is the understanding that "pushing out" or disseminating new evidence through research reports, practice guidelines, and other passive strategies is necessary but not sufficient for ensuring that evidence is actively "pulled into" or implemented in practice.

Most KT research has focused on professional groups of practitioners working in acute health-care settings, including doctors, nurses, and allied health professionals, leaving LTC settings and support workers in the shadows. Therefore, the second strand of inquiry in this study is *care assistants* who care for older people living in *long-term care* (LTC). In the United Kingdom, this setting is home to a resident population of approximately 414,000; this represents less than one per cent of adults between the ages of 65 and 74 but almost 16 per cent of those aged 85 and above (AgeUK, 2013). The vast majority of care for these residents is provided by care assistants, whose role includes assisting residents with activities of daily living (ADLs) such as eating, dressing, bathing, and using the toilet; performing a range of clinical tasks such as recording vital signs and collecting specimens; assisting with range-of-motion and other mobility measures; engaging residents in activities; and, least measurably, providing social interaction and emotional support. Because they have the most sustained contact with residents, care assistants also play a critical role in monitoring their health and reporting any changes or potential problems. These staff, therefore, have significant influence over residents' day-to-day quality of life, especially for those residents with the most severe physical and/or mental impairments and thus the highest level of dependence.

Efforts to improve the quality of LTC – which has been recognised as falling behind the evidence-based curve (Farkas et al., 2003; Levenson and Morley, 2007) – must, therefore, take into account care assistants' knowledge and practice. However, with little formal

training and limited autonomy in their role, these staff certainly do not fit the profile –
already problematised within KT studies – of the sovereign practitioner who reads the
relevant reviews, analyses the findings in light of their professional expertise, discusses the
matter with colleagues, and makes reasoned choices about implementation. Given the lack of
evidence about how these staff *do* learn about, develop, and change their practice, most
interventions default to standard in-service training approaches, with little attention to how
the training content will be transferred to and sustained in practice.

This issue is particularly salient for the introduction of *person-centred care* (PCC), which is
the third strand of this research. Person-centred care has become the watchword for high-
quality care in LTC for older people in recent years (Edvardsson et al., 2008; Slater, 2006).
Far from a single, neatly packaged piece of research evidence, PCC is a complex approach
which requires significant changes to the organisation, management, and delivery of care;
hence, in the United States, it is commonly referred to as "culture change". PCC places
particular responsibility on care assistants, as the primary providers of hands-on care, to get
to know their residents as individuals, and to incorporate this knowledge into their daily
practice. The evidence base for PCC remains relatively weak and so, pending further research,
it is largely being disseminated as an alternative philosophy of care rather than a set of
defined and discrete interventions.

Drawing the strands back together, then, this research study is designed to contribute to the
KT literature by drawing specific attention to auxiliary nursing staff and LTC contexts, and to
the literature on PCC through rigorous attention to how it is understood and translated "on the
shop floor". Given these intentions, this study does not attempt to engage systematically with

the philosophical, theoretical, or historical underpinnings of PCC, which are varied, sometimes contradictory, and inconsistently developed. Valuable concept analyses have been undertaken elsewhere (McCormack, 2004; Morgan and Yoder, 2012; Slater, 2006; Welford, 2010), and further work in this area would justify a separate research endeavour. In other words, this is not a study of PCC *per se*. Instead, in order to draw out translational issues, the focus is restricted to PCC *as it is* communicated to and understood by staff in specific care settings.

## 1.3    Intellectual coordinates: Age, care, and organisations

Although the primary focus of this research is care assistants' knowledge and practice, it is important to locate this work on its broader interdisciplinary terrain. Specifically, three broad themes – informed by medical sociology, studies of work and organisations, nursing, education, and KT research – provide the intellectual coordinates for this research. These are: age, ageing, and ageism; care, gender, and the body; and work in organisations. The following section will briefly discuss how scholarship across these three areas guides the current study.

First, this study is broadly located within studies of *age and ageing*, although the focus is on staff who work with older people rather than on older people themselves. The basic point here, drawn primarily from social gerontology and medical sociology, is that ageing is a multidimensional concept with physical, psychological, and social dimensions. There is no such thing as "old age", in terms of a homogeneous identity or set of characteristics or experiences among those who have survived a defined number of years, or attained certain

physical milestones. However, the social construction of ageing – manifested in the proliferation of both positive and negative stereotypes in the media, health care, education, and everyday conversation – has real effects on the way that those of a certain age are categorised and treated (Cuddy and Fiske, 2002; Hummert et al., 1994; Kornadt and Rothermund, 2011; Nussbaum et al., 2005). Positive stereotypes of ageing highlight the knowledge and experience of older people, along with their capacity for caring, their integrity, and their gentleness, while negative stereotypes highlight frailty, infirmity, dependence, intransigence, and ill-humour. These social constructions underpin *ageism* (Butler, 1987) in various milieux, including health-care policy and practice, as evidenced by the lack of priority given to older people's care and by problems of demeaning, infantilising, or objectifying treatment within particular services (Anderson et al., 2005; Kane and Kane, 2005; Roberts et al., 2002; Ryvicker, 2009).

For older people living in LTC, the social construction of ageing interacts with the notion of citizenship to exacerbate the problem of ageism. That is, citizenship rights in the dominant liberal tradition adhere to the independent, autonomous, rational adult; by contrast, "those who are dependent on care and are unable to control their world such that they can negotiate with others the terms of their care, are determined to *lack* autonomy and the traits of full personhood" (Dodds, 2007, p. 502), and thus full citizenship. As incomplete or failed citizens, older people in LTC care are cast as "vulnerable" and in need of protection, which has undertones of surveillance and control (Fineman, 2008). This has further implications for how care services are prioritised, organised, and delivered.

The second major theme, drawing from a range of fields including medical sociology, nursing, feminism, and social policy, is *care*. Dodds (2007, p. 501) defines care as:

> … an activity undertaken with the aim of providing an individual with the social, material, and emotional supports that either allow that person to flourish as far as is possible, or (as far as possible) to bring the life of a person with some recognised physical, cognitive, or psychological disability into a position where their autonomy can be realised.

This definition usefully highlights the active, relational, and multidimensional nature of care.[1] Just as with age, however, there is nothing fixed or given about what care entails, who needs care, nor how it is provided (Glucksmann, 2006, p. 55); these are all emergent, fluid, and contested issues. From the expansive literature engaging with these issues, three key elements with particular relevance to the current study can be highlighted, namely: gender, work, and embodiment.

First, feminist scholarship from the 1970s onwards has drawn attention to the gender inequality that characterises care work, given its traditional association with the private sphere and with female-ascribed characteristics such as nurturing, helping, serving, and emotionality (Twigg, 2004). Assumptions about the intuitive or instinctive nature of caring had previously rendered care work almost invisible, characterising it as a "labour of love"

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[1] Some theorists have developed this concept further by differentiating between *types* of care (Blustein, 1991; Tronto, 1993). Blustein (1991), for example, distinguishes between: caring for, which rests on affection for another person; having care for, which implies a responsibility or duty; caring about, which entails some kind of interest or stake in the individual; and caring that, which refers to a more abstract or general concern. These distinctions can be helpful for considering, for instance, how care assistants may be encouraged to provide high-quality care according to their occupational obligation (through *care of* the residents) without being expected to *care for* every individual in a personal, affectionate sense.

(Finch and Groves, 1983) rather than an activity deserving recognition and remuneration (Glucksmann, 2006). As James (1992, p. 492) summarises this point: "It is the gender division of labour which predicts that women provide the greater part of direct care, and it is the gender division of labour which structures the value attributed to physical and emotional labour".

The provision of care has changed considerably – in terms of where, for whom, and by whom it is provided – as a result of changes in demography, family structure, and the lifecourse. However, the gendered nature of care work continues to have salience both within current social-policy debates (Daly and Lewis, 2000) and in practice contexts. In practice, it can be seen in the gender imbalance across disciplines, for example between those in hands-on versus managerial positions, and in pay disparities between men and women. Even when considering the traditionally female-dominated profession of nursing, for instance, a recent US census report shows that male nurses earn an average of nine per cent more than their female counterparts (Landivar, 2013).[2] Notably, those in the lowest tier of care work are overwhelmingly female; this includes approximately 90 per cent of direct-care workers in LTC care.[3]

The gendered nature of care work – discussed here in a necessarily reductive manner – is important as a material aspect of the research context. Furthermore, it serves as a sensitizing

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[2] This figure is for men and women working in full-time, year-round nursing positions; the gap widens further when taking into account those in part-time or temporary positions.
[3] It is very important to acknowledge here that care work is also unequally structured along racial and ethnic lines, both within national contexts and in terms of what has been called the "global care chain" (Yeates, 2004) or the "global heart transplant" (Kittay, 2008). However, the current study did not yield enough data to provide the basis for robust and relevant claims about racial and ethnic disparities; therefore, this issue remains on the margins rather than fully discussed.

concept (Bowen, 2008) to help problematise assumptions, both disparaging *and* reifying, about care workers' (gendered) knowledge and practice, and thus to develop accounts which are more accurately grounded in their daily work.

This relates to the second key element of care, which is that it involves *work*. This may seem self-evident when studying paid carers, but the notion extends beyond the job description and quantifiable daily tasks to encompass relational and affective "work" as well (Carmack, 1997). The concept of emotional labour is particularly helpful here. Originally developed by Hochschild (1983) to explain emotional management among flight attendants, this concept has since been used to examine how staff, particularly nurses, manage and display appropriate emotions in health and social care (Henderson, 2001; James, 1989). Erickson and Grove (2008) note that the very centrality of emotional labour in the caring professions paradoxically renders it invisible (as compared, for example, to emotional labour in customer service); this means that the stress and damage that may be sustained through the effort to express appropriate emotions in challenging care environments *also* go unrecognised (Bailey et al., in press; Mann and Cowburn, 2005). Echoing Strauss and colleagues' (1985) concept of "sentimental work" in health care, emotional labour is helpful in drawing attention to the less-codified, but perhaps no less important, aspects of the work of care assistants in LTC, especially in the overlap and interstices between evidence-based practice and PCC.

Focusing on *work* also helps locate specific caring roles within the broader organisation of labour. For example, within the health-care hierarchy, the professionalisation of nursing has shifted responsibility for the "dirty work" (Ashforth and Kreiner, 1999; Hughes, 1962) of hands-on care – such as bathing and toileting – entirely onto auxiliary staff, with implications

for how these workers are positioned, by themselves as well as by others, within the wider field (Theodosius, 2012). This strand of research provides a reminder that any particular dyadic care encounter must always be understood within its social and organisational context.

This brings us to the third element, drawing together insights from the sociology of the body and the sociology of work and organisations (Gimlin, 2007), which is that care work is *body work*. Body work is defined as "work that focuses directly on the bodies of others … that thus become the object of worker's labour" (Twigg et al., 2011, p. 171). This definition brings two important issues into focus: first, the body itself, and second, the relationship between bodies and care work. The roots of the first issue – what is the body? – extend back, of course, to Descartes's work on mind/body duality and beyond; more recent traditions have focused on either the phenomenological experience of the pre-existing body (known as *foundationalist* accounts) or on the construction of the body through discourse (known as *anti-foundationalist* accounts) (Prout, 2000). Informing the current research are theories of embodiment which transcend dualisms by suggesting that the body is not just an instrument, a conduit, or a discursive construction: rather, linking structure and agency, these theories foreground "the substantive, living body as conditioned possibilities for both *being* in the world and for *shifting* worlds" (Latimer, 2008, p. 9; Shilling, 2007). That is, it is through our bodies that we both exist in the social world and contribute to its constant reproduction.[4] Along the same lines, Lawler (2006[1991]), who coined the term "somology" to capture the embodied nature of nursing, describes the body as simultaneously an object, a means of experience, a means of expression, a manner of presence, and part of personal identity.

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[4] On a similar note, in the introduction to a key text on medical sociology, Williams and colleagues (2000, p. 8) argue for an "embodied sociology" in order to "put the mind back in the body, the body back in society and society back in the body".

Embodiment will be discussed further in Chapter 4, but the key point here is that the "living body" is both a (reactive) material object and a (productive) social force. This has implications for the second issue, which is the relationship between bodies and care work. Almost all care assistants' work involves direct, often intimate contact with residents' bodies: pushing, pulling, transferring, rolling, repositioning, wiping, washing, dressing, feeding. Without attention to personhood, this work can become objectifying: hence, for example, Gubrium (1997[1975]) refers to carers' emphasis on "bed and body work", and Lee-Treweek (1997) writes about their production of "lounge-standard residents" (rather than individualised care) (see also Reed-Danahay, 2001). By drawing attention to these bodies as bodies *and* as objects of labour, the concept of body work helps to interrogate the distinct spatial and temporal aspects of carers' practice (Twigg et al., 2011): how do they negotiate, for example, the difference between "clock time" and the bodily needs of their residents, which may not follow any predictable temporal pattern? Wolkowitz (2002, p. 505) suggests that one of the key areas for exploration in body-work studies is "whether and how workers normalize the tension between processing the body as an object and interacting with the body as a materialization of personhood"; this has particular salience for the current study on PCC, especially with regards to what types of balancing, negotiating, or reconciliatory activity this work requires of care assistants.

Reinforcing the argument made above, focusing on *bodies* also necessitates locating care work within gender, class, and race inequalities, all of which are inscribed in and expressed by the body. Finally, it is important to locate "body work" in the broader discourse about the sustainability of contemporary LTC across both public and private provision. As Cohen (2011) notes, it is difficult to apply normal efficiency measures, such as rationalising tasks or

replacing manual labour with technology, when the object of labour is bodies; this is because hands-on care by definition requires at least one carer per resident per task, and because bodies have a social significance that tends to discourage their total objectification. Nonetheless, commodification and cost-cutting are defining aspects of LTC, a reality which – although it is not the central focus of the current research – must be kept in mind when considering the (competing) expectations of PCC.[5]

The third major theme of this research is *work in organisations.* In particular, the literature on "new institutionalism" from organisational studies provides guidance for how LTC organisations can be understood. Implicit in many studies of KT, as discussed further in Chapter 3, is a view of organisations as machines composed of interconnected but divisible components, or as formal and relatively stable structures with clear goals, structures, and boundaries. According to such views, the organisation serves as the taken-for-granted container for the action of individuals, and is rarely considered as an object of investigation in its own right (Davies, 2003). This engenders theories of change that privilege top-down, strategic decision-making. By contrast, the new institutionalism approach suggests that organisations are *not* whole, stable systems but rather "loosely coupled arrays of standardized elements" (DiMaggio and Powell, 1991, p. 14). These "coupled arrays" are sustained in *relatively* stable forms through common practices and shared cognition, which in turn draw on supra-organisational – in other words, *institutional* – symbols and patterns of activity. In DiMaggio and Powell's (Ibid., p. 9) words:

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[5] Greener (2011) uses labour-process theory to develop an excellent analysis of the effects of privatisation on the frontline delivery of care in LTC for older people.

The constant and repetitive quality of much organized life is explicable not simply by reference to individual, maximizing actors but rather by a view that locates the persistence of practices in both their taken-for-granted quality and their reproduction in structures that are to some extent self-sustaining.

This notion of the "persistence of practices" as the basis of organisations directly informs the theoretical position developed in Chapter 4, so requires no further elaboration here. To emphasise, however: the guiding assumption here is that there is nothing intrinsically static or stable about the division of labour or any other organisational element; these elements are always and constantly being renegotiated and reproduced. Organisational change thus occurs not so much as "a matter of technical rationality or increased efficiency" than as "a means of meeting the expectations of significant actors in the environment" (Allen and Pilnick, 2005, p. 687) – for example, as seen in Chapter 8, in response to the introduction of new systems of top-down state governance.

## 1.4    Thesis outline

This chapter will conclude with a brief description of the thesis structure. The next chapter provides a broad, three-dimensional overview of the research context: first, by sketching out the history and policy of LTC in England and the United States; second, by developing a demographic and occupational profile of the LTC workforce in each country; and third, by discussing PCC as a new model of service delivery in this sector. Taking a step sideways, Chapter 3 presents a critical review of the KT literature, examining a number of influential models and frameworks (and related empirical studies) in order to draw out key issues for further investigation. The chapter concludes by proposing that KT is a relational, contested,

and contextualised learning process which integrates multiple sources of evidence. This proposition provides the basis, developed in iterative engagement with the research data, for the theoretical approach presented in Chapter 4. Drawing on practice theory, and particularly the key conceptual tools of habitus, capital, and field which constitute Bourdieu's theory of practical logic, this theoretical approach helps to explore PCC not as a set of cognitive properties or principles but as a set of practices that must *make sense* in relation to the other practices that are performed by care assistants within their particular position in the field. This approach also incorporates the idea of institutional logics from new institutionalism theory in order to help explain variations in practice – according to the logics of the home, the medical facility, or the business – and to identify opportunities for reflection and change. Chapter 5 specifies the study design and methods, explaining why ethnography was chosen as the best way to address the call for "finely grained and holistic analyses of the process of knowledge translation within real-life clinical settings" (Dopson, 2007, p. S76), particularly in the neglected area of LTC for older people (Berta et al., 2010). The chapter goes on to introduce the two case studies in some detail, then covers the ethical dimensions of the study and the role of reflexivity before concluding with a description of the data collection and analysis methods.

The subsequent three chapters develop an analysis of the empirical findings of the study, structured according to three essential tenets of PCC that had particular salience in both research settings vis-à-vis other practices. Chapter 6 considers the notion of *individualised care*, which is contrasted in PCC discourse against the depersonalising practices that pervade conventional LTC settings. This chapter argues that the emphasis on "putting the individual first" must be considered in relation to established communication practices, including

handover, daily documentation, and care plans, which in turn relate to the division of labour and associated distribution of power within the field. These factors help explain how individualised care is understood in practice and whether or not it *makes sense* for staff to share the information that is required for its fulfilment. Chapter 7 looks at *taking time to care*, which is promoted in PCC as a flexible, personalised alternative to task-based and routinised approaches. Challenging, although certainly not dismissing, the default explanation that there is simply "not enough time" to provide flexible care, this chapter explores the divergent temporal qualities of the three main institutional logics described in Chapter 4. This brings to light the (albeit limited and hidden) agency and reflexivity that carers exercise in negotiating these logics as they organise their work. The chapter concludes by discussing the conflicting ways that this aspect of PCC translates into practice, given these considerations of institutional logics and power. Finally, Chapter 8 considers autonomy, an important concept across health and social care which has particular importance in PCC in terms of promoting independence and choice. This chapter argues that efforts to promote autonomy cannot be disentangled from the risk-management and reporting practices that are required within the broader regulatory framework of LTC, especially when accounting for carers' vulnerable position within these practices. Although making limited claims about the extent to which autonomy, as it is understood beyond the four walls of LTC, can *make sense* within this setting, the chapter concludes with a discussion of inclusion and discretion as two potential sites for change.

The concluding chapter begins by summarising the findings from the previous three chapters with reference to the theoretical approach developed in Chapter 4. The discussion focuses on how the three selected principles of PCC – putting the individual first, taking time to care,

and promoting autonomy – become meaningful in and through carers' practice, relative to other practices, when taking into account their habitus and access to capital within the field. This discussion also emphasises the similarities and differences across the two research settings that have threaded through the analysis. The chapter goes on to emphasise the contribution of this study to research, policy, and practice on both KT and PCC, structuring this discussion around the three main themes identified in the literature review. In brief, this section asserts that the research findings indicate that efforts to translate new ideas, principles, or evidence into carers' practice must take into account their knowledge, skills, positionality, and existing practices (including those related to teamwork and communication); validate and promote rather than limiting or dismissing their contribution to the overall delivery of care; and include non-punitive processes for collective reflection, problem-solving, and action-planning. After describing dissemination and future research plans, the thesis concludes with a brief reflection on the possibilities and challenges of improving practice for the benefit of both the recipients and providers of LTC.

CHAPTER 2: LONG-TERM CARE AND "CULTURE CHANGE"

## 2.1    Introduction: Population ageing and long-term care

Due to changes in fertility and longevity, the world population is ageing at an unprecedented rate. According to the United Nations Population Division, an estimated 21 per cent of the total population will be aged 65 or above by the year 2050, compared to only 8 per cent in 1950 and 10 per cent in 2000 (UNDESA, 2002). The number of those aged over 80 – the "oldest old" – is predicted to double in the same period (OECD, 2013).

Population ageing has major economic and social implications, not least of which is the increased demand for long-term care (LTC) services, meaning the health and social-care services provided on an ongoing basis to those with chronic conditions and disabilities, including up to half of all older people (OECD, 2013).[6] These services can include medical and nursing care, including preventive, rehabilitative, and palliative care; assistance with ADLs and IADLs; and/or residential or "hotel" services. Although differentiated for policy purposes, in practice these components tend to be closely interrelated; for example, basic assistance with mobility may be a social-care intervention but with important health-related functions in terms of pressure-sore prevention. Spending on LTC currently averages 1.6 per cent of GDP across OECD countries, but is expected to increase two- to four-fold by 2050 (Appleby, 2013; OECD, 2013).

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[6] Although this research focuses on LTC in relatively affluent countries, it should be acknowledged that population ageing is occurring more rapidly and at lower levels of socio-economic development in the global South, with less lead-in time for economic and social policy responses (UNESA, 2002).

Long-term care policy has tended to favour home- and community-based provision in recent decades, due to consumer preference and for cost-containment purposes. However, there remains a critical demand for institutional care, particularly among those who are oldest and/or experiencing the most severe impairments or co-morbidities. Furthermore, although two-thirds of LTC users receive services at home, according to OECD (2011) averages, spending on institutional care accounts for 62 per cent of total LTC expenditure; hence the importance of maintaining research attention on this sector.

A particular issue for LTC provision is the increasing prevalence of dementia. An estimated 35.6 million people are currently living with dementia worldwide, and this number is expected to increase to 115.4 million by 2050 (ADI, 2013). Dementia has been identified as the strongest determinant of entry into residential care for those aged 65 and over, and some form of dementia affects over two-thirds of care-home residents (Alzheimer's Society, 2007).[7] Dementia presents particular challenges for care assistants working in institutional settings, including those attempting to implement person-centred care (PCC), as will be shown throughout this thesis.

The following chapter provides a tripartite introduction to the LTC context in England and the United States. The first section presents a broad historical and policy overview of LTC in each country, highlighting the residential sector in particular. The subsequent section

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[7] Dementia refers to a set of symptoms, including memory loss and problems with communication and reasoning, which are caused by a number of conditions. Alzheimer's disease is the most common form, while other forms include vascular dementia; dementia with Lewy bodies; and fronto-temporal dementia, including Pick's disease. Each of these forms of dementia is associated with different symptoms, disease progression, and treatment, though none are yet preventable or curable. Dementia may also be caused by other diseases, including multiple sclerosis, motor-neuron disease, Parkinson's disease, and Huntington's disease.

develops a profile of the LTC workforce, focusing primarily on the demographics, training, role, and experience of care assistants. Finally, the third section introduces the "person-centred care revolution" (Rahman and Schnelle, 2008) in this sector, briefly comparing how it has been espoused and implemented across the two countries.

## 2.2    Long-term care: A comparative overview

To set the scene for the following discussion, Table 1 provides a brief summary of population ageing and LTC in the United Kingdom and United States as compared to averages across the OECD.

**Table 1: Population ageing and care**

|  | **United Kingdom** | **United States** | **OECD (average)** |
|---|---|---|---|
| Population aged 65+ (versus 2050 estimate) | 16.6% (24%) [†] (2012 data) | 13% (20%) [†] (2010 data) | 15% (25.7%) [†] (2010 data) |
| Population aged 80+ (versus 2050 estimate) | 4.3% (10%) [†] (2012 data) | 3.7% (7.4%) [†] (2010 data) | 4% (10%) [†] (2010 data) |
| LTC spending as per cent of GDP | 1.5% (1% NHS/social care, 0.5% private) [◊] | 1% (0.6% public, 0.4% private) [*] | 1.5% (1.2% public, 0.3% private) [*] |
| Percentage of those 65+ in LTC institutions | 4% [◊] | 1% [†] | 4% [†] |
| Beds in LTC institutions (per 1000 people 65+) | 56 [*] | 42 [§] | 44 [*] |

([†] OECD, 2013; [*] OECD, 2011; [◊] Hancock et al., 2007; [§] CMS, 2010)

### 2.2.1   Care homes in England

<u>Legislation and funding</u>

There are approximately 18,500 care homes providing 500,000 beds for older people in the United Kingdom (Milne and Dening, 2011). About 90 per cent are run by voluntary and for-

profit organisations; however, three-fifths of provision across these sectors is commissioned by local authorities, which also own the remaining 10 per cent (Forder and Allan, 2011). According to the Audit Commission (2013), overall expenditure by local authorities on social care for those over aged 65 was £9.07 billion in 2011/2012, which represented more than half the total adult social-care budget. Because social care has been devolved, the discussion from here will focus on England, which is the location of the research and home to 85 per cent of the United Kingdom's older population.

The contemporary care-home sector stands at the crossroads of ongoing tensions between health and social-care provision in England, with roots in the punitive institutionalisation practices carried out under the Victorian Poor Laws (and before). Since the middle of the last century, there has been a trend towards community-based care as socially and economically preferable to institutionalisation, first marked by the 1962 Hospital Plan and echoed throughout various policy documents over the following decades (Scales and Schneider, 2012). A defining policy shift then occurred in the late 1980s, after it was discovered that a minor change to social-security regulations had created a perverse incentive towards institutionalisation.[8] This prompted a review of public spending on social care, then the 1988 Green Paper *Community Care*, the 1989 White Paper *Caring for People* and, ultimately, the National Health Service and Community Care Act 1990. The Act tasked local authorities with assessing needs and *commissioning* services, using a fixed budget of social-security funding, while the bulk of service *provision* was shifted to the independent sector, including voluntary, charitable, and private-sector organisations – and thus the "mixed economy of

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[8] Specifically, this change allowed the Department of Health and Social Services to pay for private residential and nursing-home care through uncapped supplementary benefit payments, rather than paying for their care in the community through the social-care budget.

welfare" was established (Wistow et al., 1994). Although the changes were slow to implement, their impact was radical: in 1980, 63 per cent of care homes had been provided by local authorities, with 17 per cent privately owned, but by 2002, this balance had been entirely inverted (Lievesley et al., 2011).[9]

Currently, up to 33 per cent of all care-home residents are self-funded (Lievesley et al., 2011), at an average rate of £758 per week for a single room (AgeUK, 2013, based on 2012 data). The rest receive local-authority funding based on a two-stage process, which includes needs and means assessments. The existing "upper capital threshold", above which the individual pays the full cost of their care, is £23,250. The value of the home is usually included in this calculation after the first 12 weeks, a policy which has generated considerable debate about the fairness of having to "sell the family home" to pay for care. Below this threshold, the state meets some or all of the costs of care according to the individual's assessed means. If local-authority funding falls short of the required fees for a particular care home, it is possible for another party to "top up" the difference, but an individual cannot use their own capital below the means-test threshold. In addition, residents of registered care homes qualify for nursing care from the NHS, which is reimbursed directly to the care home at a rate of £109.79 per week (at the 2013/14 standard rate). Some individuals with complex long-term health needs are eligible for "NHS continuing health-care", which covers all costs of care.

Since the Coalition Government came to power in 2010, health and social care has again been

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[9] Other key legislation for care homes includes the Care Standards Act 2000; the Care Home Regulations 2001; the National Care Standards Commission (Registration) Regulations 2001; and the National Care Standards Commission (Fees and Frequency of Inspections) Regulations 2001. These were developed from previous legislation which included, primarily, the Registered Homes Act 1984 and the Registered Homes Amendment Act 1991.

radically reorganised, with the main changes encapsulated in the Health and Social Care Act 2012. This Act provides the primary legislation for the 2010 White Paper *Vision for Adult Social Care* and was informed by recommendations from the Law Commission's comprehensive review of adult social-care legislation and from the Commission on Funding of Care and Support (known as the Dilnot Commission) – although not without many months of debate, consultation, and amendment. The Act emphasises better integration between health and social care, as well as promoting: personalisation; universal prevention, education, and advice services; and national standards for eligibility, service quality, and workforce capacity. The new Act has a number of implications for the funding of long-term residential care (as well as for the organisation of the NHS, which is beyond the scope of this discussion). Namely, the Act mandates a £72,000 cap on the cost of care, to be implemented from 2016; raises the upper limit for support to £118,000 from 2016; and sets new eligibility criteria and a national eligibility threshold, to address the problem of the "postcode lottery" across local authorities (McDaid et al., 2007).[10] The Act also stipulates the piloting of "direct payments" in residential care services.[11]

Monitoring and inspections

As per the Health and Social Care Act 2008, all health and adult social-care services in England are regulated by a single, integrated body called the Care Quality Commission (CQC); this replaced the previous Healthcare Commission and Commission for Social Care

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[10] The current model for determining eligibility is based on national guidance issued in 2002, which established four bands of eligibility: critical, substantial, moderate and low (DOH, 2003). By 2010, evidence suggested that three-quarters of councils were meeting critical or substantial needs only; this represented a sharp decline in provision since 2006, when 52% of councils were meeting moderate needs (Dunning, 2010).

[11] Personal budgets were introduced into English social-care policy in the 2007 *Putting People First* concordat and subsequent circulars, following the Individual Budget Pilot programme in 2005-7. In the 2010 *Vision for Adult Social Care*, the Coalition government confirmed and extended the policy commitment to personal budgets as part of their broader personalisation agenda (Routledge and Carr, 2013).

Inspection. All care homes are legally required to register with the CQC and to meet a set of national standards regarding: involvement and information; personalised, appropriate care; safety and security; workforce capacity; and ongoing quality control processes. The CQC carries out annual, unannounced inspections of all registered care homes, as well as "themed" inspections, such as the 2011 inspection on dignity and nutrition, and "responsive" visits in the case of complaints. If services do not meet national standards, the CQC has a number of options and enforcement powers which include: issuing a warning or fixed penalties; restricting services or stopping new admissions; suspending or cancelling registration; or prosecution. Due to significant concerns about the limited extent to which these powers have been exercised, however – with only one per cent of inspected care services, for example, found to be seriously deviating from the minimum standards in 2012 (OECD, 2013) – the CQC regulatory model and governance structures are currently being reviewed and revised.[12]

Person-centred care

Person-centred care for older people has been written into UK policy for at least a decade. Standard 2 of the 2001 *National Service Framework*, a 10-year plan for the development of health and social-care services for older people, required that "NHS and social care services treat older people as individuals and enable them to make choices about their own care" (DOH, 2001, p. 23). More recently, the consultation report *Delivering Dignity* (LGA, NHS Confederation, & AgeUK, 2012, p. 11) promoted PCC as care that "champions compassion and respect and puts the individual at the heart of all decisions" and called for providers to focus "on the relationship with the person behind the task, not on the task for its own sake".

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[12] Following the recommendations of the Francis Report (2013) on the failings at Mid-Staffordshire NHS Foundation Trust, the CQC opened a public consultation on hospital care regulation in June 2013, with a further consultation on adult social care and general practice expected later in 2013.

Although the new NHS Constitution (DOH, 2013, p. 5) refers to "respect and dignity" rather than PCC *per se*, the chief executive of the NHS Confederation commented that "used in the right way, the constitution can help trigger a major cultural shift in the way the NHS thinks about dignity and person-centred care" (NHS Confederation, 2012).

In addition, the National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE) jointly published a guideline on dementia care which states that "there is broad consensus that the principles of person-centred care underpin good practice in the field of dementia care", namely:

- The human value of people with dementia, regardless of age or cognitive impairment, and those who care for them;

- The individuality of people with dementia, with their unique personality and life experiences among the influences on their response to the dementia;

- The importance of the perspective of the person with dementia;

- The importance of relationships and interactions with others to the person with dementia, and their potential for promoting well-being (NICE/SCIE, 2006, p. 6).

These principles were echoed in the 2009 publication *Living Well With Dementia*, a national evidence-based strategy for improving local provision of "good-quality care for all with dementia from diagnosis to the end of life, in the community, in hospitals, and in care homes" (DOH, 2009, p. 2). The strategy comprises 17 recommendations around three themes: raising

awareness and understanding, promoting early diagnosis and support, and improving conditions for those living with dementia.[13]

### 2.2.2 Nursing homes in the United States

<u>Legislation and funding</u>

There are an estimated 16,100 skilled nursing homes in the United States, comprising 1.7 million beds. Approximately two-thirds of which are private, while just over a quarter are not-for-profit and the remaining six per cent are government-owned (CDC, 2004). The national average daily rate (in 2012) for a private room in a nursing home was $248, while the cost for more common "semi-private" rooms, shared by two residents, was $222 (MetLife, 2012).

Public funding for LTC comes primarily from Medicaid, a means-tested social health insurance program established in 1965 and jointly funded by federal and state governments. (Medicare, the other federally funded program which serves as the primary health-care insurance program for those over 65, covers only 100 days of skilled nursing or rehabilitative care, not the ongoing costs of LTC.) Some Medicaid benefits are mandatory, including institutional and home-health services for eligible recipients, but the majority of benefits are left to state discretion.[14] Eligibility requirements also vary from state to state, but tend to

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[13] With this document, which was initially funded for £150 million, England became one of a very few countries (also including Norway, France, Scotland, Australia, and South Korea) to make dementia a national policy priority. More recently, in March 2012, the Prime Minister announced his "challenge on dementia", focusing on three key areas for action: improving health and care, creating dementia-friendly communities, and improving dementia research.

[14] Since 2001, a number of states have implemented pay-for-performance (P4P) measures, whereby Medicaid reimbursement is determined in part by the nursing home's performance on a number of measures, such as

require individuals to "spend down" their personal assets to indigent levels before becoming

eligible for assistance. There is also a well-developed private market for LTC insurance in the

United States; however, rather than spreading the costs across the population, this remains "a

niche product, which principally serves the segment of the population with relatively higher

income and accumulated assets" (OECD, 2011).

The American nursing home sector changed dramatically in the 1980s, after widespread

concerns about neglect and abuse prompted the commissioning of a report from the Institute

of Medicine (IOM). Published in 1986, this report – "Improving the Quality of Care in

Nursing Homes" – led to a set of reforms known as the Nursing Home Reform Act, which

were incorporated in the 1987 Omnibus Budget Reconciliation Act (OBRA-87). These

reforms, which comprised 47 recommendations for improving measurement, reporting, and

oversight of quality and performance in nursing homes, included the development of a

Resident Assessment Instrument (RAI) to be used in all Medicare- and Medicaid-certified

nursing homes (CMS, 2008[2002]).[15] The RAI, implemented in 1990, provides a standardised

system for assessing every resident, the data from which can be used with the linked

assessment protocols to undertake individualised care planning. This data also feeds into the

Minimum Data Set (MDS), which is used to monitor nursing-home quality and to classify

residents into Resource Utilization Groups (RUG-III) for the purposes of Medicare and

Medicaid reimbursement. In the intervening years, the MDS has been revised several times –

with the "final draft revision" of the MDS 3.0 released in 2008 – in order to better capture

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clinical outcomes and staffing. Although P4P falls outside of the scope of the current discussion, Werner et al. (2013) provide a useful and timely analysis.

[15] The majority (90%) of US nursing homes are "dually participating", which means that they accept both Medicare-/Medicaid-funded <u>and</u> privately-funded residents. Such homes must comply with the regulations described here.

residents' own experiences and quality of life, including through resident interviews. Overall, OBRA-87 regulations have been associated with a decline in the use of restraints, psychotropic drug use, and urinary catheters, as well as improved physician performance and infection-control rates, and better adherence to routine quality-improvement processes (see Colón-Emeric et al., 2010, p. 1283 for a review of the evidence).

Major changes to the American health-care system – and to a lesser extent, the LTC sector – were introduced in 2010 with the passage of the highly controversial Patient Protection and Affordable Care Act (ACA), also known as "Obamacare".[16] Provisions relating to nursing homes include: improved reporting and complaints resolution; a requirement to establish in-house compliance and ethics programmes and Quality Assurance and Performance Improvement programmes; mandatory dementia and abuse-prevention training for all CNAs; and the introduction of background checks for all employees with direct access to residents. Some of these changes have been implemented while others are still underway.

In addition, the Act incorporated the Community Living Assistance Services and Supports Act (or CLASS Act), which sought to broaden access to LTC insurance through a national, voluntary system. However, amidst concerns about the accessibility and sustainability of the programme, it was repealed in the American Taxpayer Relief Act of 2012. In its place, a national LTC commission has been convened to "develop a plan for the establishment, implementation, and financing of a comprehensive, coordinated, and high-quality system that ensures the availability of long-term services and supports for individuals in need of such

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[16] ACA continues to be challenged in Congress, federal courts, and in some state courts, even though a 2012 Supreme Court ruling upheld its constitutionality.

services and supports" (according to Section 643 of the Act). Although the commission was expected to vote on a "comprehensive and detailed report" within six months, this seems unlikely given that the first meeting was not convened until June 2013.

Monitoring and inspections

The Centers for Medicare and Medicaid (CMS) contract with each state – usually through state departments of health and/or human services – to conduct annual inspections that determine whether nursing homes are meeting quality and performance standards. (Inspections may be conducted more frequently for poorly performing homes, or in the case of a complaint.) On these unannounced visits, the "survey team" undertakes a two-staged systematic inspection through observation, interviews, and record review. The first stage includes sampling, investigation, and synthesis of 84 resident-centred and 27 facility-level indicators of quality of care and quality of life; these comprise the Quality Indicator Survey (QIS), which is designed to improve the consistency, reliability, and accuracy of the nursing-home inspections process nationwide as well as bringing it into alignment with the OBRA-87 regulations, particularly around PCC (Lin and Kramer, 2013). The second stage involves further investigation of issues that have been "triggered" in the first stage, documenting the severity and scope of noncompliance. Possible actions from CMS include a fine, denial of payment, assignment of a temporary manager, or installation of a "state monitor". If noncompliance persists, the nursing home risks losing its licensure and thereby its reimbursement agreement with the CMS.

Survey results and MDS data are translated into a 5-star rating system for all registered nursing homes and published on the national "Nursing Home Compare" website, along with

information about previous inspection results and penalties. These ratings are based on 11 quality measures across three domains: health inspections, quality measures, and staffing. The health-inspection rating is based on the three most recent annual inspections, as well as any inspections due to complaints; the quality measures are based on a combined subset of MDS reporting measures; and the staffing ratio is based on RN hours and total staffing hours per resident day.

Alongside the inspection system, every state is required to have a Long-Term Care Ombudsman Program, as per the Older Americans Act of 1965. Overseen by the Administration for Community Living (formerly by the Administration on Aging), volunteer and paid ombudsmen serve as advocates for residents of nursing homes and assisted living facilities. In 2010, the Ombudsman Program investigated almost 212,000 complaints nationwide and provided general LTC information to another 278,104 people (AoA, 2011).

Person-centred care

The IOM report published in 1986 promoted PCC as "care that is respectful and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions" (IOM, 1986, p. 49). Together with the subsequent OBRA-87 reforms, nursing homes became "the only sector of the entire health care industry to have an explicit statutory requirement for what is now called 'person-centered care'" (Koren, 2010, p. 313). According to the report's person-centred recommendations: nursing homes should provide a comfortable and homelike environment; residents should have choice over their surroundings, schedules, care, and activities; residents should be treated with dignity and respect; and

residents should have the opportunity to interact with others inside and outside the facility (IOM, 1986, p. 83).

## 2.3    The long-term care workforce

Between one and two per cent of the total workforce across the OECD is employed in LTC, a percentage which is predicted to double by 2050 (OECD, 2011). Of this workforce, it is nursing assistants – known by a variety of related titles across community-based and institutional settings, as mentioned in the Introduction – who undertake the overwhelming majority of direct contact with care recipients, from feeding, bathing, dressing, and toilet care through social interaction and emotional support (Beck et al., 1999; Hartig, 1998; Nolan et al., 2008; Ron and Lowenstein, 2002; Secrest et al., 2005). A brief comparative profile of this group of workers is provided in Table 2.

**Table 2: Long-term care assistants in England and United States**

|  | **England** | **United States** |
|---|---|---|
| Per cent of working-age population in LTC workforce | 0.3% [*] | 2.2% [*] |
| Per cent female | 91% [§] | 90% [§] |
| Average age | 40 (across adult social care)[†] | 38 (nursing homes only)[◊] |
| Foreign-born | 25% [Δ] | 21% [†] |
| Ethnic minority | 19% (6%-64% by regional variation) [†] | 52% (30% African-American, 14% Spanish or Latino) [◊] |
| Turnover/vacancy rate | 18.8%/ 2.1% [⌂] | 42.6%/ 5.1% [○] |

([○] AHCA, 2010; [*] OECD, 2011; [§] Fujisawa and Colombo, 2009; [◊] PHI, 2009; [Δ] Skills for Care, 2011; [⌂] Skills for Care, 2010a; [†] Skills for Care, 2010b)

Despite their indispensable role, care assistants earn relatively low wages and have low occupational status in both countries. In the United States, the median hourly wage for certified nursing assistants (CNAs) was $10.48 in 2007, which is significantly less than the overall average for American workers ($15.10) (PHI, 2009). Nearly a quarter of CNAs do not have health insurance, and 45 per cent fall under 200 per cent of the federal poverty line and are therefore eligible for most state and federal welfare assistance (Ibid.). In England, the average hourly wage for a care assistant was £6.10 in 2009, with regional variations from £5.81 in the East Midlands to £6.56 in London; this was just over the adult national minimum wage, which was £5.73 for that year (Skills for Care, 2009).

The minimal remuneration for care assistants parallels the limited training requirements in both countries.[17] In the United States, OBRA-87 mandates that new nursing assistants undergo a minimum of 75 hours of training, including 16 hours of clinical or "hands-on" training in a LTC facility, and successfully pass an exam within four months of starting work.[18] In addition, CNAs must complete 12 hours of continuing education each year thereafter. These regulations apply to all individuals performing CNA duties on a full-time, part-time, per diem or any other basis in nursing facilities receiving Medicare and Medicaid funding. Notably, these training requirements fall short of the requirements for many other "body work" vocations (Twigg et al., 2011); for example, to obtain licensure as a "nail

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[17] It should be noted that inadequate training for support workers is not a problem that is unique to these two countries; indeed, one survey found that staff qualifications as well as staff shortages were the top concerns for LTC policymakers across 19 OECD countries (OECD, 2005). On the other hand, there are also positive outliers: for example, certified care workers in Japan undertake three years of training (OECD, 2013).

[18] The exam includes multiple-choice questions and a practical component. For the practical component, the test-taker is assigned three clinical skills to perform, each of which comprises a number of "checkpoints" that are weighted according to their importance. Examples include catheter care, changing an occupied bed, measuring pulse and respiration, feeding, and mouth care. For each skill, "hand-washing" and "indirect care" skills – which include greeting the resident by name, asking about their preferences, and promoting their comfort, rights, and safety – are also assessed.

technician" in New York State – where the CNA training curriculum is set at 100 hours, slightly above the federal minimum – requires 250 hours of training.

There is no corresponding training requirement for care assistants in England, with the Health and Social Care Act 2008 recommending only that staff should be "appropriately trained". To that end, Skills for Care has developed a set of Common Induction Standards (CIS), which are supposed to be completed by all workers in adult social care within 12 weeks of starting a new job. The CIS include three days' training in first aid, moving and handling, infection prevention, dementia awareness, nutrition and hydration, and dignity. However, the standards do not provide any specific guidance or content, and evidence suggests that CIS completion is not always confirmed by inspectors (Cavendish, 2013). Unsurprisingly, therefore, there is considerable concern about whether this workforce is adequately prepared, particularly for the specific challenges of providing dementia care (Alzheimer's Society, 2007; Chalfont and Hafford-Letchfield, 2010), although the recently published Cavendish Review (2013) of unregistered health and social-care staff, discussed in the Conclusion, may encourage progress in this area.

There is a range of optional qualifications available to care assistants in England, however, although with limited impact on job advancement or pay. These qualifications, which are designed to align closely with the CIS, include:

- Level 1 Award in *Preparing to Work in Adult Social Care*;

- Level 2 and Level 3 Certificates in *Preparing to Work in Adult Social Care*;

- Level 2 and Level 3 *Health and Social Care* (HSC) Diplomas, which have replaced the Level 2/3 Health and Social Care National Vocational Qualifications (NVQs).

The HSC Diplomas can be generic or tailored to a specific area, such as dementia care, and the Level 3 Diploma fulfils the minimum entry requirements for nurse training.

It was suggested in the Introduction that, as a historically female-dominated sector, care work is often assumed to be unskilled, or to require only "common sense" or a caring temperament. Nonetheless, the limited research on nursing assistants highlights the complexity and importance of their role. In a thematic review of the literature, for example, Moran and colleagues (2010) found that these staff work across at least four domains (direct care, indirect care, administration, and facilitation), and draw on a range of core attributes which include helper, companion, facilitator, and monitor.[19] Other studies have identified their role as managers of the "raw data" of residents' everyday lives, which is obtainable only through the provision of constant hands-on care (Anderson et al., 2005). For example, a study of pain management in nursing homes found that CNAs "observe patient pain, a subjective symptom with often-subtle signs, on a daily basis" and thus have the potential to provide "meaningful insights into successful pain management approaches for this particularly vulnerable population" (Wright et al., 2003, pp. 154-5).

However, this potential contribution is often impeded by their exclusion from formal channels of communication, knowledge exchange, and care planning (Anderson et al., 2009; Korczyk, 2004). In the pain-management study, for example, "the aides directly identified knowledge deficit or lack of good communication among staff as causes of increased or initiated pain situations" (Wright et al., 2003, p. 157). Participants felt they were often given

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[19] This study looked at "support workers" *across* health and social care; however, it is assumed that the basic findings pertain to the specific sub-group of LTC assistants who are the focus of this research.

inadequate information/instructions about avoiding and treating pain, and also that their input and opinions went unheard. In another study of the translation of resident care plans into practice, Adams-Wendling et al. (2008) found that less than half the intended interventions across 10 nursing homes were communicated to direct-care staff through these documents.

A key characteristic of care assistants' role is that it is *relational*: building relationships with residents and their loved ones is the means by which they obtain information, perform their job, and also derive meaning and reward from their otherwise low-status role (Ball et al., 2009; Berdes and Eckert, 2007; Bowers et al., 2000; Brown Wilson et al., 2009; Robison et al., 2007; Train et al., 2005). There is a risk, however, that this relational or affective element is perceived as distinct from and less important than physical care. Berdes and Eckert (2007, p. 340) found in their secondary analysis of interviews with African-American and immigrant LTC workers, for example, that the workers "applied affective care in an elective way, so that the caring task was the minimum, universal form of care and added affective care created an enriched form of care". Proponents of PCC, as will be seen in the next section, resist such distinctions, stressing instead that "humanistic" knowledge about residents' personal and emotional lives is just as essential as "technical" knowledge about their medical condition and physical needs, with regards to providing comprehensive, holistic care for every individual in the often dehumanising LTC environment.

## 2.4    Introducing person-centred care

Person-centred care has roots in Carl Rogers's person-centred psychology, a humanistic approach to counselling which focuses on developing a warm, "congruent" (meaning

authentic or genuine) relationship between the counsellor and client, which is marked by "unconditional positive regard" and "empathy" (McLeod, 2008). Rogers's approach posits that it is this relationship – rather than what the therapist actually says or does – which enables clients to develop.

In recent years, the concept of PCC – and its cognates, including patient-, client-, and people-centred care – has spread across the health and social-care sector (Amann Talerico et al., 2003; Edvardsson et al., 2008; Innes et al., 2006; McCormack, 2004; Picker Institute, 2013). In LTC in particular, PCC has been discursively adopted as an alternative to the conventional biomedical model, which is associated with impersonal, hierarchical relationships; cold, clinical environments; routine-driven daily care; and pharmacological fixes.

Drawing together previous research by McCormack (2004) and Suhonen et al. (2002), Morgan and Yoder (2012, p. 3) provide the following definition of PCC:

> [A] holistic (bio-psychosocial-spiritual) approach to delivering care that is respectful and individualized, allowing negotiation of care, and offering choice through a therapeutic relationship where persons are empowered to be involved in health decisions at whatever level is desired by that individual...receiving the care.

This definition highlights a range of elements which tend to feature in any discussion of PCC, with varying emphases (Chapin, 2010), including:

- Primary emphasis on the individuality of each resident (Kitwood, 1997a);
- The importance of individuality, ensuring that residents "are not lost in the tasks of caregiving" (Crandall et al., 2007, p. 47);

- A focus on choice and autonomy (Crandall et al., 2007; Mead and Bower, 2000; Pioneer Network, 2004);

- Attention to the psychosocial and physical environments as well as the individual's medical needs (Brooker, 2004; Epp, 2003; Kitwood, 1997a).

What becomes immediately clear is that PCC is a diffuse and complex intervention rather than a specific solution to a discrete problem. Perhaps for this reason, the evidence base for PCC remains relatively shaky (Edvardsson et al., 2008). One outcome study of a person-centred bathing intervention, which took into account the preferences and comfort of the resident, the physical environment, and interpretation of behaviours as expressions of unmet needs, found that measures of discomfort, agitation and aggression declined significantly in the intervention groups without compromising hygiene, and that staff care-giving behaviour was positively affected (Hoeffer et al., 2006). Research has also found that PCC training may reduce the provision of neuroleptic medications (Fossey et al., 2006); that life-history interventions are associated with reduced aggression and other positive outcomes (Egan et al., 2007; McKeown et al., 2010); and that person-centred and dementia-care mapping interventions (described below) reduce agitation in people with dementia in residential settings (Chenoweth et al., 2009). Some studies on implementation of the Eden Alternative, also discussed below, have shown associations with lower levels of boredom and helplessness (Bergman-Evans, 2004); higher functioning among residents in physical and social domains, though without significant change on most objective indicators (Hinman and Heyl, 2001); and improved family satisfaction (Rosher and Robinson, 2005). Another study showed that perceived empowerment and the provision of individualised care increased with the introduction of *any* "culture-change model", but with better results for a facility-specific

model than for the Eden Alternative (Caspar et al., 2009). A year-long evaluation of one nursing home that had adopted the Eden Alternative found no beneficial outcomes in terms of cognition, functional status, survival, infection rate, or cost of care, but qualitative results indicated positive results for staff and residents (Coleman et al., 2002). Finally, one 15-month evaluation of another influential initiative, the Wellspring Model, developed in 1994 in Wisconsin, found that Wellspring facilities saved money and accrued fewer regulatory penalties compared to other nursing homes. Although there was no clear evidence of improvement in clinical outcomes, the evaluation found improvements in staff-resident interaction and quality of life (Stone et al., 2002).

### 2.4.1  *A comparative perspective on person-centred care*

Person-centred care has emerged somewhat differently in the LTC sectors on either side of the Atlantic.[20] In the United States, PCC is framed as "culture change", with a broad emphasis on transforming LTC facilities into more homelike environments through physical and operational restructuring. A key milestone for the American movement was the formation in 1997 of the Pioneer Network by a small group of nursing-home professionals who were concerned that the legislative reform of the previous decade had failed to eradicate endemic problems in the sector. Now a large non-profit organisation based in Chicago, the Pioneer Network links more than 30 state coalitions and works in strategic partnership with organisations such as the Commonwealth Fund, CMS, and the American Medical Directors Association to embed "person-directed values" in policy and practice (see Box 1).

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[20] With appreciation to Dr. Davina Porock from the School of Nursing at the University of Buffalo for our fruitful discussions on this topic.

**Box 1: The values and principles of person-directed care**

- Know each person

- Each person can and does make a difference

- Relationship is the fundamental building block of a transformed culture

- Respond to spirit, as well as mind and body

- Risk-taking is a normal part of life

- Put person before task

- All elders are entitled to self-determination wherever they live

- Community is the antidote to institutionalization

- Do unto others as you would have them do unto you

- Promote the growth and development of all

- Shape and use the potential of the environment in all its aspects: physical, organizational, psycho/social/spiritual

- Practice self-examination, searching for new creativity and opportunities for doing better

- Recognize that culture change and transformation are not destinations but a journey, always a work in progress

(Pioneer Network, 2013)

Also in the 1990s, geriatrician Bill Thomas developed the Eden Alternative, which was to become one of the most well-known culture-change models (and the one adopted by the US facility in this research). Framed as a "principle-based philosophy", it aims at "transforming care environments into habitats for human beings that promote quality of life for all involved" (Eden Alternative, 2012). As listed in Box 2, the 10 principles present the problems inherent in conventional settings (principle 1), the solution (principle 2), three specific antidotes (principles 3 through 5), guidelines for practice (principles 6 through 8), and drivers of change (principles 9 and 10). The "antidotes" include introducing companion animals and

indoor plants, facilitating frequent visits by children, and flattening hierarchies in order to place decision-making into the hands of elders and their primary caregivers (such as CNAs).

**Box 2: The 10 principles of the Eden Alternative**

| | |
|---|---|
| 1. | The three plagues of loneliness, helplessness, and boredom account for the bulk of suffering among our Elders. |
| 2. | An Elder-centered community commits to creating a human habitat where life revolves around close and continuing contact with plants, animals, and children. It is these relationships that provide the young and old alike with a pathway to a life worth living. |
| 3. | Loving companionship is the antidote to loneliness. Elders deserve easy access to human and animal companionship. |
| 4. | An Elder-centered community creates opportunity to give as well as receive care. This is the antidote to helplessness. |
| 5. | An Elder-centered community imbues daily life with variety and spontaneity by creating an environment in which unexpected and unpredictable interactions and happenings can take place. This is the antidote to boredom. |
| 6. | Meaningless activity corrodes the human spirit. The opportunity to do things that we find meaningful is essential to human health. |
| 7. | Medical treatment should be the servant of genuine human caring, never its master. |
| 8. | An Elder-centered community honors its Elders by de-emphasizing top-down bureaucratic authority, seeking instead to place the maximum possible decision-making authority into the hands of the Elders or into the hands of those closest to them. |
| 9. | Creating an Elder-centered community is a never-ending process. Human growth must never be separated from human life. |
| 10. | Wise leadership is the lifeblood of any struggle against the three plagues. For it, there can be no substitute. |

(Eden Alternative, 2009)

These verbatim excerpts from the Pioneer Network and Eden Alternative clearly illustrate the emotive, value-laden, and in many cases faith-based tone of the culture-change discourse. In addition, and unsurprising in the American context, there is a noticeable emphasis on the sovereignty of the individual, with an implicit assumption of intact cognition and communication. The ideal-type resident, in other words, is a reasonably articulate older person who, when provided with sufficient support and opportunity, can engage in reciprocal relationship-building and communicate their preferences.

In the United Kingdom, by contrast, proponents of PCC for older people have focused primarily on *dementia* care. This approach, led by the late Tom Kitwood and carried forward by the Bradford Dementia Group, challenges the prevailing attitude that the experiences and behaviours of persons with dementia are symptomatic of the disease, and brings more focus to the enabling or disabling elements of their surrounding social psychological environment. The central idea is that individuals' "personhood" – which is defined as "a standing or status bestowed upon one human being, by others, in the context of relationship and social being" that "implies recognition, respect, and trust" (Kitwood, 1997a, p. 8) – can be maintained even as cognition declines. The promise that personhood can be preserved through relationships implies the inverse, which is that an individual's personhood can also be undermined by the failure to recognise their needs and rights.

Underpinning this idea is the theory that human beings share a number of fundamental and overlapping psychological needs, which all relate to the "central need for love" (Kitwood, 1997a, p. 81). These include the need for comfort (physical and emotional); attachment (through specific and reciprocal bonds); inclusion (being part of a group); occupation (being

meaningfully involved); and identity (having a sense of self). By addressing these specific needs, nursing staff can theoretically support their residents' personhood.

Brooker (2004; 2007) distilled Kitwood's concepts into the mnemonic "VIPS", which stands for the following:

**V**aluing people with dementia and those that care for them (V)

Treating people as **I**ndividuals (I)

Looking at the world from the **P**erspective of the person with dementia (P)

A positive **S**ocial environment (S)

This framework highlights the complexity of person-centred interventions. Brooker argues furthermore that under- or over-emphasis of any single element can change the culture of care; for example, under-emphasis on "valuing people with dementia" can lead to discrimination within policy and practice, while over-emphasis may lead to abstract evangelism.

Person-centred dementia care has been operationalised through "Dementia Care Mapping", which is an observational tool for helping staff improve their practice. The tool quantifies care by coding residents' actions and interactions according to 17 "personal detractors" and their corresponding "enhancers" (see Box 3 for examples), relating these to 23 behaviour codes as well as observed mood and level of engagement. The data gathered during Dementia Care Mapping produces a "wellbeing score" for each observed resident which is used to educate staff and develop action plans for improvement, and it has also been used as a research tool (Zimmerman et al., 2008).

**Box 3: Personal detractors and enhancers**

| Domain | Detractors | Enhancers |
|---|---|---|
| Comfort | Intimidation | Warmth |
| | Withholding | Holding |
| | Outpacing | Relaxed pace |
| Identity | Infantilization | Respect |
| | Labeling | Acceptance |
| | Disparagement | Celebration |
| Occupation | Disempowerment | Empowerment |
| | Imposition | Facilitation |
| | Disruption | Enabling |
| | Objectification | Collaboration |
| Inclusion | Stigmatization | Recognition |
| | Ignoring | Including |
| | Banishment | Belonging |
| | Mockery | Fun |

(Brooker, 2007)


In summary, US approaches to PCC tend to emphasise broad changes in the care environment in order to allow each individual resident to express preferences, exercise autonomy, and contribute to their care and the community. In the United Kingdom, there is more of an emphasis on developing skills to provide personalised care for people with cognitive impairment, although the loss of personhood is certainly a risk for anyone residing in an institution and coping with infirmity and/or disability. However, there is considerable overlap and cross-fertilisation between these approaches. Indeed, although initially focusing on the individual care dyad, Kitwood shifted focus over time to the "interpersonal care culture" that allows the maintenance or disruption of personhood, and did frame the transition to person-centred dementia care in terms of "culture change" (Baldwin and Capstick, 2007, p. 263; Kitwood and Benson, 1995). Conversely, "culture change" in the United States does require staff to learn specific new skills, rather than appealing exclusively to their emotions

or faith, and many of these skills are relevant to dementia care. Furthermore, both – or rather *all*, taking into account the many variations along the PCC spectrum – present an alternative to the efficient, task-driven approach characterising conventional LTC institutions, and require staff, primarily care assistants, to actively recognise and support the individuality or personhood of each resident.

The intention in drawing out these distinctions, therefore, is primarily to highlight the questions that may be asked about any particular person-centred model or intervention. Such questions include: Is the intervention expressed in language that is appropriate, accessible, and meaningful? Do the ideas translate into specific, actionable guidance for staff? To what extent does the intervention focus on individual relationships versus the broader context of care, taking into account resources, regulations, and routines? And are the complex and multiple needs of care-home residents, including those with dementia, adequately addressed?

## 2.5    Summary: The care-home context

This chapter has provided a brief comparative overview of the long-term residential care sector in England and the United States. Four key points from this discussion require particular emphasis. The first point is that, given population and policy changes, LTC facilities have become home to the oldest-old and those with particularly complex health and social-care needs; more than 75 per cent of residents require assistance with three to six ADLs, for example (AHRQ, 2001), and two-third have dementia. This renders care-home work physically as well as psychologically demanding. This leads to the second key point, which is that the vast majority of care is provided by care assistants, who fulfil the role with

very little training, remuneration, opportunities for continuing education or advancement, or job benefits and security. Vulnerability, in other words, is shared by both residents and workers in this context of care.

The third point is that, despite legislative changes and increased monitoring and regulation of the sector over the past several decades, acute concerns about malpractice persist. These concerns are regularly inflamed by reports of neglect and abuse, such as the Winterbourne View care-home scandal that was exposed by a BBC Panorama documentary in 2011.[21] On the day of writing this chapter, an article in *The Daily Mail* led with the shocking and yet not-unfamiliar claim that "elderly residents at a care home were stuck in their rooms for months, starved and left in filthy sheets while their cries were ignored by staff who removed call buttons so they could sleep through shifts" (Bentley, 2013). Such reports often serve as damning indictments of individual perpetrators. However, the fourth point to emphasise from this chapter is that particular episodes of care should not be dislocated from their immediate context nor from the broader debate about the cost and sustainability of LTC for older people. Inadequate training, job instability, resource limitations, and other factors all have inevitable and indeed profound implications for the delivery of care.

These factors also have implications for the translation of new evidence, knowledge, and ideas – including about PCC – into practice, as discussed in the next chapter.

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[21] Although Winterbourne View served people with learning difficulties rather than older people, this story fuelled fears about what goes on behind the closed doors of any service for individuals who are vulnerable and voiceless.

**CHAPTER 3: TRANSLATING IDEAS AND EVIDENCE INTO PRACTICE**

## 3.1    Introduction: A background note on evidence-based practice

The idea of "evidence-based practice" originated in the medical sciences, where it was conceived as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients" (Sackett et al., 1996, p. 71). Since then, developing into what has been described as a *paradigm shift* (Evidence-Based Working Group, 1992) or a *social movement* (Estabrooks, 1998; Pope, 2003), the emphasis on evidence-based practice has spread across all domains of health and social care, with "nursing, the allied health professions, health administrators and policymakers … all fast at work rearticulating their areas of practice as evidence-based domains" (Mykhalovskiy and Weir, 2004, p. 1060).

It is widely acknowledged that this evidence-based discourse far outpaces practice, however, creating a mismatch between expectations and outcomes that the Institute of Medicine (IOM, 2001, p. 1) labelled a "quality chasm". In a review of evidence from the long-term care (LTC) context in particular, Levenson (2007) found that treatments for a range of common concerns, including constipation, urinary-tract infections, nutrition/hydration deficiencies, dysphagia, and behaviour/mood disturbances, commonly contravene the best available evidence.

Supply and demand was the initial explanation for this gap between evidence and practice: researchers are not supplying adequate evidence and/or practitioners are failing to implement the evidence that is available (Proctor, 2004, p. 227). The solutions, then, are to increase the

supply of empirical evidence and overcome practitioners' resistance to implementation. But this explanation falls short of accounting for the complex and contextualised processes by which practitioners acquire, synthesise, adapt, and apply (or discard) new knowledge, for a range of historical, political, social, economic, scientific, cultural, and/or organisational reasons (Glasgow and Emmons, 2007; Nutley et al., 2003). Hence interest in developing more nuanced explanations has been revived under the broad umbrella of knowledge translation (KT) and related terms. At the heart of this field of inquiry is the understanding that "the dissemination of knowledge is not synonymous with the utilization of knowledge" (Farkas et al., 2003, p. 48) – in other words, simply "pushing out" ever-larger quantities of empirical evidence will not necessarily enhance the evidence base of practice without corresponding attention to the "pull" of knowledge into practice.

The present chapter will critically review a number of influential KT models and frameworks in order to draw out the ontological and epistemological issues that they raise, particularly with regards to the nature of evidence/knowledge, the social relations of translation, and the importance of context.[22]

## 3.2    Knowledge translation: Antecedents, attributes, and application

The accepted definition of KT, which was developed by the Canadian Institutes of Health Research (2004), is as follows:

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[22] The intention here is to examine a purposive sample of approaches rather than undertaking an exhaustive review, which would duplicate recent efforts. (Examples of recent reviews are referenced throughout this chapter; see also Estabrooks et al., 2004; Mitchell et al., 2010; Thompson et al., 2006.)

> Knowledge translation is the exchange, synthesis and ethically-sound application of knowledge – within a complex system of interactions among researchers and users – to accelerate the capture of the benefits of research.

This definition, which has also been adapted for use by the World Health Organisation (WHO, 2005), emphasises the complexity of KT. Rather than assuming the straightforward implementation of research into practice, KT "encompasses *all steps* between the creation of new knowledge and its application to yield beneficial outcomes for society" (Canadian Institutes of Health Research, 2004; added emphasis).

The term KT overlaps with a multitude of related terms which are often used interchangeably and without explicit definition. In fact, Graham and colleagues (2006) identified 29 terms used across 33 applied-research funding agencies in nine countries to denote the broad concept of "knowledge to action" and McKibbon et al. (2010), using broader search methods, found 46 KT-related terms across the literature. Table 3 highlights some of the most prominent terms.

**Table 3: Select terms related to knowledge translation**

| | |
|---|---|
| **Diffusion** | "The process by which an innovation is communicated through certain channels over time among members of a social system" (Rogers, 2003, p. 29); see below. |
| **Dissemination** | Communication of new knowledge or evidence; may be passive (for example through publications) or active (through specific interventions). |
| **Implementation** | Putting new knowledge/ideas, such as scientific evidence, into practice. |
| **Implementation science** | Empirical study of methods to promote systematic implementation of clinical research in practice; includes study of individual/organisational behaviour and evaluation of behaviour-change interventions. |

| Knowledge exchange | Collaboration between researchers and practitioners or decision-makers to plan, produce, disseminate, and/or implement new research. |
| --- | --- |
| Knowledge transfer | Moving new evidence or ideas between stakeholders; most widely used term beyond health care, but criticised as too unidirectional. |
| Research utilisation | Term used in nursing since the 1970s to describe implementation of research evidence (as one subset of knowledge) into practice; research utilisation may be instrumental, conceptual, or symbolic. |

(Aita et al., 2007; Estabrooks et al., 2006; Graham et al., 2006; KT Clearinghouse, 2011; KUSP, 2011; Mitchell et al., 2010)

This proliferation of overlapping terminology is mirrored in the extensive range of models and frameworks that have been published to explain and/or guide KT processes. For example, in a systematic scoping review, Wilson et al. (2010) identified 33 frameworks relating to research dissemination, 20 of which had been designed to guide researchers in their dissemination activities. Using broader inclusion criteria, Tabak et al. (2012) identified 109 models for dissemination and/or implementation processes in health care. Included in their final narrative review were 61 models organised along three dimensions: construct flexibility (broad to operational); focus on dissemination, implementation, or both; and socioecologic framework (individual, organisation, community, and/or system).

The place to begin the current review is "diffusion of innovations" theory, which underpins the overwhelming majority of translation research, albeit implicitly in most cases (Estabrooks et al., 2008). This theory finds antecedents in Tarde's (1903) *Laws of Imitation,* Ryan and Gross's (1943) influential Iowa seed study, and Coleman et al.'s (1957) research on physicians' adoption of a new drug. However, rural sociologist Everett Rogers (2003[1962]) receives principal credit for developing the diffusion of innovations theory in the 1960s to explain the adoption of new agricultural technologies. In his approach, innovation refers to

"an idea, practice, or object that is perceived as new" (Ibid., p. 12) and diffusion is the process by which that innovation is "communicated through certain channels over time among members of a social system" (Ibid., p. 29).

Taken together, these two brief definitions highlight several important features of diffusion of innovations theory. First, the theory allows for an "innovation" (or, for the purposes of the current discussion, "evidence" or "knowledge") to take a variety of forms, from a tangible piece of technology to a new idea or way of working, with impact on the rate and success of its diffusion. Rogers (2003[1962], p. 219) identifies five key attributes of any given innovation: the *relative advantage* of the innovation, which refers to perceived effectiveness and efficiency relative to alternatives; *compatibility* with potential users' existing values and needs; *complexity*, or how difficult the innovation may seem to users; *trialability*, which is the extent to which the innovation can be tested in limited experiments; and *observability*, or the degree to which the innovation can be observed in use by other potential users.

Second, diffusion is explicitly understood as a social process occurring through networks of communication and influence, including mass media and interpersonal communication. Different individuals play key roles within this process: *innovators*, who are often seen as mavericks or risk-takers, are the first to try new innovations; *early adopters* are opinion leaders who, having tried the innovation, will bring on board the *early majority*; the *late majority* wait until the innovation has become the status quo in their local context; and finally the *laggards* are traditionalists who retain their commitment to prior ways of working. The theory suggests that, when designing KT interventions, it is the innovators and early adopters who must be leveraged as *change agents* in order to bring the majority on board over time

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(Prochaska et al., 2001, p. 258). Closely related to this understanding of diffusion as a social process is the importance of time, which Rogers (2003[1962], p. 221) frames as the *rate of adoption*, or "the relative speed with which an innovation is adopted by members of a social system".

Although taking into account social networks, communication, and influence, this theory assumes a fairly linear five-step process which culminates in *individual uptake* of a given innovation. Rogers (2003[1962]) conceptualises this as the "knowledge-innovation process", comprising knowledge, persuasion, decision, implementation, and confirmation, with potential for re-invention or discontinuance. Ultimately, the emphasis is on the individual's "rational" decision to adopt or reject a new technology or practice, without taking into account their capability and skills, the local context, or other factors. These assumptions of linearity and individual agency become problematic in light of further research on KT processes, as discussed below.

First, though, to consider one relevant contemporary application: Kovach et al. (2008) used Rogers's diffusion theory to guide an intervention on behaviour change in nine nursing homes. The aims of the pilot project were to examine the nursing homes' capacity for change before initiating the intervention; compare nurses' assessment and treatment practices before and after the intervention; and describe facility-level factors that supported or hampered the sustainability of the intervention. The intervention itself, which was an evidence-based protocol for assessing and treating the unmet needs of persons with advanced dementia, included five steps, beginning with physical, affective, and environmental assessment, progressing through non-pharmacological comfort interventions and pain management, and

moving to psychotropic treatment only as a final step (Kovach et al., 2006). The authors conclude that diffusion of innovations is "an effective model for making changes in performance of healthcare organisations" (Kovach et al., 2008, p. 138). However, the pilot intervention relied entirely on individual nurses changing their (self-reported) behaviour after receiving a single day of training, after which scale-up to the facility level was implemented primarily through the use of posters, educational materials, and action plans. The diffusion process therefore looked very similar to conventional efforts to "push out" evidence, which rely on individual behaviour change, rather than integrating evidence into practice in a meaningful, sustainable way.

Greenhalgh and colleagues (2004) conducted a very useful meta-narrative review of nearly 500 "diffusion of innovation" studies which have relevance for health-service organisations. Illustrating the breadth of influence of this theory, the studies were informed by 13 research traditions deriving from a range of academic disciplines including sociology, psychology, anthropology, organisational studies, management, economics, and information sciences. Drawing on empirical evidence, the authors of the review enhance the complexity of diffusion of innovations theory by developing a conceptual model which comprises the following components:

- The innovation itself, which can be assessed according to a range of attributes including but also in addition to those identified by Rogers;
- Adoption by individuals, which is translated from Rogers's "stereotypical and value-laden terms" (Ibid., p. 598) into psychological antecedents, the meaning of the innovation, and the nature of the adoption decision;

- The adoption process, which has three stages: pre-adoption, early use, and established use;
- Assimilation by the system, which is generally "organic and often rather messy" (Ibid., p. 601);
- Diffusion and dissemination, which rely on a number of components, including formal dissemination programs as well as the engagement of opinion leaders, champions, and boundary spanners;
- System antecedents for innovation;
- System readiness for innovation, including how the innovation "fits", the amount of support, time, and resources available, and capacity for evaluation;
- The outer context, from informal inter-organisational networks to top-down political directives;
- Implementation and routinisation, which depend on organisational structure, leadership and management, human resources, funding, inter-organisational communication and networks, feedback, and adaptation/reinvention.

This represents an impressively thorough attempt to integrate a sprawling field of study into a single unified model of the diffusion of innovations in health care. However, the authors assert that it is still a preliminary effort with the purpose of "illuminating the problem and raising areas to consider" (Ibid., p. 613), and that considerable work is still required to operationalise and test the inter-relationships between the model's numerous components. Further, the authors identify "demons in the literature" (Ibid., p. 614) which arguably reflect the inherent limitations of the theory for explaining and guiding KT. These "demons" include a focus on centralised, top-down innovations at the expense of peripheral, informal ones; the lack of empirical evidence for the "adopter traits" that are frequently cited from Rogers's work; and, with particular relevance for this study on PCC, the lack of research on the sustainability of complex service interventions as opposed to single innovations.

Therefore, it is useful to look to other contemporary approaches, such as the Knowledge to Action framework (KTA; Graham et al., 2006). This approach broadens the scope of enquiry by including knowledge *creation* as a key component of the KT process, along with the *action* of implementation. Use of the term "action" as opposed to *practice* is intended to account for additional stakeholders, including policymakers and service users as well as practitioners. Knowledge creation and action (or "application") are described as two processes: knowledge creation is conceptualised as three gradually "tailored" phases from inquiry through synthesis to the development of tools/products; and action is conceived as a cycle which involves identifying a problem and selecting/reviewing knowledge, adapting the knowledge and assessing barriers to its implementation, monitoring and evaluating the knowledge use, and sustaining it over time. Although presenting these as ideal phases in the framework, the authors acknowledge that in reality the process is complex, dynamic, and characterised by blurred boundaries (Ibid., p. 18). Different action phases may occur simultaneously or sequentially, may cause feedback loops, and may be influenced by the process of knowledge creation. Importantly, conceptualising KTA as a *cycle* of knowledge creation and action provides multiple opportunities for ensuring that knowledge products are obtained, packaged, and promoted appropriately for potential users in specific local contexts.

Although building feedback loops into the process, the KTA framework retains two assumptions about knowledge and agency that will be developed and critiqued below. First, as a result of the authors' interest in planned-action theory, the framework still relies on a relatively individualised and deliberative understanding of action, whereby a decontextualised rational actor identifies a gap in their knowledge and takes action to address that gap. The second, related assumption is that, although knowledge may encompass more

than just scientific evidence, it is still a discrete "product" that can be produced in one domain and disseminated to another, with minimal disruption or distortion. The implicit assumption is that the knowledge can then either be adopted, thereby augmenting or replacing previous ideas and practices, or rejected – an assumption that does not adequately account for the interactions between different types of knowledge and practices.

To address the implementation of research findings in gerontology specifically, a group of researchers associated with the Roybal Centers for Translational Research in the Behavioral and Social Sciences of Aging developed the "Knowledge Dissemination and Utilisation Framework" (Farkas et al., 2003). The four elements of this framework are: exposure, experience, expertise, and embedding. *Exposure* refers to increasing knowledge through a range of traditional and innovative dissemination methods that are based on an understanding of users' "information-seeking behaviour" (Ibid., p.49). *Experience* refers to enhancing positive attitudes towards new knowledge, for example through mentoring or role modelling. *Expertise* focuses on enhancing competence in using new knowledge through training and capacity-building initiatives. Finally, *embedding* strategies are designed to institutionalise new knowledge as ongoing practice, through technical assistance and changes in organisational structures, broader legislation and policy, funding mechanisms, and so on. Taking an "active learning" approach, the authors stress that, for each of the four elements, particular strategies must be modified to meet the needs and goals of the "target population", which may be researchers, practitioners, or "consumers" and their families.

Like KTA, this framework allows for different points of intervention, rather than positing KT as a strictly linear process from knowledge creation through implementation. It is also

relational, focusing on the links *between* target groups as well as specifying strategies for *each* group. However, the framework fails to account for the context of research production and implementation, instead falling back on implicit assumptions of individual agency and discrete, non-interacting knowledge products that can be adopted or rejected in relative isolation from existing practices.

Turning to KT studies in nursing, the PARiHS conceptual framework has particular prominence (Promoting Action on Research Implementation in Health Services; Kitson et al., 2008). According to this framework, successful implementation of research is a function of three interrelated elements (and their sub-elements), each of which can be assessed on a continuum from low to high. These elements are: the type of evidence; the context or environment in which the research will be implemented; and the method(s) by which implementation will be facilitated. The PARiHS framework has been empirically tested and refined over the past 15 years, with each of these elements subjected to separate concept analyses (McCormack et al., 2002; Rycroft-Malone et al., 2002). The framework rests on the hypothesis that implementation – a dynamic and complex process – will occur when scientific evidence resonates with clinical expertise and patient preferences; when the context supports change through a positive culture, strong leadership, and appropriate monitoring/feedback; and when skilled internal and external facilitators are involved.

A particular strength of the framework, as with KTA, is that the concept of "evidence" accommodates more than codified, scientific knowledge: also included are clinical experience, patient preferences and experience, and local data, such as from evaluations or quality-improvement initiatives (Rycroft-Malone et al., 2004). Also, by bringing in the

"context" dimension, PARiHS highlights the need for systemic or structural change, rather than focusing exclusively on individual practitioner behaviour. As one example of its empirical application, a team of researchers in Alberta, Canada, used the PARiHS framework to develop and test a theoretical model of organisational influences on research utilisation by nurses (Cummings et al., 2007). Using a sample of 6,526 hospital nurses, the team employed measurements of the three dimensions of context (culture, leadership, and evaluation) to sort cases into four mutually exclusive data-sets that reflected less-positive to more-positive contexts. The study found that staff development, opportunities for nurse-to-nurse collaboration, and staffing and support services were all facility-level variables that enhanced research utilisation, thus corroborating the importance of taking context into account.

Although considerably more parsimonious than the diffusion of innovations approach outlined above, the PARiHS framework nonetheless contains ambiguities which require further refinement and testing. In their critical synthesis of the PARiHS literature, Helfrich et al. (2010) identified, in particular, the need for greater conceptual clarity about the definition and interrelationship of the sub-elements of evidence, context, and facilitation, in order to address the current problems of overlap and duplication. For example, the problematic notion of "culture", which will be discussed further below, appears as a function of the sub-element of the "receptive context" ("cultural boundaries clearly defined and acknowledged"), but also as a separate sub-element ("able to define culture(s) in terms of prevailing values/beliefs") (Rycroft-Malone et al., 2004). Other constructs are insufficiently developed: "facilitation", for example, is defined solely in terms of individual roles and relationships, without taking into account a broader range of implementation interventions such as social marketing, which would require different specification and measurement. Another example is that the notion of

evidence does not contain the same level of attribute specification that can be found, for example, in diffusion of innovation theory.

Finally, despite acknowledging complexity and contingency, the PARiHS framework does not appear to adequately address the dynamic interdependence of the three elements and their sub-elements, which are assessed along separate linear continuums. This interdependence means that the same implementation intervention "may have wildly different effects in different settings" and at different times (Helfrich et al., 2010, p. 17). Thus the notion of context remains problematically static, as a container within which implementation may or may not occur; this is a point that will be developed further below.

The Participatory Action Knowledge Translation (PAKT) framework developed by McWilliam et al. (2009) aims to add to the PARiHS framework by accounting for the *praxis* of translating knowledge into practice. PAKT incorporates a participatory-action approach and phenomenological analysis to capture how the social processes of a particular KT intervention are experienced, identifying four specific patterns of social interaction: overcoming barriers and optimising facilitators; integrating science-push and demand-pull approaches; synthesising the research evidence with professional craft knowledge; and integrating knowledge creation, transfer, and uptake throughout everyday work. Though relevant to the theoretical discussion in the next chapter, the empirical basis for the analysis is somewhat weak; that is, the study relies on three single meeting transcripts recorded at the beginning, middle, and end of the intervention (by each of nine action groups), plus limited fieldnotes. However, PAKT is useful in bringing action research to bear on theory development. Action research is increasingly acknowledged as a critical component of

effective KT because it meaningfully integrates knowledge users in the entire process, from problem identification through knowledge creation to implementation (Baumbusch et al., 2008; Booth et al., 2007; Bowen et al., 2005; McWilliam et al., 2009; Tolson et al., 2006). Taking this approach, argue Green and colleagues (2009, p. 168), means that:

> [T]he dissemination task can be framed less as a pipeline push strategy and more as a social marketing or participatory pull strategy of determining what people need and want to know or do and should package the scientific knowledge to address those needs and wants.

A final approach to consider is the Stetler Model of Research Utilisation, which was developed by nursing researchers in the 1970s (as the Stetler/Marram Model) and later refined to reflect the growing emphasis on evidence-based practice across health care (Stetler, 2001). This model prescribes five steps: preparation, validation, comparative evaluation, translation/application, and evaluation. It also proposes a set of criteria for applying specific knowledge to an identified issue: substantiating evidence, current practice, fit, and feasibility. The model inscribes the following assumptions:

- Research may be used informally by practitioners as well as facilitated or directed through formal organisational policies and protocols;
- Research utilisation may be instrumental, conceptual, and/or symbolic; that is, implementation is not always directly observable, but may manifest as a change in attitude or opinion;
- Research findings will usually be combined with other types of knowledge to facilitate decision-making or problem-solving;
- Individual and environmental factors affect use of research evidence;

- Probabilistic information from research may require adaptation according to individuals' preferences, needs, and status; and
- Successful research utilisation requires specific knowledge and skills.

The Stetler Model provides a practical tool for implementing evidence-based practice through "a series of critical-thinking steps designed to buffer the potential barriers to objective, appropriate, and effective utilization of research findings" (Stetler, 2001, p. 278). Since 1994, the model has been refined to account for groups as well as individual practitioners, and has had particular influence in the United States through the Veterans Health Administration Quality Enhancement Research Initiative. However, the model remains on the margins of broader KT research and theory development, perhaps given its relative lack of attention to relational, contextual, or structural considerations.

In summary, the conceptual models and frameworks discussed here have been developed within the past several years in light of growing recognition that passive dissemination of evidence – for example, through consensus recommendations or clinical guidelines – is not sufficient to achieve meaningful changes in practice (Bero et al., 1998), and that, rather, it is important to investigate the dynamic, interactive processes involved. That is why KT has been chosen an appropriate umbrella term in this study, incorporating ideas such as diffusion, implementation, and utilisation, because, as Wood et al. (1998, p. 1734; added emphasis) put it, "the key point here is how evidence is *translated within* the assumptive world of practitioners", not simply *transposed* from one domain to another.

## 3.3    Further interrogations of knowledge and translation

From this selective review of KT research, the next section will distil and unpack three key, interrelated issues. First is the nature of evidence and knowledge, which will be discussed in terms of instability, contestability, and multidimensionality. Second is the inherently social nature of knowledge; that is, knowledge as a relation between people rather than an individual cognitive property. Third is the central importance of the context of practice in the process of KT. Developing these arguments represents an attempt to contribute to the paradigm shift in KT research, as identified by Reimer-Kirkham et al. (2009), away from the dominant positivist paradigm which relies on relatively static concepts of evidence and practice. The following discussion will draw on substantiating empirical evidence about KT among nonprofessional staff and/or in LTC facilities where possible, although as mentioned these research areas are notably underdeveloped.

### 3.3.1   *What is knowledge?*

Each of the KT approaches discussed above consider *what* is being translated; for example, "the type of evidence" is one of the three main elements of the PARiHS model, and Rogers (2003[1962]) refers to the five attributes of any given "innovation". From across this literature, three ontological assumptions about knowledge can be derived (for the purposes of the current study).

The first is that knowledge is *unstable*. By contrast, the evidence-based practice movement inscribes the understanding that knowledge is a stable and discrete product, packaged in the "gold standard" form of systematic reviews and meta-syntheses of findings from randomised

control trials. The related assumption is that this product can then be passed across the "Cartesian gap" between research and practice while retaining the same fixed meaning (Wood et al., 1998, p. 1729). These assumptions have led to a focus on improving methods of communication and transfer, in order to make information more accessible and increase its transfer across settings; hence the Cochrane Collaboration reviews and so forth. There is an inherent paradox here, however, which is that the mathematical estimates of benefits versus harms that are derived from research on *population* samples must be applied to decision-making about the diagnosis or care of *individuals* (Greenhalgh, 2010). This necessarily entails reframing the information, both from population to the individual and from controlled research conditions to the local context of practice. As suggested by studies in the sociology of translation, this requires a process of disembedding from the original context and re-embedding in a new context, with new local meanings (Czarniawska and Sevón, 1996). As Nicolini et al. (2008, p. 1013) put it: "to circulate and to transfer is to transform".

This notion of translation as transformation, due to the inherent instability of knowledge and meaning, is supported by Wood et al. (1998) in their qualitative, comparative case study of four change initiatives in acute health-care settings. Rather than encountering examples of discrete and fixed knowledge, such as evidence-based interventions, they identify instead "an indeterminate process of stabilisation and destabilisation"; that which is known is not a stable product but a "momentary slowing down or arresting of an essentially indeterminate process of becoming" (Ibid., p. 1730, 1735). In other words, there is no such thing as *the* evidence, there are simply constructions and reconstructions of different sources of knowledge to support any given position or action in any given local, relational context.

The second ontological assumption relates to the *multidimensionality* of knowledge. Again, evidence-based practice tends to assume that practitioners can and should pick only from the "current best evidence", read as evidence from clinical trials. This assumption has been challenged, particularly by nursing researchers, in favour of a broader understanding of what constitutes evidence. Importantly, nursing research often attempts to account for the non-instrumental knowledge that is intrinsic to frontline care work. In an influential early paper, Carper (1978) identified four fundamental patterns of knowing in nursing: empirics, aesthetics, personal knowledge, and ethics. *Empirical knowledge*, or the "science of nursing", is "factual, objectively descriptive and generalizable" and "discursively formulated and publicly verifiable" (Ibid., p. 16); this is evidence-based knowledge, in contemporary parlance. *Aesthetics* is the "art of nursing", which defies discursive formulation but can be recognised in certain nursing practices. *Personal knowledge* is relational and reciprocal, and involves recognising the subjectivity of the individual person. The following explanation of personal knowledge is worth quoting at length because it reveals the challenges that nurses – and, as will be seen, nursing assistants – face in balancing different sources of knowledge and knowing:

> An authentic personal relation requires the acceptance of others in their freedom to create themselves and the recognition that each person is not a fixed entity, but constantly engaged in the process of becoming. How then should the nurse reconcile this with the social and/or professional responsibility to control and manipulate the environmental variables and even the behavior of the person who is a patient in order to maintain or restore a steady state? … What choices must the nurse make in order to know another self in an authentic relation apart from the category of patient, even when categorizing for the purpose of treatment is essential to the process of nursing? (Ibid., p. 19)

Finally, *ethical knowing* refers to the moral choices that nurses must make about "what is good, what ought to be desired, what is right" (Ibid., p.21). These four patterns of knowing are not mutually exclusive, but rather are interconnected and reinforcing, together producing the type of practice that is not just mechanical or habitual but flexible and individualised.

An important point here is that different patterns of knowing involve different theoretical orientations and draw on different types and sources of evidence, as demonstrated by Fawcett et al. (2001), who used Carper's work to expand understandings of what constitutes evidence for evidence-based practice. As already mentioned, developers of the PARiHS model – which postulates successful implementation as a function of evidence, context, and facilitation – also suggest that *evidence* encompasses codified and non-codified sources of knowledge, including clinical experience, craft knowledge, patient preferences and experiences, and local information as well as research evidence (Rycroft-Malone, 2004). Similarly, Aita et al. (2007) found in their review that nursing practice draws on clinical judgement, theory, tacit knowledge (elaborated below), and intuition as well as scientific research. More broadly, Blackler (1995, pp. 1032-3) concluded from his review of knowledge in the organisational studies literature: "Knowledge is multi-faceted and complex, being both situated and abstract, implicit and explicit, distributed and individual, physical and mental, developing and static, verbal and encoded."

Estabrooks's (1998) survey of nurses in Alberta (*n*=600) provides useful empirical evidence about the multidimensionality of the knowledge underpinning practice. Respondents cited individual patient information and personal nursing experience as the two most common sources of knowledge, followed by formal nursing education, with use of published research

falling into the lowest quintile. The author concludes that, as well as appropriate curricular content, nurses may benefit from better support in developing the critical thinking skills required to match different sources of evidence to particular clinical-practice contexts. This echoes the assumption in the Stetler Model that research findings will usually be combined with other types of knowledge to facilitate decision-making or problem-solving. Although they cannot be mapped directly onto this study, these empirical findings serve as a signpost to the importance of investigating the particular sources and types of knowledge which are salient to nonprofessional staff. In one nursing-home case study, Anderson and colleagues (2005) found that attempts to change practice among nursing assistants must take into account the pre-existing mental models which they bring to their work, namely the "golden rule" and their "mother wit", as well as their formal knowledge.

A deeper challenge to the notion of evidence as a singular, discrete entity is the recognition of the tacit dimension of knowing (Polanyi, 1966). Echoing Ryle's (1949) distinction between "knowing *how*" and "knowing *that*", Polanyi argues that every act of knowing contains an explicit dimension and a tacit dimension. Tacit knowledge is the embodied and contextualised realisation of explicit knowledge; it is that which remains unarticulated no matter how diligent our attempts to codify knowledge into propositions or rules (or to "convert" tacit into explicit knowledge; Nonaka, 1994). Hence Polanyi's (1966, p. 4) famous claim that "we can know more than we can tell". The key point is that attempts to translate explicit or codified knowledge, such as scientific evidence or new ways of working, may be unsuccessful without attention to the corresponding tacit knowledge – the knowing *how* which makes the evidence actionable. What's more, attempts to codify previously tacit

knowledge may actually have de-skilling rather than up-skilling consequences, as Duguid (2005, p. 112) suggests:

> The codification of knowledge may be less a matter of translation (though translation itself is rarely innocent) than transformation, whereby the codified no longer serves the purpose of the tacit it replaces. Uncodified knowledge provides background context and warrants for assessing the codified. Background no longer works as background when it is foregrounded.

By highlighting "knowing how" as knowledge that is realised through action, Polanyi's work feeds into the practice approach developed in the next chapter.

The third ontological assumption is that knowledge is *contested*. Inscribed in the evidence-based practice movement is the notion of a hierarchy of evidence, with clinical trials providing the "most objective" evidence, and therefore the least problematic to implement. Instead, a critical KT perspective highlights the historically and politically inscribed processes by which certain types of evidence are defined and recognised, while others are marginalised or invalidated (Reimer-Kirkham et al., 2009). In a broad review of the evidence-based movement from the perspective of critical pedagogy, Denzin (2009, p. 142) summarises this point:

> The politics and political economy of evidence is not a question of evidence or no evidence. It is rather a question of who has the power to control the definition of evidence, who defines the kinds of materials that count as evidence, who determines what methods best produce the best forms of evidence, whose criteria and standards are used to evaluate quality evidence?

This issue of power and contestation has received limited direct attention in the KT literature (Poole, 2008), although it is rigorously explored in other fields. Foucault's (1980) genealogy and knowledge/power studies, as a notable example, demonstrate that any change in the distribution of knowledge subverts the established relations of power in a given context. This suggests that the introduction of new knowledge will be one of struggle and contestation over credibility, and helps explain why knowledge can be "sticky", if adopting it threatens existing relations of power and status (Szulanski, 2000). As stated by Fitzgerald et al. (2002, p. 1444):

> [S]ome of the factors which are seen to influence adoption or rejection decisions are not rational, but political. Thus, a practice community might be reluctant to accept the efficacy of a novel treatment because it threatens their established skills base and thus threatens their status and professional position.

The limited research on nonprofessional nursing staff points out at least two specific implications of the contestability of knowledge. First, the power relations which privilege scientific evidence tend to render invisible the knowledge and skills employed by low-status frontline workers. Meerabeau's (1992, p. 110) argument that focusing on why practitioners do *not* use research-based knowledge fails to identify the ways that practitioners also *create* new knowledge – which "is often not codified or published" – is relevant here. Second, although possessing little formal authority over the production or dissemination of knowledge, studies have shown that nonprofessional staff nonetheless (or as a result) exercise power "on the shop floor" by circumventing top-down efforts to translate new practices which are perceived as inappropriate, irrelevant, or unworkable (Foner, 1993; Kontos et al., 2010; Lee-Treweek, 1997). Thus efforts to integrate new ideas into existing practice may be thwarted through lack of attention to the power struggles that mark the process of embedding one type

of knowledge and marginalising another, and to the acts of resistance that this process may engender.

To summarise this section: eliding different sources and types of knowledge risks oversimplifying the processes of KT and implicitly endorsing the primacy of scientific evidence. This is particularly problematic when turning to nonprofessional nursing staff, who are neither trained nor expected to draw on scientific evidence using the methods required of doctors and other professionals – and yet nonetheless *somehow* acquire knowledge to undertake their work (Anderson et al., 2005; Ayalon et al., 2009; Piven et al., 2008). Attempting to understand KT among this cadre of staff requires us to identify the sources and types of knowledge they already employ *as well as* the mechanisms which support or inhibit the introduction of new knowledge. Understanding knowledge as unstable, multidimensional, and contestable is the first step, leading into an understanding of KT as relational and contextualised.

### 3.3.2   *The social relations of knowledge*

As mentioned in Section 3.2, there has been a tendency within KT and related research to rely, more or less implicitly, on a rational-actor approach which casts individual practitioners as autonomous decision-makers and frames KT as a largely cognitive process, albeit one that is complicated by contextual barriers such as inadequate resources or managerial support. And indeed, individuals do bring to the practice context their own personal biographies, educational backgrounds, and personal characteristics (Fuller, 2007). For auxiliary nursing staff, who have not undergone extensive professional socialisation like that experienced by

registered nurses or doctors and who do not possess a similar codified knowledge base, these personal characteristics may have particular influence. In a grounded-theory study of nursing assistants in LTC facilities in Canada, Janes and colleagues (2008) identified several personal characteristics which influence knowledge utilisation, alongside relational and contextual factors; these included flexibility and persistence, compassionate understanding as well as codified knowledge, composure, and willingness to embrace challenge. Cultural background, confidence on the job, attitudes towards dementia, family experiences, and caring personality traits have also been identified as individual characteristics which influence care staff's practices in LTC settings (Ayalon et al., 2009; Ball et al., 2009; Hughes et al., 2008).

However, there is increasing acknowledgement that the implementation of new knowledge "includes, but goes well beyond, cognitive and attitudinal change at the level of the individual practitioner" (Angus et al., 2003, p. 226; see also Berta et al., 2010; Estabrooks et al., 2003; Kitson, 2009; Rycroft-Malone, 2008). This derives in part from the recognition that health-care knowledge is highly fragmented and dispersed, requiring cooperation and collaboration across organisational and professional boundaries. Thus, in a participatory study involving more than 100 semi-structured interviews, Bowen and Martens (2005) found that the quality of relationships and the level of trust between stakeholders are critical components in effective KT. Similarly, in the comparative study of acute-sector change initiatives mentioned above, the researchers found that the quantity and quality of local inter-relationships were important influences, along with change agents, in the success of knowledge transfer (Wood et al., 1998). Looking specifically at the introduction of new non-pharmaceutical technologies into healthcare practice, a systematic review confirmed that adoption and assimilation by individual users is often shaped by discussions with peers and colleagues (Robert et al., 2010).

In other words, these studies support the argument that "health professionals do not simply apply abstract, disembodied scientific research rigidly to the situations around them, but they collaborate in discussion and engage in work practices, which actively interpret and (re-) construct its local utility" (Fitzgerald et al., 2002, p. 1439). It is through trusted relationships, that is, that practitioners learn about, adapt, and adopt new information.

Particularly compelling support for the social basis of knowledge comes from Gabbay and Le May (2004), who conducted an ethnographic investigation of evidence-based decision-making in two general practices in the United Kingdom. Their findings suggest that physicians and practice nurses rarely rely directly on published evidence, but rather draw from socially constituted *mindlines*. Mindlines refer to:

> [C]ollectively reinforced, internalised tacit guidelines, which were informed by brief reading, but mainly by their interactions with each other and with opinion leaders, patients, and pharmaceutical representations and by other sources of largely tacit knowledge that built on their early training and their own and colleagues' experience (Ibid., p. 3).

This informal and largely tacit knowledge-in-practice was mediated by features of the organisational context, a point that will be revisited in the next section.

From nursing research, Quinlan's (2009) institutional ethnography of nurse practitioners in three health-care settings in Saskatchewan highlights dialogical exchange between team members as the basis for knowledge creation, transfer, and application. In another ethnographic study of nurses in an acute setting, Hunter and colleagues (2008) found that

knowledge was transferred through informal, incidental, interpersonal, and interactive processes. Finally, in the LTC study mentioned above, Janes (2010) found that relational factors influenced nursing assistants' knowledge utilisation because: they draw on human sources of best practice; they rely on positive social relations to motivate and emotionally equip themselves to use their knowledge; and they face power differentials that constrain their use of knowledge.

Exploring KT through relationships and interactions links directly back to the argument above about the mutability and contestability of knowledge. That is, it is through interpersonal processes of dialogue, debate, and negotiation that evidence is translated and transformed. This understanding of KT parallels the emergence of social theories of learning, which suggest that individual uptake of knowledge cannot be isolated from local and relational processes and practices (Brown and Duguid, 1991; Corradi et al., 2010; Fox, 2000; Gherardi et al., 1998; Hughes et al., 2007; Lave and Wenger, 1991; Wenger, 1998). Since this point will be taken up again in the following chapter, the key point to emphasise here is that KT occurs through a relational, negotiated, and partially tacit process of learning among a particular group of workers within a given organisation (Duguid, 2005; Gherardi et al., 1998). Rather than foreclosing analysis at the individual or group level, however, it is critical to consider the broader practice setting.

### 3.3.3  Translation: A matter of context

There is increasing recognition that, when it comes to translating knowledge into practice, context matters – not as a hindrance but as a defining element:

Context and "confounders" lie at the very heart of the diffusion, dissemination, and implementation of complex innovations. They are not extraneous to the object of study; they are an integral part of it. The multiple (and often unpredictable) interactions that arise in particular contexts and settings are precisely what determine the success or failure of a dissemination initiative (Greenhalgh et al., 2004, p. 615).

Thus context is one of the three main elements of the PARiHS model, defined as "the specific environment in which implementation, utilisation, and creation of evidence may take place" (McCormack et al., 2002, p. 101). But how KT strategies can account for context remains an open question; as Mitton et al. (2007, p. 756) found in their review and synthesis, very little is yet known about what KT strategies work best in which contexts.

The literature suggests that context is a complex, multi-faceted concept which includes both "hard" factors such as resources and "soft" factors such as routines (Rycroft-Malone, 2008); these various factors are synthesised in Figure 1 below. Dopson and colleagues (2002, p. 43) characterise the various elements of context as "a layered set of influences, which commence at the outer layer with influences from government health policy and move inward to regional/local influences, and finally to influences that are specific to a single organization and individual practitioner". The key point is that, contrary to more conventional or "commonsense" definitions, context should not be understood as an empty container in which events happen, or a backdrop against which events unfold (McDermott, 1996). Rather, situated practices and relationships interconnect in unique, historical, and evolving ways to constitute the context. Any new knowledge is adapted and integrated into those situated elements, therefore changing the context overall, however minimally.

"Culture" is often cited as a component of context. In the PARiHS framework, it is mentioned as one criteria of the sub-element "receptive context" (with "boundaries clearly defined and acknowledged"), along with physical, social, structural, system, and professional/social network criteria. It also appears as a second sub-element of context, with the following criteria: "able to define culture(s) in terms of prevailing values/beliefs; values individual staff and clients; promotes learning organisation; and consistency of individual's role/experience to value: relationship with others, teamwork, power and authority, and rewards and recognition" (Rycroft-Malone et al., 2004). Culture is a slippery concept, however, as it is understood and deployed very differently across a range of academic disciplines as well as in everyday parlance – as in, for example, ubiquitous references to the "culture of care" in the NHS and the "culture change" movement in the LTC sector.

Rather than taking culture as an aspect of context, therefore, an alternative holistic approach from organisational studies is to frame culture and context as one and the same. In this view, culture is not something that an organisation *has* but something it *is* (Smircich, 1983, p. 347). As Manley (2000, p. 35) puts it: "every aspect of an organisation is part of its culture and cannot be understood as separate from it – culture is not an objective tangible or measureable aspect of an organisation; organisations are cultures". In order to avoid being sidetracked into "the endless crossroads" characterising the concept of culture (Prasad and Prasad, 2009), this holistic understanding of culture will be adopted for the current study.

**Figure 1: Components of context**
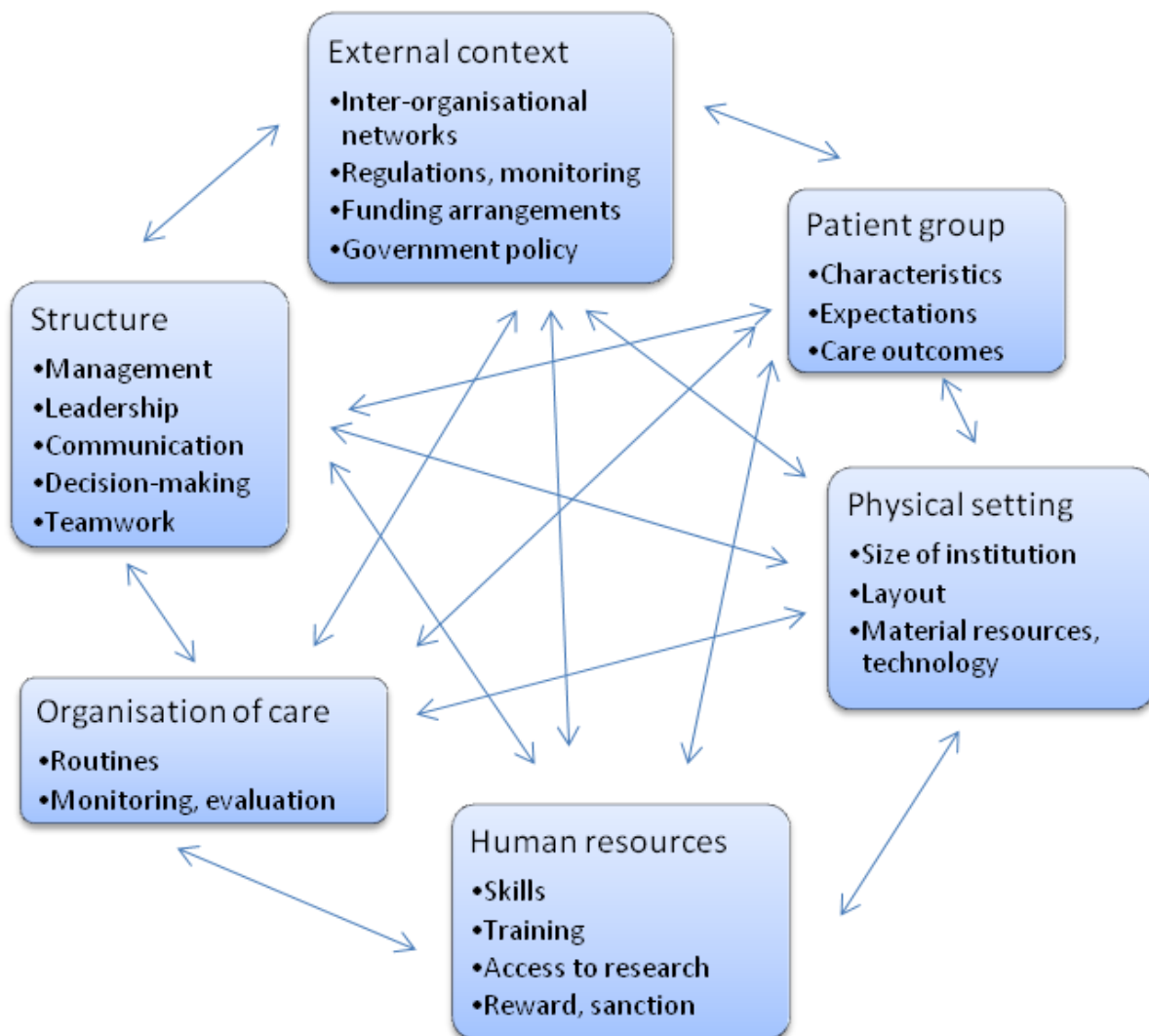


(Anderson et al., 2005; Angus et al., 2003; Aylward et al., 2003; Berta et al., 2010; Boström et al., 2007; Dopson, 2007; French, 2005; Janes et al., 2008; Kontos and Poland, 2009; Levenson and Morley, 2007; McCormack et al., 2002; Meijers et al., 2006; Messinger-Rapport, 2004; Nay, 2003; Piven et al., 2008; Thorne et al., 2001)

Within KT research as well as in a more literal sense, the specific context of LTC for older people remains largely hidden (Berta et al., 2010; Moriarty et al., 2010; Szczepura et al., 2008). Nonetheless, the complexity of residents' care needs, the emphasis on care versus cure, the regulatory and funding context, the reliance on nonprofessional staff, and the limited availability of tailored (psychosocial as well as biomedical) research suggest a particular set

of contextual issues. Further, a defining contextual element for nonprofessional staff in particular is their double marginalisation as low-status workers within a marginalised care sector (Nolan et al., 2008).

In general, the research which has been conducted in nursing homes tends to be small pilot interventions (Stolee et al., 2009) or descriptive case studies (Diamond, 1995; Kovach et al., 2008; McLean, 2007). One notable exception is a multiple case study conducted by Berta et al. (2010) in Ontario care homes on the translation processes that are entailed in the adoption and implementation of evidence-based clinical practice guidelines. Drawing on organisational theory and focusing on within-organisation KT, which the authors label "knowledge application", this study takes into consideration the organisational context in which learning about new knowledge takes places, individual-level factors that influence learning about new knowledge, micro- and macro-environmental influences on application and learning, and the influence of the nature of the knowledge itself (echoing Rogers's (2003[1962]) argument about the attributes of the innovation). Their findings confirm the importance of organisational factors in the LTC context, with organisational leaders (including clinical leaders and managers) playing a vital role.

This discussion of context suggests that the challenge is not only to identify influential aspects of context but also to analyse how these aspects interact in different and contingent ways to influence KT outcomes (Kontos and Poland, 2009; Scott et al., 2008). Otherwise, evaluations of targeted education and training interventions in the LTC setting may continue to show inconsistent or unsustained outcomes, as suggested by current systematic reviews (Beeber et al., 2010; Moyle et al., 2010; Nolan et al., 2008).

## 3.4    Summary: Lessons learned for studying KT in LTC

Based on a review of the theoretical and empirical literature on KT and from related fields, this discussion has developed an understanding of KT as a relational, contested, and contextualised process which draws on multiple types and sources of knowledge. Given the relative paucity of studies focusing on non-professional nursing staff in LTC, the review has selectively highlighted research findings, primarily from the nursing literature, which may relate most closely to this occupational group. However, reiterating a point made in the previous chapter, this is *not* to suggest direct correspondence, since care assistants do not share, as nurses do, a professional history, identity, code of ethics, or explicit knowledge base. Further, as mentioned above, the knowledge they are likely to implement relates primarily to ways of caring – such as PCC – rather than specific treatment approaches.

On the latter point, care assistants might actually be positioned to help facilitate the implementation of evidence in LTC, given their holistic and hands-on role. That is, a tendency towards "medicine-by-numbers", whereby the resident is fragmented into a series of body parts and ailments (such as dementia, mobility issues, dietary needs, infections, pressure sores, and so on) to be assessed and addressed by different professionals, can actually be more harmful than beneficial. As Levenson (2007, p. 495) cogently argues:

> The evidence strongly suggests that we need more – not less – involvement from those who can evaluate the risks and benefits of specific interventions by looking at the whole patient, not just more consultants to deal with pieces of the patient. ... Addressing issues in isolation may simply lead to complex incompatible or irrelevant regimes that cause significant complications.

Without overstating the claim, it may be suggested that the knowledge developed by nursing assistants through non-specialised, hands-on daily care, if appropriately leveraged, may help facilitate the delivery of evidence-based interventions by specialists – given that the evidence in LTC supports holistic rather than piecemeal interventions.

More directly, however, the review in this chapter has provided guidance for the development of a theoretical approach to the current research that can account for the following:

- Non-instrumental forms of evidence, such as the knowledge about relationship-building which is critical to PCC;
- The social relations through which care assistants generate and share their knowledge, despite having limited access to formal channels of learning and communication;
- The particular issues that may be unique to KT in long-term as opposed to acute-care settings.

This theoretical approach, drawing together Bourdieu's concept of practical logic and the neo-institutional theory of institutional logics, will be developed in the next chapter.

## 4.1    Introduction: Knowledge in/as practice

From a critical review of knowledge translation (KT) and related research, the previous chapter concluded that the implementation of new knowledge in health-care contexts must be considered not as a linear pathway but as a relational, contested, and contextualised process. This seems almost self-evident when considering the translation of person-centred care (PCC), which is at best a heterogeneous combination of intuition, ideas, values, holistic philosophical approaches, and targeted, evidence-based interventions. Understanding the translation of this admixture into the practice of care assistants – whose work is largely embodied rather than embrained (Blackler, 1995), manifestly relational rather than individualised, and located in the peripheral world of the nursing home – indicates the need for a theoretical approach that can adequately account for these issues of communication, conflict, and context. This is where practice theory offers a promising alternative to the more linear, rational-actor approaches which proliferate in KT research.

"Practice theory" is a broad term describing a variety of approaches that conceive *practices* as the primary unit of analysis in social theorising.[23] These approaches are proposed in contrast to both *individualist* and *societist* accounts which focus, respectively, on the interrelated actions of individuals or on broader, irreducible social structures and systems (Giddens, 1984; Schatzki, 2005). According to practice theory, social life is produced and reproduced through

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[23] Hereafter, for parsimonious rather than reductive purposes, the singular term "practice theory" will be used with reference to this diverse body of approaches.

actors' embodied, material, contextualised, and interconnected practices. Importantly, *knowing* is also a practice, rather than a static product (as often assumed in KT studies); it is considered "as an activity, as a collective and distributed 'doing' … situated in time and space" (Gherardi, 2009, p. 353). In a paper titled "Practice as the Site of Knowing*"* that inspired my interest in this approach, Nicolini (2011, p. 603) makes a similar claim:

> [K]nowing manifests itself in, and transpires through, the accomplishment of organisational practices, so that when we examine a practice we inherently examine an instance of knowing*.* … The knower and what is known – the knowing subject and the knowing object – emerge together in practice.

This quote neatly summarises the fundamental interconnectedness between the individual knower, what is known, and the practices through which these emerge, which is central to the theoretical argument developed in this chapter.

The chapter will begin by briefly outlining the philosophical roots of contemporary practice theory before looking in more detail at the conceptual tools provided by Pierre Bourdieu. Particularly helpful for the current study is Bourdieu's precise articulation of the recursive relationship between the embodied nature of practice (in *habitus*), the location of practice (in *fields*), and the dynamic power relations within and between fields (through the distribution of different forms of *capital*). These concepts will be combined with insights from the literature on *institutional logics* in order to develop a theoretical framework for investigating how the particular social location and disposition of care assistants, vis-à-vis other players in the field of long-term care (LTC) and following particular logics, condition their knowing-in-practice as well as receptivity to new practices. In the words of Bourdieu and his close

colleague Loïc Wacquant: "The task of science is to uncover the structure of the distribution of species of capital which tends to determine the structure of individual or collective stances taken, through the interests and dispositions it conditions" (1992, p. 114). The specific task in *this* study is to uncover the structures and structuring of knowledge about PCC in LTC, which first requires developing the necessary theoretical "toolkit" (following Nicolini, 2013).

## 4.2  A brief history of practice

The noun "practice" has three dictionary definitions (Oxford Dictionaries, 2013): first, practice is the application of a specific idea or method, such as the practice of prescribing medication for dementia-related "symptoms". Second, practice implies habitual activity, such as the routine-driven practices observed in many institutional-care contexts. Third, practice refers to the repetition of an activity in order to attain or maintain proficiency, such as improving manual-handling skills through daily practice. These definitions inform commonsense understandings of practice as something that people "do" – circumscribed and observable activities – as opposed to what they say, think, or theorise. Hence the notion of a "gap" between evidence and practice, with KT interventions conceived as bridging the gap by improving communication and removing barriers to implementation. This understanding can be heard as a lasting echo of Plato's hierarchical distinction between *epistêmê* (knowledge) and *technê* (craft or art), as elaborated by subsequent generations of philosophers.

Practice-based approaches, by contrast, subsume such binary oppositions – practice versus principle, knowing versus knowledge – into a much broader and more inclusive concept of "practices". Within the past decade or so, this concept has gained currency across a range of

fields, particularly in studies of knowledge and learning in organisational settings – a trend that has been labelled the "practice turn" (Schatzki et al., 2001) or, more recently, the "practice bandwagon" (Corradi et al., 2010).

Although there is considerable diversity among approaches, most practice theorists are indebted to the intellectual groundwork laid by Heidegger and/or Wittgenstein (Reckwitz, 2002, p. 250). Heidegger, a key figure in the existentialist and phenomenological traditions, focused on the problem of *being*, striving to address the question of whether there is an essence of existence (being *qua* being) or a multiplicity of ways of existing.[24] Put simply, his conclusion was that being has no underlying, timeless substance (cf. Plato, Aristotle, and subsequent philosophers) but is meaningfully, historically *appearing* in a world that already exists – as expressed by the term *Dasein,* which is translated as "there-being". As he writes in *Being and Time* (1962, p. 84):

> It is not the case that man "is" and then has, by way of an extra, a relationship-of-Being towards the "world" – a world with which he provides himself occasionally. Dasein is never "proximally" an entity which is, so to speak, free from Being-in, but which sometimes has the inclination to take up a "relationship" towards the world. Taking up relationships towards the world is possible only because Dasein, as Being-in-the-world, is as it is.

Thus Dasein is actively involved in creating the world, whether with conscious awareness or not, through engagement in practices that derive meaning from their social and historical context, and that are always related to the practices of others (*Mitsein*).

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[24] With thanks to Dr. Colin Wright for his characteristically illuminating lecture on Heidegger (*Tradition of Critique* series, University of Nottingham, 3 December 2012).

Wittgenstein also paved the way for the emergence of contemporary practice approaches through his later work on language and meaning. In this work, he challenged philosophy's treatment of the meaning of a proposition as something "external", located in an objective space, or "internal", located in mental representations. Instead, he suggested that meaning derives from use or application, arguing that "if we had to name anything which is the life of the sign, we should have to say that it was its use" (Wittgenstein, 1958, p. 4) and, even more succinctly, "practice gives the words their sense" (Ibid., 1998[1977], p. 97). In other words, meaning is activated through practical and interpersonal activity in a particular context.

The basis of the regularity of practices, according to Wittgenstein, are the rules that we follow in enacting them. His notion of rules encompasses the explicit directions involved but also the background know-how which – resonating with the discussion of tacit knowledge in the previous chapter – is largely unarticulated, and learned through hints, examples, observation, and repetition. As opposed to the rational actor who decides what to do in advance, Wittgenstein's actor follows a rule "blindly", then determines in practice whether their interpretation has been right or wrong (Nicolini, 2013, p. 39). This is a collectivist account of rule-following (Barnes, 2001, p. 26), in that:

> Rules can never be sufficiently informative or well exemplified to keep instances
> of rule-following behaviour relevantly identical in all the situations wherein rules
> are followed. … Whatever is accounted agreement in the following of a rule is
> produced by the membership that follows it, not by "the rule itself".

This last point about the social constitution of rules is echoed by Tsoukas and Vladimirou (2002, p. 981) in their analysis of organisational knowledge, where they argue that

"organizational tasks are thus accomplished by individuals being able to secure a shared sense of what rules mean (or by agreeing upon, reinforcing, and sustaining a set of justifications) in the course of their work". Although not all practice theorists subscribe to the notion of rule-following, Wittgenstein's work has been influential in suggesting that meaning is embodied, relational, and activated through regular ways of acting which, as an interlocking system of practices, represent the taken-for-granted background of daily life.

Another key figure from the "first generation" of practice theorists, although not explicitly recognised to the same extent, is Marx, who argued that the material conditions of production – not abstract ideas – are the driving force of history:

> [W]e do not set out from what men say, imagine, conceive, nor from men as narrated, thought of, imagined, conceived, in order to arrive at men in the flesh. We set out from real, active men, and on the basis of their real life-process we demonstrate the development of the ideological reflexes and echoes of this life-process.
>
> (Marx, 1845, Ch.1a, quoted in Nicolini, 2013, pp. 29-30)

As will be seen below, several themes from Marx's work are echoed in Bourdieu's work, including his emphasis on *praxis* (from Aristotle) as the basis of the re/production of social life and his argument that "social being determines consciousness" rather than vice versa (Brubaker, 1985, p. 748). Under the practice umbrella, Marx has also had significant influence on cultural and historical activity theory (CHAT) (Engeström, 2001) and on Giddens's (1984) structuration theory.

This last point speaks to the diversity among contemporary practice theorists.[25] Nonetheless, all approaches share the same basic premise that social life is produced and reproduced through recurrent practices, in other words the "sayings and doings" of everyday life (Nicolini, 2011, p. 610). It is through practices that the binaries mentioned above – including agent/structure and theory/practice – are reframed as mutually constituting rather than oppositional:

> The notion of mutual constitution implies that social orders (structures, institutions, routines, etc.) cannot be conceived without understanding the role of agency in producing them, and similarly, agency cannot be understood "simply" as human action, but rather must be understood as always already configured by structural conditions … Social regularities are always "in the making", that is, they are ongoing accomplishments.
>
> (Feldman and Orlikowski, 2011, p. 1242)

Bourdieu was particularly rigorous in his attempts to transcend these binary oppositions by putting practice first, so we will now move from this brief historical overview to considering his contribution in more depth.

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[25] Ethnomethodology is another significant area of research which falls under this umbrella, to the extent that it focuses on "everyday activities" and the "methods" that members use to enact and account for these activities (Garfinkel, 1967). A key difference is ethnomethodology's exclusive attention to activities as self-organised and self-contained, to the extent of bracketing off (as ontologically distinct) any broader contextual elements that are not directly manifest therein (Grahame, 1998; Nicolini, 2013). Practice theory, especially Bourdieusian theory as discussed below, tends to take a broader perspective by looking at how translocal phenomena are implicated in practice due to individuals' membership across groups (each with their attendant social positioning and relations) and participation in interconnected rather than singular activities (Crossley, 2001).

## 4.3    Bourdieu's logic of practice

Bourdieu's ideas about the dialectical relationship between objective structures and subjective dispositions provide a new direction for KT research which avoids "individual finalism" (Bourdieu, 1990a, p. 43) without resorting to structural accounts that obscure individual action altogether. As he articulates these ideas in *The Logic of Practice*:

> The principle of practices has to be sought instead in the relationship between external constraints which leave a very variable margin for choice, and dispositions which are the product of economic and social processes that are more or less completely reducible to these constraints, as defined at a particular moment… There is an economy of practices, a reason immanent in practices, whose "origin" lies neither in the "decisions" of reason understood as rational calculation nor in the determinations of mechanisms external to and superior to the agents.
>
> (Bourdieu, 1990b, p. 50)

This "relationship" has three main components: habitus, capital, and field. The following section will describe each of these concepts in turn before elaborating how they interconnect. Following Bourdieu's own advice, these concepts will be considered selectively as "thinking tools" (Wacquant, 1989, p. 50) for studying the implementation of PCC, rather than with the intention to analyse them thoroughly within his entire oeuvre.

### 4.3.1  Habitus, capital, and field

The concept of habitus provides a starting point for the reconciliation of social structures and individual agency. In Bourdieu's (1990, p. 53) words, habitus refers to "systems of durable,

transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles which generate and organize practices and representation". That is, habitus is structured by a person's upbringing, socialisation, and experiences, but it helps to structure their present and future practices. It is a structure because it has a pattern, purpose, and underlying principles; thus Bourdieu distinguishes his "genetic account" of habitus from similar but "existential accounts" of embodied habits and practices, such as Merleau-Ponty's (1962) being-in-the-world (Grenfell, 2008, p. 56). It is durable because it lasts over time and transposable because it can be activated across different social contexts.

Thus, although habitus is the embodied history of the *individual*, it manifests in behaviour, actions, physical bearing and mannerisms, aesthetic tastes, and so on which can seen across groups or social classes, because individual biographies are linked into collective histories. Habitus reflects, reinforces, and indeed naturalises these social divisions between groups, as it provides "a 'sense of one's place' which leads one to exclude oneself from the goods, persons, places, and so forth from which one is excluded" (Bourdieu, 1984, p. 471).

Experienced simply as a "sense of one's place" or a "feel for the game", habitus often goes unrecognised except when actors find themselves in unfamiliar situations which require them to think consciously about what to say and do – when they feel like a "fish out of water", to use yet another metaphor. However, although habitus *generally* operates below the level of reflective thought, this does not imply blind adherence to rules and norms or "fixed and mechanical blueprints for action" (Crossley, 2001, p. 88); rather, the habitus provides a basis of cultural competence from which to innovate and improvise. It is important to emphasise that this competence is lodged firmly in the body, and feeds into an embodied sense of

identity: "what is 'learned by body' is not something that one has, like knowledge that can be brandished, but something that one is" (Bourdieu, 1990b, p. 73). The concept of habitus thus links: learning (habitus is the outcome of "pedagogical work" (Wacquant, 2011, p. 86)); the body (what is learned is internalised as a "*feel* for the game"); and identity (habitus is "something that one *is*"). Thus the concept of habitus is particularly important for understanding how ideas about PCC translate into the embodied practices of care assistants.

Individuals are always located in a particular position in a specific *field*, which is the second key concept. Fields are structured networks of social relations, within which players vie to occupy positions of authority and power. Within a given field, which may or may not coincide with formal institutional or organisational boundaries, individuals are like players in a game, "actively pursuing their ends with skills and competence but always within the rules of the game" (Crossley, 2001, p. 84). Importantly, although these "rules" are actively constituted and reproduced by the players themselves, just like on a sports pitch, fields *appear* as external, pre-existing, objective realities which circumscribe "the limits of reality and possibility itself" (Ibid., p. 90).

Bourdieu defines fields as relatively autonomous but homologous, in that each field "has its dominant and dominated, its struggles for usurpation and exclusion, its mechanisms of reproduction, and so on" (Bourdieu and Wacquant, 1992, p. 106) and exists within the larger "field of power", which is the economic field. The concept of field has had particular purchase in organisational studies, where researchers have used it to study both organisations-*as*-fields, in other words individual organisations, and organisations-*in*-fields, analysing the relationship between different organisations (see Emirbayer and Johnson, 2008).

The third key concept, *capital*, refers to the assets that individuals leverage in the struggle for position and authority within a particular field – including but not limited to economic capital. In fact, capital is conceptualised like "a pile of tokens of different colors, each color corresponding to a given species of capital" that an individual holds (Bourdieu and Wacquant, 1992, p. 99). Other forms of capital include:

- Cultural capital, which includes knowledge, skills, and abilities; this may be *embodied* in movement/speech or *institutionalised* in formal qualifications;
- Linguistic capital, which is leveraged through language use;
- Social capital, which derives from one's position in networks of relationships; and
- Symbolic capital, which is a composite arising out of the other forms of capital; this is the form that different capitals take when they are perceived and recognised as legitimate in a given field.

For example, the evidence-based practice discourse can be seen as a form of symbolic capital in health-care contexts: "individual practitioners may learn the appropriate choreography to perform with the key terms in order to accrue capital for themselves so that they can become 'competent' and 'successful' clinicians within a health-care facility" (Brown et al., 2006, p. 13). That is, through their effective deployment of key discursive terms, practitioners gain symbolic capital and correspondingly more status in the field. It is important to emphasise that capital has different value across different fields; indeed, "capitals only exist in relation to particular fields whose profits they command" (Friedland, 2009, p. 898). Evidence-based discourse might not currently have as much value for practitioners in a nursing home, for example, as for those working in acute settings.

These three concepts interconnect to produce a "logic of practice", expressed by the following heuristic: (habitus x capital) + field = practice (Bourdieu, 1984, p. 104). That is:

> [P]ractices cannot be deduced either from the present conditions which may seem to have provoked them or from the past conditions which have produced the habitus… They can therefore only be accounted for by relating the social conditions in which the habitus that generated them was constituted, to the social conditions in which is implemented.
>
> (Bourdieu, 1990b, p. 56)

In other words, practices arise from the interaction between an individual's habitus (the social conditions of their past) and the capital they can leverage from their location in a particular field (the social conditions of their present). Through those practices, individuals reproduce the field, with recursive effects on their habitus and future actions.

Thus "context" becomes not a backdrop for action, as implied in some KT studies, but as the contingent, negotiated, and somewhat unstable outcome of ongoing practices. Importantly, however, it appears to those who are producing and reproducing it as pre-existing, natural, and immutable; it is just "the way things are". This is *doxa*, according to Bourdieu, our taken-for-granted understanding of the world – which often serves to mask the *symbolic violence* that is perpetrated through social inequality. Symbolic violence is "implacably exerted through the order of things, through the logic of practice, through complicity and interior defeat, suggesting that the symbolically dominated conspire and commit isolated treasons against themselves" (Everett, 2002, p. 65). The often-repeated claim that "I'm just a care assistant" (Cavendish, 2013) could be seen as an example of this symbolic violence: the

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reproduction of a "commonsense" – but in fact arbitrary and constructed – understanding that direct-care work is less valuable in the "order of things" than, for example, professional medical intervention.[26]

## 4.3.2   Accounting for agency and change

Bourdieu's conceptualisation of practice has been subject to considerable analysis and critique from a variety of disciplinary perspectives. Two closely related critiques will be highlighted here. First and foremost, although ostensibly accounting for innovation and improvisation in practice, Bourdieu's approach appears to deal much better with reproduction and continuity than with change. For example, in the following passage he speaks to the simultaneously synchronic and diachronic constraints on action:

> [H]ow can one fail to see that the decision, if decision there is, and the "system of preferences" which underlies it, depend not only on all the previous choices of the decider but also on the conditions in which his "choices" have been made, which include all the choices of those who have chosen for him, in his place, pre-judging his judgements and so shaping his judgement.
>
> (Bourdieu, 1990b, pp. 49-50)

This statement appears to leave very little room for engaging in new practices, given the path-dependent and interconnected nature of every decision. Nonetheless, others have argued that potential for change arises from the interrelationship between Bourdieu's concepts, primarily

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[26] Bourdieu developed these concepts most fully in his studies of education, in which he suggested that inequalities in educational outcome stem not just from the amount of economic capital invested (yes, affluent parents invest more in their children's education) but also to differences in dispositions towards education, developed within particular class positions, which "function as codes of inclusion and exclusion" (Smaje, 2000, p. 75) and assign different symbolic value to the returns on such investment.

because any shift in one part of the equation will necessarily entail changes elsewhere. As Mutch (2003, p. 391) found in his study of pub managers in the United Kingdom, for example, changes in the workforce led to changing structural conditions of work that had profound effects on the habitus of the managers. Furthermore, even though practices are reproduced, they are reproduced each time "for another first time", within a field that may have altered somewhat due to the arrival of new players or changes in the distribution of capital. This generates "a dynamic of innovation in repetition" (Corradi et al., 2008, p. 19), with iterative effects on habitus and field and thus on future practices.

Furthermore, Bourdieu (1984) acknowledges that there will often be imperfect correspondence between mental and social structures: a particular individual's habitus may not perfectly match the *doxa* of a particular field. By recognising this mismatch, actors render the taken-for-granted world problematic, which opens up opportunities for challenge and change. As Friedland (2009, p. 890) puts it:

> It is through the gap between habitus and institutional structure – whether due to the conditions of formation of a habitus being misaligned with the conditions in which the agent operates or due to the very economical quality of its operations that depends on a "fuzzy logic" – that makes both creative agency and critical social movement possible.

Indeed, Sallaz and Zavisca (2007, p. 25) suggest that for Bourdieu, this is a central task of sociological inquiry: to destabilise fields by exploiting these gaps in order to expose the symbolic violence masked within the doxic order.

The second, related critique is that, in his attempts to avoid the trap of "individual finalism", Bourdieu ends up developing an overly objectivist account which allows no scope for agency, deliberation, or decision-making. Indeed, Jenkins (2002, p. 97) condemns his approach as "a celebration of (literally) mindless conformity". In response to this charge, however, others have stressed that as a "transposable" as well as "durable" system, habitus does not and indeed *cannot* provide explicit rules for action in any and every field at any point in time. Therefore, individuals must deploy a type of deliberative action which is guided but not prescribed by their "feel for the game". As Blackler (1995, p. 1938) puts it: "General abstractions are no more than resources to be used in specific circumstances where (in actions, improvisation and dialogue) creativity is ubiquitous".

This debate about agency is well-rehearsed and ongoing. Some take a middle ground, which will be the approach in this research, by identifying a "partial theory of agency" (Lau, 2004) in Bourdieu's work, as manifested in his use of phrases such as "more or less conscious" and "consciously or unconsciously". The notion of partial, or embedded, agency suggests that actors are indeed guided and constrained by their habitus, as described above, but allows for the possibility of explicit accounting and decision-making, particularly through reflexivity: according to Bourdieu, "everybody is capable of reflexively elevating assumptions and presuppositions into discourse and reflection" (Crossley, 2001, p. 93). (This links to the "epistemic reflexivity" that characterises Bourdieu's methodology, which will be discussed in the following chapter.)

The theory of institutional logics, which derives from neo-institutional theory, opens up additional space for considering change and agency within a practice-based approach. As

discussed in the following section, this theory suggests that institutions – such as the family or the state – are organised according to ideas and principles that are both constitutive of and constituted by related material practices, paralleling what has already been stated about individual practices. In any given field, several different institutional logics may be discernable, generating different practices *or* different meanings for the same practices. Thus considering these logics helps identify one of the important mechanisms through which individual biography, or habitus, links to collective identities through practice.

## 4.4    Institutional logics

As yet, the institutional-logics approach has had limited influence on contemporary practice theory, although its relevance to understanding how practices unfold within particular organisations-as-fields has been identified (Thornton et al., 2012).

Developed within the "new institutionalism" school of institutional theory, the concept of institutional logics aims to describe the contradictory practices that arise from the main institutions of "modern Western societies", namely capitalism, state bureaucracy, and political democracy. According to the architects of the theory, each of these institutions has a central logic that "guides its organizing principles and provides social actors with vocabularies of motive and a sense of self" (Friedland and Alford, 1991, p. 101). Institutional logics are posited as affecting practices in a number of ways, including by:

- Providing a sense of collective identity on which to base action;
- Providing different vocabularies to use in claims for status and power;

- Providing different systems of classification and understanding; and

- Structuring attention, that is, "generating a set of values that order the legitimacy, importance, and relevance of issues and solutions" (Thornton and Ocasio, 2008, p. 111).

The theory of institutional logics incorporates five main principles (Thornton and Ocasio, 2008). First is the notion of *embedded agency*, whereby individuals' "interests, identities, values, and assumptions are embedded within prevailing institutional logics" (Ibid., p. 103). That is, institutional logics both enable and constrain the means and ends of individual action. Second, society is an *inter-institutional system* which entails interplay and overlap between institutional logics. The health-care system, for example, may be shaped by market, state, and medical-professional logics (Scott et al., 2000). Third is the idea that institutions *develop and change* due to interaction between cultural and material forces – so they provide "highly contingent social norms" which inform practices, but those practices in turn may shape institutional ideas and norms (Thornton and Ocasio, 2008, p. 106). The fourth and fifth principles are that institutions can be studied at various *levels* and are *historically contingent*.

The institutional-logics approach thus conceives institutions as simultaneously material and ideal, rational and trans-rational. Friedland and Alford (1991, p. 249) use the example of private property, which is a "non-observable *symbolic* relation" that is rendered concrete through legal ownership, which is a *social* relation that organises objects in time and space. Similarly, the abstract idea of a god is made material through the situated and social practices of church attendance. The theory does not suggest that either thing – God or private property – actually "exists" through the material practices, but rather that the practices make sense in relation to the symbolic systems, and the symbolic systems make sense in terms of the

practices. This clearly parallels Bourdieu's emphasis on structured and structuring structures, by positing that institutional logics shape and are shaped through the practices of concrete, situated actors.

An important point to emphasise about institutional logics is that they may coexist within the same field, although with varying influences on and instantiations in practice. This argument was developed by Goodrick and Reay (2011) in their historical case study of pharmacists' professional practice, in which they identified four ideal-type logics: professional, corporate, market, and state. From this analysis, they suggest that different logics may exist in *competitive* relationships, entailing a zero-sum game where one logic replaces another, or in *cooperative* relationships, where it is possible for more than one logic to prevail. They further distinguish between cooperative relationships that are *facilitative*, wherein fulfilling one logic helps fulfil another, and those that are *additive*, wherein a particular practice fulfils more than one logic. Furthermore, they argue that competition between logics may be ameliorated by *segmenting* practices, whereby part of the practice is guided by one logic and part by another, thus allowing both logics to coexist over time. Competition may also be overcome through collaboration between actors, as Reay and Hinings (2009, p. 645) found in their study of the "uneasy truce" in Alberta's health-care system between the coexisting logics of medical professionalism and business-like health care, whereby "actors collaborated to achieve short-term goals, but through the process of working together developed new institutionalized working arrangements that supported the co-existence of competing logics".

The idea that multiple logics may coexist *within* the same field, and also that individuals themselves live and work *across* fields, implies the potential for change, as suggested in the

previous section. As Binder (2007, pp. 567-8) notes in her study of social workers, "people are engaged with not just one or two prevailing logics, but with multiple logics … and with multiple ways of encountering those logics". This suggests that no single logic is uniformly *doxic* across an organisation but that, instead, several different logics may *make sense* to different staff, depending on where they are positioned within the organisation and what understandings, experiences, and abilities they "import" from outside, through their habitus. As individuals engage with, question, and implement different logics in practice – in interaction with others' creative practices – it seems likely if not inevitable that practices will change, with recursive effects on their meanings and future enactment.

Goodrick and Reay (2011, p. 403) conclude that "to understand professional work, it is important to focus attention not only on apparently dominant logics but also on the full set of relevant institutional logics". This may create opportunities for individuals to exercise embedded agency, as they deliberate between different logics, but may also generate confusion, stress, and contradiction, as they attempt to negotiate between competing demands. This will be seen in care assistants' work, as they are asked to fulfil a home-like logic of PCC while also meeting the demands of the health-care and workplace logics.

### 4.4.1   Logics of practice in the nursing home

Following the use of ideal types in other studies of institutional logics (Goodrick and Reay, 2011; Thornton and Ocasio, 2008), it is helpful to identify and briefly sketch out the key logics that may be available and influential within the nursing home; namely, the logics of the home, the medical institution, and the business.

First, a LTC facility is, for the people that live there, **home**. This is one of the central messages of PCC; for example, the Eden Alternative (2009) claims that "where elders live must be habitats for human beings, not sterile medical institutions". The logic of the home is associated with the private sphere, with familial relationships, with independence and freedom from bureaucratic control, and also with norms of protection, care, and reciprocity. (It is important to emphasise, again, that these are ideal types; any individual's actual home life may look very different.)

A nursing home is also a **medical institution**, however, which prioritises physical health, bodily comfort, and cleanliness, as well as consistent documentation and quality control. Although these medical practices are certainly not antithetical to the "home" logic, neither do they entirely correspond to the latter's emphasis on flexible, individualised patterns of daily life and the development of meaningful, sustained, and reciprocal personal relationships. An important difference between these two, broadly speaking, is that the medical institution is informed by the medical model of disability, whereby the biological basis of infirmity/impairment provides the point of departure, whereas the social model of disability, which focuses on the enabling or disabling effects of the individual's surroundings, has more salience in the home (see Williams and Busby, 2000 for a good comparison of these two approaches).

Finally, whether public, private, or non-profit, nursing homes must also operate according to a **business** logic – influenced by the logics of the state and market – in order to provide an acceptable standard of service using the resources available and according to external accountability mechanisms. Managing the workforce to deliver this service with optimum

efficiency and effectiveness is paramount, and the impact for workers is an emphasis on fulfilling job descriptions, demonstrating competence in recognised job skills, and so on. These three logics are sketched out in Table 4.

**Table 4: Logics of practice in the nursing home**

| Characteristic | Home | Medical institution | Business (state/market) |
|---|---|---|---|
| Type of knowledge | Personal | Clinical | Financial |
| Control over knowledge | Individuals | Medical professionals | Managers, owners, shareholders |
| Relationships | Family | Patient and medical provider | Worker and clients/consumers |
| Time | Individual; flexible; extended trajectory | Clinical needs and staff resources; routine-based | Priority on efficiency, standardisation, measurement |
| Spaces | Private | Public with private domains | Public |
| Emotions | Authentic | Managed | Managed |

(Modelled from Goodrick and Reay (2011, p. 383))

The idea is that these three institutional logics, possibly along with others, may influence what carers know (in the sense of knowledge as "collective, situated, and provisional" (Sole and Edmondson, 2002, p. 18, in Corradi et al., 2010)) and how they enact this knowledge in particular moments in specific settings, to the extent that they provide alternative ways of thinking, collective identities, claims to power, and priorities for action.

## 4.5    Summary: A practice-based approach to knowledge translation

What distinguishes the approach outlined in this chapter from a host of other sociological theories of everyday action is its attempt to collapse micro/meso/macro distinctions into a

single theoretical account of material social practices as situated within, inseparable from, and constitutive of the social world (Jenkins, 2002; Rhynas, 2005). In his logic of practice, Bourdieu conceptualises these social practices as arising from a recursive relationship between individuals' habitus, which is formed within specific social conditions, their position in a given field, and the distribution of capital within that field. By bringing in the concept of institutional logics, we can attempt to further identify how and why individuals "choose" – in a limited sense – to act and speak in certain ways, what meanings they ascribe to these choices, and where there might be opportunities to alter either the meanings or the practices.

In order to understand the implementation of new practices in LTC, in other words, we must look at what care assistants already *do*, including their most "mundane" daily care tasks. Equally, we must take into account the field of practice in which their actions are located, their relation to the distribution of capital in that field, and the overlapping institutional logics which organise that field and provide meaning(s) for their actions. This theoretical framework is particularly relevant to studying KT because, as stated in the Introduction, it brings *knowing* and *doing* together, rather than considering knowledge as a separate, abstract construct. Knowledge is constituted through action and interaction, according to this approach, and cannot be separated from it.

In summary, this chapter has argued that knowledge becomes manifest and meaningful through practice, which is a product of the relation between individuals and their positionality (and power) within given social fields. The chapter has further argued that the meaningfulness of knowing-in-practice may be informed by one or more supra-organisational logics, with the possibility for change deriving from reflexive engagement among these

logics. This theoretical approach has been developed through conversation between the literature reviewed in Chapters 1 and 3 and the empirical findings of the research, which will be presented in Chapters 6 through 9. First, Chapter 5 will describe the study design and methods, as well as introducing the case studies which it examines.

**CHAPTER 5: RESEARCH DESIGN AND METHODS**

## 5.1 Introduction: The ontological implications of "practice"

The theoretical approach developed in the previous chapter is underpinned by what Schatzki (2005) calls a "site ontology". Site ontologies, as discussed, navigate a middle road between *individualist* and *societist* approaches in social research by focusing, not on individuals nor on irreducible social structures, but on the *context* of social life. All social life, that is, transpires in a particular site, field or, in Heidegger's (1962) terms, "clearing", which represents the horizons of possibility for action and meaning. Individuals and their social structures are thus ontologically continuous, as they are equally implicated in the contextualised practices which constitute the "building blocks of social reality" (Feldman and Orlikowski, 2011, p. 1241).

This ontological perspective requires a research design which focuses on what people *do* as the empirical key to understanding social relations and processes, such as knowledge translation (KT) about person-centred care (PCC). As Nicolini (2011, p. 605) proposes, "we must turn our attention to the real-time accomplishment of a specific sited practice and the texture of relationships that connects it to other practices". In this study, *ethnography* has provided the tools to examine the contextualised practices in question. The following chapter will explain the ethnographic design of this study before going on to discuss the research settings and methods in more depth.

## 5.2    Research design: Comparative ethnographic case studies

Originating in social anthropology, ethnography can now be found across a broad spectrum of disciplines, including sociology, organisational studies, education, and health care. In contemporary usage, ethnography may refer to a *process* (the research methodology) or a *product* (the written account) (Savage, 2006). Some reserve the term for participant-observation studies, while others use it more loosely to describe any qualitative research seeking emic explanations. Wolcott (1999) refers to ethnography simply as a particular "way of seeing".

Most broadly, ethnography can be understood as the "intensive empirical investigation of everyday lived cultural reality" (Foley, 2002, p. 472; also van Maanen, 2006). A naturalistic approach, ethnography requires studying "people in places" in order to gain a contextualised understanding of their actions and meanings (Zussman, 2004). It generally relies on prolonged periods of fieldwork[27] using different research techniques, including participant observation, in-depth interviews, and textual analysis, in order to develop a "thick description" of a particular setting (Agar, 1996; De Laine, 1997; Geertz, 1973; Savage, 2006; Wolcott, 1999). In contemporary ethnography, as elaborated below, reflexivity about the researcher's own position constitutes a significant element of this descriptive account (Madison, 2005; Skeggs, 2001); this reflexivity in part addresses concerns about the validity (and imperialist origins) of ethnography's claim to speak about or for "the Other".

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[27] Malinowski is credited with developing fieldwork as the central element of ethnography as a methodology (Rabinow, 1985).

By emphasising the "situated rationality of action" (Murphy and Dingwall, 2007, p. 2224), ethnography provides a way to circumvent the scapegoating that often characterises accounts of care for older people. In other words, ethnography requires the researcher to look beyond individualised explanations in order to understand how the context of care shapes (without determining) the particular knowledge and practices that emerge (Allan, 2006). Referring back to Bourdieu, this means seeing people not as atomised, rational individuals but as occupiers of different positions within a particular field, with differential access to capital; that is, considering both "the social mechanisms that affect the entire category to which any individual belongs" *and* "the conditions, inseparably psychological and social, associated with a given position and trajectory in social space" (Bourdieu, 1999, p. 612, in Emirbayer and Johnson, 2008, p. 34).

By placing primary importance on direct participation in the field, ethnography also allows the researcher to *experience* as well as examine the often-tacit, physical and emotional processes by which people gain competence as practitioners in a particular context (Smith, 2001, p. 224). Wacquant (2005, p. 466) refers to this as "carnal sociology", which "treats the mindful body of the analyst as a fount of social competency and an indispensable tool for research". His carnal sociology took place in the boxing ring; mine took place in residents' bedrooms, bathrooms, and dining rooms, as I learned the hands-on "body work" (Wolkowitz, 2002) required of a competent care assistant.

Indeed, as I reflect on my months of fieldwork, the memories which flood back are intensely visceral. The weight of immobile bodies as I tug, turn, lift, roll, and reposition them; the tropical dampness of the shower room, the sweat trickling down my back on hot afternoons,

and the rank, close air of the sluice room; the smell and texture of pureed meat and vegetables; the rush of adrenaline when an accident is just barely averted; the dryness of my skin after endless scrubbing with antibacterial soap; the soreness in my back and increasing definition of my biceps as fieldwork wears on; the involuntary sting of hot tears at the end of a trying shift; the sense of a heart full of affection and sadness. It was *through* these embodied experiences, as I became a competent care assistant, that I made sense of the practices that I witnessed and heard about.

My own experience of the disjuncture, for example, between training and practice provided insight into the complex and dynamic relation between "knowing that" and "knowing how" (Section 3.3.1). This is illustrated by the following fieldnote from Richardson's, the US research site, which describes one of my first attempts to transfer a resident from his wheelchair to his bed, together with another inexperienced carer:

> *Standing there, holding up a sagging dead-weight resident with whatever body parts we could, trying to drag him backward while he kept his feet planted and held onto the dividing curtain with an iron grip, the wheelchair in the way, the bed seemed miles away and the moment interminable. I can't even remember how we got him to the bed eventually but I think it was sheer force. ... The whole situation reinforced the myriad small adjustments that experienced staff must make in order to execute these tasks without drama or delay.*
>
> (Fieldnote, Richardson's, Shift 17)

Although I "knew *that*" there was a sequence of steps that I should follow in this scenario, I had not developed the embodied "know *how*" which would enable me to execute them efficiently and safely. This experience therefore provided useful data, accessible by taking a reflexive stance as described below, which would not have been captured by observation or interviews alone.

Adopting an ethnographic approach places this study at the intersection of two research traditions, namely, ethnographies of work (Hodson, 2004) and ethnographies of health care, particularly nursing homes (Bloor, 2001; Savage, 2000).

### 5.2.1   *Workplaces and nursing homes: An ethnographic crossroads*

Ethnographic studies of work emerged in the first decades of the 19th century, in recognition of the changing conditions of working life wrought by rapid industrialisation. Taylor's scientific-management studies, first published in 1903, were followed by detailed "shop-floor ethnographies" (Fine et al., 2009) exploring issues such as power, resistance, and informal working relations. As a well-known example, the "Hawthorne Studies" used quantitative and qualitative methods to examine productivity and worker cohesion (Roethlisberger and Dickson, 1947). Other examples from this era include Hersey's (1932) study on emotions in the workplace, which involved living and working alongside employees of the Pennsylvania Railroad System; Whyte's (1948) research in restaurant kitchens, which highlighted informal chains of command; Roy's (1959) study of an industrial machine shop, which looked at how workers beat the "beast of monotony" through group resources; Dalton's (1959) *Men Who Manage,* which contrasted official and unofficial managerial practices; and Kanter's (1977)

*Men and Women of the Corporation*, which looked at the construction of gender roles within bureaucratic organisations.

Influential health-care workplace studies include Goffman's (1961) *Asylums* (discussed in Chapter 6); *Boys in White* (Becker et al., 1961), which explored the socialisation of medical students; and Strauss and colleagues' (1963) research into the "negotiated order" in hospital settings, which highlighted how different occupational groups negotiate roles and meanings within formal organisational structures. Although the prevalence of such ethnographies in organisational studies declined as researchers adopted less expensive and ostensibly more "objective" statistical methods, a recent return to detailed examinations of the context and culture of work – as generative factors rather than confounding variables – has been noted (Zickar and Carter, 2010, p. 7).

Ethnographic studies of long-term institutional care constitute the second research tradition in which the current study is located. Two early examples are Stannard's (1973) study of patient abuse in an American nursing home, which attempts to show how the everyday conditions of work "normalised" abuse. With sweeping generalisations about the race and class of the research subjects, however, Stannard's work reads more like an indictment than a careful analysis. More thoughtful is Gubrium's (1997[1975]) *Living and Dying at Murray Manor*, also conducted though participant observation, which explores the different "worlds" of the nursing home, stressing the importance of everyday, negotiated practices. Another notable example is Diamond's (1995) *Making Grey Gold,* a critical ethnography of three American nursing homes which locates situated care practices within the broader context of "commodifying" social and economic policies. Similar themes are identifiable in *Women,*

*Resistance and Care,* Lee-Treweek's (1997) ethnography of nursing auxiliaries in a private nursing home in England, which challenges essentialist arguments about gender and care by linking paid care work to other low-wage service jobs.

Setting a direct precedent for my own research, Kayser-Jones's (1981) *Old, Alone, and Neglected* compares a long-term geriatric hospital in Scotland and a private American nursing home, discussing the divergent impact of national health-care policies on staff and residents' daily experiences. The study's conclusions, which are that publicly-funded health care and better needs assessment lead to preferable care in Scotland, are undermined in part by the limited theoretical justification for comparison, a concern that will be addressed in Section 5.2.2. More recent ethnographies have included Baumbusch's (2008) critical ethnography of two LTC facilities in western Canada, which finds that daily care practices and relationships in nursing homes are underscored by gender oppression, power relations, and discourses of ageism and corporatism; Bland's (2007) critical ethnography of three nursing homes in New Zealand, which looks particularly at the notion of "comfort" as a multidimensional, idiosyncratic, dynamic and context-dependent concept; and Ryvicker's (2009) ethnography of two nursing homes in New York which suggests that both "home" and "hospital" models of care can have contradictory effects on residents' preservation of self within the broader context of ageism and related stigma.

## 5.2.2  *Comparative cases*

The current study is described as "ethnographic case studies" because it uses ethnographic methods to examine two specific cases of KT about PCC.[28] This follows Yin's (2009, p. 18) two-fold definition of a case study, which is: first, that it is used for an "in-depth" empirical enquiry into a contemporary phenomenon "within its real-life context"; and second, that it relies on "multiple sources of evidence" that can be gathered with guidance from prior theoretical propositions.

The two cases have been selected as examples of medium-sized residential facilities providing skilled nursing care to a mixed population of older residents (including those with dementia and/or physical impairments), which have explicitly embraced a PCC approach. By including two separate cases, the intention is not to identify causation or to produce generalisable results, as with positivist comparative research which follows *a priori* assumptions about similarity or difference (Teune and Przeworski, 1970). Rather, this research proceeds from the assumption that all interpretive research is inherently comparative, in that researchers must compare what they discover against their previous knowledge and against other findings through an abductive, iterative process (Yanow, 2013 (forthcoming), p. 23). With two cases, similarities and differences in the situated particulars of practices across the sites can be identified and queried, alongside comparisons within each site, producing knowledge that is explicitly concrete and context-dependent (Flyvbjerg, 2006, p. 223).

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[28] Admittedly, those who distinguish ethnography and case studies as distinct methodological approaches – with case studies following a predefined protocol and striving for an external gaze while ethnography uses an emergent and immersive design – will consider "ethnographic case studies" a contradiction in terms (e.g. Fitzgerald and Dopson, 2009).

By comparing facilities in two different national contexts, the impact of national and regional policies on local practices can be included in this analysis, but again without making claims to causality. In other words, comparing two cases in their national contexts facilitates the "zooming in and out" that provides a fuller account of practices, as advocated by Nicolini (2009, p. 1411):

> Just as the global can be explained as a nexus of locality, the local is itself fragmented and multiplied, a node in a complex nexus of actions that enter into it and traverse it. Practice (including the practice of organizing) is the result of this complex interplay between local and global.

There are certainly other ways that the comparative basis of this research could have been developed, primarily – following Kayser-Jones's (1981) approach – as a direct comparison of the organisation and administration of LTC within the broader health and social-care system of each country. This approach would have drawn on the comparative social-policy literature, starting for example with Esping-Andersen's (1990) influential work on welfare-state typologies and also drawing on comparative American/European research (e.g. Daly and Lewis, 2000; Navarro and Schmitt, 2005; O'Connor et al., 1999; Pontusson, 2005), and would have involved rigorous analysis of relevant policy documents from each country. However, this would have entailed a very different research design using methods that would not necessarily have been appropriate to the localised study of care assistants and KT. In summary, therefore, the identification of differences between the two sites has been an integral element of the analysis in this study, and connections have been suggested, wherever possible, to broader differences across the two national settings. However, additional

empirical research would be needed to extrapolate robust comparative conclusions about the topic at hand.

## 5.3    Ethics and reflexivity

Before introducing the case studies and research methods, it is important to make note of the ethical and reflexive implications of the study. The research was granted ethical approval by the School of Sociology and Social Policy at the University of Nottingham in accordance with the University of Nottingham's Code of Research Conduct and Research Ethics. Through separate application processes, it was also approved by the research-governance committee of Forest Lodge, the UK case study, and the Social and Behavioural Sciences Institutional Review Board at the University at Buffalo.

In accordance with these "procedural ethics" (Guillemin and Gillam, 2004), I posted information about the research on noticeboards at each facility, and introduced myself at staff meetings, handovers, and in conversation with staff. I also distributed participant information sheets/consent forms when I arrived and throughout the duration of my fieldwork, making sure to obtain signed consent from all those who were interviewed and/or included in my fieldnotes (using pseudonyms) (see Appendix).

Although essential, obtaining informed consent from the participants was not sufficient to ensure the ethical rigour of the study. The specific features of this ethnographic research – which include the length of time I spent in the field, the personal relationships I developed, the emergent nature of the analysis, and the vulnerable position of both staff participants and

residents – required ongoing attention to ethical considerations, throughout every stage of the research.

Of paramount importance was my ethical responsibility to the residents for whom I was providing direct care. They were not covered by the ethics review, because they were neither the focus of nor direct participants in the study. However, it was incumbent on me to protect their interests as I balanced my dual role as hands-on carer and researcher, as they were the most overtly vulnerable actors in the setting. Fulfilling this responsibility was clear in many cases: it simply meant providing appropriate and compassionate care to the best of my abilities. In other cases, the ethical terrain was rockier: should I intervene (or not) when I witnessed care that was objectifying, undignifying, and/or misinformed? How would the immediate outcome for the resident stack up against the impact on the other staff in terms of embarrassment or even a sense of betrayal (as I side-stepped from apprentice to critic)? What might be the repercussions for my research in terms of their future disclosure and/or my understanding of how things "really" happen (*without* my intervention)? These were questions that I had to keep in mind as I negotiated every shift.

A further ethical consideration relates to informed consent. Informed consent ostensibly depends on a clear understanding of what is entailed in participating in the research but, in qualitative research and particularly with ethnography, explanations of risks and benefits are inevitably partial, due to the emergent nature of the research and to the necessity of achieving a balance between comprehensive and comprehensible explanations (Murphy and Dingwall, 2007, p. 2227). As Anspach and Mizrachi (2006, p. 717) admit: "Were they fully candid about the purpose of their research, fieldworkers would have to admit that host members

would find sociological research irrelevant, arcane, or potentially harmful". I found that to be true in my research: as much as I wished to be clear and transparent, I was also concerned about alienating and/or boring my participants by using unfamiliar or "academic" terminology, particularly given the limitations on their time. Therefore I found myself using brief, simplified explanations that emphasised my broad interest in learning about care assistants and LTC, not disguising my research but glossing over the specific details. This may yet have ethical implications, if the products of my research (particularly the feedback provided directly to the facilities) reveal a level of scrutiny which my participants had not fully understood or expected.

It was also important to assess the conditions under which participants gave their consent, paying particular attention to *power*. In other words, what does consent mean in an organisational setting where access has been granted by a gate-keeper who occupies a position of authority, such as the owner or manager? How much scope did that provide the care assistants – who might have perceived that participation was a job requirement even if assured otherwise – to opt out? This came to light for me at Richardson's, the US facility, when, after giving my research spiel at a series of staff meetings, several CNAs joked with me about their relief that I was not "from State" (whom no-one has the power to refuse). I had already been doing fieldwork at Richardson's for several weeks by then, and thought that I had been clear about my role as a university researcher – but these "jokes" prompted me to reconsider my explanations and renegotiate informed consent. In the end, only one participant (from Forest Lodge) opted not to be included in my fieldnotes.

In another example, I was reminded that informed consent requires protecting confidentiality on the participants' own terms, as well as according to the approved research protocol. I started doing interviews in my third month at Richardson's. In order to make sure that everyone in the facility knew about the interviews – which I pitched as an opportunity for staff to voice their thoughts and opinions – I typed a short announcement for distribution along with every pay-stub. I also posted a sign-up sheet near the time clock, since that was a focal point for all hourly employees. However, perhaps obtusely, I did not consider how this public location compromised the staff's perception of confidentiality, until one care assistant took me aside and told me that, although she was willing to be interviewed, she had not signed up because "*she didn't want 'them' to know she'd be talking to me*" (Fieldnote, Richardson's, Shift 24). Thereafter, I took the sign-up sheet down and made one-to-one interview arrangements instead.

Reciprocity was also an important ethical concern in this research. In one sense, reciprocity entailed respecting the participants' workloads, trying to be useful rather than disruptive, and providing tokens of appreciation ($10/£5 vouchers) for unpaid interview time. In an ongoing sense, it means maintaining a commitment in the research to represent care assistants in sensitive and relevant terms, avoid sensationalism and vilification, and protect rather than undermine their morale. This has required spending enough time in the field to fully appreciate (in an embodied, "carnal" sense) the challenges, complexities, and context of the work, and retaining this appreciation throughout the analysis and writing process.

Encountering, acknowledging and addressing the "ethically important moments" that are embedded throughout every stage of the research process (Guillemin and Gillam, 2004, p.

262) requires considerable *reflexivity*. Reflexivity refers to the process of turning thought back onto itself in order to examine the relation between the knower and what is known. This renders the researcher's analytic reconstructions as objects of study in themselves, rather than accepting them as unproblematic representations of reality.

The type of reflexivity that is common in ethnography as well as feminist research is what Foley (2002) calls "confessional reflexivity". Through confessional reflexivity, the researcher identifies his or her own embodied, historical, situated self in the text, in relation to the participants and the research setting (Atkinson and Hammersley, 2007; Bransford, 2006; Lincoln and Guba, 1985; Madison, 2005). Superficially, this means identifying myself as a white female in my 30s, middle-class, postgraduate, and politically liberal. Going further, reflexivity requires me to consider how, in this study, being a North American living in England provided a liminal national identity that kept me from being entirely native or foreign in either research setting. Another "confession", as discussed in the Preface, is that my father was taken into full-time care just as I was starting the research. How did that impact my interpretation of the care context? How did it affect how the other participants viewed me? Such questions cannot be conclusively answered; the counterfactual, in other words what the research might look like if conducted by a different individual, is simply not available. Nonetheless, being reflexive means remaining aware of how my identity and positionality *might* have affected every stage of the research, from initial introductions through fieldwork and analysis.

Beyond this confessional reflexivity, however, there is a more fundamental "epistemic reflexivity", which can be considered the "origin and the heart" of Bourdieu's work (Deer,

2008, p. 199). Bourdieu refers to this type of reflexivity as "participant objectivation", meaning a "full sociological objectivation of the object *and* of the subject's relation to the object" (Bourdieu and Wacquant, 1992, p. 68). That is, it involves methodical reflection on the techniques, actions, and social conditions of *objectivation* itself, assuming that all knowing occurs within certain social fields rather than claiming any epistemological privilege for "objective" or "neutral" social-scientific knowledge. For me, this means considering how my habitus and the *doxa* of the academic field affect what and how I think and write, as well as determining what is not thinkable (Golsorkhi et al., 2009). This consideration can be seen throughout my fieldnotes and analysis, as I reflect on and question what I have seen and how I have interpreted it.

My claim to knowledge in this thesis, then, derives from the ontological understanding that the social world transpires through situated, embodied practices; the epistemological assumption that knowledge is actively produced through reflexive engagement in the field; and ethnographic methodology which allows me to participate in practices while also "objectivating" and interpreting my participation through extensive, reflective fieldnotes. While I cannot claim to speak entirely outside of the vocabulary, categories, and explanations available to me, through embodied participation and epistemic reflexivity I can at least interrogate the doxic order which other players in the field may struggle to see, such as the positivist, masculine, biomedical doxa that justifies the marginalisation of direct-care work as less skilled, less valuable, and less worthy of remuneration than other work. This has made it possible to produce research that challenges, to a modest extent, the dominant strands of KT research which ignore these workers or treat them as impediments to evidence-based practice, rather than considering them as valuable partners in the common pursuit of better care.

## 5.4    The case studies: Rosemont, Richardson's, and Forest Lodge

The following section will describe Rosemont Homes, where I began fieldwork by completing the 100-hour certification programme for nursing assistants (mentioned in Chapter 2), then introduce the two main case studies, Richmond's and Forest Lodge.[29] The chapter will conclude with a detailed description of the data-collection and analysis methods.

### 5.4.1   Training: Rosemont Homes, USA

Rosemont Homes is a non-profit residential health-care complex providing a continuum of LTC for older people which includes independent, intermediate, rehabilitative, and skilled nursing services. The Rosemont Residence, which opened in the 1960s, consists of approximately 140 beds, including a 35-bed dementia unit and a 20-bed rehabilitation unit.[30] Adjacent to the Rosemont Residence is the Rosemont Nursing Home, a 120-bed skilled nursing facility which opened in the early 1970s. These two facilities (hitherto referred to as "Rosemont"), which are connected by a covered walkway, are set on a large property just north of a major urban centre in New York State. The driveway into Rosemont circles around the front of an attractive plantation-style entrance flanked by manicured gardens, with large parking lots in front and to both sides of the buildings. At separate locations, Rosemont Homes also offers an assisted living facility and a recently opened retirement community.

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[29] A note about tense: while past tense will be used to denote the situated nature of all study findings, present tense will be used in this section when describing somewhat more "static" features of the research settings.

[30] All bed capacities have been rounded to the nearest multiple of five to protect anonymity.

The most recent ratings from Medicare's "Nursing Home Compare" website, which gives ratings (out of five stars) for every Medicare and Medicaid-certified facility in the country, are as follows:

- Overall rating: 3 stars
- Health inspections: 2 stars
- Nursing-home staffing: 4 stars
- Quality measures: 3 stars

Rosemont's mission statement refers to providing "dignified, holistic residential and health care" that is "based on Christian values" and delivered "in an environment that promotes life enrichment, independence, and meaningful living". The organisation proudly declares itself to be a "pioneer" in the culture-change revolution, after embarking on a "person-centered care journey" almost a decade ago. Efforts to implement culture change at Rosemont can be seen in the physical reconstruction of the traditional nursing units into smaller "households" which comprise a cluster of resident rooms around a central lounge/dining room with kitchen facilities where "housekeepers" prepare and serve meals. "Consistent assignment" had also been introduced, whereby aides work primarily with one group of residents in one household rather than rotating throughout the facility as in the past; this was designed to facilitate relationship-building between aides and their residents, leading to more personalised care. The interior decoration of the facility reflects a more "homelike" environment, with carpeted floors, warm colours, wood furnishings, and pictures on the walls. Additional elements include potted plants and large glass cages of finches located throughout the facility, and a resident cat on one unit. Attempts to achieve culture change are also reflected in Rosemont's policy about using more respectful and personalised (rather than institutionalised and objectifying) language. This means adopting the term "elder" rather than "patient" or

"resident", and also referring to elders by their full names, unless invited to use first names, rather than by their last names, pet names, or bed/room numbers.

The other students on the CNA course at Rosemont had all been provisionally hired as new staff, contingent on their successful completion of the examination. My own fieldwork at Richardson's was also contingent on certification, so I participated fully in the course, but also considered this participation as part of my research. This meant obtaining consent from the other students and course leader, writing fieldnotes each day, and including those training notes in the complete data-set for analysis.

### 5.4.2   Case study 1: Richardson's

After I had successfully obtained certification, I conducted my first ethnographic study at "Richardson's", a family-owned skilled nursing facility located in New York State. Established in the mid-1900s by the current administrator's grandmother, Richardson's originally accommodated 30 residents in a two-story converted house, and was later relocated to its current, purpose-built, 80-bed building.

<u>The building</u>

An unassuming, one-story red brick building, Richardson's is located just off a main two-lane road which cuts through the suburban environs of an attractive, relatively affluent small town. The front lobby is accessed through double-glass doors from the parking lot on the western side of the building. In the lobby is a reception desk with administrative offices behind, a

number of chairs and sofas upholstered in rich, dark colours, and corridors leading off to the left and right.

Around the corner to the left is the employee time-clock, opposite a wall on which staff hang their ID badges when leaving shift. Further down the corridor are the employee bathrooms/locker rooms; the large laundry rooms, emitting a near-constant hum; and stock rooms which provide access to the back parking lot. Turning right, the adjacent hallway leads towards residents' rooms along the east wing of the building, with another hallway branching left towards the built-on rehabilitation unit. Off this latter hallway, there is also a resident lounge with a dining table and chairs, a television, and a small, minimally-used kitchen area. At the end of the east wing, another right turn leads towards the "back hall" of the west wing, and then right again to the "front hall". Where these two hallways meet, there is another very small common room which faces the front lawn and the road beyond.

On each wing there is a nurses' station with a supervisor's office nearby. At the nurses' stations, which are partially shielded by high countertops, are two desktop computers, shelves for resident care plans and other documentation, and cupboards of nursing supplies. The medication carts for each wing, which are kept locked when not in use, are parked here.

Almost all residents' rooms are double occupancy, with a bed, bedside table, reclining chair, and free-standing cupboard on each side of the room. Privacy curtains can be pulled around each bed when giving personal care. Each room has a sizeable sink and mirror and a small en-suite toilet, which can also be accessed from the adjacent bedroom in most cases. Each

wing also has a separate bathroom with a Parker bath[31] and shower; heat lamps and towel warmers have been recently added to make these large rooms feel cosier. There are also sluice rooms which staff visit between every personal-care intervention: these contain large laundry bins, garbage and clinical waste containers, and sinks, including a special sink with a flush mechanism for rinsing heavily soiled garments. Although Richardson's is not pervaded by unpleasant smells, which is a common complaint about facilities with lower standards of care, it is advisable not to linger in the sluice room, especially in warmer weather.

Leading directly off the front lobby is a large, bright room called the "atrium", with the southern side offering large windows and entry into the small central courtyard. The front half of the atrium is carpeted and furnished with several grouping of sofas and chairs, a piano and a large-screen television. The back half, which ends at the main kitchen, is the dining room, with about 10 large tables and a linoleum floor. Although it is comfortable and well-appointed, I noted that most residents only visited the atrium for the relatively brief duration of meals and organised activities; that was because they were dependent on staff for "transport" to the atrium and not allowed to remain there unsupervised for safety reasons. Thus most residents spent the time between meals in their rooms or lined up along the corridor on each wing.

Across from the kitchen is the staff breakroom, a big room with a small kitchen area (where coffee and iced tea are provided) and several large tables. Most staff sat around the largest group of tables nearest the kitchen to eat their meals, then many would head out to the picnic

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[31] The Parker bath is a height-adjustable, reclining bath with a door on the side that allows residents to be transferred in/out manually or using a mechanical lift.

table at the back of the facility to smoke. As the weather turned colder, it was also common to see staff sitting alone or together in their cars during breaks.

Ratings

Richardson's is rated 4 out of 5 stars, or "above average", on all four summary ratings listed on the "Nursing Home Compare" website. The facility has not received any fines or payment denials from Medicare/Medicaid, nor has it been cited for any deficiencies from complaints or self-reported incidents within the past three years. At the last inspection date (in early 2013), three health deficiencies were reported (as compared to a national average of 6.8); all of these were assessed at level 2 out of 4, which corresponds to "minimal harm/potential for actual harm" affecting "few" residents. The previous year's inspection, which covered the period of my fieldwork, reported no deficiencies, but in 2011 there were seven reported: one each for mistreatment, resident assessment, resident rights, pharmacy services, and administration, and two deficiencies in nutrition/dietary. Again, these were all also assessed at level 2, for minimal harm.

Philosophy of care

Richardson's mission statement refers to making residents and their families feel welcome, and to upholding a tradition of dignity, compassion, and respect. Core values include excellence, a family feeling, a team approach, and integrity, and the vision is of a "resident-centred culture".

Noel, the administrator at Richardson's, recalled first hearing about the Eden Alternative more than a decade ago, when two staff members attended a training event. Within the past

several years, the facility has embraced PCC, sending almost half the staff group on the Eden training (amounting to approximately 80 people from across the departments). Resulting changes have included bringing in pets, introducing restaurant-style dining with choices and courses, and instigating consistent assignment (as discussed further in Chapter 6). Even so, Noel still talked about being at the beginning of the PCC "journey", in part due to the limitations of the building's physical layout:

> *... [I]t's very institutional, and so, the challenge is to try and get away from that, we can't afford to build a new building that <u>would</u> allow us to do "green houses", which I would <u>love</u> to do, um, so, trying to figure out how to change it within the structure that we have now, so, we've tried to do those little things, and we say we're just taking, we've taken baby steps, not like Rosemont, we don't have "neighbourhoods" yet, um, we have aspirations to do that…*

<div align="right">(Interview, Richardson's, Noel)</div>

Sustaining interest and action past the initial training had also proved difficult, with attendance at the monthly "culture-change meetings" dwindling to a handful of administrative staff only. This appeared to have resulted in a significant divide within the facility between those on the administrative side, particularly the administrator, director of nursing and assistant director of nursing, who were very articulate and enthusiastic about culture change, and the direct-care staff, including nurses and CNAs, who expressed little familiarity with the concept. As one CNA described a recent in-service training that had touched on PCC: "*It was useful but it was all different –, all these words thrown in instead of*

*just coming out and sayin' what you're supposed to be sayin'… It was, it was kinda confusing"* (Interview, Richardson's, Nadine).

Training and orientation

As mentioned, carers were required to become certified, either through a community-college programme or at another facility, before they were eligible for work at Richardson's. Their offer of work was also conditional on a criminal background check and a drug-test administered by the New York State Department of Health, the costs of which were covered by Richardson's; a brief physical examination conducted by the attending physician at the facility; and a physical-capacity test administered by a member of the physical-therapy team.

All new staff completed a one-day orientation with the assistant director of nursing, which involved brief introductions from the "head" of each department, including therapy, dietary, housekeeping, and maintenance. On the day I attended orientation, we were also offered the influenza vaccine (along with all other staff across the facility). Although voluntary, the shot was strongly encouraged; for example, the staff newsletter for that month included a section in bold caps that read "AS A HEALTH CARE WORKER, WE HAVE A MORAL RESPONSIBILITY TO BE IMMUNIZED".

The orientation folder provided to new CNAs included individual instructional memos for just over 30 clinical skills, from bed baths, dressing, feeding, and moving and handling, to the use of various pieces of equipment, isolation precautions, and post-mortem care. There was also a "CNA clinical performance/orientation record", which listed 58 items and sub-items to cover throughout the orientation, and a checklist for the "Tutor CNA" to mark off during on-

the-floor training. The training checklist included seven "safety skills", 11 "general skills" referring to such things as dignity and respect, tidiness, willingness to work, and completion of "bookwork", and space for comments about the CNA's attitude towards residents, co-workers, charge nurses, and supervisors. The checklist concluded with the question: "is this CNA in training ready to be considered a full CNA at Richardson's?" The personnel handbook, which was also provided on the first day, included comprehensive information about employee rights and responsibilities, and a "code of conduct" statement, which referred to being fair and honest, maintaining adequate records, recognising privacy and confidentiality within legal standards, minimising waste, and avoiding conflicts of interest. The handbook included a final section describing "your rights as a nursing home resident in New York State and nursing home responsibilities", which was published by the New York State Department of Health in 2010.

After completing the one-day orientation, new hires at Richardson's are placed with an experienced CNA for up to three weeks before being given their own "card" of residents to care for. I trained with Ilene, a very experienced and diligent CNA who trained most new CNAs on the 3-11 shift on both wings. She told me that the length of time for training depended largely on the new carer's experience and learning style, but was sometimes accelerated due to short-staffing. Nonetheless, she assured me that she was always available to answer follow-up questions after the training period, an offer that I saw other new CNAs take up on several occasions.

### 5.4.3   Case study 2: Forest Lodge, UK

Forest Lodge is a 65-bed skilled nursing and residential care facility located in the leafy suburbs of a small town in a rural county in the East Midlands of England. After coming to the brink of closure in the previous decade, the facility was bought and transformed by Reddington Homes, a private provider of more than 200 LTC facilities in the United Kingdom, which has received accolades in national media and from agencies including, among others, Skills for Care and NAPPI UK (which provides training in "non-abusive psychological and physical intervention").

<u>The building</u>

Forest Lodge is a two-story building tucked out of sight in a residential area within walking distance of the town centre. Outside the main entrance, which faces a small parking lot, are a couple of outdoor café tables and chairs; in favourable weather, several residents could usually be found sitting outside, greeting visitors as they arrived. Inside the front entrance is a small vestibule where visitors must sign in, then press a doorbell or enter a code to pass through into the carpeted lobby. Directly inside is the front desk, beyond which is a small seating area created by two sofas and a long coffee table. There is usually a bowl of fresh fruit on the table, as well binders of photos and media clippings and other reading material, and on a sideboard there is a tea/coffee machine with ceramic cups and saucers. Photos of residents and special events hang on the walls, and cheerful music usually plays from the CD player near the front desk.

Immediately to the right of the front entrance is the main lounge. In the front half of the room are sofas and chairs grouped loosely around a large television (but rearranged as needed for

entertainment and activities); while the back half is a dining room and entrance to the kitchen. Although the layout is similar to the atrium at Richardson's, this room is somewhat smaller and rarely empty, so tends to have a more lived-in atmosphere. The small, well-maintained back garden, which has paved pathways and a selection of seats, can be accessed from the hallway that leads off the far right corner of the lobby. This hallway also leads to the training room, a key-coded back entrance/exit for employees, the staff bathrooms and a small break room (where coffee, tea, and biscuits are supplied), and another entrance to the kitchen. Across from the front desk, another hallway leads to the administrative offices, and then to rooms for residents requiring minimal assistance and care.

From the lobby, there is a lift and staircase up to the second-floor nursing unit, which was generally just referred to as "upstairs". This unit provides care for residents with physical-health needs, although many have some degree of cognitive impairment as well. Three hallways of bedrooms branch off from the central reception area upstairs, all of which are single occupancy with en-suite toilets. Furniture in the rooms includes a bedside table, free-standing cupboard, and chest of drawers. Sluice rooms and bathrooms are also located along these hallways. Between two of the hallways is the nurses' office, where all the residents' care plans are stored, and there is a small medications closet nearby. The door to the nurses' office was often closed but, like fish in a tank, the nurses could see and be seen through its large windows. To the left of the main entrance is the upstairs unit's lounge and dining room, which has a small kitchen in one corner and large windows which help the room feel relatively bright and airy.

Back on the ground level, just behind the front desk, are the locked doors to Vintage Vale, the dementia unit. This unit is laid out in a T-shape, with a central hallway of bedrooms splitting off to left and right at the end. To the left are more bedrooms, a bathroom that has been re-purposed as a sluice room, a small toilet, and the old facility kitchen which is now used for storage. To the right are more bedrooms and two large common rooms. The left half of the first common room is furnished with a range of chairs and sofas, and the right half is given over to large dining tables and a corner kitchen. Through this room is a second room known as the "garden room", which has more seating, a television in one corner, and double-doors to an enclosed garden.

Along the hallways and in the lounge areas, there is much more "stuff" at Forest Lodge than at Richardson's: musical instruments, including an upright electric piano; hooks on which hang an assortment of scarves, bags, and hats; shelves of games, puzzles, and "rummage boxes"[32]; dolls, stuffed animals, and their furnishings; and, on Vintage Vale, a faux storefront stocked with vintage products, as well as an old-fashioned railway bench and bus stop.

Ratings

On the recent routine inspection carried out by the Care Quality Commission (CQC) in October 2012, Forest Lodge met every standard within the five main categories (as listed in Chapter 2). The descriptive text of the report provided specific examples to show how each standard was met, and did not identify any areas for improvement. According to the previous CQC four-star rating system, Forest Lodge was rated as "three-star excellent service" in 2010.

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[32] Rummage boxes are filled with an odd assortment of small items of various shapes and textures, provided as sensory stimulation for people with dementia.

Philosophy of care

Reddington Homes, the parent company of Forest Lodge, is well-recognised for its work on PCC, particularly the person-centred *dementia* care that is provided through their Vintage Vale communities. The company identifies 10 elements of PCC, which have been paraphrased to preserve anonymity:

1. An environment adapted to the needs and comprehension of the person with dementia.

2. Recognition of the individual's history.

3. Staff who are trained to engage in meaningful communication.

4. Provision of activities and opportunities.

5. A focus on increased well-being.

6. Staff who know to interpret behaviour as meaningful expressions of emotion.

7. Emphasis on comfort and a sense of belonging.

8. Emphasis on understanding each individual's reality.

9. Helping residents to feel safe and emotionally supported.

10. Promotion of freedom rather than control.

Reddington has worked with a dementia expert to develop a training package that addresses these 10 elements. The main aim of the training is to teach staff to get to know residents in order to be able to recognise the underlying emotional reasons for what they say and do. On Vintage Vale, this was supported by the use of Memory Books, which were scrapbooks of photos and biographical notes created by carers through conversation with residents and their families. Although there was evidence that very diligent effort went into the creation of

Memory Books, however, the practice seemed to stall during my fieldwork, perhaps because the staff were expected to make the books in their own time and of their own initiative.

Overall, the impact of the training was evident in the way that staff generally drew on (and shared) biographical knowledge of the residents in order to tailor their communication and interventions, rather than defaulting to "reality orientation". This was particularly true on Vintage Vale as compared to the upstairs unit, where the case-load was much "heavier" in terms of physical needs, and dementia was a secondary concern. However, staff across the facility were fairly consistent in their attempts to acknowledge the facility as the residents' home, for example by knocking on bedroom doors, greeting residents whenever they entered the room, and so on. As one carer from the upstairs unit said about PCC in her interview:

> *I mean I'm, I'm learning about person-centred care every single day, just as much as probably everybody else is here – and you, you just learn to … Put them first, you know, make, make sure that <u>they're</u> comfortable, make sure that they're living in their <u>home</u>, the way that they want to, and the way that – they're basically letting <u>us</u> into <u>their</u> home, we have to treat it like it's their home, treat them with respect.*

> (Interview, Forest Lodge, Hayley)

Although Forest Lodge does not use consistent assignment, there is a "key worker" policy across Reddington's care homes which involves assigning a nurse and a care assistant to each resident. These designated staff are then supposed to take a "special interest" in the resident, spending at least 10 minutes per shift with them outside of direct care, noting birthdays and

other special events, ensuring that their preferences are met, promoting their social inclusion and opportunities for meaningful engagement, and helping resolve any problems that arise.

Training/orientation

As a volunteer, I received minimal training and orientation at Forest Lodge, especially by comparison with Richardson's where I underwent the full new-hire process. My training consisted primarily of one three-hour moving and handling session, a requirement for all new carers before becoming "hands on", which was taught in the training room and then practised on the upstairs unit using the transfer machines and slide sheets. New carers are officially "inducted" onto the units by an experienced carer, following a checklist of skills ranging from specific tasks such as oral care to more general approaches such as "respecting residents' personal items". On the induction checklist are columns for noting when each item has been (1) observed, (2) demonstrated, and (3) mastered. Induction at Forest Lodge seemed to be more *ad hoc* than at Richardson's, which reflected the more fluid organisation of the team on each unit (as discussed in the following chapter): in particular, during a busy period at Forest Lodge when several new staff had started at once, induction was provided by different staff within and across shifts, rather than consistently by the same carer as at Richardson's.

## 5.5    Data collection and analysis

### 5.5.1  Collecting the data

Data collection began, as mentioned, with the three-week CNA course at Rosemont in August/September 2011, followed by fieldwork at Richardson's from September through mid-December 2011. Fieldwork at Forest Lodge was then conducted from May through

August 2012.[33] The level of participant observation, which was the primary method of data collection, varied by research site. At Rosemont, I participated fully along with the other students, because my subsequent fieldwork depended on my successful completion of the course and certification exam. At Richardson's, similarly, I participated fully as a paid member of the team, working an average of three shifts per week as a CNA (30 shifts in total).[34] Although I was mainly assigned to the 3-11 shift, I also completed several "day" shifts (6-2 or 7-3) and stayed late to observe the start of "midnight" shifts (11-7). At Forest Lodge, by contrast, I remained a volunteer, which gave me more flexibility around my working hours, but also necessitated ongoing negotiation with staff about my level of engagement; I wanted to participate as fully as possible, like at Richardson's, but without being perceived as a nuisance or burden. I still followed standard shift patterns fairly closely (8-2 or 2-8), but sometimes helped out during the midday hours across the two shifts. I worked 25 shifts at Forest Lodge in total, clocking approximately 500 hours of participant observation across the three fieldwork sites.

Writing fieldnotes about each shift was essential for capturing my observations and experiences in as much visceral and contextualised detail as possible. Although the non-stop demands of the work made note-taking while on shift nearly impossible, especially at

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[33] A note about access to the research sites: access to Richardson's was negotiated by a former colleague from the University of Nottingham who had recently taken up a post at SUNY-Buffalo. In her new role, she was working with a regional alliance of LTC facilities, including both Rosemont and Richardson's, which had been formed to promote and implement person-centred care. She facilitated my initial contact with the administrator at Richardson's, who was very receptive to my research proposal, and also helped me obtain a place at short notice on the CNA training at Rosemont. I was referred to Forest Lodge by a Reddington employee who was already collaborating with colleagues at the University of Nottingham, then introduced to the general and deputy managers by Reddington's dementia-services specialist, who was also very supportive of the research.

[34] Richardson's suggested hiring me in order to ensure that I was fully covered by their insurance, code of conduct, and other protocols during my fieldwork. Forest Lodge, which had just hired a number of new carers, opted instead to host me as a volunteer researcher.

Richardson's, I did carry a pocket-sized notebook with me at all times in order to record brief notes and reminders, especially during formal breaks. Then, after each shift or series of shifts, I would develop these scribbled "jottings" (Emerson et al., 1995) into an extended chronological record of everything that I could remember seeing, hearing, and experiencing, using pseudonyms from the outset. Given the importance of the discursive (as well as material) dimension of practices, I attempted to record "sayings" as well as "doings"; due to the *ex post facto* nature of my transcription, however, these were usually approximations rather than verbatim quotes. I also used square brackets to differentiate – to the extent possible and without claim to absolute epistemological distinction – my personal reactions and reflections from the transcription of observed events or conversations. This attempt to record my "native" observations separately (Allan, 2006, p. 401) was designed to enable another (hypothetical) analyst to develop their own interpretation of my written notes; through the lens of my experience, certainly, but without this experience entirely eclipsing other possible perspectives on events.

Towards the end of my fieldwork at Richardson's and Forest Lodge, I also conducted 24 in-depth, open-ended interviews with care assistants, nurses, and members of management (Table 5). Interviews with care staff focused on their personal care biographies, their training, their understanding of PCC, and their perspectives on issues such as communication, documentation, and legal safeguarding. Interviews with managers and administrators, on the other hand, focused on broader organisational issues, including the history, mission, and values of the facility, the policy and regulatory context, and the tensions and challenges involved in implementing PCC. I developed the broad schedules for these interviews at the

outset, then amended them through observation and informal discussions with staff on shift during the data-collection period.

With the participants' permission, I recorded and transcribed the interviews, again using pseudonyms to protect anonymity.[35] At the end of each phase of fieldwork, I collated my fieldnotes and the interview transcripts into a full data-set for each site, although without considering these different data sources as equivalent.

Alongside collecting data through participant observation and interviews, I reviewed a range of published materials and grey literature on PCC and care homes in order to gain a broader perspective on the context of care. These materials included marketing and training documents, newsletters, and posted messages at each facility, as well as academic and policy documents.

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[35] Acknowledging that transcription is itself an interpretive act (Lapadat and Lindsay, 1999), it is important to add a note of explanatory detail here. I transcribed the interviews verbatim, without correcting for language use or pronunciation, and included nonverbal sounds such as sighs, laughter, and background noises. I did not transcribe further textual details, however, beyond using the underline function to denote spoken emphasis. In the excerpts included in the thesis, ellipses (…) are used to indicate omitted text and square brackets ([]) to denote clarifying information. In fieldnote excerpts, double quotation marks ("") are used to distinguish verbatim quotes from paraphrased dialogue or commentary. The fieldnotes have not been edited for grammar or word choice.

**Table 5: Profile of interview participants**[36]

| Richardson's | | | | |
|---|---|---|---|---|
| | *Pseudonym* | *Gender* | *Age* | *Experience* |
| **Care assistants** | Brenda | Female | 50s | 30+ years as a CNA; 21 years at Richardson's |
| | Daria | Female | 20s | ~3 years as an aide; 1.5 years at Richardson's |
| | Eden* | Female | 20s | 6 years as a CNA; <1 year at Richardson's |
| | Edie | Female | 50s | Newly certified; first CNA position |
| | Ilene | Female | 40s | ~30 years as an aide, majority at Richardson's |
| | Iris | Female | 50s | >35 years as an aide; 26 years at Richardson's |
| | Louise | Female | 50s | 22 years as a CNA, all at Richardson's |
| | Nadine* | Female | 20s-30s | ~1 year as a CNA (at Richardson's) |
| | Nat | Female | 30s | 19 years as an aide; 3 years at Richardson's |
| | Yolanda* | Female | 20s-30s | 11 years as a CNA; <1 year at Richardson's |
| **Nurses** | Audrey | Female | 60s | ~48 years as an RN; 39 years at Richardson's |
| | Evan | Male | 30s | 2.5 years as a CNA; <1 year as an LPN (at Richardson's) |
| | Hannah | Female | 30s | 4 years as a CNA, 9 years as an LPN |
| | Nancy | Female | 50s | 4 years as a CNA, 11 years as an LPN (at Richardson's) |
| **Management** | Alicia, Ass't Dir of Nursing | Female | 30s | ~15 years' experience as a nurse; 12 years at Richardson's |
| | Noel, Administrator | Female | 50s | Previous experience as a CNA and RN; 22 years as administrator at Richardson's |
| | Yvette, Director of Nursing | Female | 50s | 25-30 years as a nurse; 11 years full-time at Richardson's |

*Eden, Nadine, and Yolanda were interviewed as a group.*

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[36] Age ranges and years of experience are approximate, as of the interview date.

| Forest Lodge | | | | |
|---|---|---|---|---|
| | *Pseudonym* | *Gender* | *Age* | *Experience* |
| **Care assistants** | Danielle | Female | 20s | 5 years as a carer (at Forest Lodge) |
| | Eric | Male | 40s | >1 year as a carer (at Forest Lodge) |
| | Hayley | Female | 20s | 2 years as a carer plus work experience during school (at Forest Lodge) |
| | Lidia | Female | 40s | 12 years as a carer; 10 years at Forest Lodge |
| | Sherman | Male | 20s | 3 years as a carer; <1 year at Forest Lodge |
| | Trisha | Female | 30s | 4 years as a carer (at Forest Lodge) |
| **Nurses** | Aimee | Female | 40s | 30 years as an RMN; 2 years (?) at Forest Lodge |
| | Bonnie | Female | 40s | Unknown |
| **Management** | Ian, General Manager | Male | 50s | 28 years' experience in the NHS (RMN by background); <1 year at Forest Lodge |
| | Louisa, Deputy Manager | Female | 50s | 15 years at Forest Lodge |

## 5.5.2 *Analysing the data*

With ethnography, analysis begins with data collection, as an essential and inseparable component of the process of observing and recording events (Buch and Staller, 2007; Emerson et al., 1995). In other words, watching, participating, and note-taking are all selective and interpretive activities which, however unintentionally, privilege some moments or events as more significant than others. My own gaze was already conditioned by prior understanding of KT and PCC, and by the intention to learn more about these processes in a specific and situated sense; this would have influenced what I saw (and failed to see), how I recorded it, and how I interpreted it in light of prior and subsequent events. This approach to the research process contrasts ethnography against some other qualitative methodologies, particularly grounded theory, which assume that the data "stands alone" prior to analysis.

After completing fieldwork at Richardson's, I began data analysis in earnest by reading the full set of fieldnotes and interview transcripts from start to finish and then, using QSR NVivo 9 software, coding the data line-by-line. The next step was to begin grouping this extensive list of open codes into themes relating to the research questions about KT and PCC. Table 6 provides some examples taken directly from my analysis.

**Table 6: Example themes and constituent codes**

| Theme | Codes |
|---|---|
| Teamwork | - Teamwork<br>- Partners<br>- New girl<br>- MY resident<br>- Not MY fault/responsibility |

| Time | - Time to care <br> - Busy/ not busy <br> - Conflicting timeframes <br> - Organising care <br> - Routines <br> - Impatience <br> - Cutting corners |
|---|---|
| Safety | - Accidents – real or potential <br> - Regulations <br> - Care plans <br> - Reporting <br> - Repercussions for aides |
| Scope of practice | - CNAs versus LPNs/RNs <br> - Scope of practice <br> - MY resident <br> - Not MY fault/responsibility |

After completing the second case study at Forest Lodge, I read through the data-set in its new entirety before again conducting line-by-line coding, using and amending the existing codes as appropriate. Throughout this iterative process, I tested my developing themes through memos and short conference papers, referred back to the literature, and began to develop a structure for my final argument.

The analysis was guided by the broad research questions, with sensitisation to issues identified from the literature on practice theory, including: the sayings and doings of practice, the materials and artefacts that are involved in and mediate practice, the practical concerns around which individuals orient their actions, the positionality and capital of individuals within the field, and the situated-learning processes by which individuals become competent practitioners. By referring back to policy documents and other external resources, I also

attempted to "zoom out" (Nicolini, 2009) to explore how carers' daily practices interconnected in time and space with other practices, such as regulatory policies.

### 5.5.3 *Evaluating the validity of the research*

Given that the criteria by which positivist, quantitative research has traditionally been evaluated – including internal and external validity, reliability, and generalisability – have little relevance for the thick description of ethnographic accounts, the concept of "trustworthiness" provides a useful alternative for this study. Trustworthiness, according to Lincoln and Guba (1985), comprises at least four elements: credibility, transferability, dependability, and confirmability.

*Credibility* addresses the "fit" between the participants' views and the researcher's representation. A good fit is difficult to establish, particularly keeping in mind the Bourdieusian argument about positionality in the field: what I see from my perspective as a researcher may not match what my participants believe, but this does not render either perspective invalid. However, I attempted to enhance the credibility of my findings – without seeking a *perfect* fit – by spending several months at each research site, loosely triangulating[37] my data through participation, observation, and interviews, and engaging in informal "member checks" (Morse et al., 2008) during fieldwork and interviews.

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[37] Triangulation is used here not in the positivist sense of looking at a fixed point from several angles, but in the interpretive sense of using different methods to "obtain a more complete picture of a complex and diffuse phenomenon" (Tobin and Begley, 2004, p. 394).

*Transferability* refers to how well the research findings can be generalised on a case-to-case, rather than universal, basis. In other words, the goal is not a single correct interpretation but an interpretation that is "good enough" to be tested on another case. Undertaking two ethnographic case studies rather than focusing on a single case was critically important here, as the comparative design allowed me to juxtapose similar data from the two sites in order to distil what was interesting and different about each one. This yielded a richer set of findings with better transferability, perhaps, to a third site or, in an applied-research sense, to practitioners from several sites.

*Dependability*, which is also known as *auditability* (Baumbusch, 2011; Sandelowski, 1986), indicates whether the research is well-documented and "traceable", rather than directly replicable. I aimed for auditability by taking extensive fieldnotes that clearly distinguished my observations from my emotional reactions and interpretive musings; recording and transcribing all interviews; coding through NVivo; and writing short memos around my developing analyses. Auditability relates closely to the fourth criteria, *confirmability*, which refers to how clearly the data links to the analysis. Again, this is demonstrated by making explicit connections between the data, the codes, the themes developed from the codes, and the explanations of those themes, with reference back to specific examples from the data.

According to Cho and Trent (2006, p. 321), these criteria represent a *transactional* form of research validity, which involves an "interactive process between the researcher, the researched, and the collected data that is aimed at achieving a relatively higher level of accuracy and consensus by means of revisiting facts, feelings, experiences, and values or beliefs collected and interpreted". They suggest that there is also a *transformational* form of

validity, however, which rests on the social change that is prompted by or achieved through the research. For this research, the four transactional validity criteria described above – credibility, transferability, dependability, and confirmability – can and should be applied. But further down the line, transformational validity criteria may also become relevant in assessing whether the results are useful, relevant, and actionable for the consumers of this research, including practitioners and policymakers, as well as being meaningful representations of the experiences of the original participants.

With these transactional and transformational validity criteria in mind, it is time to turn to the empirical findings of the research, which are presented in the following three chapters. As described in the Introduction, these chapters are each structured around one significant principle of PCC: putting the individual first, taking time to care, and promoting autonomy. The analysis in each chapter focuses on how these ideas became meaningful when translated into care assistants' daily practice, highlighting other interconnected practices which particularly influenced the translation process. Throughout the discussion, the intention will be to examine how and why these particular meanings, or practical interpretations, *made sense* to carers, given their habitus, the institutional logics available to them, and their modest but important share of capital in the field.

## CHAPTER 6: PUTTING THE INDIVIDUAL FIRST: COMMUNICATION AND CAPITAL

### 6.1    Introduction: From mortification to individualisation

Traditional nursing homes, especially as invoked in the discourse of person-centred care (PCC), correspond uncomfortably well to the "total institution" model described by Erving Goffman (1961). According to Goffman (Ibid., p. 24), when an individual enters a total institution – whether nursing home, prison, or monastery – they surrender at the door their personal identity and connection to the outside world:

> The recruit comes into the establishment with a conception of himself made possible by certain stable social arrangements in his home world. Upon entrance, he is immediately stripped of the support provided by these arrangements. … His self is systematically, if often unintentionally, mortified.

Such mortification occurs through the loss of privacy and dignity; the dispossession of personal effects; subjection to institutional routines and depersonalising treatment; the negation of prior social roles; and so on. The model inmate becomes passive and dependent in this setting, allowing him or herself to be washed, dressed, fed, toileted, and medicated without interference or resistance. Any expression of individuality, personal preference, or agency is interpreted at best as symptomatic of disease and at worst as deliberately "intransigent" (Ibid., p. 62); either way, the response from staff is verbal, physical, and/or chemical restraint, so that they can get on with their daily tasks.

Gubrium's (1997[1975], p. 140) description of the "institutional plain" style of dress for residents at Murray Manor, the nursing home where he conducted ethnographic research, provides a stark illustration of this depersonalising tendency in total institutions:

> After living at the Manor for a while, women come to be dressed and coiffured in "institutional plain". … If a "plain" female patient is taken to the beauty shop to have her hair styled, aides are genuinely amazed when she returns to the floor. They are likely to comment that "they just can't believe it"… Another event that amazes the routine-prone floor staff is being shown pre-Manor photos of "plain" patients. Sometimes a relative and occasionally the patient himself shares such pictures with aides and nurses on the floor. As with an unusual coif, floor staff looks, is surprised, and gossips about it. Again, as one aide said, "You just can't believe that that's the same person that's here".

Dressing and styling residents in identical ways minimised differences to the extent that staff were "amazed" – when confronted by a new hairdo or an old photo – that their residents did indeed possess individual personalities. Notably, this was not considered bad practice at the time (in the early 1970s); in fact, Murray Manor was one of the best facilities in the region, and "institutional plain" would have simply been seen as an indication of good hygiene rather than "mortifying" treatment.

Similarly, participants in my research periodically reflected on the routinised and alienating provision of care "back then", prior to the introduction of PCC. For example, as Denise,

thetrainer at Rosemont, said whilst demonstrating how to fasten a waist restraint.[38]

> *"I look back and think, I can't believe we did that – but it was normal then," she said. She described how she could toilet three residents at once: put one on the toilet, "strap 'em on," then the next, then the next – and then it would be time to return to the first resident.*

> (Rosemont, Training, Day 2)

An experienced nurse at Forest Lodge shared similar memories of the homogenising care practices she encountered earlier in her career:

> *Aimee: ... You know, years ago, you know what they used to do, Kezia, way before your time, and it's <u>mortifying</u>, and I knew it was wrong then, and I used to try and change it. They used to come out with these big, big jugs of tea, and um, they used to put about eight tea-bags in it, milk and sugar –*
> *Kezia: I've heard those stories – yeah ...*
> *A: That was only, that's not that long ago! And, uh, I've probably told you before, at, at, you know, at [another facility], they used to say, right, it's toilet round at 10 o'clock, and they'd sit everybody at the toilet next to each other, on commodes. Not, nothing in between ... just in the room. And, you know, three baths in a row, not with sh-, anything in between. Just three baths, like sheep dipping. Boom, boom, boom. Massive baths. Fill 'em up, everybody be just in their – bathing*

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[38] The use of restraints has been discontinued in many care homes, including all three research facilities, but restraints remain on the CNA training curriculum because they are still used in some medical and/or mental-health settings.

*three people in a row. Everybody wore the same clothes, you know: they'd have a large, small, medium pile.*

(Interview, Forest Lodge, Aimee)

These examples – lining up residents on commodes or in bathtubs, dressing them from a communal wardrobe – reinforce the impression of traditional nursing homes as "total institutions". Aimee's example of the "big jug of tea" provides a particularly poignant illustration, given the British proclivity for a comforting cuppa: each resident would receive a cup of tea, certainly, but only at the appointed time, lukewarm, and without regard for individual preferences about milk and sugar.

Person-centred approaches, by contrast, foreground the fact that care-home residents arrive with a lifetime's accumulation of tastes and preferences, talents and interests, capacities and capabilities; indeed, these unique attributes are considered the building blocks of personalised care. Staff are encouraged to "get to know" their residents, for "it is only through gaining in-depth knowledge of individuals and how they relate to the world around them that we can avoid assumptions and make plans to meet individual needs" (Loveday, 2013, p. 108). Such in-depth knowledge allows staff not just to adapt care routines but indeed – referring back to the relational, contextualised understanding of personhood discussed in Chapter 2 – to recover their residents' personhood from the combined and "mortifying" effects of disease, dislocation, and institutionalisation.

The following chapter will explore how this central tenet of PCC, "putting the individual first", translated into the daily practices of care assistants at the two research sites. Two

related processes which were essential to accomplishing this objective will be examined: first, developing a direct relationship with the individual, and second, exchanging knowledge with others. The chapter will argue that, through these two processes, carers generated a stock of "individualised knowledge" which they could parlay – somewhat differently in each setting – as a limited source of symbolic capital to offset their lack of influence within formal processes of knowledge exchange and care planning. The chapter will begin, first, by briefly describing the scope and significance of carers' "individualised knowledge".

## 6.2    The situated significance of "individualised knowledge"

Observing carers at work, it was eminently clear that they drew on a wealth of detailed knowledge about their residents to make ongoing adaptations to their care. Consider the following excerpt from a morning shift at Forest Lodge, when I helped Trisha, a care assistant, wash and change a resident:

> *After we'd washed his face, arms, underarms, and lower regions and changed his pad and vest, Trisha and I repositioned Richard, using the slide-sheet to move him up the bed and then propping him up with pillows. There was one pillow that seemed to be trapped at the end of the bed, so I asked Trisha about that and she told me that it stays there – he's on a special mattress that's a bit shorter than the bed frame, so they keep it there to prevent his feet from getting caught in the gap. ... As we were finishing up, Trisha told me to always "offer liquid" when in the room. She put a towel under his chin before giving him the drink, explaining to me in a whisper that "he's started dribbling". When she was washing his face*

*earlier, she had also pointed out how important it was to dry under his chin because "we don't want it to get sore under there" – since his chin stays clamped down tight to his chest, preventing the area from air-drying and increasing the risk of infection. She used the syringe to squeeze some liquid into his mouth and then said, since he did so well with that, you can offer him the cup – and so I offered him some more sips directly from the cup.*

(Fieldnote, Forest Lodge, Shift 6)

This excerpt illustrates the range of generalised and specific information that Trisha incorporated into a single care intervention. She drew on specific knowledge of Richard's physical limitations, together with her general familiarity with the equipment (including the mechanical bed and slide-sheet), to move and position him safely, with the repurposed pillow in place. She also adapted her "pacing" (Strauss et al., 1985, p. 134) to Richard's needs, for example by initially using the syringe to gauge his swallowing, and implemented personalised preventative knowledge as she checked for spillage under his contracted chin.

Ilene, an experienced CNA, demonstrated similarly detailed knowledge about each resident at Richardson's, as I noted during my training:

*With the bedtime routine, [Ilene] also knows without hesitation which combination of sheets and blankets to use for each resident, whether to pull them all the way up to their chin or only to their waist or shoulders, where to place the pillows, whether to tuck them in tightly or leave them "nice and loose" – telling*

*me each time as she tucks someone in, for example, "so and so likes all his*

*blankets, so you can just pull them all up at once".*

(Fieldnote, Richardson's, Shift 10)

Both excerpts above appear to prioritise the residents' *physical* status and needs. This begs the question: did ensuring that Richard's extra pillow was correctly positioned, or that another resident was tucked into bed tightly, indicate the type of knowledge that is required to "put the individual first"? Certainly, this is not the kind of information that I would share about myself to new acquaintances at a cocktail party. However, Trisha and Ilene stood out as exemplary providers of PCC, and my observations of their work suggest that this information *was* a major resource for providing care that reflected and reinforced personhood.

This was because, arguably, such knowledge pertained directly to their workplace responsibilities. Carers were not paid exclusively to sit and talk with residents, nor to engage them in activities; they were paid to do "bed and body work", however person-centred the intent. (As James (1992, p. 496) notes in her study of hospital and hospice nursing, physical tasks are "the principal component of 'work' in the sense of paid labour".) Information about each resident's biography, personality, routines, and preferences may have been useful, therefore, but only insofar as it became meaningful through its relevance to direct care. This follows the situated-learning argument that meaning is a *product* of learning rather than an inherent *property* of information (Lave, 1996; Lave and Wenger, 1991). One resident used to work nights, another has been vegetarian since childhood: such facts could be transformed into meaningful knowledge, in the context and enactment of daily tasks, as carers adapted the first resident's bedtime or sought an alternative meal option for the second. Personal

information adhered to knowledge about the residents' physical needs. Therefore, throughout this chapter, the term "individualised knowledge" will be used to refer to the inextricably interconnected bio-psycho-social knowledge that carers enacted in practice.

It is important to emphasise two points about carers' individualised knowledge before moving on to examine how it was acquired and shared. The first and perhaps obvious point is that this knowledge had direct instrumental value for carers, as well as being relevant to clinical record-keeping, care planning, and PCC. In this sense, there was an *additive* relationship between the institutional logics informing carers' practice, rather than "competing mandates" (Goodrick and Reay, 2011, p. 403). That is, individualised knowledge helped carers fulfil the demands of their workplace and the medical facility while also – in some cases – enhancing the personalisation of care. This can be seen in the following excerpt from an interview with Trisha, mentioned above, who was perhaps, of all my research participants, the most overtly committed to PCC. In this excerpt, she is describing her attempts, during the morning routine on Vintage Vale, to individualise care within the parameters of her role:

*I've tried to think of things, um, a balance between, uh, things – for instance, like, I try to get Leo up reasonably early because Leo's diabetic, and I feel that Leo, to sleep in, um, is not very good for his diabetes, and, and I think that that affects his mood, as well, so the earlier Leo can have his, get up and have his breakfast – and he is an early riser, you know, he feels, when you go into him early, he, he says oh, I've gotta get up for the day, you know, because, you know, that's always been his routine, um, when he was working and things, so, um, I, I try to think,*

*that, all these things are running through my mind, while I'm also on the floor working, um… Nell's another one, I try to not leave Nell too late because she's a diabetic, but she'll, but, that's a balancing act because Nell likes to have a lay in, so it's a matter of popping in and checking, and the, you know, when she's awake, the first opportunity of when she's awake, <u>then</u> go … I try, uh, to go into Candace quite early, because I feel, um, Candace responds better earlier, I think that, the more of a lay-in that Candace has, again, I think probably goes back to their workdays, um, I think that um … <u>I</u> feel that she doesn't respond so well if she has a lay-in, I think that there's something <u>there</u>, um, you know, like sometimes when you oversleep, sometimes you get up more tired, does that make sense? … [A]nd then from there, really, it's about working on <u>their</u> time. You know, and, and I know that there's certain people that like to get up earlier, then there are people that like to get up later, like Pippa, is usually one of the last, and it was an issue that Kathleen used to have, and she used to say oh, why do you always leave Pippa till last? It's not a matter of <u>leaving</u> Pippa till last, it's a matter of when Pippa is <u>ready</u> – and Pippa is not ready at 9 o'clock in the morning [laughs]. Do you see, what I'm saying? And, um, you know, because she's not ready, she will just fight against it, and it's not productive for anybody, you're just upsetting her, you know, and it's, you know, so, but I usually find, if you leave her till a little bit later, just, it's just <u>knowing</u> her, really, knowing them. You know. Um, and really just working around that, nipping in and out of the rooms, seeing that – cuz not every day is the same, some people like to get up early one day, and then have a lay-in another, so, sort of, it's about nipping in and out the rooms and checking on them, it's, it's – and a bit like that, you know, and then when you find*

*somebody's who awake and who, who's ready, then, then you go with it, with them, because I find that those are the times <u>to</u> go with it, with them, you know.*

(Interview, Forest Lodge, Trisha)

This excerpt is quoted at length in order to accurately present Trisha's attempts to balance the medical needs of her residents against their personal preferences on a day-to-day basis, taking into account her own job responsibilities. Her comments highlight the additive relationship between these logics; for example, getting up before nine was not Pippa's preference, nor was it (therefore) logical from Trisha's point of view, because the task would be that much harder. ("[*B*]*ecause she's not ready, she will just fight against it*".) Later in the morning, Pippa might be happier about getting up *and* Trisha could complete the task more efficiently.

Ilene, the experienced CNA at Richardson's, made a similar point:

*Ilene: I feel … it's very important to know each resident as an <u>individual</u>, because that way, once you get to know them as [an individual], you'll know how to approach 'em, you know, and – and you'll know how to go in the room and, and be <u>organised</u>, you know, to be able to get everything done for them. It's always good to know what they can do for themselves – and what they can't do for themselves – cuz that's helpful for you. If they can do some things for themselves, you can busy them doing <u>that</u>, while you're – getting their room ready, or getting their bed ready. You know, things like that are helpful too. If they can do anything for themselves.*

*Kezia: Yeah. Which is also good for them –*

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*I: Yes, very good for them, yes.*

*K: Right.*

*I: Mm-hm. And very helpful for us!*

(Interview, Richardson's, Ilene)

Although it is obvious in retrospect that I steered Ilene towards acknowledging the benefit of individualised care for residents (with my comment that encouraging the residents' independence is "*good for them*"), she quickly reemphasised that it was *also* helpful for staff. This emphasis on using individualised knowledge to manage residents' care was echoed by the assistant director of nursing at Richardson's when she told us during orientation about the importance of getting to know the residents. "*It can be helpful to know, for example,*" she said, "*that one resident 'likes an extra Sweet and Low with her dinner – it's the little things that can make the night really easy or difficult'*" (Fieldnote, Richardson's, Orientation). Again, this indicates a cooperative relationship between the logics of the home (catering to individual preferences) and the workplace (having an "*easier*" shift). The extent to which these logics were actually cooperative or competitive varied by setting and scenario, however, as described throughout this chapter.

The second point is that, within this (Bourdieusian) field of unequal positions, it was care assistants who held the greatest share of this "individualised knowledge". This was apparent through observation and often explicitly stated by staff. As Hayley, a carer at Forest Lodge, put it:

*I mean, if we find somebody needs assessing, we just tell the nurses and they, they turn round and say yes, okay, you know, we'll assess them, and they do and, if it's the right thing to do, they do it. But I mean we're the ones that see it on a day-to-day basis, we're the one that, ones that – that know what hurts us, what hurts them, what's best for them, what's not best for them. Although the nurses have the authority, they don't always see it, you know, we, we're the ones washing, we're the ones repositioning, we're the ones getting up, we're the ones talking to the residents. And I find that we have more knowledge on their day-to-day routines ... than a nurse knowing their medical history.*

(Interview, Forest Lodge, Hayley)

Although nurses had privileged access to codified information such as medical notes, that is, Hayley was suggesting that carers' knowledge was more timely and detailed. The reifying tone of her comments – "*we're the ones that see it ... we have more knowledge*" – underscores the value that carers placed on this knowledge with implications, as will be shown, for the extent to which such knowledge was shared or withheld in each setting.

The next sections will discuss the two main channels – direct care and communication with other staff – by which care assistants developed their individualised knowledge.

## 6.3    Getting to know the residents

Care assistants at both Richardson's and Forest Lodge frequently referred to the importance of "getting to know the residents" – by learning about their needs, routines, and preferences –

in order to deliver more personalised care. In part, this was supported by facility-level efforts to emphasise residents' individuality: for example, encouraging residents to bring in their own belongings; hanging boards beside residents' beds to display photographs, cards, and other items; and posting biographical notes about residents on their en-suite bathroom doors (at Richardson's). Although modest in scope, these efforts nonetheless signalled a departure from the "institutional plain" approach discussed above. They also entailed significant logistical challenges, such as how to ensure that bedding and clothing were washed and redistributed appropriately; how to accommodate personal belongings in limited spaces, particularly in the double-occupancy rooms at Richardson's; and how to avoid "pilfering"[39] or simple misplacement of items.

Richardson's had also introduced "consistent assignment", which as explained in Chapter 5 is a pillar of culture change in the United States, within the last three years. To a certain extent, this seemed to be working well, as indicated by the following comment from a CNA working on the east wing:

> *[The assistant director of nursing] didn't want to put me back on east [after an*
>
> *altercation with a nurse on that wing], she wanted me to go over to west, I said*
>
> *"no – no. I've, I've worked hard to get a rapport with <u>my</u> residents, and I have a*
>
> *permanent list, and I'm not leaving them", I said, "so no, I'm not going over to*

---

[39] *Pilfering* and *hoarding* are among a range of terms commonly used to describe the behaviour of people with dementia; however, they are generally avoided in PCC discourse because they imply an emphasis on symptomatic outcomes of disease rather than reflecting an effort to interpret such behaviours as intentional and meaningful.

*west, I have my residents, and it's taken me this long to get their trust, to let me*

*do their care – and I'm <u>not</u> leaving them."*

(Interview, Richardson's, Edie)

Edie's comments about rapport, trust, and personal connection ("<u>*my residents*</u>"), which were echoed by other aides, suggest that consistent assignment did help encourage meaningful, sustained relationships − thus bridging, at least somewhat, the social distance and attendant hostility that Goffman (1961, p. 18) observed between staff and inmates. However, it had contradictory implications for PCC when taking into account teamwork and knowledge exchange, as discussed below.

Care assistants generally struggled to articulate *how* they got to know their residents and build the type of relationships to which Edie alluded, however. Another CNA at Richardson's, Daria, said in her interview when I asked her how she got to know each resident: "*it's not always something that you can really put on paper, um, just, I mean, people are individuals, they need different things, they like different things*". And this was Ilene's reply to a similar question:

*Kezia: Yeah, I mean, how do you know who this person <u>is</u>?*

*Ilene: [taking breath] Well, you just kind of − it's that first, um, impression I*

*guess – yeah. Um, speaking with 'em, you know, um, and then, I guess, initially,*

*physically having to assist them, when they first come, because most of the time*

*they come in by wheelchair, so you're, you know, your, you greet 'em, you speak*

*to 'em, and then you switch 'em from one chair to the other, you know, and I*

*guess that's how you <u>first</u> get to know 'em. From there on it's basically a day-to-day thing, you know.*

<div align="right">(Interview, Richardson's, Ilene)</div>

These statements suggest that getting to know residents was a process which relied on visual impressions, communication cues, physical contact, and intuition as much as (if not more than) explicit or codified information. Habitus can be seen to play an important role here as the "structured and structuring structures" by which such sensory and tacit information translated into a *sens pratique* about how to proceed.

## 6.3.1   The role of habitus

Ilene's "feel for the game" had been developed through years of experience as a CNA and formerly as a home-care aide. But even a brand-new aide enters the field not as a blank slate but as an experienced adult with preconceptions and experiences of ageing and care. These form part of their habitus, affecting how they enact the care-assistant role, including how they gather and interpret information about the recipients of their care.

For example, carers bring into the field their culturally-informed understanding of the ageing process. This understanding was often articulated through negative comments, both in training and on the job, about not wanting to "end up like" the residents. For example, one day during the CNA training at Rosemont, a female student declared: "*When I get old, I just wanna be independent.*" A slightly older and more experienced student replied: "*Don't talk like that. I'm not gonna <u>get old</u>*". The first student said, laughing: "*Oh, well, let me know how*

*that* works out for you" (Fieldnote, Rosemont, Day 5). The message was clear: growing older is not a good thing, especially if it requires relying on the assistance of others.

Related to this general cultural anxiety around ageing are specific fears, reinforced by media reports as well as through personal experiences, about undignifying, neglectful, or even abusive treatment in care homes. The following example records another exchange between students at Rosemont:

> *At one point during the skills practise, Leona acted towards the "patient"[40] in a way ... that prompted Gemma to tease her "I'm never going to let you take care of my grandparents." ... Then Aiesha said, "I think I'm going to put <u>my</u> grandmother in a nursing home so that she can <u>get</u> some cruelty," which Takira nodded to, saying something about her own grandmother. "I love my grandmother," Aiesha said, "but she's <u>rude</u>", going on to describe some of the ways that her grandmother annoys her.*
>
> (Fieldnote, Rosemont, Day 8)

Aiesha's unchallenged assumption that nursing homes are "cruel" places was notable given that she was training to work in one (and indeed had already worked in a similar role in another residential-care context). Similarly, an experienced CNA at Richardson's told me that she would never put her own parent in a nursing home:

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[40] Although the training at Rosemont was designed to promote PCC, frequent slippages in language (and practice) occurred; one example was the consistent use of this term, "patient", rather than "elder" or even "resident".

*I feel, this is my personal opinion, cuz my Dad's 85, and he's startin' to go down, and I know that, and I've always told him, uh, when the time comes, I said, you can come and live with me, and I'll, I don't have to w-, I don't <u>have</u> to work, I just work cuz I like this, but I don't have to work. And, um, I told him, he can come and live with me, but I always felt that if you can take care of your family, take care of 'em. I don't believe in put-, I would <u>never</u> put my Dad [whispered] in a nursing home.*

(Interview, Richardson's, Iris)

Although Iris did not mention cruelty, she did suggest that institutional care should be a last resort. Similar sentiments about the preference for familial over institutional care were voiced by a carer at Forest Lodge who was from Southeast Asia:

*I feel like ... how can I say this? I feel sad for [the residents] because, in my culture, it's different, we don't have nursing home. If your mum gets old, you'll take care of them until they die. If your grandma gets old, they will stay in your house, they will, you're the one, family will take care. So, I feel sad for them, I feel sorry for them for being here.*

(Interview, Forest Lodge, Sherman)

The point here is that carers' assumptions about ageing and nursing-home care – whether expressed as fear, mistrust, or pity – were inscribed in their habitus through their upbringing and experiences. In addition, many staff drew on prior informal or paid caring experience, as illustrated by the following interview excerpt:

> *Edie: Before [becoming a CNA], I did home care. I actually worked privately, alongside hospice, and I went in people's homes and took care of their loved ones... in their final days.*
>
> *Kezia: So what kind of training did you have going into <u>that</u> role?*
>
> *E: Oh gosh. My second son was born with a <u>lot of</u> medical problems, and I'm the oldest of 8 kids, and I've more or less been a mother from the time I been five, I been the caregiver, I raised my brothers and sisters ... I just kind of fell into the caregiving role. ... I've always been – I have four deaf sisters and a deaf son – so I've always done everything for everybody.*
>
> (Interview, Richardson's, Edie)

Comments such as these suggest that prior caring experiences provided staff with an embodied know-how to underpin the codified information they received about residents. In Edie's case, having "*always done everything for everybody*" seemed to give her confidence and competence in her role, even as a relatively newly-certified aide, but perhaps also contributed to her reputation for "spoiling the residents" – which meant, for example, providing personalised care at the expense of taking her allotted breaks.

To broadly summarise, this section has suggested that *habitus*, as structured both by socio-cultural assumptions about ageing and by previous caring experiences, shaped how care assistants acquired, interpreted, and enacted "individualised knowledge" about their residents. Information about "who the resident is", in other words, was combined in this process with habituated assumptions about "how they should be cared for". There was also an important role for emotions in this process, however, which must be taken into consideration.

## 6.3.2 Emotional logic(s)

According to practice theory, emotions and affect are intrinsic properties of all practices; what it makes sense to say and do cannot be separated from what it makes sense to *feel* while saying and doing it. Through socialisation into particular practices, these appropriate feelings and emotional expressions are learned, reinforced, and reproduced (Fuhrer, 1996; Lave & Wenger, 1991). No task is free from emotional engagement, then, but neither is there always a neat, one-to-one correspondence between tasks and their appropriate affects. Different institutional logics, this section will argue, suggest different types of emotional engagement, with differing implications for "putting the individual first".

Person-centred care, of course, is an explicitly relational proposition which encourages mutual emotional engagement. The Eden Alternative (2009, added emphasis), for example, exhorts care staff to "begin to open their *heart* to new ideas", promoting the role of emotions above intellect, and the person-centred dementia care training at Forest Lodge was explicitly structured around "feelings". Getting to know residents in order to personalise their care implies, likewise, establishing an emotional connection rather than simply collecting factual data. Resonating with the logic of the home, this seemed to make sense to carers, who often referred to emotional engagement as one of the highlights of their work. The following fieldnote describes a conversation at Forest Lodge with Deirdre, a carer who used to work as a health visitor for the NHS:

> *Amy [another carer] asked her, and I said I was also wondering, if it wasn't*
> *frustrating to work as a carer now, when she has such a lot of health-care*
> *experience, but Deirdre said right away that she doesn't mind it, she likes*

*working directly with the residents, she likes learning about them, getting to know them. She told me … that she feels like they really care about the residents here, not that she has much experience with any other care homes, also she likes how touchy-feely it is here (not her words); how she was surprised at first because in a hospital setting, you have to be formal, have a professional distance, but here you can give people a hug if they're sad, you can hold their hands, you can laugh with them, when they pass away you can cry with their family – you couldn't do that in a hospital.*

(Fieldnote, Forest Lodge, Shift 18)

However, the level of emotional engagement encouraged by PCC was far from easy to sustain. This was partly because, as mentioned in Chapter 2, the majority of residents were significantly impaired in their communicative abilities, and some exhibited "challenging behaviours" such as repetitive movements or sounds and/or violent physical or verbal responses. As most residents end their lives in the care home, furthermore, carers were being asked to "love" (often on unfamiliar terms or with limited reciprocity) and let go in a fairly constant cycle, the emotional impact of which was not well-acknowledged or addressed.

At the same time, carers also worked within the institutional logic of the medical facility, which prioritises emotional control and distance over potentially unbounded intimacy. This emotional distance was critical in allowing staff to manage the cycle of attachment and loss mentioned above without missing a step in their practical responsibilities. The medical logic was reinforced to carers through messages about *not* sharing too much of themselves, even as they were encouraged to develop personal relationships with their residents. Carers thus had

to navigate between two competing logics of practice, as suggested by the following comments from Lidia, a carer and "shift leader" (as explained in Chapter 7) on the upstairs unit at Forest Lodge. On the one hand, she said:

> [Y]ou have to give a little bit to get a little bit, as I say to them. Give a little bit to get a little bit. When you're talking to them, um, tell them a bit about yourself, and then it brings them out of themselves, and it's nice, they know something about you. And they can relate to things that you say to them.

But on the other hand:

> And the moods, the moods of the care staff also relate to the moods of the people that live here. Cuz if the care staff come in miserable – then they're gonna know that, and they're gonna sense that, and they're gonna feel it. So you've got to come in as happy as you can. Leave your troubles behind you.

<div align="right">(Interview, Forest Lodge, Lidia)</div>

These comments highlight the *work*, or emotional labour, that was required of staff to balance the expectation about establishing meaningful emotional connections against the obligation to maintain a consistently positive emotional climate and proceed with prescribed tasks.

Death brought this often-invisible work into sharp relief. In LTC, the convention has been to remove deceased residents "through the back door" (often literally), inconspicuously, in order to avoid upsetting other residents. Proponents of PCC argue that this practice fails to

acknowledge the importance of relationships developed within the nursing home, however, and deprives those left behind of the basic right to grieve. Thus, in both facilities, there were attempts to "normalise" death and its associated emotions, for staff as well as for residents. However, although staff may experience grief, they also had to be prepared to get on with the job: laying out the body, stripping the bed in preparation for the next admission, and so on. On Vintage Vale, the balance tipped furthest towards emotional engagement: sadness was expressed quite openly among staff and with relatives of the deceased resident, although there was still a risk of becoming "too emotional":

> *I chatted to Trisha in the kitchen area for a little while when she first arrived –*
> *she said it was another busy shift yesterday, and I said oh, really?, and she said*
> *yes, because of Nate passing ... I asked her what time she'd been working, and*
> *she said she was scheduled till five but she stayed until about quarter to six.*
> *"Because of everything that was going on?" I asked. She said yes, but she*
> *couldn't bring herself to stay any longer – "I was starting to get emotional," she*
> *said, smiling still, "and we're not supposed to – well, not that we're not supposed*
> *to, but it's not… productive". She said that she used to bring Nate here for day*
> *care, "so we've been together from the beginning, so to speak".*
>
> (Fieldnote, Forest Lodge, Shift 3)

I reflected in my notes that I was surprised to realise, halfway through this conversation, that I had been following a workplace logic – that is, sympathising with Trisha about the inconvenience of working overtime – whereas she had responded in a much more emotional

register. I switched gears, then, to sympathise with her loss rather than commiserating about working conditions.

I believe that I had learned to take this initial emotional stance, which was one of detachment, from my fieldwork at Richardson's, where the medical and workplace logics seemed to predominate in terms of emotional expression. The following excerpt describes one CNA's care for Alice, who was on end-of-life care:

> *Nat [a CNA] had positioned Alice in bed so that her head was raised, her feet were raised, and she was cocooned by pillows on either side. This helped keep her in place (though there seemed little danger of her getting/falling out of bed anymore), but also propped up the sheet so that very little fabric touched her skin directly. She seemed quite proud of her expertise in constructing this nest for Alice; she told me about it and I also heard her later tell more than one other aide "did you see what I did with Alice?" The trace of empathy/ compassion that I thought I'd discerned seemed to have been replaced with a sort of combined pride and amusement – Nat laughed as she pointed out what she'd done with Alice, and the focus seemed to be on the spectacle of it – and the technical skill she had employed – without any overt reference to the resident herself. It's not that Alice was the object of amusement, but rather that she seemed incidental to the picture even as she quietly suffered away her last moments of life.*
>
> (Fieldnote, Forest Lodge, Shift 17)

This scenario illustrates, uncomfortably, the complexities involved in genuinely "putting the individual first". Nat certainly adapted her caregiving actions to Alice's physical needs, which was the primary way to support her personhood, given that Alice, who had already been at an advanced stage of cognitive decline, was now entirely non-communicative. However, without being underpinned by any evidence of empathy or emotional engagement, this personalised care came across as profoundly *de*-personalising.

Contrasting these examples – of a grieving carer at Forest Lodge and a task-focused CNA at Richardson's – is not meant to suggest, of course, that staff at Forest Lodge were emotionally engaged while those at Richardson's were not. Trisha and Nat had very different personalities, communication styles, and orientation to the work – and neither should be considered directly representative of her staff team.[41] The claim here is simply that different types of emotional engagement were available to both carers, according to different institutional logics, but while the person-centred emphasis on "authentic", reciprocal emotionality – *"we've been together from the beginning"*, Trisha said of her relationship with Nate – was more available and appropriate to staff at Forest Lodge, a logic of emotional restraint seemed to predominate at Richardson's (*"she seemed quite proud of her expertise"*). Staff at Richardson's *talked*, in generalised terms, about feeling sad when residents passed away, but those at Forest Lodge *expressed* those emotions (through tears, hugs, and so on) more often in the workplace. The difference between the emotional engagement which characterised staff's efforts to "get to

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[41] Likewise, the differences highlighted here may relate more broadly to variations in, for example, the emotional habitus of working-class females in the two regional settings of this research. Such a comparison would be beyond the scope of this project. In a very generalised sense, however, the fact that these findings contravene the stereotypes of American expressivity and English reserve has been taken as an indication that, although broader socio-cultural differences may apply, it is possible that organisational-level differences may have had more influence.

know" their residents, furthermore, had implications for how they understood and used that knowledge.

## 6.4 Sharing "individualised knowledge" with others

The previous section discussed how "putting the individual first" required developing a direct relationship with each resident: an embodied, affective process guided by habitus and influenced by institutional logics, rather than a "one lump or two?" fact-finding exercise. This direct, personal knowledge of the resident also had to connect, however, to a broader knowledge base that was shared by staff within and across every shift, in order to maintain consistent standards of care and minimise errors.

Knowledge exchange happened informally and continuously, while carers worked together, passed each other between tasks, and talked over breaks, as well as through formal communication channels, including handover, daily notes, and care plans. The following section will examine how these communication practices – in interaction with other aspects of practice, particularly the organisation of the staff team – affected what information was shared and how this affected the situated meaning of individualised care.

### 6.4.1 Handover

Handover, also known as handoff, report, or signout, is used across health-care settings to pass information and responsibility from one shift to the next. Although this practice has been the focus of research for some time, knowledge about best practices remains inconclusive, particularly with regards to balancing efficient communication against secondary functions

such as staff cohesion, identity maintenance, and reflective practice (Cohen & Hilligoss, 2010; Riesenberg, Leisch, & Cunningham, 2010). Acknowledging these broader issues, this section will focus primarily on how the structure of handover at each facility intersected with relations of power to help or hinder the transfer of carers' individualised knowledge about residents.

At Richardson's, one nurse on each wing passed along information about residents at shift changes (7AM, 3PM, and 11PM) to the incoming nurses. The nurses held this "report" while sitting next to each other by the computers at the nurses' station. Although aides were usually in the vicinity – checking and writing down their assignments, chatting with each other – they rarely appeared to listen to report. Indeed, as an aide myself, I was not sure whether I was *entitled* to listen until well into my fieldwork.

The CNAs' limited participation in report meant they risked missing or failing to contribute to updates that were relevant to their direct-care tasks. One CNA (Edie) told me that because she did not hear report, she often did not know about changes that had occurred since her last shift: "*if she comes in after having been off for the weekend, she may have residents with new pressure ulcers that she doesn't know about until she gets in there and sees them*" (Fieldnote, Richardson's, Shift 29). Not only would Edie not know about her residents' condition in such a scenario (beyond her own sense-evidence), she would not learn about causes or treatments either; meaning that the significance of the update would fail to translate along with the update itself.

At Forest Lodge, the format of handover varied by shift and unit. On Vintage Vale, carers participated in morning handover when they came on shift at 8AM, while the overnight carer stayed on duty to supervise the residents. At the afternoon shift change, while the nurses again shared notes in the office, the carers would give a separate handover to each other in the dining room. Most of the carers participated actively in both types of handover, although a small minority remained less engaged.

As well as being a mechanism for sharing updated information about each resident's health and mood, handover on Vintage Vale also provided an opportunity to reflect and troubleshoot. The following provides an example from an afternoon shift, when two carers (Trisha and Olivia) handed over:

> *Olivia had managed to have [Tamsin, a new resident] sit in the dining room for breakfast <u>and</u> lunch – she said "she sat right here in this chair", indicating the chair closest to the edge of the kitchen, which looks out over the room. I didn't really give her the choice, she said, but just encouraged her to come in for her meal, and then she gave back her crockery and went back to her room again. ... Olivia suggested, maybe have her sit back in that same seat for supper – Trisha agreeing that a "routine" like that might help. Olivia repeated her suggestion, saying "I've only just thought of that now but she can sit here" – indicating the same chair – "have her own place, be able to see everyone", have her meal and then return to her room.*

> (Fieldnote, Forest Lodge, Shift 11)

It was notable that, even during the course of this handing-over conversation, the two carers generated and shared new insights. Furthermore, as a participant in this handover, I learned specific strategies for the shift ahead alongside information that would be captured in the daily notes.

On the upstairs unit at Forest Lodge, carers' involvement in handover was much more limited than on Vintage Vale. Although I was told that carers did sometimes sit in on morning handover – which took place in the nurses' office, often with the door closed – I never witnessed this. Instead, when they arrived, the carers gathered around the table outside the nurses' office, received their assignments from the nurse, and went straight to work. Similarly, when carers came in for the afternoon shift, they immediately started helping with lunch. In lieu of handover, carers were supposed to check for updates in the "Communication Book", a loose-leaf binder kept on the table outside the nurses' office. According to one carer, however, there was not enough time: "*you get in at 8,*" she told me, "*and get stuck right in*" (Fieldnote, Forest Lodge, Shift 21). Another carer, Sherman, put this down to a lack of initiative rather than lack of time: *"Yeah, they don't read it! ... And then they're going to complain 'nobody told me'. It's in the book. You don't look. 'I don't know, where's the book?' You should <u>know</u>"* (Interview, Forest Lodge, Sherman). There was more informal communication between carers on this unit than at Richardson's, which related in part to the organisation of teamwork (as discussed later in this chapter); however, the lack of formal handover, combined with under-utilisation of the (notably top-down, non-interactive) Communication Book, did preclude the consistent, collaborative knowledge exchange that took place on Vintage Vale.[42]

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[42] As a comparative example, when the resident (Tamsin) who had been discussed in thoughtful, personalised detail in the previous excerpt was moved upstairs, she was incorrectly assumed by the carers to have dementia

Cross-cutting the verbal communication practice of handover was the practice of codifying information about residents through daily documentation and care plans, as described below.

### 6.4.2 Daily documentation

As with handover, much can and has been said about the "information work" (Strauss et al., 1985) that goes into daily documentation, including what information gets transmitted (or not), by and to whom, when, and why (Buus, 2006). In the nursing-home context, daily documentation is essential for updating care, as well as for fees/reimbursement calculations, regulatory compliance, and legal safeguarding. This section will focus mainly on the implications of the computerised documentation system at Richardson's, with brief mention of the corresponding daily "paperwork" at Forest Lodge, which had a much more limited impact on the carers' workload. The analysis is framed within the general theoretical understanding that the properties of any given technology, in this case a new software programme, are emergent and social rather than predetermined; in other words, the "potential and power of a technological device to shape an interaction is not pre-given but is realised in practice" (Timmermans, 1998, p. 148 in Allen & Pilnick, 2005).

Several years earlier, Richardson's had switched to "6N", a computer software program which is designed for record-keeping in nursing homes. It was available as a touch-screen application at both nursing stations and on screens set into the walls along each hallway. When a CNA logged in, the names and photographs of "their" residents would appear on the

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and treated accordingly – even though she was suffering from severe depression, not memory loss. This example indicates how easily essential information can be lost through the gaps between formal channels of communication.

front page. By clicking on a name, a list of tasks would appear in chronological order; for example, if a resident was on a two-hour toileting schedule, then continence care would show up as one of the first tasks, and several more times further down the list. There were also tasks related to meals, snacks, mobility, transfers, hygiene, and mood/behaviour. Each task presented a list of criteria to click through; with the toileting task, for example, it was necessary to record the mode of toileting (toilet, commode, pad, or "activity didn't occur"), the actual output, the level of assistance the resident required, and the mode of transfer.

The level of detail supported by the 6N system contrasted considerably with previous paper reporting at Richardson's, whereby CNAs simply initialled a pre-written list of tasks at the end of each shift. There were even some free-text fields available for the aides' own notes, although this option was rarely utilised. As the assistant director of nursing said to me:

> *Alicia: The CNAs have a lot more routes for communication now with 6N, um, whereas they had, um, next to <u>nothing</u> compared to that before, as far as documenting anything they do know, behaviours, all those things weren't documented prior to 6N.*
>
> *Kezia: I have a question about that, do aides ever type in, do you find that they ever type in specifics in 6N?*
>
> *A: Not as much, not as much as we'd probably like them to, um, but there are spots for that to happen, um, sometimes with behaviours they will.*
>
> <div align="right">(Interview, Richardson's, Alicia)</div>

Alicia's last comment about "behaviours" suggests that computer charting offered an opportunity to capture and share carers' knowledge of residents' psychosocial needs as well as their physical status, thus facilitating PCC. In practice, however, the system appeared to undermine the individualisation of care by encouraging CNAs to think and act in terms of the specific tasks listed for documentation. The nursing axiom "if it's not documented, it didn't happen" was thus inverted to "if it's not documentable, then it's not required". This point is illustrated by the following break-time conversation about a resident on the rehabilitation unit:

> *[A small group of staff] talked about how this resident had started saying mean things, making constant demands, and expressing paranoia about people talking about her in the hallway. ... Naomi [a nurse] asked whether they could pre-empt her repeated requests by asking, as they are leaving, "now can I get you some iced water before I go?" or something. Rianna and Cathy [two CNAs] agreed that she'd just come up with another excuse for ringing. One example they gave was how she's started complaining that her ice cream hasn't come yet, half an hour before they usually bring it: "it ain't even <u>in</u> the computer", said Rianna, "we just give it to her".*

> (Fieldnote, Richardson's, Shift 24)

It is important to note Rianna's emphasis on the fact that ice cream was a treat provided at the staff's discretion, *not* a prescribed "nourishment" (care-plan speak for snack) for this resident. Although this indicated an individualised approach to care, it also suggests that the staff made a distinction between those tasks that were "in the computer" and the actions which they fulfilled spontaneously or autonomously. The attendant risk is that those interventions which

were not "chartable" – even if they were tailored to meet identified needs or preferences – would be the first to go on busy shifts or when staff were feeling less generous or motivated.

In a broader sense, the "6N" system appeared to reinforce the carers' role as one based largely on completing a sequence of tasks in a prescribed order – a care-by-numbers approach – rather than promoting the flexible and individualised approach that is integral to PCC. The following interaction took place one afternoon at the beginning of my shift, when I helped another carer (Aliyah) check a resident's incontinence pad:

> *We went to the [resident's] bedside ... and, once there, I pulled down the bedclothes and started raising the bed a little. Aliyah clarified "we're not laying her in the bed", and I said I knew that but thought it was better to change her on the sheet than on top of her velour blanket. ... Aliyah responded with that ambiguous and discomfiting (for me) smile of hers that could mean anything from "okay, no problem" to "okay, bitch, but I'll remember this". When we laid Anne down, we found that she was completely dry; that is, the brief was neither wet nor stained. Aliyah said she'd change it anyway, and I said with surprise "really? Even though it's completely clean?" She said yes, if she didn't do it then she'd feel bad about it when she got home. I was tempted to press her further – why would she feel guilty about not doing a task that clearly wasn't required? ... But I felt that I had stepped out on thin ice with my first question – potentially to be interpreted as a challenge – and wasn't brave enough to go further.*

> (Fieldnote, Richardson's, Shift 24)

When I realised later that Aliyah had been near the end of her shift, I understood why she had insisted on changing the dry pad: so that she could honestly document that she had completed all her prescribed tasks. What appeared illogical when interpreted as concern for the resident – why would she "*feel bad*" later about not having changed a dry pad? – *did* make sense in light of her responsibilities as a worker.

This interpretation is underpinned by the strong messages from management that the computers served as a monitoring tool. CNAs were pushed to document "*at the point of service*" in order not only to provide an accurate "*snapshot of care*", because tasks could not be back-dated, but also in order to "*get credit*" for their work, in the administrator's words (Fieldnote, Richardson's, Shift 7). If I did not document any tasks for an incontinent resident until the last hour of my shift, for example, the time of entry would suggest that I had neglected her for seven hours; I would not receive recognition for having checked and changed her every two hours as directed. Thus it made sense for aides to prioritise the tasks listed in the computer and forgo individualised care that might go unnoticed. In other words: changing a dry pad made sense according the logic of the workplace, if not from the perspective of PCC; while giving ice-cream to a "demanding" resident was an individualised task that might eventually be dropped, regardless of her preference, because "*it ain't even in the computer*".

The potential for computerised reporting to support more personalised care was also undermined by the time-saving strategies that CNAs deployed, which affected the accuracy of the recorded information. For example, even when Ilene (easily the most diligent CNA at Richardson's) used the computers, she frequently made "*fair guesses*", in her words, based on

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her knowledge of the residents and various other factors. The following is an example of guesswork by Nat, another experienced aide:

> *Nat and I had "floor feeds"[43] tonight, so we worked together to pass the trays, then I went to feed Olivia while Nat fed Mr. Elston. When I came out, Nat was already at the computer at the nurses' station. I told her how much Olivia had eaten, and she was surprised, saying "I can never get her to eat". I also told her how much Hector had eaten/drunk, but when she saw me examining the next tray I collected, as I was walking with it back towards the cart, she called out to me that she'd already entered the rest since they always eat about the same.*

(Fieldnote, Richardson's, Shift 19)

Making a "fair guess" saved time, and also reinforced the carers' sense of competence; watching them tap rapidly through the documentation screens, it certainly looked like they knew, without a moment's doubt, all the key facts about their residents. The obvious concern is that relying on knowledge of how someone *usually* eats, sleeps, or acts – which is certainly important information – may mean overlooking changes on a *particular* day, as evidenced by Nat's surprise at Olivia's consumption. Thus, the process of entering data into the computer, according to externally imposed parameters and taking into account the pressure on aides' time, tended to "fix" the residents in two dimensions rather than reflecting their complex and

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[43] To "have floor feeds" meant staying to pass trays to those residents who stayed on the unit for dinner, rather than going down to the dining room. One set of shift partners was given the "floor feeds" task each shift.

changing needs and preferences (*or* encouraging the aides' to contribute their daily knowledge).[44]

In contrast to Richardson's, care assistants at Forest Lodge held minimal responsibility for daily documentation. Each unit documented residents' meals on a paper form, but these forms were much more basic than the corresponding section on the computers at Richardson's, in that there was only space to tick or write "refused" for each course – nothing about quantities consumed or level of assistance needed. For those residents who stayed in bed, there were additional forms in the bedrooms to record repositioning, bed-rail safety checks, and interventions such as continence care. There were also daily forms for recording washing, dressing, and baths/showers. Carers were also supposed to record residents' bowel movements, including details on the size and consistency, but this seemed to happen intermittently at best, as it required going into the nurses' office to hunt for the appropriate care plan in the resident's folder each time. Altogether, and in contrast to reports from across the health-care spectrum, I heard very few complaints from care assistants at Forest Lodge (although considerably more from nurses) about completing "the paperwork", as it was known. Accordingly, the actual practice of completing daily documentation seemed to play a much less significant role in the construction of resident care for care assistants at Forest Lodge than at Richardson's.

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[44] In retrospect, it is clear that an additional issue that may affect the accuracy and implementation of documented information is literacy levels among frontline staff. However, as this issue did not come up during my observations or interviews, nor did I proactively explore it, it is not possible to make claims about its relevance here.

In both settings, carers had little awareness of the output of daily documentation. This was particularly noticeable at Richardson's, however, where aides spent a lot more time completing their "bookwork". As explained cogently by one CNA:

*From a documentation point of view, I'm sure [computer charting] is great, um, but as a CNA right now, I, I have nothing to do with care after it's been done, like, uh, I, I do my cares, and I put it in the computer, and I don't ever look at it again, that's somebody else's job to process all of that data. So, to have to do that, which takes another, you know, half hour, 45 minutes out of your 8-hour day, um, pain in the ass! But [brief laugh], I'm sure, um, it's probably very constructive for them to know exactly what's going on throughout the day, and to be able to just look at it at a glance, rather than having to go through, you know, tons of paperwork – but, to be honest, I don't really <u>know</u> what they do with that information, all I do is put it in the computer, and I don't ever look at it again. So ... as a CNA, all I really see of it is the extra work it is for me, so it's hard to judge whether or not it's useful or productive…*

(Interview, Richardson's, Daria)

Daria, who was planning to train as a nurse, was quite adept in her interview at reflexively contrasting the CNA perspective against others (in Bourdieusian terms, objectivating the conditions of her own knowledge). Thus, in the excerpt above, she acknowledged that "*it's probably very constructive for them*" while also admitting that computer documentation primarily felt like extra work to aides. Other staff who were more firmly entrenched in the

CNA role tended to echo this latter point without acknowledging the relevance of the data for personalised care.

Nonetheless, information that was recorded on a daily basis *did* have direct relevance for the development and maintenance of residents' care plans, which are discussed in the following section.

### 6.4.3 Care plans

The care plan is an essential tool for collecting and sharing comprehensive information and maintaining consistent care, although it can be more or less effective depending on length, content, and specificity (Dellefield, 2006). At Richardson's, care plans were developed (following the federally mandated RAI described in Chapter 2) by an interdisciplinary care team which included the attending physician, an RN, and representatives from other departments such as dietary and activities. Although "person-centredness" implies that the resident, their family, a legal representative, and/or their direct-care worker would also be essential participants in the care-planning process, this was not always the case. Each resident's complete medical records were stored at the nurses' station, while the care plan was distilled onto a single sheet of paper (described as a "cheat-sheet" during induction) and hung in a plastic envelope inside their closet door. Following a standardised format and updated approximately monthly, this one-page care plan included details about the resident's health, abilities, and preferences, including with regards to mobility; safety and risk; continence care; eating and nutrition; eyesight, hearing, and communication; and general

comfort. The care plans were framed discursively as the authority on care, with primary emphasis on legal safeguarding (as discussed in Chapter 8).

At Forest Lodge, the term "care plans" referred to thick folders of information for each resident that were stored on shelves in the nurses' offices. The folders contained 12 standard forms, each with a different "CP number" (for care-plan number), which were issued by the parent company. These forms covered in much more detail the same types of information listed on the care plans at Richardson's. Notably, the care plans at Forest Lodge were primarily referenced as person-centred tools rather than legal safeguards, although also serving the latter purpose. For example, when I asked the assistant manager at Forest Lodge about PCC, she referred almost immediately to the care plans in her answer:

> *Kezia: Now would you tell me kind of what … person-centred care means to you, or how you understand it?*
>
> *Louisa: Mm, mm, it's – me looking at you as an individual, finding out as much as I'm able about Kezia, how Kezia likes their hair, your – your washing routine, you know, because, I know what I'm like, first thing I have to do, is brush my hair, <u>then</u> have a wash, you know, so it's, it's us, finding out your likes, your dislikes, and writing it all in your, um, care plan. And, possibly looking at your life history, and how we could occupy you … looking after you as an individual in your own ways…*
>
> (Interview, Forest Lodge, Louisa)

The care plan served to capture the personal details, Lousia suggests, which inform PCC. Furthermore, the care plans were used as a tool to reinforce person-centred language, with carers instructed to avoid conventional shorthand such as "challenging behaviour" or "aggression". As Trisha told me: *"mind you, you're not allowed to put negative things in though so it's a matter of choosing your words"*. When I asked for an example, she said *"for our 'residents who wander', you're not allowed to say they wander, say instead that they're 'exploring their environment'"* (Fieldnote, Forest Lodge, Shift 1). However, as carers rarely wrote in the care plans, there appeared to be limited opportunity for them to practise using this language or consider the relationship between their choice of language and associated care strategies.

In practice, the care plans at both Richardson's and Forest Lodge did not map directly onto practice, because they were often either overlooked or (more or less covertly) contested. At Forest Lodge, although the amount of detail included in the care plans was a source of pride, it was also seen as an impediment to implementation; as Aimee, a nurse, put it: *"all these long-winded notes leave you wondering, but what am I supposed to <u>do</u>?"* (Fieldnote, Forest Lodge, Shift 11). Similarly, when I asked the assistant manager whether carers accessed the information they needed from the care plans, she replied: *"They don't have time. If, if they had to read all this ... when would they do the caring? I mean there's so, there's so much in these, aren't there?"* (Interview, Forest Lodge, Louisa). Indeed, there was even some confusion among carers at Forest Lodge about whether they were entitled to read the care plans (Fieldnote, Forest Lodge, Shift 16).[45]

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[45] Lidia, who had recently been appointed as "shift leader" at Forest Lodge, told me that she had begun encouraging the other carers to read and contribute to the care plans: *"If they get time in the morning, if they get*

Even at Richardson's, the one-page care plans were sometimes overlooked, as Ilene noted:

*On rounds, when changing another resident that we hadn't worked with today, Ilene pulled down the cover to check his feet, saying, "I think he's supposed to wear totes[46] in bed at night", then went to check his care plan to be sure. She came back saying that he is supposed to wear totes ... but that "some of the girls" don't seem to know that – "it only says it in big bold letters on the care plan!" (I checked and it was written in all caps.) She also showed me how all of his covers are supposed to be tucked in between the bed and the wall on the far side, to keep him snug – reiterating that this is also in his care plan, but that "the girls" don't always check, though [admitting] there "is a lot of information on there" by way of concession.*

(Fieldnote, Richardson's, Shift 11)

Although information overload may have been part of the issue, resistance also seemed to stem from a sense that the care plans were just artefactual representations of the carers' superior practical knowledge. In the following interview excerpt, Ilene describes a scenario in which a new CNA asked for her advice in working with a more experienced aide who was not following a resident's care plan:

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*a spare five minutes in between doing something, I'll say, go and get so-and-so's care plan, go sit down and have a quick read of it, and write down what you've done with them today. And that way, they'll get to know a little bit more about that person. But if you give them too much information, it's too much for them to hold, for so many people up here. So just give them a little bit about one person who they've been with on that day, and it helps retain that information, and then the next time they go to them, they'll remember"* (Interview, Forest Lodge, Lidia). Although I have no evidence about its impact, this strategy suggests an effort to transform the care plans from abstract textual representations (like the computer charts at Richardson's) into accessible and useful tools. However, it might not have addressed the gaps in knowledge exchange, if carers only read the care plans as and when they had that elusive "*spare five minutes*".

[46] "Totes" are socks with rubber nodes on the soles, often used in medical settings to avoid the risk of slipping.

*[W]ith the same person I just spoke of, she had a problem with a fellow aide, who wasn't doing things according to policy – and she felt she wasn't doing it – but she wasn't sure, so she came to me to ask me, she says, "well, um, I got a question", she's like, um, "if you see another aide doing something that's <u>not</u> on the care plan, or not following something on the care plan – what should I do?" I said, "well, you bring it to her attention, and let her know what she's doing wrong. And, if, even if you have take her right to the care plan to show her that it's <u>in</u> the care plan and that <u>should</u> be done this way". She's like, "well, she keeps telling me that, <u>she</u> knows, she's been an aide, she knows, she knows!" I said, "well, just watch her for a while, after you've already told her, and spoke with her, just watch and see, you know – if you see she's still not following what you've told her to do, you know, because it <u>is</u> care plan, it <u>is</u> policy – go to Alicia [the assistant director of nursing]!"*

(Interview, Richardson's, Ilene)

This scenario implies two simultaneous power struggles. One was the struggle between a novice CNA attempting to adhere to her training and a more experienced CNA who claimed expertise through experience. The second was between CNAs, who collectively sought authority to interpret care plans through their own embodied experience, and the top-down authority of facility managers: "*it <u>is</u> care plan, it <u>is</u> policy*". In both struggles, the legitimacy of the care plan seemed to be symbolically juxtaposed against the carers' own knowledge, a point which will be picked up again in the Discussion.

### 6.4.4   The organisation of the team

These standard channels of communication – handover, daily notes, and care plans – are important for ensuring that comprehensive information about residents' care circulates among all staff across every shift. The success of these methods in facilitating more individualised care was significantly influenced by the organisation of the care assistants as a team, however, as well as by the practices themselves.

As mentioned, Richardson's had recently adopted consistent assignment, which meant that CNAs were responsible for the same "card" of residents on every shift. On the one hand, this was an explicitly person-centred change designed to enhance the individualisation of care. However, it also led to or at least supported the individualisation of the CNAs' *workload* which – taking into account other aspects of their work, such as time- and risk-management (as discussed in subsequent chapters) – appeared to undermine the exchange of information that was critical to "putting the individual first".

In part, this was because competence as a CNA came to be associated with knowing as much as possible about one's *own* residents; conversely, asking for more information signified incompetence, while providing information risked promoting others' competence above one's own. Even in my own practice as a CNA, I occasionally noticed this tendency:

> *Back on the unit after supper, Ava [another CNA] helped me get Rose into bed to use the bedpan. Her daughter was there and insisted that she "said she needed to go", even though she was halfway through her soup when I came in, spoon in hand. When I went to check her care plan to make sure I had everything straight*

*before calling for help, her daughter said "she's two-assist with the hoyer". I said thank you but kept looking at the chart, as if somehow I needed to demonstrate to her daughter that she couldn't tell me everything about how to do my job.*

(Fieldnote, Richardson's, Shift 13)

Being told what to do by Rose's daughter triggered a surprisingly defensive reaction in me, rather than gratitude for the shared knowledge. In retrospect, I can interpret my defensiveness as a reaction to an unspoken challenge to my very limited authority as a CNA, an authority derived solely from *demonstrating* (if not feeling) competence in direct care. (Later on in my notes from the same shift, I wrote about feeling "*absolutely burned out and hopeless about how the night had gone*" – indicating the shakiness of my sense of identity as a competent CNA.)

Another example comes from training on the east wing one morning with Allie, who had made a career change into LTC after working in the financial sector. We had a new resident to care for, Mr. Gifford, who had just moved from the west wing. From working with him there, I knew that Mr. Gifford was quite particular in his preferences. Although Allie had not worked with him before, however, she seemed to resist admitting her lack of knowledge about these particulars. When I read aloud from Mr. Gifford's care plan, she did not respond immediately, and I thought that she had deliberately ignored me until she eventually said "*what, K*?" When I repeated myself, however, she still did not reply. I reflected in my fieldnotes that, in this situation, it felt really difficult to tell Allie what I knew about the resident, from the care plan and from my prior experience, without calling into question the

image of competence and confidence that I had seen her project in other care scenarios, and perhaps destabilising her authority as my trainer.

The disincentive to share knowledge suggested by these examples had roots in long-standing animosities between CNAs at Richardson's, known as the "shift wars" and "wing wars". As the director of nursing put it:

> *[T]here's a huge division between the shifts that is … difficult. I mean, that, that valley is very, very deep, and filling it so that we can all be on a little bit better page, I, I don't have a plan for it! [laughs]… It's always been, the day shift always blames the midnight shift, the midnight shift always blames 3 to 11, 3 to 11 always blames days. You know, and, and dietary blames nursing for eating the cookies, you know!*
>
> (Interview, Richardson's, Yvette)

According to the assistant director of nursing, the introduction of consistent staffing had reinforced the divisions along which these battle lines were already drawn:

> *[I]t's kinda funny that now, while on one hand we say, you know, you work for [Richardson's] and you know, they're <u>all</u> your residents, they, we've reinforced with the consistent staffing that, you know, well, these are <u>mine</u>, these are <u>my</u> residents – so even when they have a day off, the residents are starting to, um, note that, you know, oh well you know, when I have a part-time aide, things aren't exactly the way I want 'em, because she does not always know, so we*

*talked about them filling out the rosters and we kinda, even if they can personally touch base with that part-timer, hey, you know, I'm gonna be off, just so you know, she's going out Friday so she's gonna want this, you know, trying to, um, pass those kinds of things on, um, but … they don't feel comfortable doing that, you know what I mean, like um, the full-timer doesn't feel like she can tell the part-timer, she feels like she's telling her what to do, the part-timer doesn't think she has to listen to the full-timer because she's on the same level, so there's a lot of dynamics there… A lot of dynamics.*

(Interview, Richardson's, Alicia)

Part of Alicia's message here is that consistent staffing had affected residents' expectations such that they felt short-changed when cared for by someone other than their full-time aide. This could be offset by effective knowledge-exchange between the "full-timers" and other CNAs, she suggested, except such communication was thwarted by the perception that sharing information equated to "*telling [another aide] what to do*", an exercise of power that was strongly resisted. This must be contrasted against the power imbalance that certainly *was* recognised between frontline staff, including CNAs and nurses, and members of management and administration, who were known as the "carpet people" (since their offices were located along a separate carpeted corridor). The care staff did not appear to share any sense of solidarity with the carpet people – even though the administrator, director, and assistant director of nursing were all RNs – and interaction between the two groups was limited.

There were two sets of distinctions among personnel at Richardson's, then: between "us" and "them" (the care staff and the carpet people) and, among CNAs, between those working on

different wings and across different shifts. Within this network of strained relationships, where carers' main claim to power derived from their daily, embodied competence in providing direct care to their own residents, it often did not *make sense* to ask for information (thereby admitting fallibility or incompetence) or provide information (thereby undermining one's own proprietary supply).

By comparison, varied shift patterns at Forest Lodge led to a more fluid and *ad hoc* style of teamwork, with staff forming into different arrangements on any given shift. This acted against the calcification of differences within the care-assistant group that was seen at Richardson's; although of course carers expressed individual affinities and antipathies, there were no shift wars or wing wars at Forest Lodge. Furthermore, the sense of "ownership" that was generated through consistent staffing at Richardson's was not evident at Forest Lodge, where knowledge seemed to be considered as a shared resource. In this context, care assistants tended to emphasise the importance of information exchange and mutual learning. For example, when I asked Trisha how she acquired her exceptional knowledge of the residents on Vintage Vale, she told me:

> *I think some of it, you learn from other carers, um, some of the information I've learnt – story-telling, you know, the other carers telling me stories. I think, um, that's really where a lot of information began, you know … I think that's actually your first primary source of getting to know the resident, actually.*

> (Interview, Forest Lodge, Trisha)

On Vintage Vale in particular, this knowledge exchange often took the form of collective problem-solving or "detective work" (Stokes, 2008), such as with the handover example above, which resonated with the person-centred emphasis on using the individual's life history to interpret their current disposition and actions.

On the upstairs unit at Forest Lodge, knowledge exchange was facilitated by the creation of a new "shift leader" role, which an experienced CNA (Lidia) was filling on a trial basis during my fieldwork. In this position, Lidia helped organise the team on each shift, and also acted as a conduit for communication between carers, nurses, and managers. Importantly, she communicated information about the residents' personalities and biographies as well as their current medical status:

> *I often talk to, um, new staff, a little bit about the person, if they, that person can't communicate, I have the advantage whereas I know a lot of people here, I know a lot of people who live here, I've known them for quite a while, I've seen them when they were – more able-bodied, more able to talk, so I know their history, a little bit of their history as they were, as a person, and I can tell them that this person used to love doing this, this person had a cheeky laugh, this person had this. I says, talk them about it. And I can relay that back to them, and it makes a new person see, this person is an individual, this person has his, their own character, this is this person, this is what they're about.*

> (Interview, Forest Lodge, Lidia)

In sharing this information with new staff as she worked alongside them, in a situated-learning sense Lidia thus helped translate it from abstract facts into relevant, actionable knowledge. In this role, she also helped bridge the gap between CNAs and other staff – referring to this as "*translating*" information to and from carers, who might feel "*timid*" about talking to nurses or management. She was also well-placed to repeat and reinforce messages in order to avoid information blockages or miscommunication: "*I have to keep telling them, and telling them. ... But that's not a problem, I don't mind it, I don't mind, I'd rather tell them a hundred times rather than get it wrong*".

The assumption throughout this section has been that "putting the individual first" requires good communication among staff, through a number of channels. Overall, this seemed to happen more informally and effectively at Forest Lodge, where there were fewer perceived divisions between staff, than at Richardson's. However, it must be acknowledged that the information exchange about residents sometimes produced objectification over personalisation. Consider the following example from Vintage Vale:

> *[Trisha, Bonnie and I] worked together to get Selina ready for bed, talking over the top of her head as we undressed her about how she hates to be touched, etc. Trisha said they had said it must be something to do with her personal history, some past trauma, but she thought that Selina had been here long enough "to get comfortable with us" – so she thinks that's "just part of who she is", that she dislikes people touching her. Bonnie said "and I'm always afraid of hurting her, when she grabs on like that".*

> (Fieldnote, Forest Lodge, Shift 14)

I reflected in my fieldnotes that this conversation seemed to indicate a genuine attempt to understand why Selina reacted negatively against personal care, an attempt which reflected Vintage Vale's person-centred emphasis on understanding the intentionality and meaning of residents' behaviours. Nonetheless, as the carers speculated over the top of Selina's head about her traumatic past during the very type of intervention that was acknowledged to cause her distress, the moment seemed more depersonalising than person-centred.

In other cases, when intimate details about residents were shared among staff without obvious relevance to their direct care, the objectifying outcome was more obvious. In the following uncomfortable example, for example, "individualised knowledge" was used to make a resident the object of ridicule:

> *Back at the nurses' station towards the end of the shift, there was more joking about Jackie and her particular requirements when it comes to the bath/shower, particularly her insistence about washing and drying thoroughly and repeatedly between her legs. "Get into the cracks!" said Rianna [a CNA] in imitation ... Marcia [a nurse] said, "yeah, just keep going long enough for me to have an orgasm" and Isobel [another nurse] said, "no, that's not it" in a tone that suggested that Marcia had perhaps gone too far, as she headed away from the desk. "Oh, I've shocked you now, haven't I," said Marcia, "but really, that's what it is!"*

> (Fieldnote, Richardson's, Shift 14)

Although such informal conversations, which were fairly common at Richardson's, were generally more humorous than malicious in tone, they nonetheless represented a violation of residents' privacy and dignity. This reinforces the argument that "individualised knowledge" is a type of symbolic power. Residents did not have the power to withhold private information about themselves, due to the nature of the care context, nor could they defend themselves against its misuse in staff conversations. The power in this instance was with the care staff who held this knowledge along with the ability to share or withhold it.

## 6.5    Discussion: Individualised knowledge as symbolic capital

This chapter has highlighted a number of practices which were necessary for supporting the individualisation of care, as opposed to the "mortification" of the individual. The first set of practices related to "getting to know the resident" directly, including through physical interaction and emotional engagement. The second set of practices, including handover, daily documentation, and care plans, facilitated information-exchange between staff.[47] The way that care was organised, in terms of more or less individualised ways of working, was highlighted as a mediating influence.

Two central claims which have been made in this chapter will be elaborated here. The first is that individualised knowledge served as an important (if limited) source of symbolic capital for carers, which had recursive effects on how it was shared and implemented. The second,

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[47] Sharing information with family members is another important way to learn about residents (Brown Wilson et al., 2009). This type of knowledge exchange certainly happened on Vintage Vale, where family members were most integrated, and to a more limited extent on the upstairs unit and at Richardson's. However, I did not obtain enough data through my fieldnotes or interviews to make reasonable claims about the extent or significance of this type of communication.

related claim is that the formal and informal channels by which care assistants acquired this knowledge were critical in shaping how it was understood and utilised, with more or less person-centred outcomes.

First, considering carers' "individualised knowledge" as a source of symbolic capital helps explain the relative effectiveness of various communication practices, particularly when interlocking practices such as teamwork are taken into account. In general, carers were excluded from formal communication practices, namely handover and care planning, so that they could get on with physical care-giving tasks; as quoted above, "*you get in at 8 and get stuck right in*". This contributed to the sense that their knowledge was being siphoned off rather than exchanged for mutual benefit.

This varied between the facilities, however. CNAs seemed to discern little compensation for the time they spent on computer documentation; while handover on Vintage Vale, by contrast, offered a more meaningful opportunity for carers to engage in discussion and exchange information that had direct relevance to their practice. However, while attempts were being made to involve CNAs more meaningfully in handover at Richardson's, or possibly to instate a separate "CNA report", the direction of travel was reversed at Forest Lodge; soon after I had finished fieldwork there, carers were asked to stop participating in morning handover in order to expedite the morning routine (see Chapter 7). As well as directly impacting the flow of information on the unit, excluding carers from handover might have had implications for their sense of the value of their knowledge, and consequently their willingness to share it.

This linked to the exchange of information among carers, which was (in part) a function of the organisation of the team. At Forest Lodge, there was much more informal knowledge exchange between carers, where the team was organised shift-by-shift, than at Richardson's, where individuals were responsible for their own residents, and did not demonstrate a sense of joint responsibility. In this latter case, sharing information about "my resident" equated to yielding symbolic capital, rather than enhancing the collective knowledge supply.

The findings suggest that trying to enhance the implementation of PCC through better communication, particularly in terms of adapting care to individuals' evolving needs, might have paradoxical outcomes. That is, to ensure that information is not lost – without relying too heavily on informal knowledge exchange, which is subject to error, or individual carers' memories – it is imperative to capture and consistently communicate as much information as possible to all staff across every shift. However, codified information about residents in notes, care plans, and so on tends to "fix" them in two dimensions, which can have a deskilling effect on carers if it devalues or edges out their daily, situated, evolving knowledge. Blackler (1995, p. 1031) identifies this deskilling effect in studies of work systems that become "informated", thus bypassing the workers' use of "immediate, physical responses to situated cues" in favour of pre-defined, codified categories. Computer charting at Richardson's, for example, was very important for ensuring consistent care, but risked replacing CNAs' direct observation of residents' needs with a proxy list determined in advance.

The second claim in this chapter has been that individualised knowledge can be understood and implemented in notably different ways. In some cases, carers certainly used their individualised knowledge to balance the logics of practice and provide individualised care –

as suggested by the lengthy quote from Trisha, in which she asserts that "*it's just ... really, knowing them, you know, um, and really just working around that.*" In other cases, the instrumental value of this individualised knowledge was more evident, as in Ilene's comment that "*it's very important to know each resident as an <u>individual</u> ... what they can do for themselves – and what they can't do for themselves – cuz that's helpful for you.*"

To a significant degree, however, the evidence suggests that carers used the symbolic power derived from individualised knowledge not to *individualise* care, per se, but to *manage* care within their overall workload. The intention here is not to ascribe malicious intentions, but rather to recognise that, within time constraints and following the logic of the workplace, it *made sense* for carers to use their knowledge in ways that maximised efficiency rather than, necessarily, for holistic care.

Using knowledge as a tool for managing residents was, to a certain extent, underpinned by the methods of communication discussed above. That is, by reducing residents to two-dimensional artefacts, communication tools such as care plans and computer documentation helped expedite care under time constraints; in other words, they allowed carers to learn just enough individualised knowledge about their residents to provide efficient care, and no more. Care that was supposed to be more flexible and adaptable, according to the ethos of PCC, thus shifted back into codified, task-driven care that reflected the logic of the medical facility and business rather than residents' changing needs and preferences.

Building on this claim, the defining influence of *time* on the implementation of PCC will be the focus of the next chapter, "Taking time to care: The temporal structures of practice".

# CHAPTER 7: TAKING TIME TO CARE: THE TEMPORAL STRUCTURES OF PRACTICE

## 7.1    Introduction: The tempo of practices in the nursing home

A familiar image of life in a nursing home is that of residents sitting in a circle of chairs, inert, staring dully at the television or dropping into sleep. The monotony is broken only by routine care tasks, such as trips to the toilet; by mealtimes, which are served like clockwork; and by the provision of "activities", known as the "3 Bs" of bingo, birthdays, and Bible study (or just, as the joke goes, bingo, bingo, and bingo). The time between those brief interruptions stretches into endless empty hours.

Person-centred care (PCC) challenges staff to adjust their pace of work, drawing on principles of flexibility and spontaneity rather than following a standardised, routinised approach, in order to bridge the temporal gap between those endless hours and their brief interruptions. As Eric from Forest Lodge put it: "*We're told that there's no such thing as time. Things take as long as they take*". The idea is that "taking time to care", which implies responding to individuals' needs, preferences, and capacities on any given day, not only disrupts the monotony of the institutional routine but also provides more opportunities for independence and engagement, thereby further affirming personhood rather than simply accommodating impairments. But "taking time to care" can also seem like an impossible request without increasing the number of staff who share the workload.

In most PCC approaches, *time* is (implicitly) assumed to be extrinsic to practice. That is, time is linear, invariant, and quantitative; the backdrop to human activity. The clock will keep on ticking at the same pace from the moment I punch in until the moment, eight hours later, that I punch out again. This common-sense understanding of temporality is often referred to as "clock time" (Colley et al., 2012) or "physical time" (Jones, 2010), and

In contrast to this *objectivist* account, sociological perspectives suggest that time is also *subjective,* constructed in social groups according to norms, beliefs, and customs (Orlikowski and Yates, 2002). This is known as "event time", in that time is present *within* socially constructed events, rather than externally defining them. Childhood and old age are both examples of "event time": although these are understood as objective categories based on chronological age, there is in fact nothing fixed or given about either category (as mentioned in the Introduction). This approach helps explain how time is experienced as passing slowly or quickly, at the "right" or "wrong" pace, and so on, depending on the particular event and its context.

Practice theory provides a third perspective that challenges this objective/subjective distinction.[48] According to practice theorists, time is an intrinsic property of all practices; indeed, temporality is one of practice's "defining characteristics" (Nicolini, 2011, p. 611), as all actions are performed in time as well as space. The temporal organisation of practice – alongside its spatial, relational, and other dimensions – inscribes shared understandings of

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[48] This, of course, vastly oversimplifies a broad range of theoretical approaches to *time*; Munn's (1992) review provides a useful entrée into this literature.

when things should happen, how long they should take, when other actors should become involved, and so on. As Bourdieu (1990b, p. 75) puts it:

> Social disciplines take the form of temporal disciplines and the whole social order imposes itself at the deepest level of the bodily dispositions through a particular way of regulating the use of time, the temporal distribution of collective and individual activities and the appropriate rhythm with which to perform them.

Extrapolating to the workplace, it can be assumed that such temporal considerations must initially be learned by newcomers as part of their socialisation into a particular set of practices, but then are absorbed over time into their habitus and thus transformed into a tacit, taken-for-granted sense of time as something given, external, and inflexible – as "clock time".

From a practice perspective, Orlikowski and Yates (2002, p. 684) propose the concept of *temporal structures* which "guide, orient, and coordinate" activities; these structures are "neither independent of human action (because shaped in action), nor fully determined by human action (because shaping that action)". They propose, furthermore, the notion of *temporal multiplicity*, suggesting that actors may enact "multiple and often interdependent temporal structures" at once, thereby engaging with different and perhaps contradictory "explanations" of the overall temporal logic of practice.

This notion of temporal multiplicity resonates with the theory of institutional logics which has been deployed within the current study. Institutional logics arguably have their own temporal "features" which provide meaning or justification for particular situated acts. For example, *efficiency* is particularly important in the business context, where time is money;

whereas *regularity* is important when it comes to the provision of care (especially medications, dressings, and so on) in the medical facility; and *flexibility* makes more sense in the home. These different logics may inform identical or distinct, overlapping or competing temporal structures. There may be very little variation, for example, in how the act of feeding someone is temporally structured; it takes a certain amount of time, regardless of rationalisation efforts (Colley et al., 2012). However, the task may be performed and experienced differently by both caregiver and recipient, depending on when it is structured around other tasks and according to which institutional logic(s).

The following chapter will use these concepts to move beyond the "time to care/no time to care" impasse – which assumes that hiring more staff, a near-impossibility in the current funding climate, is the only route to personalised care – in order to analyse *how* care assistants temporally structured their practice. The chapter will suggest that care remained largely routine-driven at both facilities, despite attempts to introduce more flexible ways of working, as carers were socialised into a workplace role that equated speed and efficiency with expertise and competence. However, although these temporal structures remained relatively unchanged, it will be argued that the availability of different institutional logics provided evidence of the *potential* for translating PCC into practice, with particular reference to the tempo of practice on Vintage Vale.

## 7.2    Person-centred care: "Not having these routines"?

In the following interview excerpt, Richardson's assistant director of nursing recalls the first time that she heard about "culture change":

*Kezia: … [D]o you remember when <u>you</u> first heard of culture change?*

*Alicia: Mm-hm.*

*K: And what did it sound like to you?*

*A: It sounded absolutely wonderful and, holy cow, why have we been doing this the way we've been doing it for so long?*

*K: Okay, okay. So what did you think was particularly different about what was coming in?*

*A: Um… the whole concept of not having these routines, um, because from my perspective, um, just from a nursing perspective, everyone has to get up, everyone has to eat breakfast, everyone has their bath assigned to this day, everyone has bath time assigned to this time, they have to be in the dining room at 11:30, and, um, you know, these are basically their choices for a meal, you know, if they don't like that, they can have something else of course, and then, the meal time is now, and then, you know, you go to bed after that – or you don't go to bed after that. And then, you know, you get back up, there's an activity at two, it's the same activity for the last 10 years, it's at two on Tuesdays, and then, you know, every day, and just all the things, you know, med times, um, um…. Med times and treatment times and, um, all those things are just so regimented to the point where, um, we had the bath schedule, and, it wasn't a person's name on the bath schedule, it was a room number, and so if that person left or passed away, then the next person that came into the room got that bath day [laughing].*

(Interview, Richardson's, Alicia)

In this quote, peppered with terms such as "everyone", "the same", "regimented", "routines", and "schedule", Alicia articulates the routine-driven, depersonalising tendency in institutional care that both research sites were attempting to overcome by introducing PCC. Similarly, Lidia from Forest Lodge described the tempo of practice prior to PCC as "*too much routine, if you know what I mean, and not enough actual consideration for the people they were looking after. It was, we've got wash, we've got to dress, we've got to get them out, bang, job done*" (Interview, Forest Lodge, Lidia).

But in the statement above, Alicia also speaks to the intersecting practices – and institutional logics – which must be taken into account when introducing more flexibility into the provision of care: the carers' imperative to maintain residents' hygiene, for example, as well as the nurses' responsibility to ensure timely medication administration and the dietary staff's requirement to serve meals on time.

Before addressing these complexities, however, it is important to acknowledge that moments (however fleeting) of "exemplary" PCC in practice *did* occur at each facility. One such moment occurred on an afternoon shift at Forest Lodge. I walked into the upstairs lounge to find Sherman, a care assistant, sitting on a low stool next to one of the residents' armchairs (Fieldnote, Forest Lodge, Shift 24). He was periodically offering the resident, Vienna, sips from a glass of juice while she remained engrossed in playing with a purple teddy bear, chuckling with glee as she made it "walk" towards or away from him. Sherman would laugh cheerfully in response, repeating the few recognisable words she uttered, before encouraging "Auntie V", as he called her, to accept another sip. As the room was otherwise empty except for two sleeping residents, this interaction did not appear staged or self-conscious; rather,

Sherman seemed to be taking a very natural, unhurried approach which seamlessly combined the medical imperative (to ensure adequate hydration) with the person-centred emphasis on affirming personhood through social interaction and stimulation.

Another such moment occurred on a morning shift at Richardson's (Fieldnote, Forest Lodge, Shift 9). Towards the end of the shift, my CNA trainer, Allie, sat down next to a resident with dementia, Ruth, who had been secured with a lap belt in her customary chair across from the nurses' station. Allie spent about 15 minutes – which was a long time according to the pace of work at Richardson's – flipping through a magazine with Ruth, pointing things out, speaking very clearly and appearing to carry on a sustained conversation. In contrast to the example above, Allie *did* have a potential audience, but nonetheless she appeared to be focusing entirely on Ruth rather than delivering a performance for the nurses at the desk.

### 7.2.1 *The power of routines*

Apart from these rare exceptions, care at both facilities continued to adhere to a fairly routinised approach, which reflected and perpetuated a considerable disconnect between the overall tempo of the day for residents versus staff. At Richardson's, a typical day for residents began soon after their primary CNA arrived, which was at either six or seven o'clock in the morning. Breakfast was at eight, lunch at noon, and supper at five, with each meal served and concluded promptly. Between meals, residents spent the majority of their time lying in bed or sitting in their rooms, along the corridor, or in one of the small lounges on each wing. For aides, on the other hand, each shift was an almost-constant treadmill of tasks from the moment they clocked in until their last resident was "done". The schedule at

Forest Lodge was broadly similar, although mealtimes were extended and the pace of work was somewhat slower, particularly on Vintage Vale.

Indeed, as suggested above, the heavy workload made this persistence of routine-driven care seem the only option within the time available. As Ilene describes the morning shift at Richardson's:

> *Well, let's say, if you're scheduled at seven o'clock, you come in at seven. They serve breakfast at eight. That gives you one hour to get the information from the nurse, you know, your – that you need to know, from report, and then get, and then see who you <u>have</u>, and then get on the floor and do what you [laugh in voice] gotta do! You don't have a lotta time! <u>That's</u> what bothers me. There's not enough time.*
>
> <div align="right">(Interview, Richardson's, Ilene)</div>

This perceived lack of time translated into a very depersonalising morning routine, according to my own observations:

> *The process of getting residents up in the morning was this: go into their room, turn on the lights, get out their basin, undress and wash their top half in bed, put on their clothes, leaving their pants around their ankles, put on their socks and shoes – and then pull the sheet back up before moving to the next resident. Once all the residents have been washed and half-dressed like that, start getting them out of bed and into their wheelchairs. Allie told me that rounds would have been*

*done at six, so the residents should mostly be clean and changed – which was*

*why we didn't change any briefs or wash their lower halves.*

(Fieldnote, Richardson's, Shift 8)

Although it jarred with the person-centred ideal of individualised, dignifying, homelike care, this routine nonetheless *made sense* according to the time pressure on the aides. In order to care for each resident holistically while also meeting the eight o'clock breakfast target, by contrast, they would have had to wake some residents even earlier, then leave them sitting in their wheelchairs for an hour or more while washing and dressing others.

Time pressures also discouraged carers from accommodating individual residents' requests when these contravened established routines, particularly at Richardson's. In the following example from an afternoon shift, Nat and I were working together with Liz, a resident with a degenerative neurological condition who was physically limited but cognitively intact:

*When we'd lifted Liz with the stand-n-weigh and were in the process of changing*

*her brief, she said "and I think I'd like to go in my recliner after this". Nat gave*

*an exaggerated sigh and said "why?" or "really?!" Liz said, "yeah, why not?"*

*and Nat said, "here we are trying to get ahead" and you're wanting to go in your*

*recliner!*

(Fieldnote, Richardson's, Shift 15)

Although Nat went on to claim that she had been joking, I noted that Liz became quieter, perhaps in response to the subtext of truth in Nat's response. From an outside perspective, it

seems absurd – or perhaps unacceptable – to deny someone an hour of comfort for the sake of a few minutes' extra work. However, the additional labour that was entailed – in terms of securing the mechanical lift a second time, coordinating our actions in order to meet back in Liz's room before dinner, and so on – made this feel like a significant imposition on our (limited) time during the afternoon rush. Furthermore, Nat's comment about "*trying to get ahead*" highlighted the influence of the business logic: it made sense to hurry because, as workers, we were more likely to be rewarded for finishing promptly than for incurring a delay by fulfilling idiosyncratic requests.

This exchange revealed the power struggle that was inherent in the temporal organisation of practice. The previous chapter argued that detailed "individualised knowledge" about residents represented one of the main (if modest) sources of symbolic capital for carers in the LTC context. With this individualised knowledge, carers could and did exercise a certain amount of "practical autonomy" (Stacey, 2005) over the delivery of care; that is, they were the ones who could accurately assess, on a day-to-day basis, who to care for first, in what order, and in which particular ways. A request which required a change of routine, then, whether it came from residents themselves, from family members, or in the voice of authority, may have been perceived as threatening this small degree of autonomy and control.

The notion of power threads through the analysis of the different tempos and logics of practice in this chapter, and will be revisited in the Discussion section. First, this section will conclude by examining how carers were socialised into the temporal organisation of the nursing home from their first day on the job.

### 7.2.2  *Learning the tempo(s) of practice*

As discussed in Chapter 4, both "the knower and what is known" (Nicolini, 2011, p. 603) emerge through practice. In the situated-learning sense, this involves socialisation into "the way we do things around here", including into the temporal structures of practices.

In the United States, this process began in the CNA training course, where the emphasis was on learning to work quickly and efficiently. For example, one day a student asked the trainer, Denise, whether there was a time limit for completing the skills that we were learning (Fieldnote, Rosemont, Day 4). Denise replied that there would be a limit for the next cohort but not for us. I reflected in my fieldnotes that this in itself – testing students on how quickly they can complete daily care tasks – seemed to contradict the person-centred emphasis on "taking time to care". However, when the student clarified that she was asking about time limits in practice, Denise responded dismissively: "*Oh, you won't have time to spend a long time in the residents' rooms*". Although she did amend her reply to acknowledge that some residents with greater needs might require more time, Denise did not take the opportunity to reflect on the time pressures of the role. Instead, she made it clear that CNAs would simply have to adapt to the reality of "not having time" beyond the training context.

And indeed, the evidence from Richardson's in particular suggested that becoming a competent practitioner entailed demonstrating the ability to work quickly and thereby pull one's own weight. In the following excerpt, Edie, who was a relatively new carer, reflects on the process of obtaining acceptance by her co-workers on the east wing:

*Kezia: And when you came [to Richardson's], did you experience some of that new girl sort of thing? Did you have, did you feel like you had to prove yourself here, as well?*

*Edie: Yesss, yeah, yes. Definitely. Definitely, because when I started catching onto my residents, there was a point where … both Yolanda and Nadine [two CNAs] … the one night I, I mean I busted my butt, we were a five-aide list, so I busted my butt, and come ten o'clock, Yolanda and Nadine looked at each other and said, "look at that! She kept up with us all night!" Meanwhile, I was like "phew" [wiping brow as if sweating/exhausted]. But after that, it got much easier. Much easier –*

*K: Yeah, so you were sort of <u>in</u>.*

*E: – and Yolanda and Nadine are very good to work with, but they – stepped back, and they let me … make it or break it, kinda thing, and yeah, but after that night, things did start getting easier.*

(Interview, Richardson's, Edie)

Working a "five-aide list", as opposed to having the full complement of six aides on shift, was also referred to as "working short". In this excerpt, Edie recalls without rancour that she was required to prove that she could handle the work under these imperfect – but not uncommon – staffing conditions before being accepted as part of the team.

My own experience of socialisation into the CNA role at Richardson's was also one of speed and stress, as reflected in the following fieldnote:

> *Today was my first shift with my "own card", and it was really difficult, particularly after supper onward. I felt like I was fighting back tears as I left, and there was more than one moment during the shift when I felt a sense of desperation, like I'd never get everything done and could hardly even keep trying. Amazing how quickly you can start seeing personal care – helping people use the bathroom, wash, change, get into bed – as a list of tasks to "get done", when the conditions demand it. I'm already hearing myself talk like that: "well, I've done Oscar but I still need to do Dave", if someone asks me how things are going.*
>
> (Fieldnote, Richardson's, Shift 13)

This reflective fieldnote shows my socialisation into the mutually reinforcing "sayings and doings" of practice, including their temporal dimension. That is, I was learning to get each resident "done" quickly so that I could move on to "toilet", "feed", or "transfer" – objectifying terminology that was still in constant use, despite the introduction of PCC – the next resident on my list before time ran out.

At Forest Lodge, as mentioned in the previous chapter, this individualised pressure on staff was considerably less intense. On my third shift on Vintage Vale, I noted the difference:

> *I keep feeling surprised by how <u>nice</u> everyone is to me – and to each other. Where I keep expecting to encounter reticence or abruptness, I am met with friendliness*

*and a sense that people have <u>time</u> for me – not masses of time, but enough time to stop, to look at me, to have whatever conversation we're having. Such a stark contrast to my first experience [at Richardson's]...*

(Fieldnote, Forest Lodge, Shift 3)

Nonetheless, efficiency and speed were still an aspect of socialisation into the competent-practitioner role at Forest Lodge, particularly through on-the-job induction on the upstairs nursing unit. As an example, I once shadowed Sherman and a new carer, Adele, as they repositioned bed-bound residents: a task which involved rolling residents over, checking their pad and changing it if needed, and marking the time and new position on the paperwork (Fieldnote, Forest Lodge, Shift 22). At one point as Adele and I hurried to keep up, she said, *"he's so quick, isn't he?! Like lightning, in and out!"* Sherman laughed good-naturedly, as he laughed at most things, but did not slow his pace. I went on to reflect in my notes that *"Adele was learning from Sherman a kind of efficient care that I witnessed more often at Richardson's than at Forest Lodge"* – involving little personal interaction with each resident.

Eric, who had recently begun working on Vintage Vale, noted the pressure that he felt, as a new member of staff, to learn to work quickly rather than "taking time to care":

*Um, what I, I do notice as well is that, um – for example, when I'm attending to personal needs of people, i.e. washing, dressing, toileting – <u>I</u> do it in the timescale, and the manner, to which I think feels appropriate, okay. I, I do understand there was some criticism of me personally, within a month of starting, that I was taking too long over certain tasks. Even though – and I expected that.*

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*You know, you expect everywhere that you work that people are going to criticize you, they don't know you, they, you know, you're new, you're, you're adding to their "work burden"… But, um, I've refused to, in any sense, try to become more efficient, in inverted commas – I still take the time I think it takes. And, if they don't like that, I, I think morally I'm on the high ground, and they're not.*

(Interview, Forest Lodge, Eric)

This excerpt speaks to the importance of learning to do the work at the accepted pace in order to avoid being perceived as a "*burden*" on anyone else. By refusing to adapt his pace, Eric might have been delivering "good" person-centred care but at the risk of looking, from a different perspective, like a "bad" team player.

Drawing together the concepts of "clock time" *and* "event time", this section has briefly examined how taken-for-granted temporal structures were in fact learned and perpetuated through particular practices. This has laid the groundwork for the next section, which compares and contrasts the influence of the three main institutional logics of LTC – the home, the medical facility, and the business – on the implementation of flexible care at each facility.

## 7.3    Temporal structures and institutional logics

In the following excerpt, Eric, the care assistant quoted above, elaborates his point about "taking time to care":

*[W]e're told that there's no such thing as time. Things take as long as they take. But, in the same breath, if you haven't got something done ... So, it's, it's all contradictory. It wants to be all things to all people. ... Staffing – staffing levels. That's the whole bottom line of it. That is the whole bottom line. The whole ... and, and I'm sure, look, this is my own experience of this, I'm sure, and I know this is a good – has a good reputation, this home - <u>but</u>, I'm sure the whole industry is like that, in fact, you know, I strongly suspect it is, in fact I think I <u>know</u> it is, really. It's staffing levels. It's <u>all</u> to do with economics and funding, at the end of the day.*

(Interview, Forest Lodge, Eric)

This quote highlights the different and sometimes contradictory logics which informed the temporal structures of practice. On the one hand, there was the flexibility and adaptability of home-like care, while on the other was the "*bottom line*" of the business logic. How staff perceived and negotiated these logics had implications for the extent to which "taking time to care" translated into practice.

*Conversation* was one area of practice where these different logics were fairly easy to discern. In our home lives, we do not generally separate conversation from instrumental activity, nor do we calculate every additional word spoken as a moment of productivity lost. Conversation is key to our relational practices. In the health-care field, verbal communication has more targeted importance; it provides insight into the subjective experience of the patient or resident, helps staff monitor changes in their health and wellbeing, and so on. However, according to the business logic, conversation is largely extraneous to the measurable tasks of

the workplace. Therefore, carers often complained that their "real" work prevented them from taking time to talk to residents. As Ilene, the experienced CNA/trainer at Richardson's, reflected:

> *I like when we're fully staffed, because to me we get a little bit more time, with our residents, to talk with them, and, you know, I mean, Elsa was always saying, come on in and sit down – I don't have time to come in and sit down! [laughing] You know, and they wanna talk to you, and, when we don't have enough staff, we don't have that time to talk with them, and stuff, and they, they enj-, they look for that, you know.*

<div align="right">(Interview, Richardson's, Ilene)</div>

While aides "*don't have time*" for conversation, according to the temporal structures of their job, residents "*wanna talk*" and "*look for that*" as integral to their daily lives in the home.

Another example was *meals*. According to PCC, mealtimes can provide sensory pleasure and social engagement as well as meeting nutritional needs – thus fulfilling the logics of the home and medical facility. However, lingering over mealtimes does not correspond to the logic of the workplace, with regards to the importance of completing sequential tasks within prescribed timeframes. For example, for aides working the afternoon shift at Richardson's, the end of supper meant the start of the bedtime routine (even as early as 6PM), as well as their own breaks rotation. Their practices linked to those of the kitchen staff, who needed to serve and clear quickly in order to begin preparing the next meal. For these reasons, meals were conducted as quickly as possible, without pause or delay.

It is important to note here that both facilities, as part of their efforts to introduce PCC, had made changes designed to enhance the mealtime experience, such as introducing more choices and serving meals "restaurant style". Richardson's had also adjusted the lunch schedule in order to *"allow our elders enough time to enjoy their meal and enough staff to assist them"*, as the facility administrator put it (Fieldnote, Richardson's, Shift 7). In part, this involved conscripting administrative staff to assist with transport and feeding, in order to reduce the pressure on CNAs. Although anecdotal evidence suggests that the involvement of administrative staff was not sustained, this example does indicate an attempt to better align temporal structures, by enhancing the residents' dining experience within the constraints of staff workloads.

A third site of overlapping – but in this case, reversed – temporal structures was *toilet care*. For an individual, going to the toilet may be a matter of urgency, particularly as the physical imperative becomes compounded by the fear of soiling oneself. Medical logic prioritises infection prevention and regularity, thus broadly corresponding to this individual logic. According to the workplace logic, on the other hand, carers were expected to complete toilet care at regular intervals – particularly at Richardson's, where the computer charts provided a prescribed toileting schedule. This meant that they often responded with a notable *lack* of urgency to their residents' toilet requests, and in some cases encouraged residents to "just go" in their continence pads, when cleaning and changing a pad (on the carers' own schedule) would be less trouble than transferring them onto the bedpan or toilet (on the resident's request).

I noted the following example towards the end of an afternoon shift at Richardson's:

*The call light went off at the usual time – around 10:30 or so – for one of the female residents on the back hallway who needed to use the bedpan. I asked Rachel [another CNA] if she'd like to go with me and she said "not really!" though she followed me anyway. Just before we went in, she said that these two were driving her crazy tonight, making a strangling motion with her hands. I said really? And she said yeah, that one of them had already asked for the bedpan three times since she put her in bed. I said "did she have to go each time?" for lack of any other response, and she hesitated before answering. I can't actually remember whether she said yes or no because I was stuck on that moment of hesitation, which implied that the question wasn't really relevant – regardless of whether she went each time or not, it was too much to ask for the bedpan three times in one evening.*

(Fieldnote, Richardson's, Shift 29)

In this scenario, the two logics – that is, the resident's perceived urge to urinate versus the carer's desire to manage her time and energy outlay – both *made sense*, but did not necessarily correspond. This implied a struggle, as suggested in the previous chapter, over the power to define the situation according to one logic over another. Edie, the carer quoted above, spoke to feeling caught in the middle of this struggle:

*I've been told that I spoil my residents, that so and so's light was just on 10 minutes ago, so ignore it – and I <u>can't</u>. I, personally, I can't. Even though I know*

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*that this person went to the bathroom 10 minutes ago, and that's what they want again, well, that's, they feel that they need to go! So – I'm going to take 'em. And I get, I really get a lot of rude remarks because that person may be a two-assist so I have to bug somebody else to get this person on the toilet again. ... You know, and this person is just recently been put on briefs, and they're still continent – 90 per cent of the time – and I know what it does to that person when they have an accident, it humiliates them, it embarrasses them, and I try very hard to meet their needs when they need to go, but sometimes it just doesn't happen. .... Yeah – because I know, when I go in the room and they've <u>had</u> an accident, they're so upset, they're ashamed, they're – and it breaks my heart, so, when the other girls give me a hard time about it, I just say oh well, that's ... me. And that's how I deal with it. But I will say that it is getting harder and harder to get the help. ... They're still on the mindset that 'she just went 15 minutes ago'... And even if they're sitting at the nurses' station doing nothing, 'she just went 15 minutes ago'... So?*

(Interview, Richardson's, Edie)

In this excerpt, Edie indicates that she was striving to follow the logic of the home field, which is essentially "when you gotta go, you gotta go" (regardless of how recently you last went). "*I know what it does to that person when they have an accident,*" she says empathically, "*it humiliates them, it embarrasses them*". On the other hand, for her co-workers – whose support was essential for those residents listed as "two-assist" – toileting was seen as a task to be completed on a regular schedule, with deviation from that schedule representing unnecessary (and unrecognised) work. If a resident had an "accident", that

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simply altered the nature of the subsequent toileting task; the resident's emotional experience of the event would not be acknowledged (as it was by Edie), because it was not relevant to this logic.

The following excerpt from an afternoon shift at Forest Lodge provides another illustration of the discontinuity between temporalities. In this excerpt, Sherman (a carer) was gently pressuring a resident (Dot) about going to bed:

> *Sherman was wanting to take Dot because she was the last one left who needs assistance – but she said no, it's too early, she wanted to go at eight. Sherman was imploring, "but my shift ends at eight, you don't have to go to sleep but can't you just get in bed, rest your legs" – trying several times to convince her. I asked her if she wanted a cup of tea and she readily agreed to that. She was equally adamant with me that she wouldn't go to bed until eight, though, when I suggested that she might like to have her tea and then go to bed after that.*
>
> (Fieldnote, Forest Lodge, Shift 20)

In this example, Sherman did not lose his characteristically warm and affectionate style. However, he did try to exert his power by cajoling Dot into accepting *his* logic, which was to have every resident in bed before the end of his shift. Dot resisted by maintaining her intention to stay in the lounge until at least eight o'clock, following an equally reasonable logic. (How many of us go to bed at home at seven o'clock?) On reflection, I realised that I had colluded with Sherman in this situation by trying to use the cup of tea as a bargaining chip. This too *made sense* in that, had I convinced Dot to go to bed after her drink, I would

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have fulfilled the task imperative of getting all residents into bed while also earning appreciation from my co-worker for this assistance.

As a final example, the following fieldnote describes an accident that happened one afternoon on the rehabilitation unit at Richardson's:

> *At some point during the shift, one of the residents on rehab had a fall – I was alerted to this when several nurses went running in that direction. Later the [nurses] had quite a lot of discussion at the nurses' station about who to call (where had she had her surgery done?), about the paperwork, etc. Her family (daughter and husband, maybe) were there for most of the rest of the shift, hovering in the hallway quite a lot, obviously quite worried and also apologetic about the resident's repeated and urgent requests for the bedpan. After the first time that they asked for help – when Eden [a CNA] did respond quite quickly and with some obvious concern – I was aware that their requests were treated as no less urgent than any other tasks.*
>
> (Fieldnote, Richardson's, Shift 7)

At the moment of crisis, the logic of the medical facility prevailed: the nurses rushed to attend to the immediate health needs of the resident who had fallen. This response seemed consistent with the logics of home and business, which would also both prioritise caring for the injured person although perhaps for different reasons. In the aftermath of the event, however, it seemed as if the temporal structures of the different logics shifted apart. For the individual resident and her family, this was *still* a crisis: she was in considerable pain, and

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they were all anxious and upset. For the nurses, however, the crisis segued into familiar follow-on tasks such as completing paperwork and seeking referrals. For the aides, the sense of crisis also soon abated, and the needs of the resident and her family were reabsorbed into the regular busy routine.

Having spent considerable time as a concerned family member in a similar context of care, I felt acutely aware of the disconnect between temporal structures in this moment, reflecting that I could empathise with the family but nonetheless, "*as an aide, hurrying from one task to the next, I found myself also skirting the couple rather than responding immediately to their needs*", in order to avoid taking on extra responsibilities that were not officially mine and that would have slowed me down.

The following two sub-sections will consider each of the two facilities in turn, in order to draw out the different temporal structures, and related institutional logics, characterising the organisation of care.

### 7.3.1 "On the clock": Temporal structures at Richardson's

Richardson's is located firmly within the medicalised context of LTC in the United States, as compared to the hybrid health and social-care context of LTC in the United Kingdom (Butterworth, 2003). The medical logic was inscribed in the computer-charting system, as discussed in the previous chapter, and reinforced through the reporting requirements and inspection processes described in Chapter 8. However, along with this medical logic, CNAs at Richardson's were clearly guided and constrained by the business logic, in terms of

fulfilling their allotted tasks on time, without impinging on anyone else's workload. Together, these two logics seemed to influence the limited extent to which daily care routines could be adapted to individual residents' needs and preferences, when also taking into account the organisation of the team and related issues with communication (as discussed in the previous chapter). The upshot was that residents were almost always clean, dry, and well-fed – but this was often accomplished in rushed, perfunctory, and depersonalising ways.

The following fieldnote provides a good illustration of the competing imperatives faced by staff as they organised their workload:

> *When [the other CNAs and I] were taking residents back to the unit, one male resident who sits by himself still only appeared to be halfway through his meal. Isobel [a nurse] said that we could bring the tray back with him to the unit – "you're not supposed to do that but just say I said you could and it'll be okay ... I don't want to sit out with him here for 12 hours while he finishes". I asked Ilene [a CNA] if it was ever permissible to leave a resident in the dining room on their own, if they are independent, and she said no, because anything could happen, they could choke or (lowering her voice) "have a coronary out here or anything".*
>
> (Fieldnote, Richardson's, Shift 4)

In this situation, following the tenets of PCC, we should have allowed the resident to finish eating, rather than requiring him to conform to institutional routines. In terms of legal accountability and medical responsibility, however, we could not leave him alone in the dining room. Given the pace of practice, furthermore, we could not spare the time to wait

with him. The only alternatives, therefore, were to take his meal away unfinished or bring it back to the unit. This dilemma arose despite the fact that this resident was listed as "independent" in his care plan, and capable of wheeling himself without assistance between the dining room and his bedroom.[49]

The dominance of the workplace routine at Richardson's, influenced by both medical and business logics, was brought into sharp relief by the arrival of visitors − individuals from outside the "total institution" who adhered to a different set of temporal structures. This is illustrated by the following fieldnote from an afternoon shift. Each afternoon, CNAs spent the first couple of hours getting each of their residents up, "toileted" or changed, transferred into their wheelchairs, parked in their room or the hallway, and eventually wheeled down to their designated places in the dining room. This last step, known as "transport", started about 4:30PM and always finished before 5PM. On this particular afternoon, my resident Rose had been visited by her son:

> *When I went back to take Rose to supper, her son was still there, in the midst of filing her nails. I let them know the time, then stopped back in a couple more times to see if she was ready. Each time he was still there and engaged in a task. Eventually, at five o'clock, I went in and said I had to take her then or she'd miss supper. I was conscious of elbowing my way into family time … literally taking back authority over Rose by grasping the handles of her wheelchair and*

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[49] In the spirit of "participant objectivation" (Chapter 5), it is worth noting how my status as a paid member of staff exposed me to these types of dilemmas; as a volunteer, as I was at Forest Lodge, I might simply have stayed in the dining room with the resident, and failed to fully grasp the competing pressures on staff.

*beginning to move her towards the dining room – after having allowed time for a*

*goodbye, of course.*

(Fieldnote, Richardson's, Shift 16)

For Rose and her son, it *made sense* to finish their visit, since there was no reason to believe that Rose should go hungry for the sake of a few minutes' delay. As an aide, however, that brief delay meant that I might fall behind on my transport duties, which also risked incurring the censure of my co-workers for transgressing our shared norms of timing and teamwork. I concluded by noting that: "*When I pushed Rose into the dining room, everyone else was already there, plates of food were being distributed, and the kitchen person said 'oh, <u>there</u> she is' as if she might have gone missing or been forgotten*" – all because it was five minutes past the hour. If Rose's son had not been there, the stringency of this schedule would not have been as noticeable; it became obvious through conflict with *his* tempo.

In another example, one resident's family asked his aide to "walk" him, which was prescribed on his care plan. The aide was irate, however, because they had asked her during the hour before supper: "*they want me to walk him while we're right in the middle of toileting*!", she said heatedly to the other CNAs (Fieldnote, Richardson's, Shift 18). The family almost certainly would not have known the significance of the hour but for the aide, their request was perceived as an impossible demand on her time. As well as illustrating different temporal structures, this example shows how identities (or dispositions), such as the uncaring aide, the interfering family member, or the non-team player, are produced through practices.

Another evening at Richardson's, at approximately eight o'clock, Eden (a CNA) complained that the daughter of one of her residents had prevented her from getting that resident ready for bed (Fieldnote, Richardson's, Shift 6). Eden had asked if she could at least get her changed and settled in her recliner, but the daughter had said *"no, she'll stay in her clothes"*. The different logics were again quite obvious. For the resident and her visitor, it did not seem "late", nor did it make sense to change into pyjamas halfway through a social visit. However, it did make sense for Eden to get everyone into bed as quickly as possible. On her wing, the carers managed their afternoon shift so that the last hour was usually free for socialising at the nurses' station, except when conducting final "rounds". Finishing sooner than the west-wing aides was a point of pride, taken as proof that those "on east" worked more efficiently and cooperatively. Forfeiting some of this free time due to an interruption in the evening routine might therefore have been perceived by Eden as reflecting badly on her competence and teamwork (as well as causing her to miss out on the chance for a rest and a chat).

This latter example highlights the intersection of the routinised approach to care and the organisation of the team, particularly in the context of the "shift wars" and "wing wars" at Richardson's. The previous chapter discussed how this antagonism undermined the communication that was essential to personalised care. To some extent, the shift wars also stymied efforts to adapt care to residents' needs and preferences, as Alicia, the assistant director of nursing, suggested in her interview:

> *Kezia: Do you ever have aides come with care questions to you?*
>
> *Alicia: Yep, mm-hmm.*
>
> *K: What kind of things?*

*A: Um, like, care plan issues, um, like, um, this is a very good example of the, the shift war and preferences, um, I had a, a girl come to me and say well, does Mr. So-and-so really need to, does he need to be in bed at night, before I leave? And I said why, and she said, well, because 11 to 7 gets really mad at me when he's not in bed when they come on! And I said, you know, well, um, what does he want, and he doesn't want to be in his bed, well then I said it's absolutely fine that he's not in his bed, um, and so, yeah, that was something that was a care issue that they just really didn't know which way to go with it.*

(Interview, Richardson's, Alicia)

Choosing whether and when to go to bed are fairly basic personal choices for adults in the home setting. However, not putting a resident to bed before the end of a shift meant passing responsibility for that task along to the next shift. Rather than the fulfilment of a flexible, person-centred approach to care, then, this could be (and usually was) interpreted as shirking.

In addition, prioritising the tempo of the workplace could be a barrier to communication in that aides were unlikely to take time from their regular duties – or to work outside their scheduled hours – in order to attend handover or care-planning meetings:

*Yvette: I think one of the barriers was, my shift ends at 3 o'clock, this shift starts at 3 o'clock, I'm not staying 15 minutes to give that report, and I'm not getting here 15 minutes beforehand, so –*

*Kezia: Right, yeah, there's no cross-over, right.*

*Y: There's no cross-over. I think that that would be extremely helpful, in the*

*continuity of care.*

(Interview, Richardson's, Yvette)

Although framed in this excerpt as a lack of individual will to participate – "*I'm not staying 15 minutes to give that report*" – the barrier to better communication between CNA shifts can be seen as a consequence of conflicting logics. That is, while "continuity of care" might be a priority for the residents' medical care, adhering to strict working hours was demanded of CNAs-as-workers. Aides were required to punch in no more than seven minutes early, and their shifts were carefully scheduled in order to minimise eligibility for overtime. (For example, if someone "called in" on a particular shift, the other CNAs would have to "work short" if the only staff available to cover were those who would accrue overtime by taking on the extra shift.) Thus, CNAs were discouraged both from communicating with co-workers by teamwork divisions *and* from taking extra time by the logic of the time-clock.

The temporal demands of the business are often blamed for shortcuts and workarounds in this context of care (Lee-Treweek, 1997), as carers try to complete all their assigned tasks within strict time parameters. This was not a major issue at either facility, where the standard of care was maintained at a high level. My observations suggest, however, that in some cases the business logic *did* affect the level of empathy and understanding demonstrated by staff. (This resonates with the discussion of emotions in Chapter 6.) For example, during one week at Richardson's, several residents died within days of each other, but this did not seem to generate much conversation or reflection among staff (at least within my hearing; Fieldnote, Richardson's, Shift 19). The only exception was when Nat and I were taking a resident to the

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toilet: "*she said that they'd had a memorial service last night for all the residents who had passed away this year, and it went until almost 8 o'clock*". As she continued talking, I realised that Nat's point was to emphasise the frustrating disruption of the evening routine, not to comment on the service itself. *"Not sure how I was supposed to respond,"* I reflected in my fieldnotes, "*I asked (lamely) whether they got behind schedule as a result, and she emphatically confirmed that they had*".

This did not necessarily suggest a personal lack of empathy or emotion, I would argue, so much as reflecting Nat's perception that she would have faced repercussions if she had failed to get her residents into bed on time, regardless of the evening's events. Certainly, she did not indicate grief or regret about missing the memorial service; but this may have been because those reactions were simply not available to her, in her position in the field. It *made sense* to adhere to the routine – and to resist any obstacles en route – in order to get her work done.

The obvious, although uncomfortable, extension of this argument is that prioritising the workplace tempo could directly affect the delivery of care, giving rise to depersonalising or undignifying – rather than person-centred – care. One example, as mentioned in the previous chapter, was the sharing of private information about residents, such as their bowel habits, in public spaces within the nursing home:

> *At the start of the meal, [Isobel, the nurse] had been helping Rose and she called*
> *over to me to ask "do you have Rose?"*[50] *When I said yes, she asked "did she go*

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[50] With this question, Isobel was asking whether Rose was one of the residents on my list for the evening, and therefore my direct responsibility.

*number 2?", I said no, and she said "she says she needs to go now". I guess I made a questioning face – so should I take her away again? – but then she said to Rose "you can go right ahead" since she was wearing a brief.*

(Fieldnote, Richardson's, Shift 29)

This conversation was held in the dining room, in front of Rose and the rest of the residents at her table and nearby tables. For Rose, as for any individual following the home logic, using the toilet and eating a meal are discontinuous temporal (as well as spatial) experiences – and to have the two conflated can be humiliating, if not dehumanising. For Isobel, on the other hand, toilet care was just one of many tasks to deal with as efficiently as possible.

The following is another notable example of how competing logics sometimes undermined the provision of dignifying care:

*Rianna filled the bath while I got Jackie undressed on top, then together and with some considerable difficulty we transferred her with the stand-n-weigh to the side of the bath, then swivelled her round so that she was facing front. Just before we hoisted her, she said "I need to use the bathroom".*

*Rianna: Number one or number two?*

*Jackie: What?*

*R: Do you have to pee?*

*J: Yes.*

*R: Oh, that's okay then, you can go in the "pool". We can't really get to the toilet right now [which was true, it was blocked by other chairs and the laundry cart].*

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*J: What?!*

*R: You can go in the water – it's okay – we sterilize it anyway.*

*J: I'll just wait then, I never go in the bath.*

(Fieldnote, Richardson's, Shift 14)

Jackie was shocked, unsurprisingly, at the suggestion that she urinate in her own bath water; in stark contrast, Rianna's comment that "*we sterilize it anyway*" indicates that she was thinking of the issue exclusively in terms of job tasks and infection prevention (following the business and medical logics).

Indeed, examples of prioritising workplace efficiency over resident experience were quite common at Richardson's. The following scene occurred when I was working on the rehabilitation unit with Anita, a CNA, after I had rushed to find the source of a "*howling cry*":

> *The resident was in bed, sobbing, and Anita was making soothing sounds as she tried to get her repositioned. She explained to me that "she says her back hurts" and so we tried to work together, one on each side of the bed, to boost her without causing any more pain. When that seemed impossible – due to the resident's immediate protests of pain – Anita said she'd raise her feet up instead. Then she said to me, conversationally, "it's been crazy here tonight, I don't know what's going on!" as if this residents' apparent agony was just another example of the "craziness" we were encountering ...*

(Fieldnote, Richardson's, Shift 30)

It is important to note that Anita was pleasant and friendly to this and every other resident in direct communication, but she did not hesitate to objectify them through comments to me about our shared workload. This might have made sense in terms of establishing some solidarity between us, but in this particular moment (as I reflected in my fieldnotes), this explicit, audible framing of the resident's painful experience as just another task on a busy evening made me feel very uncomfortable.

There were other examples of workplace efficiency at Richardson's that bordered on rough care, as in the following scenario that I recorded one morning:

*I watched as Allie and the other aide got a small, largely immobile female resident up. Allie told me yesterday "she's my grandma" and in fact she calls her "grandma" directly. (She told me yesterday that other people have a hard time getting her to eat but she doesn't…) Despite this expressed affection, their approach to getting her out of bed was very abrupt: walking into the room where she was still fast asleep, switching on the overhead lights, flipping back the sheets without first making any attempt to wake her, pulling up her pants, and then hauling her out of bed and into her wheelchair so quickly and with such a clatter (since the wheels of the big heavy chair weren't locked) that I gasped audibly. (They didn't acknowledge my inadvertent response.)*

(Fieldnote, Richardsons, Shift 9)

Again, this scenario appeared to indicate conflicting logics – pseudo-familial care ("grandma") versus the factory-line approach – which in practice produced a problematic episode of care, from my observer's point of view.

To summarise, my evidence from Richardson's suggests that the demands of the CNAs' workload significantly constrained the extent to which they could "take time to care", and often instead produced depersonalising care practices. Nonetheless, in this context the discourse of PCC was sometimes invoked as justification for achieving task-oriented results. For example, when I worked with Anita (on the same busy shift mentioned above), we had four showers on our list but only ended up giving one, which was for a resident (the administrator's father-in-law) who needed minimal assistance. One of the other residents on the list fell asleep before I had the chance to ask her about a shower, and Anita told me that another had refused, and the fourth "*will refuse*", because she always refused unless you managed to catch her *"in a really, really good mood"*. When I wondered aloud how often that resident showered, then, Anita said about once a month. I reflected in my fieldnotes that on another shift I might at least have suggested the possibility to the resident – "*but without a minute to spare, I was happy to follow Anita's assessment of the situation*". What is important here is that PCC was recognised, to a certain extent, in terms of adapting routines to individuals' preferences – but perhaps as justification for fulfilling the overriding logic of the busy workplace, and at the expense of good hygiene and personal care.

### 7.3.2  *"Flexible routines": Temporal structures at Forest Lodge*

At Forest Lodge, the conflicts between temporal logics were less noticeable – and more likely to be resolved in person-centred ways – than at Richardson's, even though the staffing ratios were approximately equal. This seemed to relate to the strength of the message, communicated through training and reinforced by nurses, about "taking time to care". It was also influenced by the fact that there was much more collective discussion and decision-making among the carers at Forest Lodge.

The following scenario serves as an example. One afternoon during the carers' handover on Vintage Vale, Neve (a carer) told the incoming shift that Selina, a fairly new resident, had stayed in bed until quite late (Fieldnote, Forest Lodge, Shift 8). Eric (another carer) and I, who had been the ones to "get her up", said that eventually we had to waken her, because otherwise she probably would have remained asleep. Neve said, "*yes, but that's how she was in the other home, they'd let her sleep all day, wouldn't let her eat, and then she'd be up all night – we're trying to break her out of that routine*". She went on to say that "*we really should have gotten her up earlier*", although quickly added that she was not blaming Eric and I, referencing instead the busy morning. This moment exemplified a fundamental dilemma in most if not all medical-care contexts, which is how to reconcile personal proclivities with medical imperatives. On the one hand, PCC suggests that perhaps Selina should have been left to sleep, if that was her indicated preference. Indeed, to demonstrate their understanding of PCC, carers at both research settings often used the example of "being able to sleep as late as you want"; for those of working age, many of them parents, this seemed like a well-earned luxury. By contrast, Neve suggested that we should encourage Selina into a new "routine", rather than adapting to her existing habits. Although this may have represented a more

conventional, coercive approach, it was also likely better for Selina, both physically and psychologically, to stay awake during the day, eat regular meals, and enjoy better sleep overnight. From this latter perspective, the logics were in fact cooperative rather than competitive.

Although it is not possible to conclusively resolve this type of dilemma, the fieldnote suggests that handover on Vintage Vale provided an opportunity for carers to develop a shared strategy – "*we're trying to break her out of that routine*" – which contrasted with the more individualistic way of working at Richardson's. This seemed to allow for the testing of alternative approaches without risking, to the same extent, the type of inter-shift resentment that Alicia and Yvette both mentioned at Richardson's.

Indeed, on Vintage Vale in particular, carers and nurses engaged in considerable discussion about how to become less "task-oriented" – a common phrase on the unit – without disregarding medical needs, risking resident safety, and so on. (This was a type of discussion that I rarely heard, by contrast, at Richardson's.) When I asked Eric about the process of getting residents up in the morning, for example, he referred to developing a *"non-routine routine"*:

> *I asked Eric how he knows where to start with getting the residents up, and he told me that the night shift usually gets up the residents who are mostly mobile – hence the four ladies sitting in a lounge right then, all gently dozing or sitting quietly, looking forward. Then usually one carer gets up those residents who only need one person's assistance, and two carers work together as a pair to get up*

*the others. He said he goes to those who are awake first, sometimes lets others sleep for a bit longer – "unless there's a medical reason they have to get up". I said how different that was to Richardson's, where aides arrive at 6 or 7 in the morning and hit the ground running, going from room to room to get people up in time. He said yes, he understands that it's "in their philosophy, or mission statement" to make it as homelike [or some similar word] as possible. Referring to the balance between letting people sleep and making sure they get up to eat, move around, etc., he said something about how the emphasis is sort of a "non-routine routine".*

(Fieldnote, Forest Lodge, Shift 3)

As with the excerpt from Trisha's interview in the previous chapter, this highlights the deliberate work that went into balancing different needs, priorities, and preferences on a day-to-day basis, drawing on the discourse of PCC. On Vintage Vale in particular, carers were also encouraged to embrace the PCC emphasis on "taking time to care" by sitting with them, talking to them, and reading or doing activities with them. The following fieldnote indicates the tempo of practice on this unit:

*Earlier, Danielle [a carer] had said to Trisha [another carer] "we have a lot to do" or something like that (after dinner), and Trisha had agreed – but since then, I hadn't gotten a sense of rushing or hurrying from their body language or interactions with the residents. Trisha didn't hesitate to stop and explain things to me – and when any of the carers interacted with the residents, they seemed to*

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*consistently allow the residents time to process and respond to their questions, rather than asking the question then assuming acquiescence and proceeding.*

(Fieldnote, Forest Lodge, Shift 1)

The business logic was clearly evident in Danielle's remark about having "*a lot to do*", but this did not entirely trump the residents' temporal needs. This may reflect the fact that there simply *was* more "time to care"; since most of the residents on Vintage Vale were still mobile, there were very few occasions requiring a mechanical hoist, and most residents could stand and walk on their own. This took a lot of physical and time pressure off the carers, as well as avoiding the physical objectification and depersonalisation that these manual-handling technologies inscribe. Staff were attempting to implement the same pace of work upstairs as well, however, as noted by Lidia, who was mentioned earlier as the shift leader:

*I think up here [on the upstairs unit] they could learn from Vintage Vale how they make that extra time to sit and talk. They make that extra time to sit and have a cup of coffee with somebody – that extra time is made. And there, working up here, I've found where those gaps are, and where it could be used, and now I, I would like to try and implement that, where they would sit, and they would spend that time that they'd made, that extra time.*

(Interview, Forest Lodge, Lidia)

This commitment to finding "*extra time*" to spend with residents was reflected in more tolerance for variation and flexibility within the daily schedule at Forest Lodge than at Richardson's. For example, Trisha mentioned in handover on Vintage Vale one morning that

they had taken most of the residents out into the garden the previous afternoon, since it had been particularly warm and sunny (Fieldnote, Forest Lodge, Shift 6). Lainie, the nurse, looked for the photos on the digital camera to show me, but Trisha had already printed them out and hung them as a collage on the wall in the dining area. The photos showed individual residents and carers sitting in sun hats; Keith with gardening trowel in hand, Louise holding a large flower, Nancy wearing one in her hair. Trisha remarked that Louise had been particularly stimulated by the experience, waving and "*chatting away*", which was notable since she rarely spoke otherwise. When another resident's daughter came in, Trisha took her over to the collage and pointed out particular photos, saying "*in four years*", until yesterday, "*I've never seen her go outside for more than two minutes, she always turns around and comes straight back in!*" This example of spontaneity indicated how temporal logics can be additive in some cases: interrupting the workday schedule benefitted the residents and staff, with ripple effects on communication with residents' families as well.

Even within this flexibility on Vintage Vale, however, staff often spoke about not having enough time for meaningful activities. During the Olympics, for example, Trisha kept suggesting ways to get the residents interested and involved, but with little success. In her interview, she talked about how she would have liked to take some of them to see the Olympic torch when it was carried through town:

> *Trisha: … [T]he torch, now, I know, um … I know it's difficult, but if there were*
> *more people, if there were more people on shift, I know, I know we're now talking*
> *about, you know, sort of the money side of things, and I don't like – but if there, I*
> *would <u>love</u> to have taken somebody, for instance … Candace would have loved to*

*see the torch going past. She'd have known, she'd have 'preciated, she <u>would've</u>.*

*Leo, I think, would have had a, an awareness, and I just think, when I said, oh, you know, logistically I know it's difficult, and I know it was first thing in the morning, you know, all these things make it difficult ... I think, regardless of your level of awareness, they should have the opportunity to have ... what, you know, what is available, you know, what is here! You know, the torch is going through their town in their lifetime, Kezia. And I think there should have been some recognition for that. In, but in this little unit, in this little building, the whole event's passed without any ... do you see what I'm saying?*

*Kezia: Yeah. Had you, had you spoken about it to anyone?*

*T: I spoke to a few people, but I think it's just, you know, it was no, it's not really appropriate, you know, it's too early, you know, but ... you know. And I just think, you know we talk about personal-centred care, I think it's difficult to do personal-centred care when we're so bogged down with the practical, and the fact that we don't have enough staff...*

(Interview, Forest Lodge, Trisha)

This excerpt speaks to the immense hurdles – in terms of time, staffing, and competing priorities – that stand in the way of even the best efforts to implement PCC in the sense of "promoting the growth and development of all" and "responding to spirit, as well as mind and body", as per the Pioneer Network, or "creating an environment in which unexpected and unpredictable interactions and happenings can take place", as the Eden Alternative suggests.

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Furthermore, towards the end of my fieldwork at Forest Lodge, there was evidence that the pace of practice on Vintage Vale was shifting back towards more routinisation rather than flexibility. This was heralded by a change in management and framed in terms of concerns about care standards relating, for example, the fact that the process of getting residents up in the morning was extending all the way until lunchtime. These concerns related in part to the changing profile of the residents on Vintage Vale, with the unit catering to, as the assistant manager put it, a "bigger spectrum of needs now", including those with greater medical needs as well as residents with "challenging behaviour". The resulting changes included: accelerating the morning routine so that most residents were up for breakfast by 9:30AM; instituting a "toileting regime"; and taking some residents to bed after lunch to reduce the risk of pressure sores.

Some carers, particularly those with experience in more nursing-intensive environments, agreed with these changes, arguing that "not being task-oriented" had become an excuse for "*laziness*" among other staff. When I questioned one carer on this comment, asking her to confirm that she believed that residents should not be allowed to sleep late:

> *She replied that she wasn't saying that if someone was fast asleep, you had to go in there and drag them out of bed – but went on to say "there are ways of doing it", you can go in, turn on the lights, say good morning... etc. She also said that they don't necessarily have to get dressed and everything, but could maybe come down to the lounge in their robe, or eat in their rooms – but that they should be up in some way, in order to have something for breakfast and then have an appetite again by lunchtime. She indicated as an example someone like Lillian,*

*who has this pressure sore and really needs to get as much vitamin intake as she*

*can in order to keep healing.*

(Fieldnote, Forest Lodge, Shift 17)

Other care assistants were not so sanguine, however. Danielle, a young carer who had started her career on Vintage Vale, expressed considerable distress in her interview about the changes:

*Danielle: Everything's just gone psshhh, that's it, and I just feel like I've wasted four years of my time [slight laugh in voice] into – and it's just all gone out the window.*

*Kezia: ... [W]hat kind of things have changed?*

*D: Like the way, like breakfast has to be done by half-past nine, and everyone's gotta be, soon as breakfast's done, we've gotta have activities out, whereas before, we used to, we used to have our own way of doing it, like, soon as, soon as, if when they want to get up, we'll, we'll give them breakfast, and did it that way, but it's – completely changed now.*

*K: Right. What do you think about that? Because that's a big change.*

*D: Yeah it is, I dunno, I'm a bit like, [half-sigh/half-laugh] I preferred it how it was before – because with all this butterfly project thing that we had going when [the previous manager] was here, every-, we, we worked our arses off [slight laugh] to get it to the unit that it was then, now it's just completely, we feel like our work's just completely gone out the window. Cuz – it was great then. Like we*

*had the Dining Experience*[51] *worked out, all the activities, like one-to-one talking
with the residents, and things like that, and it's just gone to pot [brief laugh]. It's
not as it was. ... I mean we've all, most of us have had the [in-house dementia
training] and, none of us are really working to what we've been trained, like [the
Reddington dementia specialist] says, if they don't wanna get out of bed, they
don't wanna get out of bed. If you, if you haven't got time to make the bed, don't
make the bed. But now we've gotta have all the beds made in the morning, we've
gotta get them out of bed whether they want to get out of bed or not, I'm just like
[frustrated exhale]. I feel like it's – because it's meant to be their home, so surely
they should do whatever they want to do, not – I feel like we're just putting on a
picture, like it's a fabulous home.*

(Interview, Forest Lodge, Danielle)

Danielle was frustrated because she felt like she had learned to provide PCC but was no
longer encouraged to implement it, and instead was being asked to return to a more routine-
driven form of care. Importantly, her comments that "we *used to have our own way of doing
it*" and "*our work's completely gone out the window*" indicate the disempowering effect of
these changes. The suggestion seems to be that her symbolic capital, which as discussed in
the last chapter was based on daily, evolving, "individualised knowledge" of the residents,
was being usurped by both medical authority and the business logic which, together,
prioritised measurable outcomes (such as empty, neatly-made beds) over flexible, adaptive

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[51] The "Dining Experience" was an approach to mealtimes developed by Reddington for which staff on Vintage Vale had received specific training. It involved serving meals "restaurant-style", offering choices, and bringing each course separately rather than setting out the full meal on a tray in advance.

care. This sense of demotion was exacerbated by the fact that carers were now excluded from handover and too busy to read the Communication Book:

> *Danielle: I mean, I always used, we used to go in, read the Communication Book, have a cup of tea and then decide what, who's working with whom, who's doing what, but, now we have to go straight in and do breakfast. We don't get a chance. So I don't know whether that, um, has just changed, and then nobody's just taking notice of the – Communication Book.*
>
> *Kezia: Right. Do you still go, sit for handover, when you come in? No, you don't.*
>
> *D: No, we're not allowed to do that. Only the nurses have gotta do that. So, sometimes we don't even know if that resident's all right or not, or whether they're still here or not.*
>
> (Interview, Forest Lodge, Danielle)

Thus their limited source of symbolic power was undermined, as care assistants no longer knew from one shift to the next whether or not their residents were "*all right*".

To summarise, then, staff on Vintage Vale had more "time to care" than those at Richardson's, but this was shifting due to changes in management and the unit's case mix. This highlights the precarity of carers' position in the field: while they may have derived some symbolic capital from their individualised knowledge of residents, this related only to the minutiae of daily care on each shift, and was easily undermined by broader organisational changes. Hence they showed some resistance to the introduction of routinisation on the unit

even when it directly served residents, since it threatened their already-limited power and control over the work.

## 7.4    Discussion: Juggling institutional logics and temporal structures

This chapter has explored the extent to which the person-centred emphasis on "taking time to care" – by adapting the time and pacing of tasks to the needs and preferences of individuals – translated into practice at each facility. Guided by practice theory, this has necessitated taking quite a broad perspective in order to account for the "temporal multiplicities" of the field. The central argument has been that the three institutional logics of LTC – the home, the medical facility, and the business – "produced" (in the sense of informing and justifying) different temporal structures. To some extent, these temporal structures overlapped; for example, regular repositioning to avoid pressure sores was essential to good medical care, while also benefitting residents (in terms of both comfort and social interaction) *and* fulfilling workplace auditing and reporting practices. In many cases, however, institutional logics produced conflicting rather than cooperative temporal structures. At Richardson's, this was seen in the tendency towards routine-driven, task-focused care which marginalised rather than prioritising the subjective experience of the resident. On Vintage Vale, the opposite tendency was observed: carers' attempts to adopt a more flexible, adaptive, person-centred approach, although reasonably successful, were impeding to some extent the maintenance of routines that benefitted residents' health and wellbeing, such as toilet care and nutrition.

Two main conclusions must be emphasised here. The first echoes a familiar conclusion across health-care settings, which is that there is an inverse relationship between staffing

levels and the time available for delivering personalised care (Bishop et al., 2009; Bonifas, 2008; Foner, 1993; Harrington et al., 2012; Rahman et al., 2009). In other words, how can it *make sen*se to "take time to care", however the principle is translated, if that makes it impossible to provide care to every resident within the parameters of the shift? Granted, having more staff does not guarantee PCC, as Nat suggested when she said in her interview that *"the minute they give us more time, people start slacking off"*.[52] However, having *fewer* staff on shift does unequivocally affect the time available for carers to spend with each resident.

The second, related conclusion, raised in Section 7.2.1 and revisited throughout the analysis, is that balancing the needs and preferences of each individual resident against the needs of the whole group required considerable *work* from care staff. This was particularly evident at Richardson's, where the individualised style of working meant that extra time with one resident necessarily meant less time with another; other aides could not take up the "slack", given that they were occupied with their own residents. Identified by isolated examples, this balancing act could appear as a lack of empathy for, or responsiveness to, individual residents' urgent needs, but in the bigger picture could be reinterpreted as a logical adaptation to the competing demands of practice. One of these demands was to care for every resident equally, which necessitated maintaining some level of routine; another demand was to avoid the burnout (Astrom et al., 1990; Schaufeli and Bakker, 2004; Vinje and Mittelmark, 2007) that

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[52] Along the same lines, a systematic review of the relationship between staffing levels and care quality in nursing homes showed that an exclusive focus on numbers fails to address the influence of other factors, such as turnover, training, and care organisation and management (Spilsbury et al., 2011); in other words, finding "time to care" is not *just* about adding more staff.

could result from facing the impossible task of meeting the full needs of every resident within the time available.

The work that care staff put into organising their time and workload constituted an aspect of the "practical autonomy", as mentioned earlier, that characterised their position in the field. This practical autonomy was quite limited, as illustrated by the Vintage Vale scenario; carers had little power to challenge the changes that were being brought in under new management. But on a modest scale, carers had exercised a certain amount of control over details such as the order of care, the time spent on each task, and the timing of their breaks, which seemed to provide a source of ownership and control over the work that was otherwise lacking. This is important for explaining, in part, why they might have resisted adopting person-centred flexibility, if it was perceived as a top-down managerial requirement, or even as a lateral request from residents or their families, that threatened their limited control over their workload.

A related point is that there was evidence of *agency* in the way that carers juggled the temporal multiplicities of their workplace and balanced the logics that these inscribed. As Orlikowski and Yates (2002, p. 687) suggest, through their engagement with different temporal structures, individuals "may experience the tension created by temporal conflict, but they also may realize the possibilities of alternative temporal orders, and may act to change their practices, and thus their temporal structures". So although a pessimistic reading is that carers resisted new knowledge or practices that challenged their symbolic capital and practical autonomy, an optimistic reading is that there was some room within their practice, if

encouraged through supportive management and opportunities for reflection, for achieving change by navigating these temporal multiplicities differently.

This agency was severely constrained, however, by broader practices of regulation and risk-management, as explored in the next chapter on "promoting autonomy".

## CHAPTER 8: PROMOTING AUTONOMY: RISKS, REGULATIONS, AND REPORTING

## 8.1 Introduction: Defining autonomy in the institutional context

The previous chapters have discussed two mutually constitutive practices – "knowing the resident" and "taking time to care" – that are both critical to the delivery of PCC. Together, these support a third essential practice, which is promoting residents' autonomy (Rodgers et al., 2012, p. 96). Autonomy is certainly not a new idea in health care; indeed, it is the first of the four principles of medical ethics (followed by non-maleficence, beneficence, and justice) which have guided professionals for decades (Beauchamp and Childress, 2008). Derived from the Greek *autonomía*, meaning "self-rule", autonomy in the health-care context refers to the individual's right to make free and informed choices about his or her treatment. More specifically, it has been defined as "the exercise of self-determined, goal-oriented behaviour that is or can be potentially threatened or inhibited by a variety of circumstances, real or symbolic, intrinsic or external to the person" (Horowitz et al., 1991, p. 23). Juxtaposed against a more traditional paternalistic approach whereby decisions are made *for* rather than *by* care recipients, autonomy implies independence, choice, and control.[53] It has been argued that, in residential-care settings, any effort to "deinstitutionalise" the environment by recognising and addressing individual needs can be seen as promoting autonomy (Davies et al., 1997, p. 413).

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[53] Although autonomy – primarily as operationalised through freedom of choice – is a significant concept in health care and, by extension, PCC, it should be noted that the centrality of this concept to the liberal understanding of personhood has been subject to considerable critique from feminist and other scholars. Dodds (2007), for example, makes a cogent argument for an alternative conception of citizenship based on the recognition of vulnerability and interdependence (rather than assumptions of independence and inviolability).

The importance of promoting autonomy is expressed in the Eden Alternative's (2009) eighth principle, which states that: "An Elder-centered community honors its Elders by de-emphasizing top-down bureaucratic authority, seeking instead to place the maximum possible decision-making authority into the hands of the Elders or into the hands of those closest to them". By referring to the "*maximum possible* decision-making authority", this principle highlights two pertinent issues for institutional care. The first concerns the organisational limits on autonomy. Person-centred care emphasises that residents should feel *at home*, not as if they are living in a "total institution" which requires them to check their independence and identity at the door. This implies that residents should have control over the decisions that affect their daily lives. However, these decisions are necessarily carried out within organisational parameters related to resources, routines, regulations, spaces and equipment, and so on, all of which impinge on individual freedom. Thus the scope of autonomy in the residential care setting differs from the private sphere *and* other health-care contexts, according to these particular parameters.

Second, alongside these organisational limits, autonomy is affected by residents' own decision-making capacity. Capacity is conventionally assumed to be a defining attribute of autonomy (Welford et al., 2012); how can someone make informed choices, in other words, without the capacity to freely engage in and/or express rational thought? In care homes, however, this might render moot the possibility of autonomy for the two-thirds' majority who have some form of dementia. Proponents of person-centred approaches to dementia care have therefore argued against this narrowly "hypercognitive" (Post, 2000) definition of autonomy in favour of a broader understanding. In part, this simply entails recognising that capacity *fluctuates* according to a number of factors, including day and time, mood, physical health,

medications, environment, and the nature of the decision itself (Hofland, 1994); thus, incapacity on a certain day or related to a particular condition does not correspond to incapacity across the board.

Moreover, there is growing recognition that even those with significant mental or communicative impairments can still indicate agency through meaningful gestures, movements, and other embodied expressions (Downs, 2013; Kitwood, 1993; Kitwood, 1997b; Kontos, 2004; Kontos, 2005; Kontos and Martin, 2013; Sabat, 2001). Kontos (2005, p. 559), drawing on phenomenological and Bourdieusian theory, refers to this as *embodied selfhood*, defined as "a complex interrelationship between primordial and sociocultural characteristics of the body, all of which reside below the threshold of cognition, grounded in the pre-reflective level of experience, existing primarily in corporeal ways". As a straightforward example, someone with dementia might express their desire to disengage from a particular social situation by turning away or, on the other hand, indicate a preference for company with an expansive arm gesture. Such embodied expressivity may not apply to high-level decisions about, for example, medications or care planning; however, having some autonomy regarding relatively simple matters such as food, clothing, personal care, and activities is nonetheless fundamental to retaining a sense of control over one's daily life, with links to overall well-being (Sabat, 2001).

This inclusive, embodied and relational understanding of capacity requires that care workers – "those closest to the Elders" according to the Eden principle quoted above – not only respect but actively facilitate residents' autonomy, including by encouraging residents to do

as much as they can for themselves, providing choices whenever possible, and identifying and honouring their preferences, whether or not these are explicitly stated.

However, inseparable from practices related to autonomy are those related to risk management and damage control in the context of broader legal and regulatory demands on the nursing home. Broadly speaking, risk is concomitant with independence: as adults, we choose to balance a certain amount of acceptable risk against the rewards of living an active life. Likewise, PCC inscribes a notion of acceptable risk; that is, enabling residents to exercise a certain amount of autonomy, for example in the areas of self-care, eating, mobility, and so on, requires tolerating a certain level of risk.[54] The proliferation of objects in the hallways and common rooms of Vintage Vale, for example, showed tolerance of risk in order to achieve a homelike atmosphere where residents could engage in activities on their own initiative. In a different environment, those toys, games, musical instruments, and fashion accessories might be neatly stored and brought out only for supervised sessions.

But many residents are admitted into a nursing home at the point when the risks of living at home exceed the benefits of independence (Ryan, 2003); thus, nursing homes are explicitly tasked with keeping people *safe* (Kapp, 2003a). Paradoxically, nursing homes tend to be feared as *unsafe* places, where vulnerable elders are subject to a host of heightened risks ranging from accidents and medical errors to neglect and outright mistreatment (Kapp, 2003b). Out of this contradictory situation have arisen the monitoring and regulatory

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[54] It is interesting to note that a randomised control trial comparing patient outcomes from nursing homes versus long-stay hospital wards found that, although accident rates were higher in the nursing home, quality of life was better there than on the (medicalised, risk-averse) hospital ward (Bowling et al., 1992). These findings prompted the study authors to problematise the construction of "risk": whose interests does it serve?

practices described in Section 2.4, which are designed to ensure, to the extent possible, that nursing homes do in fact protect their residents from harm – and which in the United States at least have resulted in "nursing homes becoming the most highly regulated health-care system" in the country (Colón-Emeric et al., 2010, p. 1283).

The following chapter will examine how carers attempted to reconcile the dissonance between these twin aims of autonomy and safety in the nursing-home context. The discussion rests on three interrelated assumptions derived from sociocultural studies of risk (Beck, 1992; Douglas, 2002; Giddens, 1999; Zinn, 2006), with the recognition that there is much more scope for engagement with this broad and diverse literature than undertaken here. The first assumption, in keeping with the practice-theory approach, is that safety and risk are not pre-existing or "objective" phenomena which can be simply "measured and managed" (Waring, 2009), but are constructed in situated, practical, and often contradictory ways. The second assumption is that these concepts are constructed in relation to potential (but uncertain) *outcomes*, with the idea that by controlling risks, it is possible to control these outcomes. As Giddens (1999, p. 3) states, in defining the "risk society": "it is a society increasingly preoccupied with the future (and also with safety), which generates the notion of risk … Risk is always related to security and safety." Finally, it is assumed that social actors actively negotiate these multiple and multidimensional "risk knowledges" (Green, 2009, p. 497) by drawing on situated rationalities, which Horlick-Jones (2005) refers to as the "informal logics of risk". This negotiation implies both agency and accountability, which links to the notion of culpability discussed later.

The chapter will begin by briefly discussing how autonomy translated into practice at the two facilities, using comparative observations and an illustrative case study to demonstrate that the routines and practices at Richardson's tended to limit (rather than promote) resident autonomy to a greater extent than at Forest Lodge. The next section will place these observations within the broader regulatory field in order to argue that the carers' relative powerlessness – to some extent, their *own* lack of autonomy – within this matrix of practices drastically constrained their ability and willingness to promote the autonomy of their residents.

## 8.2     Translating autonomy into practice

The following section will set the scene by comparing how the person-centred emphasis on "promoting autonomy" translated into practice at Forest Lodge, particularly on Vintage Vale, and at Richardson's.

### 8.2.1   Independence and choice on Vintage Vale

On my second shift on Vintage Vale at Forest Lodge, as I hovered in the main lounge, a resident (Nell) walked in and told me that she was hungry. I was initially stymied, wondering "*how do I know if she's already eaten or not? What do I give her? There's not a tablecloth on this table, is that okay? Where do I write what she's eaten?*" (Fieldnote, Forest Lodge, Shift 2). Luckily, a nurse (Lainie) overheard and, quickly dispelling my deliberations, suggested that Nell might like some cornflakes, adding that I should use sweetener rather than sugar. Nell chose a chair at one of the dining tables, graciously accepted the bowl of cereal, and began to eat.

Although mundane and momentary, this scenario neatly illustrates how the PCC emphasis on "promoting autonomy" can be translated into practice within the institutional setting, taking into account the capacity of a particular resident. Nell expressed a request for something to eat, and Lainie fulfilled that request by drawing on knowledge of Nell's preferences (she likes sweetened cornflakes) and her medical needs (she's diabetic).

Such examples were most prevalent in day-to-day practice on Vintage Vale. In part, this reflected the fact that residents on Vintage Vale were more physically able than those upstairs or at Richardson's. Since Nell was able to walk into the room, take a seat, and eat without assistance, for instance, her request for food outside a regular mealtime represented a negligible imposition on the staff workload. Having a kitchen on the unit that was amply stocked with snacks, drinks, and other supplies was another facilitating factor, as compared to Richardson's, where an order would have to be called through to and then collected from the kitchen (during set hours only).

Importantly, however, opportunities for independence and choice were also built into the daily routines on Vintage Vale. For example, as part of the "Dining Experience" (see footnote in Section 7.3.2), carers were entitled to a free meal so that they could eat with the residents. This was designed to create a more sociable atmosphere at mealtimes, but also to encourage independence, since some residents who lacked the capacity to initiate the motion of feeding themselves might still be inclined to mimic the actions of others. Staff built on this by identifying individualised ways to encourage mealtime independence, as in the following example:

*Lainie [a nurse] told me that sometimes … it helps to sit to the side [of a particular resident] and feed her unseen – so that she has the feeling she's feeding herself. I helped her with a few bites, which she took without resistance – and then she seemed to indicate that she could do it herself – so I left her to it, checking back in a couple of times to encourage her with another spoonful or two.*

(Fieldnote, Forest Lodge, Shift 2)

This fieldnote illustrates how carers on Vintage Vale were expected to actively enhance rather than undermine their residents' capacity. If I had simply been instructed to ensure that this resident ate her meal, I might have sat directly opposite and spoon-fed her. Instead, having been encouraged to explore alternative strategies, I discovered that, for this meal at least, the resident was capable of feeding herself. As a side note, Lainie's suggestion about "tricking" the resident into feeding herself, although pitched as a strategy for enhancing independence, still implied an exercise of power that could actually be interpreted as a *negation* of the resident's embodied intentions; this highlights the complexities involved in actualising abstract concepts such as autonomy.

In the following excerpt, an experienced carer who had just moved down from the upstairs unit at Forest Lodge describes how the notions of independence and choice translated into practice on Vintage Vale:

*… the biggest thing is choices, like, um, taking a tray of food, but if it's fish and it's sausages, take them both on a tray and say "which one would you prefer?"*

*And if they can't speak and they point to that one, then you give them that one and you know <u>they've</u> chosen that one. Like the blackcurrant and, juice and orange juice, you know, you show them the colours, and they will pick what they want, and you know they've got what they want, you haven't just <u>assumed</u> that's what they want. The biggest factor in, in care work is assuming that you – assuming you're doing the best for them when, really, you're just taking away their independence. Down Vintage Vale they encourage independence very, very much, you know, if a resident can walk but not very well, but he can walk better with a [carer], don't just stick 'im in a wheelchair, make sure he's stimulating those legs, and make sure he's walking. I'm finding a lot of that down there, that's, that's what makes me – happy to be down there as well, because you <u>are</u> keeping everybody's independence.*

(Interview, Forest Lodge, Hayley)

Hayley's cautionary statement about "*assuming you're doing the best for them when, really, you're just taking away their independence*" speaks to the difference between a conventionally paternalistic approach and PCC. She also indicates that a broadly person-centred approach must be translated into very specific material practices, such as showing a resident two meals in order to allow them the opportunity to choose.

Of course, choice and independence had to be negotiated within other practices and the institutional logics which informed them, as suggested in the following fieldnote:

*During lunch, as Aimee [the interim unit manager] was assisting Selina [a resident] and I was assisting Richard [another resident], she told me that they*

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*used to have to get everyone up by 9:30, which meant getting some residents up at six and seven – she said "that's fine if they <u>want </u>to get up but otherwise you're just rushing". "And for what?" I asked rhetorically – so they can sit here and do nothing? She agreed. She referred several times to the importance of finding a "balance" – because she <u>does</u> want to see more activities <u>and</u> sometimes it can be for someone's own good to get out of bed and/or to eat by a certain time. But if they have the capacity to choose, she said – giving the example of her Nan, who used to eat nothing but sweets until she went into a care home, where they wouldn't even let her have sugar in her tea ("she used to put sugar in her tea until the spoon stood straight up!", she said). … She was talking about this as she helped Selina with a big bowl of custard, having said "there's no point trying her on a main [course]" because she knew she'd only want something sweet.*

(Fieldnote, Forest Lodge, Shift 12)

Although Aimee disparaged the idea of "rushing" to get residents out of bed in the morning, that does make sense according to the logic of the business, which values time efficiency and measurable outcomes (as discussed in the previous chapter). How can staff performance on the morning shift be evaluated, for example, if all the residents are still in bed by noon? It also makes sense according to medical logic for some residents, such as those who are diabetic or at increased risk of pressure sores. But "rushing" residents may *not* make sense according to the logic of the home, which assumes a higher degree of individual control over daily routines. Carers therefore had to "find a balance", using Aimee's phrase, between these logics in order to respect their residents' choices – such as Selina's preference for pudding – while still meeting their job requirements and avoiding medical repercussions.

This balance had to be constantly negotiated as residents' capacity and needs changed. For example, by the following shift, Selina's condition had worsened, and Aimee told the carers to use a syringe to ensure that she received some fluids, emphasising that "*it's a care issue*" (Fieldnote, Forest Lodge, Shift 13). The implication was that this was no longer a *choice* issue; that is, Selina was not choosing to go thirsty, but simply required additional physical assistance in order to drink. Failing to recalibrate the definition of choice according to these changes in Selina's physical capacity or medical need might have led to neglect in this situation, regardless of carers' intentions.

Choice also had to be balanced pragmatically against available resources, as suggested by the following example:

> *When she overheard me saying that I'd asked Keith what he'd like for his main course, but didn't really get an answer … Vera said to me that we give residents the choice but for those – saying a couple of times, "I don't mean to sound rude but…" – who can't articulate a choice, they "kind of get whatever's left".*

> (Fieldnote, Forest Lodge, Shift 3)

I noted that it seemed very difficult for Vera – a carer who noticeably espoused PCC in her practice – to communicate this fairly sensible information to me without undermining the importance of resident choice. This signifies the work that goes into maintaining the balance between the different priorities associated with different logics of practice.

Finally, it should be noted that resident autonomy was supported but also undermined by the physical layout of Vintage Vale, the locked doors of which allowed residents freedom of movement within certain intractable limits, and by the MyAmego® alarm system that was piloted on the unit. MyAmego is described on the company's website as "a person-centred system enabling users to maintain their quality of life and a degree of 'independence' without the need for constant intrusive monitoring by carers" (MyAmego Healthcare Ltd., 2013). Particular residents were given personal alarms which were linked to beepers carried by staff; these beepers would sound if residents stayed too long in one place and also in cases of "social threat", if the resident came within proximity of other residents with whom there was a perceived risk of altercation or accident. To a certain extent, then, MyAmego provided a compromise between logics, in that it enhanced residents' autonomy while also alerting staff to any immediate safety risks. However, it begs the question: does using a tracking device – which staff would often refer to as "a medal" or "necklace" when putting them on residents – really promote someone's independence, especially when they do not understand what it is? Because the pilot project lapsed while I was conducting fieldwork at Forest Lodge, it is difficult to comment authoritatively on this question.[55] However, it is likely that the answer would depend on how the practice integrates with other practices in a given context of care. On Vintage Vale, where the ideas of choice and independence were embedded in other practices around, for example, mealtimes and personal care, the system seemed more likely to fulfil its "person-centred" purpose. On another unit which adhered to a more conventional,

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[55] There were hopes of reinstating MyAmego once the unit had "settled down" from the change of management. This lapse in implementation during a period of transition illustrates the difficulty of sustaining new practices: although the system had been embraced in theory, it had not become fully embedded in the carers' daily practice (to the same extent as using gloves for infection prevention, for example), and therefore was vulnerable to collapse without active and ongoing encouragement.

routine- and task-based approach, it might easily have become a management tool rather than enhancing autonomy.

My observations from the upstairs unit at Forest Lodge reflected, to a large extent, the observations made in this section about independence and choice. Offering residents a choice of meals, encouraging them to assist themselves to the extent possible, and encouraging freedom of movement around the unit were all standard practices. Notably, residents were also taken down to the main lounge on their request, with one carer assigned to oversee that area on each shift; this contrasted with Richardson's where, as mentioned, the central atrium was rarely used outside of mealtimes and scheduled activities. There were two key differences between the two units at Forest Lodge, however. The first was the difference in case mix: whereas on Vintage Vale, many residents still had physical capacity, the majority of the residents upstairs required full assistance with ADLs and basic mobility. This considerably restricted – although without entirely negating – the scope for promoting their autonomy. That is, although carers upstairs seemed inclined to promote autonomy, this principle was enacted within much more narrow limits when compared to Vintage Vale.

A related factor, however, was the fact that the PCC training at Forest Lodge focused on person-centred *dementia* care. This meant that the ideas covered by the training – such as providing "a world of opportunities" and having "zero tolerance for controlling care" – were framed in the language of cognitive impairment, and thus seemed more directly applicable to Vintage Vale than to the upstairs unit, where physical impairment was a much greater issue. This was not a difference identified by staff in their interviews; that is, no-one explicitly stated that the training applied only to Vintage Vale, nor that it failed to provide sufficient

guidance for delivering PCC upstairs. However, it was clear from my observations that language and specific interventions around choice and independence were more *overtly* employed on Vintage Vale than on the upstairs unit.

### 8.2.2 *Autonomy within limits at Richardson's*

Attempts to promote residents' autonomy were also evident at Richardson's, although to a much more limited degree. At mealtimes, for instance, CNAs would often mention residents' food preferences, or share suggestions about how to encourage independent eating. One shift, Edie told me that a particular resident "*likes anything she can eat with her hands*" and another only "*eats everything when his wife is here*" because she "*won't take no for an answer*" (Fieldnote, Richardson's, Shift 3). This latter comment implied conscientious attention to autonomy within the institutional context: while different rules might apply for family caregivers, Edie suggested, paid carers must be prepared to "*take no for an answer*", even if that entails a trade-off with nutritional intake.

Resident preferences were also honoured with regards to personal care and mobility, but usually only to the extent that they expedited rather than potentially disrupting the routine. This relationship between autonomy and expediency was spelled out on my first day of CNA training, when the trainer explained PCC:

> "*They've taken your home, they've taken your ---, they've taken your pets [listing quite a few things] – so all you have left is your <u>dignity</u> and your <u>independence</u>,*" *she said. Talked about letting people do things themselves – and then fixing it*

*later; for example, if someone combs their hair backward, let them do it, then smooth it down later while they're distracted. Don't take these activities away from them – because this will either lead to depression or dependence "and you'll complain later, 'why do I have to do everything??'".*

(Fieldnote, Rosemont, Day 1)

This comment highlights the potential synergy between resident autonomy and work efficiency, because residents who do things for themselves lessen the CNAs' workload. When these two goals conflicted, however, the logic of the workplace tended to prevail at Richardson's. This is illustrated by the following fieldnote, which records what happened after Violet, who was one of my shift partner's residents, asked to lie down before supper:

*Since it was somewhere between 3:30 and 4, I asked [Violet] if she could stay up till after supper, then have an early night, but she said "no" quite firmly, so I helped her onto the bed. Then I went to "confess" to Nat [my shift partner], saying "you're going to kill me but I let Violet get into bed for a nap" – but she surprised me by saying, "that's okay, she's easy", rather than giving me a hard time.*

(Fieldnote, Richardson's, Shift 20)

As with the example of Nell above, this scenario seems fairly simple: the resident wanted to lie down, so I assisted her from the chair to the bed. What is notable is my sense of wrongdoing as I "*went to confess*" my actions to my partner. Her reply that it was okay because Violet was "*easy*" indicated that resident choice only made sense within the

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parameters of the strict afternoon routine; if her request had been more difficult to fulfil, perhaps it would not have been seen as an issue of resident autonomy, but re-cast as impossible or obstructive.

A further key difference was that aides at Richardson's had received considerably less training around PCC and cognitive impairment than carers at Forest Lodge, as suggested by the following fieldnote:

> *Nat has a new resident on her card: someone who just arrived from hospital but had previously been at Richardson's on the rehab unit. She told me several times how difficult she'd been … [that] she was "in there with her for half an hour last night", trying to get her ready for bed: "you want to let them do it for themselves – but then you put it in front of them and they say, 'what am I supposed to do with this?'"*

(Fieldnote, Richardson's, Shift 22)

Nat's final comment suggests that she was familiar with the person-centred concept of autonomy, but that she did not have specific resources for translating it into practice. This directly contrasts with Hayley's description of choice and independence above, which was built around very specific actionable examples.

The process by which intersecting practices produced a noticeably narrow understanding of autonomy at Richardson's is well-illustrated by the following case study of a new resident, Noreen.[56]

*8.2.2.1      Constructing the autonomy of a new resident: Noreen's story*

I first heard about Noreen, a new resident on the west wing, during shift report, as the nursing staff traded what they knew about her so far:

> *Melinda [a CNA], standing on the other side of the desk, said "is she a couple of French fries short?" Nancy [a nurse] said, "they told me she's 'alert times three' but <u>oh no</u>, she's <u>not</u>", describing the questions she'd asked about her age, address, etc. which she'd gotten all wrong. "Then she said to me, 'don't ask me any more questions because I can't answer them'", Nancy said, which she said was fair enough, "you're 99". She was happy to let it go. At some point Melinda reaffirmed, "yeah, a couple of French fries short of a Happy Meal!" One of the nurses from the day shift said, "she's going to be a corker" when she settles in, "she can tell you the whole history of [this town]!" ... There was some discussion about what her BP readings had been, but Nancy (I think) concluded, "when you're 99, who cares?!" like it wasn't really important to dwell on these medical details. "She's on 'comfort care' anyway," someone else said ... She's not going to be taken to the hospital, we'll try to do some therapy here, we'll weigh her occasionally – but nothing more complex than that. Someone said that she's*

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[56] Although my fieldnotes do not represent a full chronology of Noreen's integration, or assimilation, into nursing-home life, they provide sufficient detail from which to build an approximate outline of the process.

*continent of stool, and two people chimed in to say that she'd had two mediums last night and another this morning. "She does have a bowel fetish", someone said.*

<div align="right">(Fieldnote, Richardson's, Shift 25)</div>

It is clear from the first sentence of this excerpt that Noreen was constructed as someone with diminished capacity from the moment of her arrival, regardless of what her transfer notes might have said. "*They told me she's alert*", said Nancy, but "*she's <u>not</u>*", since she failed to correctly answer a round of basic questions. This assessment clearly stemmed from a biomedical definition of capacity, as measured through tests such as the Mini-Mental Exam, rather than from a more person-centred perspective which emphasises both social context and the interconnection between different cognitive abilities (Sabat, 2001, pp. 167-8). Somewhat paradoxically, Nancy also *affirmed* Noreen's autonomy in a contextualised sense by affirming her right – at the age of 99 – not to be asked any more unanswerable questions. However, the lingering implication was that she was confused, but given her age, that was acceptable – or even inevitable (reflecting ageist assumptions about incapacity). Other seeds of the developing narrative about Noreen's personality were sewn with her characterisation as "*a corker*", which suggests someone opinionated and humorous, and the reference to her knowledge of local history. There was some discussion of her medical needs but, as she was on end-of-life ("*comfort*") care, these details were dismissed along with the results of her mental acuity assessment.[57]

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[57] Although not directly relevant here, it is worth noting that nothing was said about Noreen's emotional health, even though the transition into a nursing home may trigger a range of strong emotions including grief, anger, and fear. When I asked them directly about PCC, staff at Richardson's frequently talked about the importance of recognising the resident's experience of this transition; however, in practice, it seemed that this emotional

After hearing about Noreen during shift report, I logged onto the computer to learn that she was on my list of residents for that shift. Shortly after, Nancy stopped me to confirm this. She also told me that Noreen was "one-assist" and *repeated to me that she has a "bowel fetish", and I said "okay… meaning what?" She said it just meant that she wants to go all the time".* Casting Noreen's toileting needs as a "fetish" shifted the focus from a physiological need to a psychological preference, with somewhat contradictory implications. According to PCC, personal preferences should be accommodated to the extent possible, whether these relate to eating, sleeping, or visits to the toilet. In the medical and the workplace logics, however, a psychological idiosyncrasy ("*she <u>wants</u> to go all the time*") may be justifiably superseded by more pressing priorities, such as assisting other residents on the toileting list. Given the high prevalence of urinary incontinence in nursing homes, any incontinence episode will then most likely be interpreted as inevitable (Durrant and Snape, 2003; Resnick et al., 2006; Robinson, 2000), rather than a failure of care. (Indeed, Noreen was incontinent that afternoon, as indicated in the excerpt below, but that was explained by the removal of her indwelling catheter.)

When I first went to check on Noreen that afternoon, she was fast asleep:

> *… so I decided to do everyone else first, not knowing how she would be and how long it might take to get her up. When I did eventually wake her, she was quite confused about what time of day it was and very reluctant to get up. I left her room again, to give her a little more time to get oriented, and out in the hall Nat*

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dimension was largely overlooked, with staff maintaining a focus primarily on learning what was necessary to fit that new individual into existing care routines.

*[my shift partner] asked me if I needed any help. I said that I might need help convincing her to get up, and Nat said knowingly, "oh, <u>psychological</u> assistance". When we went in together, we were able to get her up quite easily, and then walk with her to the bathroom where I changed her soaking underwear and pants while she sat on the toilet, wondering and praying aloud in a constant monologue about what we were doing to her and why.*

(Fieldnote, Richardson's, Shift 25)

This fieldnote indicates the embodied challenge of translating autonomy into practice while also "getting the job done". Although I was equipped in advance with some information about Noreen's needs and capabilities, it was not easy to translate this information into appropriate words and actions in our first encounter. In part, this was because I felt uncomfortable walking into the bedroom of an adult stranger and assuming authority over her; this did not *feel*, according to my own habitus, like the "right" thing to do, even if I *knew* that it was the expected thing to do. (As another CNA, Daria, said in her interview when describing first interactions: "*It's always a little awkward, I mean, I don't know you, you don't – you know, you're not used to having that care done, most likely*".)

By contrast, as an experienced carer, Nat showed no hesitation. Although her confident efficiency was advantageous for getting the task done, it did not leave much room for Noreen to process what was happening to her, hence her confusion and distress. Although perhaps reflecting her circumstances rather than her actual cognitive abilities, that confusion then fed into the narrative about Noreen's limited capacity, with implications for future interactions. If we had taken more time, and perhaps let her use the bathroom unassisted, she would have

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been granted more autonomy in the moment *and* we might have obtained a better picture of her overall capacity. However, since Noreen's care plan required her to be assisted pending further assessment, this was not a choice that we could make (which relates to the discussion in the next section).

Towards the end of that first shift, I wrote:

> *[Noreen's] light was on constantly tonight, and all of us – not just Nat and I but also the other aides – were in and out of her room almost in rotation, reporting each time a different (and often contradictory) request: lights on, lights off, blankets on, blankets off, etc. ... One time when I went in to see what she wanted, Noreen asked for glaucoma drops for her eyes. I went to ask Nancy whether she was supposed to (or could) get eye drops, not expecting a positive response, and was surprised when Nancy said yes right away.*
>
> (Fieldnote, Richardson's, Shift 25)

In retrospect, it seems quite clear that Noreen's erratic requests indicated her general anxiety about being in a completely new "home" environment. At the time, however, she was generally perceived as exasperating and impossible to please. This appears to have conditioned my own sceptical response to her request for glaucoma drops, a request that I was prepared to dismiss as irrational – until, to my "surprise", the nurse confirmed it as a legitimate request.

The following afternoon, when I arrived at the nurses' station to start my shift:

> *… all four LPNs were discussing Noreen, mainly quoting things she'd said back and forth amidst unrestrained laughter. I stood listening, laughing too as they described, for example, how she'd grabbed one of the nurse's "biscuits" (rear end) in order, she had said, to keep from falling over. Some of her statements were quite dramatic exhortations to Jesus, God, or whoever was at hand to let her die – but delivered in a way that, on repetition at least, sounded really comical. At one point, the nurse who just started around the same time as me got serious and said something along the lines of, we're all laughing but it's not really funny, she's telling us over and over that she wants to die. Someone else said, but look at you smiling as you say that! The new RN protested that, yes, she <u>is</u> funny but also sad.*
>
> (Fieldnote, Richardson's, Shift 26)

Indeed, Noreen *was* funny. For example, on another shift, when we were walking to the den, Noreen looked across to one of the male residents and exclaimed "*hello, Miss Muffet!*" – then turned to me and said *sotto voce*, as if we were sharing a joke, "*or is that a man?!*" (Fieldnote, Richardson's, Shift 29). She delivered these lines, and many others, with comic timing and inflection that suggested a rich sense of humour. However, the risk here – underlined by the nurse's comment that "*she <u>is</u> funny but it's also sad*" – was that treating everything Noreen said as a joke may have caused her valid expressions of need or preference to go unheard, and thus unfulfilled.

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Over the next few days, some changes were made to Noreen's care which materially limited her autonomy. First, after physical assessment, she was required to wear "hipsters", which are elasticated briefs with pockets on both sides to accommodate hard-plastic hip protectors. Noreen complained extensively about *"these boards"*, as she called them, and in my fieldnotes I reflected: *"I wasn't surprised that she found them uncomfortable, and had yet another moment of wondering about the wisdom of requiring a reasonably mobile 99-year-old to suddenly wear large inserts in her pants just in case she falls – is that really for her benefit or for our own protection?"* Regardless, a new level of dependence was produced: now Noreen *did* need help when going to the toilet, because the hipsters were too unwieldy for her to pull on and off unassisted.

Second, staff had begun "parking" Noreen in the hallway most of the time, as described in the following note:

> *… I went to check on Noreen who was sitting in her wheelchair by the nurses' station. She was saying in her characteristic non-stop monologue style that she needed the bathroom but no-one was helping her, indicating that she was stuck in the chair, showing me how her feet were up on the pedals so she couldn't get out.*
>
> (Fieldnote, Richardson's, Holiday party)

Although she was not overtly restrained, Noreen was clearly positioned so that she could not get up by herself – although she was nonetheless trying to, having already freed one foot from its raised pedal. Noreen was placed in the wheelchair for safety reasons, since she was considered a "falls risk". However, given that she had been fully mobile until immediately

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prior to her move into the nursing home, this action risked accelerating her physical dependence.

She was also kept in the wheelchair for the sake of convenience, as otherwise she would have required frequent checks:

> *At one point, I came upon Evan [a nurse] standing next to Noreen's chair near the nurses' station; he was trying to keep her from standing up, which she had been repeatedly trying to do. I said, "can I just take her to bed?" and he launched into a long, frustrated schpiel about how I could put her to bed if I could make her stay there, as if I was suggesting I had some special skills on that front (that no-one else did). Eventually I had to almost interrupt him, saying "just tell me what <u>you</u> think I should do, I'm not advocating anything." He said that it would be better for her to stay sitting there "so we can watch her" – rendering moot the rest of his rant. Then he called down the hallway to Marcia [another nurse] in a loud, aggrieved voice, "Marcia, can you come up here so I can finish my charting?"*
>
> (Fieldnote, Richardson's, Shift 28)

Although obliquely recognising Noreen's right to go to bed, Evan's choleric response suggested that this right was trumped by his responsibility to prevent her from falling, which was difficult to do while also fulfilling the myriad other requirements of his role.

This brief chronology suggests that moving into Richardson's had an immediate, limiting (and bewildering) effect on Noreen's autonomy. I speculated gloomily in my fieldnotes that *"I feel sure that if I returned in a month or so, I'd find a much more resigned and less mobile resident than I'd known this past week – which makes me profoundly sad"* (Fieldnote, Richardson's, Holiday party). This was partly due to time pressures and the power of routines, as discussed in the previous chapter, but also, significantly, to the regulation and monitoring practices which structure the LTC field. The next section will consider how these practices, which are designed to safeguard residents, have engendered a level of risk aversion which is difficult to reconcile with the person-centred emphasis on independence and choice.

## 8.3    Autonomy in the context of risk and regulations

It has already been suggested that many people are fearful about safety standards in nursing homes. And indeed, even in the absence of deliberate mistreatment (which is the main focus of such fears), nursing homes are rife with the potential for errors and accidents. Medication errors, for example, are a significant risk, given that almost half (47.9%) of all residents take nine or more medications per day (CDC, 2004). Pressure ulcers, although considered to be avoidable when following adequate preventive practices, affect up to 20 per cent of residents (NPSA, 2010); falls have been estimated to occur in nursing homes at twice the rate of falls for older adults living in the community (Rubenstein, 1997); and the controversial but prevalent use of feeding tubes also entails risks related to incorrect size, positioning, and/or monitoring (Teno et al., 2011).

My fieldnotes are peppered with observations of incidents, accidents, and near-misses, such as the following:

> *... [I]n the midst of the [lunchtime] hustle and bustle, the resident [Elsie] whose son had been with her that morning stood up as if to leave. I was taking a bowl of soup to feed to Nate [another resident], who was sitting on the opposite side of the table. I set the bowl down, quickly, and went to get Elsie's walking frame, which was off to the side of the table. ... [As] I was giving her her frame, I looked over to see Nate dipping his fingers into the bowl of soup, which was still quite hot – and so quickly moved back to sit with him. Quite soon, there was one of those drawn-out moments, where everything seems to happen in slow motion: I looked up to see Elsie falling sideways/backwards, against the rolling table in front of another resident who was sitting in the chair at the edge of the lounge; Eric [a CNA] was rushing over, bending down, talking to her; the resident in the chair was looking wide-eyed with shock; an alarm was suddenly buzzing; Lainie [a nurse] was walking quickly in, saying "where's the alarm?" ... I had gotten up and rushed towards Elsie too, but as Eric was there and Lainie on her way – and Elsie on the floor was looking startled but alert – I returned to my seat and kept feeding Ken, but shaky now with adrenaline. ... When Elsie was back on her feet, Lainie looked over at me and said with a smile, "no boken brones – " correcting herself – "no broken bones!"*
>
> (Fieldnote, Forest Lodge, Shift 2)

Hot soup, an unsettled and unsteady resident, a rolling table, vulnerable residents nearby: the convergence of these risk factors transformed an ordinary mealtime moment into a near-tragic accident. This illustrates the point made by Truda, a nurse at Forest Lodge, that carers "*have to have a pair of eyes in the back of their head, because there are so many things going on, anything can happen on any given day*" (Fieldnote, Forest Lodge, Shift 18). This equates to a kind of juggling act, as for example I juggled Elsie's risk of falling and Nate's risk of burning himself on hot soup.

In such an inherently risky environment, it is carers – the ones who deliver the lion's share of daily care, often in bedrooms, bathrooms, and other unsupervised spaces – who are responsible for keeping residents safe. The following joking conversation, which took place in the staff room at Richardson's, alludes to this responsibility:

> *I can't remember how this came up, but one of the CNAs said she didn't like to use [the Parker bathtub] with residents who couldn't hold on because she was afraid that they'd slip down, and "they wouldn't like it if I drowned a resident". Isobel [a nurse] said something about hoping that she'd unplug the tub rather than just standing back and letting the resident drown. Marcia [another nurse], who had joined the table by then, said "no – you stop to think how much you like them first!" … There was more joking along these lines, Isobel miming herself standing over the tub looking down at someone, saying something like "you didn't call me names today, did you? I know you didn't call me names today" – as if requiring the resident to repent before being saved.*
>
> <div align="right">(Fieldnote, Richardson's, Shift 24)</div>

These jokes about whether or not the CNA should pull the plug to save the resident suggest that carers have power over vulnerable residents, which can be wielded for their benefit *or* harm. This certainly reflects their portrayal in reports of nursing-home scandals. But such jokes can also be read as an attempt to claim *back* power from others in the field, namely members of management, who are invoked by the statement that "*they wouldn't like it if I drowned a resident*". The obvious implication is that the aide might be able to choose whether or not to pull the plug, but she will be held directly responsible for the repercussions of that choice. These themes of risk and safety, choice and responsibility, and accidents and outcomes will be explored in this section with reference to the broader framework of risk-management practices in the "panopticon" that is the nursing home (Gubrium and Holstein, 1999, p. 950).

The evidence in this discussion must be located within a much broader trend across health-care contexts, which is to limit risk through safety systems, such as protocols, auditing, targets, and performance measures, which are all designed to standardise practice and "limit the capacity for individual discretion to manage risks to patient safety" (Hillman et al., 2013, p. 939; see also McDonald et al., 2006). Indeed, in the context of the NHS, Brown and Calnan (2010, p. 13) argue that "notions of risk and corresponding uncertainty are at the very core of medical practice" and that therefore "an increasingly systematic and expansive form of risk governance has been rolled out across the NHS in order to avoid repeats of situations where clinical craft loses sight of patient safety and quality of care". The intention here is to examine the impact of this broad trend on the micro-level of carers' practices, particularly given the existing lack of evidence about how frontline staff negotiate the balance between these priorities of safety and autonomy (Davies et al., 1997; McCormack, 2001).

### 8.3.1   *Balancing safety and autonomy*

My observations suggest that, to a certain extent, the goals of safety and autonomy could be fulfilled symbiotically. For instance, there was a resident at Richardson's who was very unsteady on her feet, but determined to keep moving, and therefore considered a "falls risk". The solution was to secure her in a wheelchair with a "lap buddy", an inflatable cushion that fits across the lap and both armrests. This prevented her from getting up but left her feet free so that she could push herself around the facility unsupervised. During orientation, the assistant administrator described this as a strategy to keep the resident "*more mobile rather than less*", reflecting the resident's preference while also minimising her risk of falling and/or developing problems related to immobility (Fieldnote, Richardson's, Orientation). Similarly, adopting a person-centred approach precludes the use of restraints, including ties and bed rails. These have traditionally been used to keep residents safe (and/or passive) but more recently have been shown to cause harm – from pressure sores to broken bones – rather than preventing it. Thus, avoiding the use of restraints can keep residents safe *and* respect their autonomy and dignity.

In most cases, however, carers had to negotiate an imperfect compromise between these two goals. In the previous excerpt from Forest Lodge, Elsie was "allowed" by her care plan to walk unassisted, and therefore was fully within her rights to leave the table. Requiring her to stay seated would have undermined her autonomy. However, her attempt to leave triggered an accident which jeopardised her safety and that of nearby residents. In this scenario, safety and autonomy thus seemed at direct odds.

For residents with limited capacity, personal-care interventions presented one of the few routine opportunities to exercise any degree of autonomy – mainly through resistance. This presented a dilemma for carers who, although expected to respect resident choice, were also required to ensure that their residents were adequately clean, dry, and comfortable. The following fieldnote highlights this dilemma:

> *Continuing to talk about one resistant resident, [Edie, a CNA] said "she beats the living daylights out of me", miming how she pulls her hair, grabs her gait belt and uses the end of it to bash her. She said her head still hurts from one blow that she received. She also said "I'm afraid she's going to fall when she's doing that [i.e. resisting] ... Luckily she's small enough I can pick her up and put her on the bed – I <u>know</u> I'm not supposed to" [looking at Ilene, the CNA who was training me, as she emphasised] "but – I'm not going to let her fall!"*
>
> (Fieldnote, Richardson's, Shift 4)

Edie's solution in this case was not ideal from a person-centred point of view, in that it did not directly address the cause of the resident's distress, nor from a regulatory perspective, since she violated the care plan. However, she was clearly motivated by the intention to safeguard her resident. This example thus illustrates the difficulty of finding a path through the work which honours, to any extent, the preferences of the resident while also expediting the process, avoiding violence, and preventing harm.

Similarly, mealtimes were another opportunity for residents to exercise some control, if only by choosing whether or not to eat. Particularly at Forest Lodge, where the emphasis on

autonomy had been most successfully incorporated into the lexicon of practices, this sometimes produced a dilemma between respecting residents' choice and meeting their nutritional needs. In the following excerpt, a carer (Maddie) talks about a new resident (Tamsin), who was suffering from depression:

> *She talked at length about more appropriate options for Tamsin, because even upstairs, she has no interaction with other residents, most of whom either are unable to talk or have dementia. She also talked about how, over the course of the day, she discovered how to interact with Tamsin in a way that seemed to work – she didn't hover over her, she gave her space, but then when it came to mealtimes, she was quite firm about sitting down to eat. She talked about how Tamsin could starve to death otherwise, because staff would keep bringing the meals back untouched and writing "refused" on the sheet (gesturing to the counter where the meals sheets always sit) – not necessarily because Tamsin doesn't want to eat but because she's realised that saying no is the easiest way to get people to leave her alone.*

<div align="right">(Fieldnote, Forest Lodge, Shift 24)</div>

Rather than simply accepting Tamsin's refusal to eat as a "choice" – which might be justifiable from an over-simplified person-centred perspective – Maddie interpreted it instead as a proxy for her preferences for solitude and peace, which she attempted to honour in other ways. Again, this example illustrates the considerable work that was required (if not always undertaken as diligently) to identify and accommodate residents' preferences in the context of their medical and other needs.

In the conversation with Aimee quoted earlier (Section 8.2.1), she went on to tell me that "*we have the law on our side if it's for their benefit*". This seemed to suggest that the regulatory context supported staff's efforts to find a balance between respecting residents' autonomy and protecting health and wellbeing. However, my observations suggest that this sentiment was not widely shared among carers; rather, there was a pervasive sense of vulnerability to legal reprisals if anything went wrong, regardless of whether they had acted for their residents' benefit or not. Most carers, in other words, did *not* feel that they had "*the law on [their] side*".

## 8.3.2 *Culture of safety or culture of blame?*

A "culture of safety" in health care, as advocated in the Institute of Medicine's influential report *To Err is Human* (Kohn et al., 2000), acknowledges the systemic causes of medical errors and accidents and promotes open dialogue and mutual learning as the solutions (Gruneir and Mor, 2008). By contrast, the system of external oversight of nursing homes, particularly in the United States but increasingly in England, espouses a "blame and shame" approach whereby detection or disclosure of errors leads to negative legal, financial, and social consequences (Castle and Sonon, 2006; Hughes and Lapane, 2006; Scott-Cawiezell et al., 2006). The MDS in the United States, for example, is ostensibly designed to facilitate ongoing assessment and quality improvement, particularly since the focus was broadened from strictly clinical issues by the introduction of Quality Indicators (1999) and Quality Measures (2002). However, the MDS simultaneously plays a policing function, highlighting problems to surveyors and consumers and leading directly to negative consequences. This bifurcated purpose "bucks a basic tenet of continuous quality improvement, that the data

required to improve care should not be used to punish the service providers" (Rahman and Applebaum, 2009, p. 730).[58]

This "blame and shame" approach – especially in combination with the mistrust deriving from media reports and/or personal experiences – perpetuates an assumption that bad practice is the norm in nursing homes. To show otherwise, nursing homes must avoid accidents and errors – and their legal consequences, which are "secondary risks" along with financial implications and loss of reputation (Hillman et al., 2013, p. 951) – at all costs. Risks are thus constructed "backwards", as mentioned at the beginning of the chapter, from their worst-case outcomes; a process which also includes ascribing accountability for those outcomes. That is, if a particular outcome obtains, there is already inscribed an assumption about who is responsible for producing it by mismanaging the risks involved.

All of this has deleterious consequences for efforts to promote resident autonomy, as suggested by Kapp (2003a, p. 202):

> Many nursing homes act – correctly or not – as though respecting the decisional rights of residents, especially decisions to take risks, will expose those residents to harm and therefore expose the provider to malpractice claims brought by family members or regulatory citations and sanctions at the hands of state surveyors or federal prosecutors if the risks should materialize.

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[58] It is worth noting that the MDS-RAI has been developed for use internationally and, although there are not yet any well-established demonstration sites for use in care homes in the UK, the MDS for home care *has* been used (Carpenter and Stosz, 2008). This may have implications for future monitoring and regulation of the LTC context in the UK.

This is not an unreasonable assumption given that, for example, a staggering 91 per cent of American nursing homes were cited for deficiencies each year from 2005 through 2008 (Levinson, 2008).

The following scenario from Richardson's illustrates the influence of the regulatory context on the carers' own experience and management of incidents and accidents. One evening, a resident with dementia (Ruth) fell when she tried to get out of bed. Nadine was Ruth's CNA, and her usual strategy had been to put Ruth into bed, then sit outside the room for several minutes to make sure that she had settled. That night, however, she had stepped away from her post to help transfer another resident, then "*came back right away and found her on the floor, curled up, smiling*" (Fieldnote, Richardson's, Shift 6). A new motion-sensor alarm on Ruth's bed, which should have been triggered when she swung her legs to the floor, had failed to activate because it had not been set properly.

Nadine was called in the next day to fill in an incident report. When she arrived, she told the other staff that she had been expecting the call; "*either that or I'd get hauled into the office when I got here*". In addition, we were all required to complete a "read and sign" in-service training, which meant reading the safety specifications for the new alarm system, which were highlighted in yellow to emphasise the key messages, then signing the last page. The unit coordinator also took us into Ruth's room for an impromptu tutorial about the alarm. While we were there:

> [T]he unit coordinator said something to which Nadine replied in a deadpan way
>
> "*or lose your job*" – and that's when it became clear to me that she was

*considered directly responsible and was worried about her individual consequences. The unit coordinator was quick to reassure her that it would take something <u>very</u> serious for someone to lose their job – saying that Richardson's will "always give you the benefit of the doubt" and "trust me, I've been here 20 years". She rattled off what <u>could</u> happen in consequence, with "<u>maybe</u> a suspension, if they have to" as the implied worst-case scenario.*

(Fieldnote, Richardson's, Shift 6)

Later in the shift, as staff continued to discuss Ruth's fall, one of the nurses said "*that's state-reportable*", which meant that it might lead to a follow-up investigation.

*Nadine's face dropped, and she started asking what it would mean for "State" to come in, what will they do, will they take her in a room and interrogate her? Yolanda [another CNA] said "this is your first one?! Girl, let me give you a card!" like it's a rite of passage to be audited in this way. Nadine repeated the sequence of events again, and the others reassured her, saying to "tell them what you just told us". There was some discussion about how the alarm had been installed without staff being shown how it works, which seemed to be seized on as the root of the problem. During this conversation, Nadine also repeated the unit coordinator's speech from earlier, saying "she said I could be suspended" as if that had been her main message.*

(Fieldnote, Richardson's, Shift 6)

Nadine clearly felt that she would be considered culpable for this accident, to the point of taking the unit coordinator's effort to reassure her (as I heard it) as, instead, corroboration of the danger that she was facing: "*she said I could be suspended*". This was compounded by the nurse's observation that this incident was now "reportable" according to a change in state requirements. The more seasoned staff, including Yolanda, did not disabuse Nadine of the assumption that she would be held responsible, but treated this as inevitable rather than calamitous: accidents will happen, carers will be held responsible, but the work will go on.

Notably, all of this – Nadine's discomfiture, the endless discussions, the incident report – transpired even though Ruth sustained no immediate or subsequent damage from the fall. This could suggest good reflective practice, whereby an incident with a fairly benign outcome was used to trigger discussion about what went wrong and what could be done differently in future. However, under the looming threat of legal sanctions, the discussion focused entirely on defining responsibility and avoiding blame, primarily by emphasising the lack of training about the alarm.

The following exchange between two aides, Eden and Yolanda, further illustrates the precarity – and potential consequences – of CNAs' position in the "name and shame" game:

> *Eden: Like, our – we hold our licence very, very closely. You do – she could have*
>
> *our licence, for the least little thing.*
>
> *Yolanda: That's right – and I need my license [laughs].*
>
> *E: Yes!*
>
> *Y: To go further in my career.*

*E: If you lose your license for something like that –*

*Y: That's right –*

*E: You get black-balled, you're –*

*Y: Just for anything.*

*E: – <u>done</u>. And that's, and that's not even just medic-, you know, in the medical field. You lose your licence –*

*Y: Everything come up, in your life, it does, it falls back.*

(Interview, Richardson's, Eden and Yolanda)

It is clear that the stakes are high: not only might a CNA lose their job if found guilty of malpractice, but they might also lose their certification. This would end their nursing-home career as well as decreasing their chances of getting a job in any other field that requires references and/or a background check.

It was clear from my own experience how quickly the emphasis on legal safeguarding came to define my understanding of good practice, as indicated in the following fieldnote:

*Very near to the end of my shift, I answered Diane's call light. She needed help to get to the toilet ... When I had her stand up and walk back to her wheelchair, I suddenly became very worried that maybe she was supposed to be two-assist rather than one, and slightly panicked that she might fall, and it would be my (legal) fault for not following the care plan.*

(Fieldnote, Richardson's, Shift 9)

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As I recorded this incident in my fieldnotes, I reflected with some surprise that, whereas I would have expected to be guided by an instinctive impulse to protect the resident from harm in that moment of danger, I was actually (or at least simultaneously) thinking of my *own* safety: "*it seemed that I was more worried about being held responsible if she fell rather than worried that she actually would fall*".

This indicates how legal safeguarding becomes incorporated into carers' habitus, generating practices that might not *make sense* to an outsider. Consider the following example from my last shift at Richardson's:

> *Anita [a CNA] … called me into one resident's room, where I saw that the resident was on her knees facing her recliner. "Did you fall?", Anita asked her, and she replied, "I just sort of slid down". "Well, we'll still have to report it," Anita said, and then said that she'd have to stay there until the nurse came in to check. I said that I could go get the nurse and Anita said that she'd tried but she was on the phone. After a minute or two, Anita said to me that I should go ahead and take my break, since "this is going to eat into our time". I said okay and left her with the resident.*
>
> (Fieldnote, Richardson's, Shift 30)

In this scenario, the resident probably sustained more discomfort by kneeling on the floor than from the initial accident. However, according to safeguarding requirements, we had to keep her in that position until the nurse could assess her and then fill in the appropriate report. Anita's comment that "*we'll still have to report it*", stated in a somewhat chastising tone to

the resident, suggests that she was following the business logic in this moment, whereby incidents are defined by their reporting requirements as much as by their severity. She made no acknowledgement that this made much less sense from the point of view of the resident, who had *not* actually fallen or sustained any injuries, and just wanted to return to her chair.

Although the broader monitoring and regulatory context had a significant influence on practices at Forest Lodge as well, as suggested by one nurse's statement that "*we're in a litigation world now*", there seemed to be more room for interpretation on a case-by-case basis. For example, Aimee (quoted above), discussed the process of documenting incidents as a "balance":

> *... Doug's got a bruise on his hand, which I have to write about, now, [another resident] held him by – but there was no violence involved, but if you – I'm not going to do an incident form, because it's not an incident, it's not an accident, they're just holding hands ... and he's just probably squeezed a bit too much. It needs to be written down but, you don't want to kinda go all, oh God, there's been a, you know, something's happened, you know, and it's balance, balancing, making decisions all the time.*

> (Interview, Forest Lodge, Aimee)

Aimee's comments suggest that there was more scope for engaging with the meaning and outcomes of incidents *in context* at Forest Lodge than at Richardson's, where incidents were defined almost exclusively in terms of their legal reporting requirements.

This appeared to lead to more opportunities for learning, as suggested by the following fieldnote from Vintage Vale:

*While I was helping Trisha [a carer] move Doris [a resident] to her bed sometime after supper, she told me that she's only had two accidents here at Forest Lodge in four years. She started talking about this because she told me, as we were using the stand-aid to transfer Doris, that she once had someone slip out of the harness ... She said it was awful when the resident slipped out, she cried "for an hour and half afterwards", to the point that the nurse had told her to "pull yourself together". I asked if she knew what had gone wrong and she said that, looking back, she does – she said they asked her to reflect on the incident a couple of weeks later, not in a punitive way (she told me), but in order to think through "what would you have done differently". She said that these machines require the resident to bear weight, and the resident in question had diarrhoea that day, so she'd "been lifting her on and off the toilet all day" – so she should have realised that the resident would be getting tired and wouldn't be able to stand anymore. She said that she knew the resident got dizzy in the full hoist, which she was trying to avoid – which meant, she said, that she was using her heart rather than her head rule the decision. (i.e. in her heart, she wanted to avoid using the full hoist because it made the resident uncomfortable, but in her head she should have known that, for safety's sake, the hoist was required.) She said that the resident slipped onto the chair and from there to the floor, so she didn't hit her head or suffer any injuries – but she still cried a lot about what*

*might have happened. From then on, she told me, she has always lifted someone*

*over a chair or the bed – "I never <u>ever</u> leave them dangling".*

<div align="right">(Fieldnote, Forest Lodge, Shift 14)</div>

It is important to note here that Trisha's immediate response was emotional: she cried about "*what might have happened*" and because she felt personally responsible. Although Trisha was particularly emotive (as mentioned in previous chapters), the tone of her reaction was shared by carers across both research sites: simply put, it was upsetting when accidents happened. (As Edie, a carer at Richardson's, said in her interview when describing her refusal, as a different facility, to engage in unsafe practices for the sake of efficiency: "*[If] anything ever happened, I would not be able to live with myself*".) This indicates that there was certainly an emotional as well as a legal dimension to the work that went into managing risk and promoting autonomy, for many if perhaps not all carers.

Importantly, however, after her initial reaction, Trisha was asked to think back and identify how she might have handled the situation differently. With hindsight, she reflected that concern for her resident's comfort and dignity had eclipsed her assessment of her changing medical needs – "*she was using her heart rather than her head rule the decision*". She determined that, although it was not the resident's usual preference, it would have been better to use the hoyer on this occasion in order to ensure her safety. Through this reflective process, Trisha distilled a clear maxim for the future, which was to "*never <u>ever</u> leave them dangling*" – a maxim that might not have had as much power if learned in the classroom rather than through direct, meaningful experience.

However, although the UK climate may have been less punitive, staff at Forest Lodge were certainly not immune to the vulnerability felt by aides at Richardson's, as expressed by Eric:

> *Can I just say, that I feel, as a carer, as a lowly, as the <u>lowest</u> of the low in this organisation, um, that I've, I strongly suspect that, uh, the organisation likes to have it <u>all</u> ways, whereby, um, it is easy for them to transfer blame downwards, and to cover themselves if something goes wrong – and we all know nowadays that there's no such thing as an accident, somebody's always got to be to blamed for an accident, um, and I just feel as a carer, I feel incredibly vulnerable, potentially, for example, if something happened while I was meant to be in charge, if it was an oversight in my, on my part, or somebody had an accident cuz I was looking elsewhere, conceivably, my whole – well, personal reputation it is, but my whole life could be changed by a law suit, or something where I was allegedly neglectful – uh, where I would often feel that the issue is to do with staffing levels! ... Yeah, basically, what I'm trying to point out is, as, that on the lower rung of it all, your, the risks you are running with your life, for, to be paid <u>so</u> <u>little</u>, are huge. .. And uh, I'm wary here that I do know as a, as um, you know, a bottom, or a low-, lowly employee that, um, I would be hung out to dry if anything went wrong "on my watch". I would get no backing. It would automatically be assumed that I was neglectful in some way – that would be the default position.*
>
> <div align="right">(Interview, Forest Lodge, Eric)</div>

Eric suggests that even in the case of a "pure" accident, which cannot be traced to an individual's deliberate actions but may relate instead to a broader contextual issue such as

staffing, someone must be assigned blame in this increasingly litigious environment. As the
*"lowest of the low"* – with relatively little invested in their training, remuneration, or
employment benefits – carers at Forest Lodge also felt that they were the ones most likely to
be *"hung out to dry"*, an unsurprising perception given the tone of most media coverage of
care homes in the United Kingdom as well as the United States.

Related to this sense of instability, which can be read as a lack of control over the bigger
picture, was the carers' sense of limited control over their immediate work practices. Granted,
the previous chapters have suggested that carers exercised a certain amount of "practical
autonomy" in their role, in terms of organising the minutiae of care delivery according to
their individualised knowledge of the residents. However, this was a precarious autonomy
that was always subject to abrogation by nurses or management. Thus carers were in a
contradictory position when it came to translating autonomy into practice: on the one hand,
they were expected to devolve more choice and control to their residents, allowing them as
much autonomy as possible in their daily lives. On the other hand, carers appeared to exercise
very little control, themselves, over their own work activities and outcomes. As Edie said:

> *If you're working with a nurse and you see somebody going downhill and you say,
> well, "so-and-so doesn't want to go to the dining room tonight" and they tell you
> "well, that's too bad, because the rules are, they go to the dining room", and the
> next day they end up passing away – that's, that gets me. That's – it just …
> infuriates me.*

> (Interview, Richardson's, Edie)

This excerpt reveals Edie's sense of powerlessness in the hierarchy, as she felt that her attempts to fulfil her resident's wishes were easily thwarted from above. Although the example of a resident dying may seem melodramatic, in fact several residents had recently passed away, so it seemed like a timely reflection of the intensity of her feelings.

A further dimension of this relative powerlessness was the carers' marginal role in monitoring and reporting processes. This relates to the issue raised in Chapter 6, which was that carers were required to undertake extensive documentation without fully appreciating its importance or function; as one carer admitted, "*to be honest, I don't really know what they do with that information, all I do is put it in the computer, and I don't ever look at it again*" (Interview, Richardson's, Daria). By the same token, carers were expected to fill in incident reports, and to have their work scrutinised during inspections, without knowing very much about the reasons or outcomes thereof.[59] Thus, it is unsurprising that their participation in these processes was characterised by defensiveness and fear rather than open engagement, reflection, and learning.

Consider the following fieldnote from Richardson's, which briefly describes a conversation about writing an incident report on a resident's unexplained bruise:

> *Rachel [a CNA] was saying "why do I have to write anything?" and Nancy [a nurse] said, "because you were the one who found her." Rachel asked what she*

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[59] In what was identified as the first study to examine safety issues in LTC homes from the perspective of nursing staff (including nurses and CNAs), Hughes and Lapane (2006) found that only two in five nursing assistants were told what happens as a result of incidence reporting "most or all of the time". In addition, one in five reported feeling "punished" as a result, and two in five claimed that the reporting of errors was seen as a "personal attack".

*should write, "I found a bruise on her hand?" Nancy told her to write what you*

*were doing at the time (i.e. what type of care). ... Then there were some jokes*

*about abuse – I was punching her, and it was on the third punch that I noticed the*

*bruise on her hand…*

(Fieldnote, Richardson's, Shift 11)

These macabre jokes alluded to a sense of bemusement about reporting procedures in this punitive legal environment, particularly at Richardson's. Like Rachel, CNAs were often unsure about what to write on incident reports, due to wariness about incriminating themselves. At the same time, it was clear that no-one who had deliberately engaged in malpractice would admit to it in an incident report. Therefore, a question seemed to hang in the air: what good did the report serve if it only recorded staff's innocence and ignorance?

## 8.4   Discussion: Promoting whose autonomy?

This chapter has argued that in the context of strict external oversight and associated reporting requirements, one of the carers' primary responsibilities was to avoid any "risks" that might incur legal sanctions (DeForge et al., 2011). This responsibility was not inconsistent with a personal desire to protect residents, but was nonetheless driven largely by the logic of protecting the facility and themselves (rather than protecting the residents *per se*). In this context, there was no question of applying the person-centred ideal of "promoting autonomy" directly into practice. Rather, notions such as independence, choice, and self-determination were meaningful only insofar as they supported rather than challenged the imperatives of safeguarding and risk avoidance. This was particularly true at Richardson's, in

the context of extensive federal and state-level nursing-home regulations, whereas there was more leeway for carers at Forest Lodge to balance risk and resident autonomy. In addition, enhanced training at Forest Lodge around promoting autonomy for those with diminished capacity provided discursive guidance for carers, particularly those working on Vintage Vale, that was not available to the aides at Richardson's. On the other hand, the increased time pressure on staff at Richardson's, together with the individualisation of their workload, further encouraged practices which kept residents "safe" at the expense of their freedom, mobility, and indeed personhood, as seen with the example of Noreen.

It is important to emphasise this notion of *balance*, as carers were shown to be the main arbiters of moment-by-moment risk and safety decisions, often at the intersection of other priorities. Consequently, the carers held a certain amount of symbolic power; it was up to them whether or not to "pull the plug", as in the bathtub example. At the same time, the onus was on them to provide opportunities for residents to express their personhood through their choices and actions, rather than subjugating them entirely to risk-avoidance regimes. This power, however, was strictly delimited by the carers' precarious position in the field. If erring on the side of autonomy resulted in an accident – for example if a resident who wished to walk unassisted subsequently fell – carers felt that they would assume the blame. Conversely, there were no obvious repercussions for erring on the side of safety; as long as residents were clean, dry, well-fed, and unharmed, and their care was appropriately documented, then the carers' work was complete in terms of measurable outcomes. Therefore, although they clearly invested effort in juggling safety and autonomy, the balance more often – and unsurprisingly – tipped in favour of risk-avoidance.

The arguments in this chapter support claims that nursing homes are a long way from the "culture of safety" that is being encouraged – albeit not yet fully embraced – across health care. Accidents and errors persist, as both the statistical evidence and my own observations show, but there is very little opportunity or incentive within the system for staff to report, discuss, and learn from these adverse events, or even from those events that are narrowly prevented – due to the "culture of blame" that is reproduced from national-level inspection, reporting, and funding practices through the micro-level of daily practice. From the point of view of care assistants, there are two secondary issues involved, however, which deserve particular attention: *inclusion* and *discretion*.

It has already been suggested that although carers played a central role in the *tasks* of documenting care and reporting incidents, they were effectively excluded from the broader practices that make these processes meaningful to residents' care. Therefore, their participation tended towards the bare minimum of "paper compliance" (Rahman and Applebaum, 2009), often with bemusement or resentment about the extra workload, and primarily in self-defence rather than in the spirit of reducing risks and improving residents' safety and quality of life. This, in turn, exacerbated the "us versus them" atmosphere that characterised interactions at Richardson's in particular: one CNA shift against another, CNAs against management, and even CNAs against residents. This last point echoes what Hillman et al. (2013, p. 950) found in their ethnographic study of risk-governance practices on acute wards for older people: "Patients, as a consequence of this blame culture, become an embodied representation of staff's potential culpability". Carers had to protect themselves from the enemies that threatened their job security from every side.

By contrast, and drawing on the evidence from Vintage Vale, efforts to enhance carers' *inclusion* in the bigger picture of care might augment their risk management and reporting practices. That is, through meaningful rather than peripheral involvement in practices such as handover and/or care-planning conferences, carers might come to *know* risk and safety, vis-à-vis resident autonomy, differently – as something for which the whole team shares responsibility *and* about which each member of the team has valuable insight and experience. This reflects the findings from (highly successful) safety practices in the aviation industry, from which health-care has heavily borrowed, that flattening hierarchies and sharing responsibility as a team has positive effects on safety (Lewis et al., 2011; Vogus et al., 2010). This claim also echoes the arguments made by Colón-Emeric and colleagues (2010), who found that regulatory practices among CNAs varied by how they were communicated. When managers emphasised the purpose behind the regulations, more *mindful* practices occurred; that is, staff engaged with the regulations in more thoughtful and deliberative ways. By contrast, when emphasis was placed on the consequences of non-compliance, the ensuing practices were more automated. In other words, the regulation of nursing homes will not change overnight. However, the way that CNAs *engage* with those regulatory requirements, in terms of their own efforts to balance safety and autonomy, might change according to how they are involved in the organisational practices which serve them.

The second issue is *discretion*, which relates to the notion of practical autonomy that has already been discussed. Risk-governance systems are designed to standardise practices, minimise uncertainties, and thereby increase the rationality, predictability, and safety of the system. Referring back to the aviation industry, a key safety practice has therefore been to "mistake-proof" the work: this "refers to designing a system so that the user finds it difficult

or impossible to make a mistake" and "aims to prevent human errors caused by forgetfulness, lack of experience, sloppiness, misunderstanding, or inattention" (Lewis et al., 2011, p. 19). But caring work, of course, entails a relational and communicative dimension which cannot be accounted for by "rules and mechanisms" (Brown & Calnan, 2010, p. 21) nor fully standardised or rationalised. Rather, it requires some discretion on the part of the individual carer.

This discretion is implied by the values statements associated with PCC, such as in the Eden Alternative's principle about devolving decision-making "into the hands of the Elders or into the hands of those closest to them", and also in the Pioneer Network's claims, for example, that "each person can and does make a difference" and "risk-taking is a normal part of life". Similarly, the system of enhancers and detractors characterising person-centred dementia care assumes a central role for care staff in balancing different factors in order to promote empowerment and collaboration, for example, rather than disempowerment and objectification.

And indeed, it has been shown that carers did exercise a certain amount of discretion in their work, in the "weak" (and often unrecognised) sense (see Cheraghi-Sohi and Calnan, 2013) of exercising judgement rather than applying rules mechanistically when organising daily care and negotiating different priorities, albeit from a position of vulnerability and self-defence. But rather than standardising practice to an extent that almost entirely edges out this discretion, as regulatory systems threaten to do in the effort to reduce errors, the alternative is to recognise and support this aspect of carers' role. In his study of older persons' autonomy, McCormack (2001, p. 441) found that nurses play a primary role in drawing together the

universal principles of autonomy together with their knowledge of the individual in order to "maximise opportunities for growth and the making of authentic decisions, i.e. decisions that are representative of the person's life as a whole … to prevent the reduction of the person to a 'thing' and to maintain personhood". Similarly, as implied in the statements listed above, care assistants play a critical role in particularising the abstract values of PCC. To overlook or attempt to minimise this discretion risks deskilling staff – undermining rather than supporting their efforts to communicate with residents and fulfil their role in translating individualised knowledge into actual autonomy.

# CHAPTER 9: CONCLUSION

> *"Old age, they say, is a gradual giving up. But it is strange when it all happens at once. That is a real test of character, a kind of solitary confinement. Whatever I have now is in my own mind."*
>
> *(Sarton, 1973, p. 14)*

These lines are taken from May Sarton's *As We Are Now*, a short, piercingly honest novel which chronicles the experiences of 76-year-old Caro Spencer following her move to Twin Elms, a small nursing home in rural New England. The story is told through Caro's diaries, which reveal her desperate but determined struggle to preserve her sense of self, indeed her soul – "*What do I mean when I use that word? Something deep down, true … the intrinsic being that is still alive even when memory goes*" (Ibid., p. 19, original emphasis) – in an unfamiliar and isolated environment, devoid of emotional connections, that strips her of all outward markers or reflections of identity and personhood.

The landscape of long-term care (LTC) has changed considerably since the publication of *As We Are Now*. Throughout the intervening decades, developments in legislation, clinical knowledge and practice, and consumer advocacy have galvanised improvements not just in clinical standards but also with relation to residents' dignity, privacy, and overall quality of life. However, the transformation from "*confined, dreadfully lonely*" (Ibid., p.26) institutions to home-like settings that are "inspired by the richness of close personal relationships and the healing power of community" (Thomas, 2006, p. 220) is far from complete.

Person-centred care (PCC), also known as "culture change", provides a way to articulate what is needed to achieve this transformation. One approach with countless variations, PCC

comprises a range of principles and practical applications, underpinned by a fragmented and incomplete evidence base. At the heart of PCC, as described in Chapter 2, is the renunciation of exclusively clinical and/or impersonal care in favour of an individualised approach that recognises and reflects the unique and enduring personhood of each care-home resident, particularly through the provision of opportunities to exercise independence, choice, and self-determination.

The aim of this study was to explore how PCC translates into practice, focusing particularly on the day-to-day work of care assistants, in order to learn something new about knowledge-translation processes (in an understudied setting, with a marginal group of staff) as well as about PCC itself. Admittedly, I embarked on the research with considerable scepticism about the idea of PCC: it sounds good, but so does motherhood and apple pie. Is it just another catchphrase? An abstract, empty concept? A bandwagon to jump on and then abandon, with disillusionment, somewhere down the road?

As stated in the Preface, these misgivings shifted as I found myself accompanying my father on his own, unexpected journey into LTC. I became further convinced about the significance of PCC after spending time at Richardson's and then Forest Lodge, the two case studies for this research, and periodically witnessing episodes of care – rare enough to stand out, but frequent enough to show promise – that promoted dignity, respected individual needs and preferences, and affirmed personhood, all within the parameters of the institutional context.

It should therefore go without saying that this thesis has not been, nor was it ever intended to be, an exposé of nursing-home practices, an insider's account of what happens behind closed

doors and privacy curtains. I was fortunate to conduct my research in two facilities that are manifestly committed to delivering holistic, high-quality care using a person-centred approach. This provided me the opportunity to learn about the considerable challenges and inevitable setbacks that characterise even the most well-meaning attempts to implement PCC. From this basis, I have told a story not of sensational scandal, but of the much more mundane compromises, balances, lapses, and exceptions that mark the situated effort to translate an idea, a piece of evidence, or a fragment of knowledge into practice.

This concluding chapter will begin by revisiting the aim and objectives of the study and summarising the guiding themes identified from the literature on knowledge translation (KT). The next section will discuss how these themes iteratively informed the development of a practice-based approach to data collection and analysis, highlighting the unique contribution to KT studies afforded by this theoretical perspective. Section 9.3 will summarise the study's key findings as presented under the three broad themes of individuality, time, and autonomy, identifying differences between the two research settings and drawing out the implications of these findings for future attempts to implement PCC. Subsequently, the chapter will discuss these findings in light of the three issues highlighted from the KT literature, namely the nature of knowledge, the social relations of knowing, and the importance of context. Throughout the discussion in these two sections, the study findings will be compared and contrasted with recommendations set out in recent policy documents in both countries, in order to highlight how this research contributes to the broader conversation about improving LTC for older people. The chapter will conclude by discussing research outputs and future research directions.

## 9.1    The research questions, revisited

This study was designed around three objectives, which were to describe how care assistants acquire and develop new knowledge, in this case knowledge about PCC; to assess the significance of personal and contextual factors on this process; and in a reciprocal sense, to highlight how this knowledge might translate "out" to the broader care team.

These objectives guided my review of the literature on KT, which covers a broad disciplinary terrain and draws on a diverse range of theoretical approaches. Unifying this literature is the fundamental understanding, as stated in Chapter 3, that "the dissemination of knowledge is not synonymous with the utilization of knowledge" (Farkas et al., 2003, p. 48). Proceeding from this basis, countless models and frameworks have been developed to capture how knowledge or evidence is disseminated, diffused, translated, transferred, exchanged, implemented, and/or utilised. Altogether, these models and frameworks highlight a multitude of themes, antecedents, actors, processes, conditions, barriers, and so on which may be taken into account. Much of this scholarship, in parallel with the evidence-based practice movement itself, has been pursued within the paradigm of logical positivism, with the intention of testing hypotheses, identifying causal relationships, and producing replicable, generalisable results (Rycroft-Malone, 2007). Other KT researchers have challenged this positivist approach on ontological and epistemological grounds, however. One target of critique has been the fundamental assumption of a "gap" between evidence and practice. Nursing scholars Doane and Varcoe (2008), for example, argue that theory, evidence, and practice are *interconnected*, such that interpreting and translating evidence are not ways of knowing but rather ways of *being* and *relating*. In their words, KT occurs not as a linear

transfer of intellectual commodities but through an "embodied process of ontological inquiry and action" (Ibid., p. 283).

As argued in Chapter 3, very little KT research has been conducted in LTC settings, nor has there been much attention focused on non-professional nursing staff who, although increasingly relied-upon across health and social-care settings, are least likely to read journals, attend conferences, discuss research with colleagues, and perhaps deliberately engage in "reflective practice" (Schön, 1983). Therefore, it seemed appropriate to adopt an exploratory design for the current research, drawing broadly on lessons learned from existing KT research rather than applying or testing one specific approach. This seemed particularly apposite since the "knowledge" in question is not a single evidence-based intervention, such as for example "bathing without a battle" (Sloane et al., 2006) or multi-sensory "snoezelen therapy" (van Weert et al., 2006), but a complex set of ideas and approaches that is still being developed and tested.

Accordingly, three main (interrelated) themes were distilled from the KT literature to guide this research, which will be briefly restated here. The first related to the *nature of knowledge* itself. Across KT studies, from Rogers's (2003[1962]) diffusion of innovations theory to the PARiHS model of research implementation (Kitson et al., 2008), it is clear that *what* is being translated – the attributes of the knowledge or evidence in question – matters. More broadly, the ontological nature of knowledge matters. Rather than assuming that knowledge is a discrete commodity that can be packaged and transferred intact from one setting or actor to another – as many KT research designs implicitly do – the literature suggests that we must

instead examine knowledge as an inherently unstable, multidimensional concept that is continuously contested and thus transformed through implementation.

The second theme was the *social relations* of knowledge. Many KT studies presuppose the existence of individual practitioners who assess and apply or reject new ideas or evidence with more or less rationality and autonomy. Certainly, individuals bring prior assumptions, understandings, and experiences to bear on their decision-making processes. However, as effectively demonstrated by Gabbay and Le May (2004) in their study of decision-making among physicians and nurses in general medicine, this process is socially constituted. Social interaction and engagement, in other words, plays a defining role in the uptake of new knowledge. According to overlapping research on "situated learning", this is because learning itself is an intrinsically social process which has as much to do with developing identities as with cognitive processing.

The third theme was the *context* of KT. According to the evidence-based paradigm, context is a confounding variable that must be controlled to the extent possible. But many KT studies show that *what* is translated is inseparably tied to *where* it is translated. That is, the specific, unique elements and interactions that characterise each setting are "precisely what determine the success or failure of a dissemination initiative" (Greenhalgh et al., 2004, p. 615).

## 9.2    A practice-based perspective on knowledge translation

Given this understanding of knowledge as unstable, social, and contextualised, and in dialogue from the first day of fieldwork with the research data, a practice-based theoretical

approach seemed most germane to the analysis of this research. Overall, this meant examining practices as the basic unit of analysis. As Schatzki (2001, p. 3) puts it, "the social is a field of embodied, materially interwoven practices centrally organized around shared practical understandings", and thus *practices* are where meaning and explanations should be sought. Bourdieu's concepts of *habitus*, *capital*, and *field*, in particular, helped identify the *sens pratique*, or practical logic, which guides action in any given setting.

Complementing this notion of practical logic, the theory of institutional logics was used to help explain variation among ostensibly similar practices, even those fulfilled by the same carer in different moments. This theory suggests that *institutions*, which are simultaneously material and symbolic, inscribe certain logics which are instantiated through particular practices. These logics structure our attention, endow us with a sense of collective identity, and provide vocabularies of classification and power. The important point is that more than one institutional logic may coexist within a particular field of practice, in cooperative or conflicting ways. My observations suggested that the LTC field is characterised primarily by the logics of the home, the medical facility, and the business, with varying influence on the intentions and outcomes of particular practices.

Thus the analysis has been guided by attention to the practical and institutional logics which guide carers' actions, taking into consideration the distribution of power (or "capital") across each setting. In adopting this practice-based perspective, this study makes two broad contributions to theoretical and empirical studies of knowledge translation. First, this approach provides a way to transcend individualist explanations, common in media accounts but also implicit in some research approaches, that inflate practitioners into "saints or

monsters" (Foner, 1994), although without resorting to structural explanations that reduce them to dupes of their working conditions. Instead, it has been proposed that KT can be examined in terms of the practical logic that guides action, which arises from the recursive relationship between an individual's habitus, or internalised disposition, their position within the field, and their available capital.

Second, this practice-based approach helps identify and explain the variable implementation – and in some cases non-implementation – of new ideas by highlighting the influence of interconnected and overlapping practices and institutional logics, while also providing insight into how further changes may be achieved. Just as practitioners' actions are structured by the *doxa* of the field as well as through their own habitus, so they produce and reproduce the field by their actions. When thoughtfully managed through opportunities to reflect on and deliberate between the different logics which guide practice, this dialogue between structure and agency may be the basis of implementing improvements in the delivery of care.

Overall, theory underpinned the sociological contribution of this research on two levels. First, and broadly speaking, the Bourdieusian approach provided a well-developed way into the dialogic relationship between theory and method that characterises ethnographic research. That is, as argued in Section 5.5.2, the first moment of fieldwork in an ethnographic study is already a moment of decision-making, interpretation, and analysis. Thus theory is the "precursor, medium, and outcome of ethnographic study and writing" (Willis and Trondman, 2000, p. 396) – not in the sense of grand theory or abstract reason, but as a practical tool for identifying questions, collecting data, and developing explanations. In this study, Bourdieu's conceptual tools and his theory of practice helped me navigate the research context and

understand the data as it emerged through my participation, observation, note-taking, reflection, and interpretation. It helped me see and interrogate, as Bourdieu (1990a, p. 20) puts it, the "non-theoretical, partial, somewhat down-to-earth relationship with the social world that is the relation of ordinary experience". By making explicit in this thesis my use of a Bourdieusian theoretical/methodological orientation, I have attempted to clarify for the reader *how* I engaged in that interrogatory process. Second, the mid-level theory of institutional logics provided a set of specific criteria by which to make sense of particular situated events and encounters – a specificity not provided by Bourdieu's conceptual tools. The theory helped explain, in other words, why individuals acted in certain ways (and not others), beyond recognising that these actions and their associated accounts were produced through practical engagement in a particular field from a particular position within that field. This helped to develop a richer understanding of how knowledge moves and evolves within organisational settings, with reference to logics that may inform the most quotidian encounters while also extending well beyond them.

By "using" theory in this bifurcated sense, this study contributes to the sociological understanding of knowledge, learning, and practice as intertwined, mutually constitutive social phenomena that are inextricably linked to the formation and maintenance of personal and collective identities. Closely aligned with the work of Nicolini (2011), Lave and Wenger (1991), and others cited in Chapters 3 and 4, the particular contribution of this research is to bring a new set of vibrant, nuanced empirical evidence from a particular organisational context into dialogue with these ideas about situated learning and knowing-in-practice. More broadly, given that this study focused on an occupational group that is largely female, working class, and racially/ethnically diverse – and one which provides care for our oldest

and most dependent older people – the research links to broader sociological discussions of the relationship between power, knowledge, and identity. Because the main focus here has not been to critique and extend theory, but rather to selectively employ theoretical tools in the development of an empirical analysis, there remains significant scope for more theoretically driven research that interrogates the connection between habitus/field/capital and institutional logics. By focusing on the comparable and contrasting ways that knowledge about PCC translates into practice in different contexts, this study has demonstrated the clear potential for further theory development and testing along these lines.

With the theoretical orientation described here, the three separate, somewhat chronological research objectives (related to learning, implementation, and practice) were drawn together into one overarching question, namely: through what mechanisms does PCC become meaningful, practicable, and sustainable in care assistants' practice in the context of LTC? The following section will summarise the "answers" that have been developed in this thesis.

## 9.3 Implementing person-centred care: Summary of findings

By the end of months of ethnographic fieldwork in two different settings, I had constructed a data-set that was rich with detailed observations and candid reflections — but also extensive, unwieldy, and overwhelming. Through careful line-by-line coding, I began to corral the data into themes and, from there, to build the broader argument. This was a selective process, requiring decisions at every stage about what to include and where. My final decision was to structure the thesis around three principal, but fairly abstract, concepts from across the PCC literature that I had also identified, through the coding process, as key practices at both

research sites: putting the individual first, taking time to care, and promoting autonomy. For each of these broad concepts, I focused on how they were communicated to and understood by care assistants; that is, the emphasis was on their "face value" rather than their philosophical or theoretical foundations. The analysis was guided by the theoretical approach laid out in Chapter 4 (as summarised above), but with somewhat different emphases in each empirical chapter: thus, the first chapter highlights in particular the importance of symbolic capital, the second draws out the differential influence of institutional logics, and the third emphasises the interconnectedness of practices in the organisational setting.

Focusing on these three concepts required, necessarily, a lesser focus on other PCC concepts including, for example: dignity (Tadd et al., 2010); privacy (McColgan, 2005); relationships, community, and reciprocity (Nolan et al., 2006); and meaningful occupation (Kitwood, 1997a). The implication is *not* that these elements are any less important to the provision of PCC; in fact, some (such as dignity) may be of a higher order, spanning across the concepts discussed here. However, because these elements were less prominent as themes in the coded data, they were not chosen as joists for the main structure of the thesis. Their lesser prominence in the analysis may relate in part to my exclusive focus on carers' practice rather than residents' (phenomenological) experience; efforts to individualise care, for example, are easier to identify from this perspective than is the quality of community among residents. Nonetheless, it should be acknowledged that another researcher might have identified different themes from the data and structured the analysis accordingly.

### 9.3.1 Putting the individual first

Identifying the person behind the disease, putting the individual at the heart of care, accounting for personal histories, needs, and preferences: these are all indivisible and essential strands comprising the core of PCC. In short, it is necessary to see each *person* (not just interchangeable "inmates") in order to provide *person*-centred care.

It was clear from my observations that carers did develop an impressive stock of "individualised knowledge" through their direct practice with residents, with their habitus mediating the meaning and significance of this knowledge. However, it was also clear that there was no direct causal link between individualised knowledge and the provision of PCC; that is, such knowledge could also be enacted for primarily instrumental purposes, to manage residents rather than personalise their care. Chapter 6 argued that the different applications of individualised knowledge related, in part, to conflicts between the institutional logics guiding practice: is meeting a particular expectation of the job, for example, antithetical to individualised care in a particular scenario?

This chapter also argued that the extent to which individualised knowledge fulfilled person-centred or conventional, managerial purposes also depended on a set of related practices around communication and teamwork, which were organised somewhat differently (with different outcomes) at the two facilities. At Richardson's, it appeared that consistent staffing practices – in the context of long-entrenched distinctions between staff (the "shift wars", the "wing wars", and nursing staff versus the "carpet people"), and given CNAs' marginalised role in formal communication practices – produced a managerial approach to resident care. "Knowing the resident", which aides spoke about frequently, transpired to a large extent as

"managing the resident". At Forest Lodge, by contrast, varied shift patterns and flexible teamwork, together with an emphasis on carers' participation in formal communication processes *and* informal knowledge-exchange practices, supported to a greater extent the delivery of individualised care.

The main conclusion in this chapter was that carers' exclusive knowledge about individual residents served as an important source of "symbolic capital" since, although not as highly valued as other forms of knowledge, it was nonetheless essential to the organisation and delivery of care. This had implications for their inclination to share or withhold knowledge, as well as influencing the (more or less person-centred) ways that it was implemented, within the context of other (supportive or undermining) practices.

### 9.3.2 Taking time to care

In conventional LTC settings, institutional rhythms and routines predominate, with regularity, predictability, and efficiency the defining characteristics. By contrast, in PCC, flexibility and adaptability of routines are seen as essential, in order to individualise care, allow opportunities for independence, and combat the risk of boredom and malaise.

My findings confirmed, to a certain extent, the assumption that there is simply not enough time, given current staffing resources, to transcend routine-driven approaches in LTC or indeed any health-care context. This may be a truism, but it takes time to "take time". However, on a more nuanced level, the tempos of practice at each facility seemed to vary according to the divergent influence of institutional logics. At Richardson's, the (primarily) cooperative logics of the business and the medical facility predominated, as evidenced in the

emphasis on completing tasks, meals, and other routine events quickly and according to schedule. Supper was scheduled for five; if it was served at five minutes past the hour, or concluded any later than 5:30, complaints could be heard among the aides. This adherence to routine related in part to the "heavy" case load at Richardson's: ensuring that every resident received their requisite care allowed very little scope for flexibility or adaptation. Routinisation was required to get the job done, in other words. But it was also because Richardson's, located in the American LTC context, was indisputably a *medical* facility, where maintaining hygiene, nutrition, hydration, and other aspects of physical care were of paramount importance. This importance was inscribed in the computer documentation system, which reinforced the CNAs' accountability for each resident on their "card". It *made sense* for carers to follow routines, completing prescribed tasks at prescribed intervals, in order to demonstrate that they were fulfilling their job requirements. Conversely, there was no obvious reward for resisting the routine, if this risked leaving any "chartable" task undone.

At Forest Lodge, there was variation in the tempo of practice between the two units. Upstairs, where residents required more nursing care, the medical imperative was evident in the adherence to toileting routines, repositioning schedules, and so on. This resonated with the evidence from Richardson's but to a lesser extent, with some more room for flexibility – reflecting the teamwork approach and the lesser demands of documentation at Forest Lodge. On Vintage Vale, where residents required the least physical assistance, carers were most likely to "take time to care": sitting with residents, engaging them in conversation and activities, encouraging independence, and so on. However, there were concerns that the home-like tempo of practice on Vintage Vale, which looked most like the successful implementation of PCC, was undermining the provision of adequate medical care; for

example, some residents were missing breakfast because the slow morning routine meant that they were not getting up until lunchtime, which was causing concerns about nutrition among the nurses. With the change in management that was underway as I concluded fieldwork, there was evidence that the balance of institutional logics on Vintage Vale was shifting. For some carers, this move towards a higher degree of routinisation was perceived as a move *away* from the person-centred logic that they had embraced, and as a threat to their limited control over the organisation of care.

The main conclusion in Chapter 7 was that, although routines may be necessary in residential-care contexts in order to fulfil medical priorities, the different influence of institutional logics did afford some opportunity for carers to organise their care differently. This represented a source of control or "practical autonomy" over their work which could be exercised for more or less person-centred outcomes, depending on what made sense within the context of other practices.

### 9.3.3   Promoting autonomy

The term "autonomy" was used in Chapter 8 in a broad sense to capture the importance, in PCC, of providing opportunities for residents to exercise independence and make choices, even with reduced capacity due to cognitive impairment. My findings suggest that the concept had translated most effectively on Vintage Vale, where the specialised training on person-centred *dementia* care provided staff with the discursive and practical resources (and justification) for promoting autonomy among residents. There was least evidence of resident

autonomy at Richardson's, as argued with reference to the case study of a new resident whose "helplessness" was constructed from the moment of her arrival.

The central argument in this chapter was that efforts to promote (or limit) autonomy must be examined in light of other practices which link outward to the external regulatory context of LTC. It was suggested that regulation of the LTC sector has engendered a "culture of blame" that carers experience as a personal threat to their job security. This was particularly true in the American setting, where fear of investigation and possible loss of certification among aides encouraged their primary emphasis on safeguarding residents and managing risks; practices that also aligned with the priority on completing work efficiently under time pressure. It *made sense* – at every level of the organisation – to keep individuals safe at any cost. At Forest Lodge, there was more tolerance of risk but there were hints that this situation might be shifting in light of external changes; both carers and nurses spoke about feeling personally vulnerable since, as one nurse said, "*we're in a litigation world now*". The difference between the two facilities was reinforced by the internal practices already discussed; that is, carers' integration into communication practices at Forest Lodge appeared to engender a sense of shared problem-solving and responsibility, whereas at Richardson's, the individualised workload aligned with a sense of individualised culpability for any problems that might arise.

A main thread of the argument in Chapter 8, echoing the concluding claim from Chapter 7, was that carers' *own* autonomy was important to the autonomy of their residents. Promoting autonomy required carers to balance safety against risks; and maintaining that balance entailed myriad minor decisions throughout every shift. Carers drew on their own practical

autonomy, or discretion, and their individualised knowledge of the residents, as well as their awareness of safety regulations, in making such decisions. Efforts to further standardise practice in the interests of maintaining safety and avoiding errors, this chapter suggested, might undermine this limited practical autonomy – incurring resistance from staff as well as impacting their ability to promote any degree of autonomy among their residents.

## 9.4 Lessons learned: Knowledge translation and person-centred care

Having summarised the study's findings about the complexities of translating three particular elements of PCC into daily practice in LTC, the next section will draw out the broader contributions of this study to our understanding about KT and PCC in this setting. Throughout the discussion, which is structured according to the three themes identified in Chapter 3 (and summarised above), comparative links will be made to the conclusions and recommendations set out in recent reports and policy documents relating to care assistants and/or LTC.

### 9.4.1 What is knowledge?

It has already been stated that PCC is, rather than a single intervention, an amorphous collection of principles and practices, evidence and anecdote, which makes it difficult to identify and evaluate in any particular setting. This is exacerbated by the limited research on complex person-centred interventions, as described in Chapter 2 – which leaves the field rich with ideas about PCC but relatively poor in terms of evidence about their operationalisation and implementation.

Attempts to introduce, test, and transfer knowledge about PCC are further complicated by the proliferation of available approaches and models. A particular issue identified in my research was the different emphasis placed on *dementia* in the discourse of PCC in the two national contexts. The implied norm in the American approach is a rational, independent older adult with specific needs, which left staff with little guidance about how to adapt PCC for those with limited or decreasing capacity. The UK person-centred tradition, drawing on the work of Tom Kitwood and the Bradford Dementia Group, is much more focused on the relational challenge of preserving personhood in the face of cognitive decline. This may help explain why PCC was most clearly implemented on Vintage Vale, the specialised dementia unit at Forest Lodge, but seemed to have less salience on the upstairs nursing unit (where dementia was prevalent but not predominant).

Furthermore, evidence from both settings suggests that the idea of PCC has not been sufficiently developed to account for the challenges of caring for people with profound and multiple needs, both physical and mental. That is, as stated in Chapter 2, residential care is generally the last resort for those who can no longer receive care in the community due to the severity of their needs. Double incontinence, immobility, obesity, contractures, dementia, depression, communication deficits, behavioural concerns: these are the characteristics, in differing combinations, of many LTC residents. It may be possible to recognise their personhood abstractly, but what about in practice, under time pressure, and through the necessary indignities of physical manipulation and intimate bodily care? I identified in my own practice, at times, a sense of total impotence with regards to the practicalities of delivering PCC in these circumstances, especially when I was feeling tired, impatient, frustrated, or unsupported.

This relates to the recommendation, echoed across numerous reports, for enhanced education and training for frontline staff. A primary, timely example is the Cavendish Review, which was commissioned by the UK Secretary of State for Health in the wake of the 2013 Francis Inquiry into the Mid-Staffordshire hospitals scandal. The remit was to "review what can be done to ensure that unregistered staff in the NHS and social care treat all patients and clients with care and compassion" (Cavendish, 2013, p. 5). The report makes recommendations under four main headings, including "recruitment, training and education"; one of these is the development of a new "Certificate of Fundamental Care" as a prerequisite for direct practice. The findings from my own research suggest that such recommendations must be underpinned by clear guidance about the content and delivery of training. In particular, training must reflect the fact that caring is particularly embodied and affective work (acknowledging the theoretical claim in this thesis that all practices are embodied and affective). If care is to be person-centred, that is, then the goals of PCC must be articulated not only in abstract terms but through specific, relevant, actionable examples which honestly address the physical and emotional challenges and conflicts involved.

There is some recognition of this in the CNA training course in the United States, to the extent that classroom teaching is complemented by hands-on "skills practice". However, skills practice is still undertaken – at least at Rosemont – under ideal conditions, with unlimited time, a compliant "resident", sufficient supplies, and so on. Perhaps as a result, the PCC approach learned in this environment failed to translate "on the shop floor", where I observed that CNA students were immediately socialised into more conventional practices.

By contrast, the person-centred dementia training at Forest Lodge *did* seem to impact practices on Vintage Vale, in that carers continued to explicitly draw on the training content in their attempts to implement PCC on a daily basis. This suggests an example of best practice in training for frontline staff that bears further examination and replication.

### 9.4.2   The social relations of knowledge translation

The emphasis on better education and training tends to assume, like some KT approaches, the primacy of individual intellect, rationality, and action. And indeed, following Bourdieu, it is possible to observe an "individual" aspect to the uptake of knowledge in the workplace, insofar as each worker brings their own habitus to the role; this impacts how they learn and integrate new ideas, such as for example PCC. My findings suggested that habitus mediated carers' understanding and delivery of care in a number of ways. For example, their understanding of the caring role was structured by previous or concurrent caring experiences; their knowledge of the residents was informed by the social distance between them, in terms of factors like socioeconomic status, race, and language; and their uptake of PCC was influenced by what they already understood about concepts such as privacy, dignity, autonomy, and independence. All of this impacted their situated learning, which was the process by which they learned to become competent carers; thus, some carers prioritised cleanliness and medical care, others emphasised choice and independence, while others focused on task efficiency.

However, the social relations structuring the LTC field were shown in this research to have significant influence on the exchange and implementation of knowledge. As the primary

providers of daily hands-on care, care assistants developed a stock of "individualised knowledge" which, because it was critical to monitoring, reporting, and planning processes, represented an important source of symbolic capital. However, as relatively low-status workers, carers were largely excluded from these broader practices, beyond the tasks of following care plans and completing daily documentation. This meant that they were effectively being asked to provide holistic, non-task-based care on the one hand, but on the other hand to fulfil tasks that had no meaningful connection to the provision of this care.

Considering their knowledge as symbolic capital within a field where the balance of power otherwise seemed stacked against them helps explain why carers may have been resistant to accruing new knowledge, either about individual residents or about PCC, if this was perceived as threatening their own authority. This point supports recommendations around recruitment and retention efforts which highlight the importance of recognising and valuing care assistants' work. The Cavendish Review (2013, p. 10), for example, states that caring should be considered a career and advocates for a "robust career development framework". The *Delivering Dignity* report (LGA et al., 2012, p. 24) likewise argues that "having recruited staff, there needs to be a strong focus on training on the job, along with providing a rewarding working environment which recognises good performance and is set within a sound career structure". In the United States, several states have developed culture-change initiatives which focus on promoting the profile of care assistants; one example is the NC WIN A STEP UP programme, which stands for the "North Carolina workforce improvement for nurse aides: Supporting training, education, and payment for upgrading performance program" and was developed in response to a crisis in workforce retention. Although these are all examples of attempts to address the broader, pressing issue of workforce retention

(Fujisawa and Colombo, 2009), the evidence here suggests that recognising and rewarding staff for the knowledge and skills that they exercise – and providing more opportunities for their meaningful engagement, rather than overlooking or attempting to co-opt their knowledge and skills without recompense – will also enhance efforts to transfer knowledge, implement evidence-based practice, and improve PCC.

### 9.4.3 The importance of context

Learning and KT are social practices which must be located within the *context* (or field) of care. Other elements of context identified in this research included the organisation of the team, training and induction practices, the use of spaces and equipment, formal and informal mechanisms of communication, and broader funding and regulatory practices. Although the deeply interconnected nature of these contextual elements seemed more likely to produce path dependency than radical transformation, the theory of institutional logics (which provide different vocabularies, priorities, justification, and even identities within and across practices) helped identify the potential for – and occasional examples of – incremental change. For one thing, considering institutional logics encourages us to think about where the rewards and sanctions of the work can be found. Are these entirely informed by the business logic of completing quantifiable tasks within set time parameters? If so, where is the incentive for carers to adopt more flexible or person-centred approaches, drawing on alternate logics? Likewise, this theoretical approach encourages us to identify and address those areas where segmentation or competition between logics occur; an example would be the safety/autonomy issue which was almost impossible for carers to resolve without guidance and support.

Perhaps most importantly, this theory orients us towards the significant work that carers put into balancing and sometimes choosing between different logics. If carers are encouraged to reflect on this balancing act, individually and collectively, rather than being left to struggle alone, they may be more empowered to make "choices", albeit constrained choices, between different logics within particular care tasks. In this way, without changing their practice dramatically, carers may attain modest increases in the delivery of PCC.

This point inverts, to some extent, the priority placed in recent reports and recommendations on ensuring that carers have appropriate attitudes and values. For example, under the "recruitment, training, and education" theme, the Cavendish Review (2013, p. 10) recommends that "employers should be supported to test values, attitudes and aptitude for caring". Similarly, the Nursing and Care Quality Forum (2012, p. 10) advocates "making sure that the right culture and the right values that put the people we care for first prevails at all times" by "testing for values", and *Delivering Dignity* (LGA et al., 2012, p. 24) suggests that "recruiting based on attitudes and values" will help address the "underlying causes of poor care". Such recommendations put the focus back on individuals rather than the context of care; indeed, *Delivering Dignity* (Ibid., p. 25) goes on to claim that:

> All care home staff must take personal responsibility for putting the person receiving care first, and staff should be urged to challenge practices they believe are not in the best interests of residents… It is individual decisions to do the right thing that ultimately change an organisation's culture.

My research has suggested that, although screening for values during recruitment may be the first step, a much bigger challenge is to support and guide staff in their navigation of the

different values that are available within the workplace, according to different institutional logics.

This relates to a final point, made in some recent reports and implicit in the PCC approach, which is that more information about how to balance different logics is required from residents themselves. During my own caring practice, as I struggled to find the right balance, I often tried to project myself into the residents' position: would I rather be left sleeping in a wet pad, or awakened in the night to be changed? Would I rather be spoken to warmly but patronisingly, or kept at a formal, respectful distance? But robust evidence would be preferable to this kind of guesswork. An American report (Capitman et al., 2005, p. 41) speaks to this issue when comparing assisted living to nursing-home care:

> Do assisted living residents actually prefer greater safety risks and less attention to management of their health conditions? Do nursing home residents really prefer sacrificing aspects of 'the good life' for better attention to their health needs? … The National Commission for Quality Long-term Care and others could foster a real national debate on these issues that seeks to articulate a clearer basis for quality LTC… Whatever the outcome, continued progress in LTC quality assurance appears to require development of a new consensus on the best resolution to the current quality of life/quality of care divide.

Similarly, the OECD report *A Good Life in Old Age* (2013, p. 26) affirms that, although regulatory controls are currently the primary mechanism for improving LTC internationally, "there are questions regarding how to strike the right balance between standardisation of assessments and tailoring of care to individual needs and circumstances, especially as concepts such as quality of life and patient-centredness gain momentum". Likewise,

*Prepared to Care* (All-Party Parliamentary Group on Dementia, 2009, p. xiii) recognises that the "personalisation agenda" has implications for staff working with people with dementia:

> There was much debate about how to balance the need for safeguards with the opportunities for choice and control presented by the personalisation agenda. The Group agrees that it is vital for people with dementia and carers to be involved in any debate about taking forward the personalisation agenda and, in particular, issues around training.

The report provides no specific recommendations about achieving this balance, but again affirms the need to include service-users' views. An important initiative in this regard is the Quality and Outcomes of person-centred Care Policy Research Unit (QORU), a research collaboration funded since 2011 by the Department of Health in England with the remit of: engaging people with long-term conditions in research; identifying ways of measuring their experiences and the effects these conditions have on their quality of life; and finding the most appropriate ways to apply and use this information to guide policymaking and practice.

In conclusion, the broad contributions of this research can be summarised as follows:

- To translate is to transform; meaning does not travel intact from one setting to the next, but develops *in situ*. This includes knowledge about PCC.
- The translational/transformational process occurs through the practices that constitute a particular setting, or "field", which are themselves located within broader networks of practice. These practices are physical and embodied as well as "embrained" (Blackler, 1995), entail ways of thinking and feeling as well as acting, and may reflect/instantiate one or more institutional logics.

- The distribution of power, or "capital", across a particular field both structures and is reproduced (or changed) through these interconnected practices.

- In the field of LTC, nonprofessional nursing staff hold very little visible power. However, their individualised knowledge of residents, their discretion over the organisation of daily care, and their embodied competence represent three important sources of symbolic capital which may be supported or threatened by the introduction of new knowledge or practices (which may, accordingly, be embraced or contested).

- This account of the dynamic interplay of habitus, capital, field, and institutional logics highlights several situated opportunities for intervention. New "ways of knowing" may be generated through changes to particular practices, for example by altering the organisation of the team or specific communication processes. Providing structured opportunities for reflexivity, by which staff can "objectivate" the otherwise taken-for-granted *doxa* of their workplace, may also help identify and generate different ways of working according to different guiding logics.

- The key message, then, is not to assume that importing new ideas, evidence, or knowledge into a particular setting through targeted dissemination efforts alone will achieve desired practice changes if those ideas do not *make sense* within the complex web practices, logics, and power relations within which staff identify themselves as competent practitioners.

- This necessarily implies more participatory approaches to KT about PCC which involve staff in identifying and implementing changes that are meaningful and sustainable.

## 9.5 Dissemination and future directions

In any academic research – but perhaps particularly in a study engaging with knowledge translation – it is incumbent on the researcher to demonstrate "impact" through vigorous dissemination efforts. In this study, dissemination is being pursued through a number of channels, including but not limited to academic conferences and peer-review journals. Select findings have already been presented at local, national, and international conferences, a comparative paper on PCC is currently under review, and a publications strategy has been developed. Beyond these academic channels, it is important to consider how to share the research findings with other stakeholders, including care assistants and nurses, care-home managers/administrators, residents and their families, and/or interested members of the general public. Examples of dissemination efforts already undertaken include: a blog post on the "time to care" theme from this research (Scales, 2012); an art-gallery talk on PCC (summarised by Birkbeck (2013)); and a webinar for the Institute for Person-Centered Care, offered for professional-development credits to nursing-home practitioners (Scales, 2013). Furthermore, I have committed to sharing the research findings directly with Richardson's and Forest Lodge through brief reports and also, if they choose, through in-person feedback sessions with staff. Communicating the research findings back to care assistants, through language that is relevant, accessible, and non-confrontational, seems particularly important, both in the spirit of what Foley (2002, p. 484) calls "linguistic reciprocity" and to avoid reproducing the purported gap between knowledge and practice which gives rise to this field of investigation in the first place.

It is also important to note the future research directions arising from this study. First and foremost, more research on PCC as a complex psychosocial intervention is required,

proceeding from the argument developed in this study that our understanding of *what works* must explicitly take into account the needs and preferences of the nursing-home population, but also the constraints of the institutional context, the pressures on staff of time, routine, and competing demands. As this evidence becomes available, further research will be required to evaluate how it is transferred to and transformed in specific care settings, in order to refine our knowledge about how to encourage and support sustainable practice change, thereby ensuring that LTC practice becomes evidence-based to the extent that is possible and desirable.

The findings from this study corroborate the need, as identified in Chapter 3, for participatory-action research in this setting (McWilliam et al., 2009; Shura et al., 2011). Through action research, care assistants and other LTC actors could participate in the entire research process, from identifying problems to developing and implementing relevant, practicable solutions. Rather than *pushing out* new ideas, the emphasis would be on *pulling in* the situated knowledge and experiences of staff. Another, admittedly challenging, level would be to incorporate LTC residents in action research in order to ascertain their views on appropriate care; this suggestion extends the call for user research made in the previous section. The Caledonian Development Model, developed from longitudinal action research on attaining evidence-based nursing care for older people, provides a useful example (Tolson et al., 2008), but much more work could be pursued in this area.

A third area for future research, bridging the findings of this exploratory study to the considerable work already undertaken around KT in other care settings, is the robust testing of current translation models in LTC. One example, currently underway, is a five-year

longitudinal study testing the PARiHS model (see Chapter 3) in care homes in Canada (Estabrooks et al., 2009), which closely parallels my own study but using quantitative as well as qualitative methods. Similar research could be usefully undertaken in the two countries featured in this research, as well as elsewhere. This relates to the need, more broadly, for comparative research examining how ideas about PCC are developed, tested, and implemented differently in other national contexts; such research would help expand the "social conditions of possibility" (Bourdieu, 2003, p. 282) for PCC in local settings.

Finally, this research has indicated the need for more research into specific areas of complexity and/or conflict in the delivery of PCC, particularly on the cross-cutting practices of auditing, monitoring, and regulation; and evaluation of specific educational and communication interventions, such as carers' report, consistent assignment versus flexible teamwork, and on-the-job versus online training.

## 9.6    In conclusion…

Bill Thomas (2006, p.219), the founder of the Eden Alternative, calls himself a committed abolitionist, stating "I hope to be present when the lights go out on America's last nursing home". Similarly, I sometimes worry that my focus on institutionalised care equates to a kind of myopia – because maybe the whole notion of nursing-home care is anachronistic. Maybe such "total institutions" need abolishing before we can hope to truly achieve person-centred care. Maybe. But this will require sweeping changes to the social relations of advanced capitalism which produce them. Meanwhile, nursing homes are where people like my Dad, and the fictional Caro Spencer, spend their days. Such people rely on care assistants for

everything from intimate daily care to social interaction. Therefore, until a radical transformation occurs beyond and within the LTC sector, recognising care assistants' situated knowledge and supporting incremental changes in their practice may be the best ways to achieve meaningful improvements in their residents' quality of life.

## APPENDIX: INFORMED CONSENT FORM

**TITLE OF RESEARCH – Knowledge translation among direct care staff in long-term care**

**What is the purpose of this study?**

The purpose of this study is to understand how staff who care for residents in nursing homes learn to do this important job. We want to know more about the opportunities and barriers staff face in developing, using, and sharing their knowledge about best practice, particularly person-centered care.

**Who is doing the study?**

This study is being conducted by Kezia Scales, a PhD student in Sociology at the University of Nottingham (UK). Her PhD supervisors are Prof. Justine Schneider and Prof. Ruth McDonald at the University of Nottingham, and she is supported by Dr. Davina Porock at the School of Nursing at the University at Buffalo (USA).

**What will happen if you decide to participate in this study?**

If you agree to participate, Kezia Scales (who has prior training and experience as a care assistant) will join you on the job and may observe and/or assist you in your tasks. You may be included in observational notes and you may be asked to take part in a one-to-one or group interview that will last approximately one hour, although you may choose to decline to be included in notes or to participate in an interview. The interview will be audio-recorded, with your permission. Informally and/or in an interview, the researcher will ask you questions about your training, your experiences working in long-term care, and your understanding of person-centered care. None of this data will be shared with anyone else in the facility.

**What are the possible benefits of being in the study?**

You have been invited to contribute your personal understanding and experience of providing long-term care for older people. Taking part in the study will give you the opportunity to reflect on your knowledge, skills, and experiences in this job. Through participation, you will also contribute toward efforts to improve the way that long-term care services for older people are provided in the future.

**What are the possible risks of being in the study?**

You will be asked to reflect honestly on your care practices and experiences, which may potentially cause you discomfort or distress, although that is not the intention. All information that you share will be kept strictly confidential and anonymous. If you agree to participate in a focus group, the researcher will request that other participants in the focus group not share information with people outside the group but cannot guarantee that other participants will maintain confidentiality outside the group.

**If you have any questions or problems, who can you call?**

If you have any questions, concerns or complaints about this study, you can call the investigator, Kezia Scales, at 07972 465764, or by email at Kezia.Scales@nottingham.ac.uk. You can also contact her Supervisors at the University of Nottingham:

Professor Justine Schneider  
Tel: 0115 846 7307  
Email: Justine.Schneider@nottingham.ac.uk

Professor Ruth McDonald  
Tel: 0115 823 0588  
Email: Ruth.McDonald@nottingham.ac.uk

**What information is kept private?**

Your individual privacy will be maintained in all published and written data resulting from the study. Observational data will be typed up anonymously using pseudonyms. The interviews will be audio-recorded, with your permission, and transcribed anonymously. Your identity, which will be available only to the researcher and her supervisors, will remain completely confidential. The data will be kept in a locked room where it will remain for approximately seven years following the completion of the project, then destroyed.

In order to monitor the ethical conduct of this research study, representatives from the Office of Human Research Protection (a federal agency) or from the Human Research Protections Program at

the University at Buffalo <u>may</u> inspect the research records. This process may reveal your identity to the auditor but your identity and information will continue to be kept in the strictest confidence.

**Can you withdraw from the study early?**

Your participation in this study is completely voluntary. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You are free to withdraw from this study at any point, without giving a reason and without any consequences. If you choose to withdraw, any information you have already provided will not be used in the analysis or reports/publications.

**Are there any costs or compensation involved with the study?**

There is no cost to you to participate in this study. If you agree to participate in an individual interview and/or focus group, you will be offered a small gift certificate for your time.

**Participant Consent**

By signing below, you agree to be in this research study. Your signature will indicate that you have decided to volunteer as a research participant; that your questions have been answered satisfactorily; and that you have read and understood the information provided above.

| | | | | |
|---|---|---|---|---|
| I agree to be observed and/or assisted by the researcher | Yes | ☐ | No | ☐ |
| I agree to be included <u>anonymously</u> in research notes | Yes | ☐ | No | ☐ |
| I agree to participate in a one-to-one interview | Yes | ☐ | No | ☐ |
| I agree to participate in a focus group interview | Yes | ☐ | No | ☐ |

_____      _____      _____
Print name                                    Signature                              Date (dd/mm/yy)

**Statement of Person Obtaining Consent**

I certify that the nature and purpose, the potential benefits and possible risks associated with participation in this research study have been explained to the above individual and that any questions about this information have been answered.  A copy of this consent will be given to the participant.

Kezia Scales (PI)              _____      _____
                                        Signature                              Date (dd/mm/yy)

-------------------------------------------------------------------------------------------------

**Audio-tape Release Form**

I give consent to be audio-taped during this study:

Please initial: \_\_Yes \_\_No

# BIBLIOGRAPHY

Administration on Aging. (2011). FY 2010 Report to Congress. Washington, DC: Department of Health and Human Services, AoA.

Agar, M. (1996). *The Professional Stranger: An Informal Introduction to Ethnography,* New York: Academic Press.

Agency for Healthcare Research and Quality. (2001). *The Characteristics of Long-term Care Users: Introduction* [Online]. Rockville, MD: AHRQ. [Accessed 30 August 2013].

AgeUK. (2013). *Later Life in the United Kingdom* [Online]. London: AgeUK. [Accessed 25 September 2013].

Aita, M., Richer, M. C. & Heon, M. (2007). Illuminating the processes of knowledge transfer in nursing. *Worldviews on Evidence-Based Nursing,* 4, 146-155.

All-Party Parliamentary Group on Dementia. (2009). Prepared to Care: Challenging the Dementia Skills Gap. London: Alzheimer's Society.

Allan, H. (2006). Using participant observation to immerse oneself in the field: The relevance and importance of ethnography for illuminating the role of emotions in nursing practice. *Journal of Research in Nursing,* 11(5), 397-407.

Allen, D. & Pilnick, A. (2005). Making connections: Healthcare as a case study in the social organisation of work. *Sociology of Health & Illness,* 27(6), 683-700.

Alzheimer's Society. (2007). Dementia UK: The Full Report. London: Alzheimer's Society.

Alzheimer's Disease International. (2013). *Dementia Statistics* [Online]. London: ADI. [Accessed 19 August 2013].

Alzheimer's Society. (2007). Home From Home: A Report Highlighting Opportunities for Improving Standards of Dementia Care in Care Homes. London: Alzheimer's Society.

Amann Talerico, K., O'Brien, J. A. & Swafford, K. L. (2003). Person-centered care: An important approach for 21st century health care. *Journal of Psychosocial Nursing and Mental Health Services,* 41(11), 12-16.

American Health Care Association. (2010). Report of Findings: Nursing Facility Staffing Survey. Washington, DC: AHCA.

Anderson, K. A., Taha, R. D. & Hosier, A. F. (2009). Know Thy Residents: An Exploration of Long-Term Care Nursing Staff's Knowledge. *Research in gerontological nursing,* 2(1), 69.

Anderson, R. A., Ammarell, N., Bailey, D., Jr., Colon-Emeric, C., Corazzini, K. N., Lillie, M., Piven, M. L. S., Utley-Smith, Q. & McDaniel, R. R., Jr. (2005). Nurse assistant mental models, sensemaking, care actions, and consequences for nursing home residents. *Qualitative Health Research,* 15(8), 1006-1021.

Angus, J., Hodnett, E. & O'Brien Pallas, L. (2003). Implementing evidence based nursing practice: A tale of two intrapartum nursing units. *Nursing Inquiry,* 10(4), 218-228.

Anspach, R. R. & Mizrachi, N. (2006). The field worker's fields: Ethics, ethnography and medical sociology. *Sociology of Health & lless,* 28(6), 713-731.

Appleby, J. (2013). Spending on Health and Social Care over the Next 50 Years: Why Think Long Term? London: The King's Fund.

Ashforth, B. E. & Kreiner, G. E. (1999). "How can you do it?": Dirty work and the challenge of constructing a positive identity. *Academy of Management Review,* 24(3), 413-434.

Astrom, S., Nilsson, M., Norberg, A. & Winblad, B. (1990). Empathy, experience of burnout and attitudes towards demented patients among nursing staff in geriatric care. *Journal of Advanced Nursing,* 15, 1236-1244.

Atkinson, P. & Hammersley, M. (2007). *Ethnography: Principles in Practice,* New York, NY: Routledge.

Audit Commission. (2013). Social Care for Older People: Using Data from the VFM Profiles. London: Audit Commission.

Ayalon, L., Arean, P., Bornfeld, H. & Beard, R. (2009). Long-term care staff beliefs about evidence-based practices for the management of dementia and agitation. *International Journal of Geriatric Psychiatry,* 24(2), 118-124.

Aylward, S., Stolee, P., Keat, N. & Johncox, V. (2003). Effectiveness of continuing education in long-term care: A literature review. *The Gerontologist,* 43(2), 259-271.

Bailey, S., Scales, K., Lloyd, J., Schneider, J. & Jones, R. (in press). The emotional labour of care assistants in secondary NHS dementia care. *Ageing and Society.*

Baldwin, C. & Capstick, A. (eds.). (2007). *Tom Kitwood on Dementia: A Reader and Critical Commentary,* Maidenhead: Open University Press.

Ball, M. M., Lepore, M. L., Perkins, M. M., Hollingsworth, C. & Sweatman, M. (2009). "They are the reason I come to work": The meaning of resident–staff relationships in assisted living. *Journal of Aging Studies,* 23(1), 37-47.

Barnes, B. (2001). Practice as Collective Action. *In:* Schatzki, T. R., Knorr Cetina, K. & Von Savigny, E. (eds.) *The Practice Turn in Contemporary Theory.* Abingdon and NY: Routledge, 17-28.

Baumbusch, J. L. (2008). *Decommissioning Citizenship: The Organization of Long-Term Residential Care.* PhD Thesis, University of British Columbia.

Baumbusch, J. L. (2011). Conducting critical ethnography in long term residential care: Experiences of a novice researcher in the field. *Journal of Advanced Nursing,* 67(1), 184-192.

Baumbusch, J. L., Kirkham, S. R., Khan, K. B., McDonald, H., Semeniuk, P., Tan, E. & Anderson, J. M. (2008). Pursuing common agendas: A collaborative model for knowledge translation between research and practice in clinical settings. *Research in Nursing & Health,* 31(2), 130-140.

Beauchamp, T. L. & Childress, J. F. (2008). *Principles of Biomedical Ethics (6th edition),* Oxford: Oxford University Press.

Beck, C., Ortigara, A., Mercer, S. & Shue, V. (1999). Enabling and empowering certified nursing assistants for quality dementia care. *International Journal of Geriatric Psychiatry,* 14, 197-212.

Beck, U. (1992). *Risk Society: Towards a New Modernity,* London: Sage Publications.

Becker, H. S., Geer, B., Hughes, E. C. & Strauss, A. L. (1961). *Boys in White: Student Culture in Medical School,* Chicago: University of Chicago Press.

Beeber, A. S., Zimmerman, S., Fletcher, S., Mitchell, C. & Gould, E. (2010). Challenges and strategies for implementing and evaluating dementia care staff training in long-term care settings. *Alzheimer's Care Today,* 11(1), 17-39.

Bentley, P. 2013. Agony of the care home residents left starving, desperate for water and locked in filthy rooms while staff ignored their cries. *The Daily Mail,* 16 September 2013.

Berdes, C. & Eckert, J. M. (2007). The language of caring: Nurse's aides' use of family metaphors conveys affective care. *The Gerontologist,* 47(3), 340-349.

Bergman-Evans, B. (2004). Beyond the basics: Effects of the Eden Alternative model on quality of life issues. *Journal of Gerontological Nursing,* 30(6), 27-34.

Bero, L. A., Grilli, R., Grimshaw, J. M., Harvey, E., Oxman, A. D. & Thomson, M. A. (1998). Closing the gap between research and practice: An overview of systematic reviews of interventions to promote the implementation of research findings. *British Medical Journal,* 317(7156), 465-468.

Berta, W., Teare, G., Gilbart, E., Ginsburg, L., Lemieux-Charles, L., Davis, D. & Rappolt, S. (2010). Spanning the know-do gap: Understanding knowledge application and capacity in long-term care homes. *Social Science & Medicine,* 70(9), 1326-1334.

Binder, A. (2007). For Love and Money: Organizations' Creative Responses to Multiple Environmental Logics. *Theory and Society,* 36(6), 547-571.

Birkbeck, F. 2013. Hubcaps, Heliotropes and Healing: Responses to The First Cut Exhibition at the Djanogly Gallery. *Institute of Mental Health Blog* [Online]. [Accessed 30 October 2013].

Bishop, C. E., Squillace, M. R., Meagher, J., Anderson, W. L. & Wiener, J. M. (2009). Nursing home work practices and nursing assistants' job satisfaction. *The Gerontologist,* 49(5), 611-622.

Blackler, F. (1995). Knowledge, knowledge work and organizations: An overview and interpretation. *Organization Studies,* 16(6), 1021-1046.

Bland, M. (2007). Betwixt and between: A critical ethnography of comfort in New Zealand residential aged care. *Journal of Clinical Nursing,* 16(5), 937-944.

Bloor, M. (2001). The Ethnography of Health and Medicine. *In:* Atkinson, P., Coffey, A., Delamont, S., Lofland, J. & Lofland, L. (eds.) *Handbook of Ethnography.* London: Sage Publications, 177-187.

Blustein, J. (1991). *Care and Commitment: Taking the Personal Point of View,* New York, NY: Oxford University Press.

Bonifas, R. P. (2008). Nursing home work environment characteristics: Associated outcomes in psychosocial care. *Health Care Financing Review,* 30(2), 19-33.

Booth, J., Tolson, D., Hotchkiss, R. & Schofield, I. (2007). Using action research to construct national evidence-based nursing care guidance for gerontological nursing. *Journal of Clinical Nursing,* 16(5), 945-953.

Boström, A. M., Wallin, L. & Nordström, G. (2007). Evidence-based practice and determinants of research use in elderly care in Sweden. *Journal of Evaluation in Clinical Practice,* 13(4), 665-673.

Bourdieu, P. (1984). *Distinction: A Social Critique of the Judgement of Taste,* Cambridge, MA: Harvard University Press.

Bourdieu, P. (1990a). *In Other Words: Essays Towards a Reflexive Sociology,* Stanford, CA: Stanford University Press.

Bourdieu, P. (1990b). *The Logic of Practice,* Cambridge, MA: Polity Press.

Bourdieu, P. (2003). Participant objectivation. *Journal of the Royal Anthropological Institute,* 9(2), 281-294.

Bourdieu, P. & Wacquant, L. J. D. (1992). *An Invitation to Reflexive Sociology,* Chicago: University of Chicago Press.

Bowen, G. (2008). Grounded theory and sensitizing concepts. *International Journal of Qualitative Methods,* 5(3), 12-23.

Bowen, S., Martens, P. & Need to Know Team. (2005). Demystifying knowledge translation: Learning from the community. *Journal of Health Services Research and Policy,* 10(4), 203-211.

Bowers, B. J., Esmond, S. & Jacobson, N. (2000). The relationship between staffing and quality in long-term care facilities: Exploring the views of nurse aides. *Journal of Nursing Care Quality,* 14(4), 55-64.

Bowling, A., Formby, J. & Grant, K. (1992). Accidents in elderly care: A randomised controlled trial (part 3). *Nursing Standard (Royal College of Nursing),* 6(31), 25-27.

Bransford, C. L. (2006). The use of critical ethnography in managed mental health care settings. *Journal of Sociology and Social Welfare,* 33(4), 173-192.

Brooker, D. (2004). What is person-centred care in dementia? *Reviews in Clinical Gerontology,* 13, 1-8.

Brooker, D. (2007). *Person-Centred Dementia Care,* London: Jessica Kingsley.

Brown, B., Crawford, P. & Carter, R. (2006). *Evidence-Based Health Communication,* Maidenhead: Open University Press.

Brown, J. S. & Duguid, P. (1991). Organizational learning and communities-of-practice: Toward a unified view of working, learning, and innovation. *Organization Science,* 2(1), 40-57.

Brown, P. & Calnan, M. (2010). The risks of managing uncertainty: The limitations of governance and choice, and the potential for trust. *Social Policy and Society,* 9(1), 13-24.

Brown Wilson, C., Davies, S. & Nolan, M. (2009). Developing personal relationships in care homes: Realising the contributions of staff, residents and family members *Ageing & Society,* 29, 1041-1063.

Buch, E. D. & Staller, K. M. (2007). The Feminist Practice of Ethnography. *In:* Hesse-Biber, S. N. & Leavy, P. L. (eds.) *Feminist Research Practice.* Thousand Oaks, CA: Sage Publications, 187-222.

Butler, R. N. (1987). Ageism. *In:* Maddox, G. L. & Atchley, R. C. (eds.) *The Encyclopedia of Aging.* New York, NY: Springer, 22-23.

Butterworth, C. (2003). Are we going 'stateside'? *Nursing Older People,* 15(5), 20-22.

Buus, N. (2006). Conventionalized knowledge: Mental health nurses producing clinical knowledge at intershift handovers. *Issues in Mental Health Nursing,* 27, 1079-1096.

Canadian Institutes of Health Research. (2004). *Knowledge Translation Strategy 2004-2009: Innovation in Action,* Ottawa, ON: CIHR.

Capitman, J., Leutz, W., Bishop, C. & Schneider, R. C. (2005). Long-Term Care Quality: Historical Overview and Current Initiatives. Washington, DC: National Commission for Quality Long-term Care.

Carmack, B. (1997). Balancing engagement and detachment in caregiving. *Journal of Nursing Scholarship,* 29(2), 139-143.

Carpenter, I. & Stosz, L. (2008). Developing the Use of "MDS-RAI" Reports for UK Care Homes. York: Joseph Rowntree Foundation.

Carper, B. A. (1978). Fundamental patterns of knowing in nursing. *Advances in Nursing Science,* 1(1), 13-23.

Caspar, S., O'Rourke, N. & Gutman, G. M. (2009). The differential influence of culture change models on long-term care staff empowerment and provision of individualized care. *Canadian Journal on Aging,* 28(2), 165-175.

Castle, N. & Sonon, K. (2006). A culture of patient safety in nursing homes. *Quality and Safety in Health Care,* 15(6), 405-408.

Cavendish, C. (2013). The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings. London: Department of Health.

Centers for Disease Control and Prevention. (2004). National Nursing Home Survey. Atlanta, GA: CDC.

Centers for Medicare and Medicaid. (2008[2002]). Revised Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 2.0. Washington, DC: DHHS.

Centers for Medicare and Medicaid. (2010). Nursing Home Data Compendium. Washington, DC: DHHS.

Chalfont, G. & Hafford-Letchfield, T. (2010). Leadership from the bottom up: Reinventing dementia care in residential and nursing home settings. *Social Work and Social Sciences Review* 14(2), 37-54.

Chapin, M. K. (2010). The language of change: Finding words to define culture change in long-term care. *Journal of Aging, Humanities, and the Arts,* 4(3), 185-199.

Chenoweth, L., King, M. T., Jeon, Y. H., Brodaty, H., Stein-Parbury, J., Norman, R., Haas, M. & Luscombe, G. (2009). Caring for Aged Dementia Care Resident Study (CADRES) of person-centred care, dementia-care mapping, and usual care in dementia: A cluster-randomised trial. *Lancet Neurology,* 8(4), 317-325.

Cheraghi-Sohi, S. & Calnan, M. (2013). Discretion or discretions? Delineating professional discretion: the case of English medical practice. *Social Science & Medicine,* 96, 52-59.

Cho, J. & Trent, A. (2006). Validity in qualitative research revisited. *Qualitative Research,* 6(3), 319-340.

Cohen, R. L. (2011). Time, space and touch at work: Body work and labour process (re)organisation. *Sociology of Health and Illness,* 33(2), 189-205.

Coleman, J., Katz, E. & Menzel, H. (1957). The diffusion of an innovation among physicians. *Sociometry,* 20(4), 253-270.

Coleman, M. T., Looney, S., O'Brien, J., Ziegler, C., Pastorino, C. A. & Turner, C. (2002). The Eden Alternative: Findings after 1 year of implementation. *Journals of Gerontology, Series A,* 57(7), M422-M427.

Colley, H., Henriksson, L., Niemeyer, B. & Seddon, T. (2012). Competing time orders in human service work: Towards a politics of time. *Time & Society,* 21(3), 371-394.

Colón-Emeric, C., Plowman, D., Bailey, D., Corazzini, K., Utley-Smith, Q., Ammarell, N., Toles, M. & Anderson, R. (2010). Regulation and mindful resident care in nursing homes. *Qualitative Health Research,* 20(9), 1283-1294.

Corradi, G., Gherardi, S. & Verzelloni, L. (2008). Ten Good Reasons for Assuming a 'Practice Lens' in Organization Studies. *OLKC Conference.* University of Aarhus, Copenhagen.

Corradi, G., Gherardi, S. & Verzelloni, L. (2010). Through the practice lens: Where is the bandwagon of practice-based studies heading? *Management Learning,* 41(3), 265-283.

Crandall, L. G., White, D. L., Schuldheis, S. & Amann-Talerico, K. (2007). Initiating person-centered care practices in long-term care facilities. *Journal of Gerontological Nursing,* 33(11), 47-56.

Crossley, N. (2001). The phenomenological habitus and its construction *Theory and Society,* 30(1), 81-120.

Cuddy, A. J. C. & Fiske, S. T. (2002). Doddering but dear: Process, content, and function in stereotyping of older persons. *In:* Nelson, T. D. (ed.) *Ageism: Stereotyping and Prejudice Against Older Persons.* Cambridge, MA: MIT Press, 3-26.

Cummings, G. G., Estabrooks, C. A., Midodzi, W. K., Wallin, L. & Hayduk, L. (2007). Influence of organizational characteristics and context on research utilization. *Nursing Research,* 56(4), S24.

Czarniawska, B. & Sevón, G. (1996). *Translating Organizational Change,* Berlin and New York: de Gruyter.

Dalton, M. (1959). *Men Who Manage: Fusions of Feeling and Theory in Administration,* New York, NY: Wiley.

Daly, M. & Lewis, J. (2000). The concept of social care and the analysis of contemporary welfare states. *British Journal of Sociology,* 51(2), 281-298.

Davies, C. (2003). Some of our concepts are missing: Reflections on the absence of a sociology of organisations in *Sociology of Health and Illness*. *Sociology of Health & Illness,* 25(3), 172-190.

Davies, S., Laker, S. & Ellis, L. (1997). Promoting autonomy and independence for older people within nursing practice: A literature review. *Journal of Advanced Nursing,* 26(2), 408-417.

De Laine, M. (1997). *Ethnography: Theory and Applications in Health Research,* Sydney: Maclennan & Petty.

Deer, C. (2008). Reflexivity. *In:* Grenfell, M. (ed.) *Pierre Bourdieu: Key Concepts.* Durham: Acumen Publishing Ltd, 199-212.

DeForge, R., van Wyk, P., Hall, J. & Salmoni, A. (2011). Afraid to care; unable to care: A critical ethnography within a long-term care home. *Journal of Aging Studies,* 25(4), 415-426.

Denzin, N. (2009). The elephant in the living room: or extending the conversation about the politics of evidence. *Qualitative Research,* 9(2), 139-160.

Department of Health. (2001). The National Service Framework for Older People. London: DOH.

Department of Health. (2009). Living Well with Dementia: A National Dementia Strategy. London: DOH.

Department of Health. (2013). The NHS Constitution. London: DOH.

Diamond, T. (1995). *Making Gray Gold: Narratives of Nursing Home Care,* Chicago: University of Chicago Press.

DiMaggio, P. J. & Powell, W. W. (1991). Introduction. *In:* Powell, W. W. & Dimaggio, P. J. (eds.) *The New Institutionalism in Organizational Analysis.* Chicago: University of Chicago Press, 1-38.

Doane, G. H. & Varcoe, C. (2008). Knowledge translation in everyday nursing: From evidence-based to inquiry-based practice. *Advances in Nursing Science,* 31(4), 283-295.

Dodds, S. (2007). Depending on care: Recognition of vulnerability and the social contribution of care provision. *Bioethics,* 21(9), 500-510.

Dopson, S. (2007). A view from organizational studies. *Nursing Research,* 56(4), S72-S77.

Dopson, S., FitzGerald, L., Ferlie, E., Gabbay, J. & Locock, L. (2002). No magic targets! Changing clinical practice to become more evidence based. *Health Care Management Review,* 27(3), 35-47.

330

Douglas, M. (2002). *Risk and Blame: Essays in Cultural Theory,* London and New York: Routledge.

Downs, M. (2013). Embodiment: The implications for living well with dementia. *Dementia,* 12(3), 368-374.

Duguid, P. (2005). The art of knowing: Social and tacit dimensions of knowledge and the limits of the community of practice. *The Information Society,* 21(2), 109-118.

Durrant, J. & Snape, J. (2003). Urinary incontinence in nursing homes for older people. *Age and Ageing,* 32(1), 12-18.

Eborall, C., Fenton, W. & Woodrow, S. (2010). The State of the Adult Social Care Workforce in England, 2010. Leeds: Skills for Care Research and Analysis Units.

Eden Alternative. (2009). *http://www.edenalt.org/* [Online]. [Accessed 28 August 2013].

Eden Alternative. (2012). *The Eden Alternative® Fact Sheet* [Online]. [Accessed 1 August 2012].

Edvardsson, D., Winblad, B. & Sandman, P. O. (2008). Person-centred care of people with severe Alzheimer's disease: Current status and ways forward. *The Lancet Neurology,* 7(4), 362-367.

Egan, M. Y., Munroe, S., Hubert, C., Rossiter, T., Gauthier, A., Eisner, M., Fulford, N., Neilson, M., Daros, B. & Rodrigue, C. (2007). Caring for residents with dementia and aggressive behavior: Impact of life history knowledge. *Journal of Gerontological Nursing,* 33(2), 24-30.

Emerson, R. M., Fretz, R. I. & Shaw, L. L. (1995). *Writing Ethnographic Fieldnotes,* Chicago and London: University of Chicago Press.

Emirbayer, M. & Johnson, V. (2008). Bourdieu and organizational analysis. *Theory and Society,* 37(1), 1-44.

Epp, T. D. (2003). Person-centred dementia care: A vision to be refined. *Canadian Alzheimer Disease Review,* 5, 14-19.

Erickson, R. J. & Grove, W. J. C. (2008). Emotional labor and health care. *Sociology Compass,* 2(2), 704-733.

Esping-Andersen, G. (1990). *The Three Worlds of Welfare Capitalism,* Cambridge: Polity Press.

Estabrooks, C. A. (1998). Will evidence-based nursing practice make practice perfect? *Canadian Journal of Nursing Research,* 30, 15-36.

Estabrooks, C. A., Derksen, L., Winther, C., Lavis, J. N., Scott, S. D., Wallin, L. & Profetto-McGrath, J. (2008). The intellectual structure and substance of the knowledge utilization field: A longitudinal author co-citation analysis, 1945 to 2004. *Implementation Science,* 3(1), 49.

Estabrooks, C. A., Floyd, J. A., Scott-Findlay, S., O'Leary, K. A. & Gushta, M. (2003). Individual determinants of research utilization: A systematic review. *Journal of advanced nursing,* 43(5), 506-520.

Estabrooks, C. A., Hutchinson, A. M., Squires, J. E., Birdsell, J., Cummings, G. G., Degner, L., Morgan, D. & Norton, P. G. (2009). Translating research in elder care: an introduction to a study protocol series. *Implementation Science,* 4.

Estabrooks, C. A., Thompson, D. S., Lovely, J. J. E. & Hofmeyer, A. (2006). A guide to knowledge translation theory. *Journal of Continuing Education in the Health Professions,* 26(1), 25-36.

Estabrooks, C. A., Winther, C. & Derksen, L. (2004). Mapping the field: A bibliometric analysis of the research utilization literature in nursing. *Nursing Research,* 53(5), 293.

Everett, J. (2002). Organizational research and the praxeology of Pierre Bourdieu. *Organizational Research Methods,* 5(1), 56-80.

Evidence-Based Working Group. (1992). Evidence-based medicine: A new approach to teaching the practice of medicine. *JAMA: The Journal of the American Medical Association,* 268(17), 2420-2425.

Farkas, M., Jette, A. M., Tennstedt, S., Haley, S. M. & Quinn, V. (2003). Knowledge dissemination and utilization in gerontology: An organizing framework. *The Gerontologist,* 43(Suppl 1), 47-56.

Fawcett, J., Watson, J., Neuman, B., Walker, P. H. & Fitzpatrick, J. J. (2001). On nursing theories and evidence. *Journal of Nursing Scholarship,* 33(2), 115-119.

Feldman, M. S. & Orlikowski, W. J. (2011). Theorizing practice and practicing theory. *Organization Science,* 22, 1240-1253.

Finch, J. & Groves, D. (1983). *A Labour of Love: Women, Work and Caring,* London: Routledge and Kegan Paul.

Fine, G. A., Morrill, C. & Surianarain, S. (2009). Ethnography in Organizational Settings. *In:* Buchanan, D. A. & Bryman, A. (eds.) *The SAGE Handbook of Organizational Research Methods.* London: Sage Publications, 602-619.

Fineman, M. A. (2008). The vulnerable subject: Anchoring equality in the human condition. *Yale Journal of Law & Feminism,* 20(1), 8-40.

Fitzgerald, L. & Dopson, S. (2009). Comparative case study designs: Their utility and development in organizational research. *In:* Buchanan, D. A. & Bryman, A. (eds.) *The SAGE Handbook of Organizational Research Methods* London: Sage Publications, 465-483.

Fitzgerald, L., Ferlie, E., Wood, M. & Hawkins, C. (2002). Interlocking interactions, the diffusion of innovations in health care. *Human Relations,* 55(12), 1429-1449.

Flyvbjerg, B. (2006). Five misunderstandings about case-study research. *Qualitative Inquiry,* 12(2), 219-245.

Foley, D. E. (2002). Critical ethnography: The reflexive turn. *Qualitative Studies in Education,* 15(5), 469-490.

Foner, N. (1993). Work culture in the nursing home: Adaptation and resistance among nursing aides. *Frontiers: A Journal of Women Studies,* 14(1), 44-67.

Foner, N. (1994). Nursing home aides: Saints or monsters? *The Gerontologist,* 34(2), 245.

Forder, J. & Allan, S. (2011). Competition in the Care Homes Market: Report for the OHE Commission on Competition in the NHS. London: Office of Health Economics.

Fossey, J., Ballard, C., Juszczak, E., James, I., Aldler, N., Jacoby, R. & Howard, R. (2006). Effect of enhanced psychosocial care on antipsychotic use in nurshig home residents with severe dementia: Cluster randomised trial. *British Medical Journal,* 332(7544), 756-758.

Foucault, M. (1980). Knowledge/Power: Selected Interviews and Other Writings. New York, NY: Pantheon Books.

Fox, S. (2000). Communities of practice, Foucault and actor network therory. *Journal of Management Studies,* 37(6), 853-868.

Francis, R. (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: The Stationery Office.

French, B. (2005). The process of research use in nursing. *Journal of Advanced Nursing,* 49(2), 125-134.

Friedland, R. (2009). The endless felds of Pierre Bourdieu. *Organization,* 16(6), 887-917.

Friedland, R. & Alford, R. R. (1991). Bringing Society Back In: Symbols, Pactices and Institutional Contradictions. *In:* Powell, W. W. & Dimaggio, P. J. (eds.) *The New Institutionalism in Organizational Analysis.* Chicago: University of Chicago Press, 232-263.

Fujisawa, R. & Colombo, F. (2009). The Long-Term Care Workforce: Overview and Strategies to Adapt Supply to a Growing Demand. *OECD Health Working Papers.* Paris: OECD Directorate for Employment, Labour and Social Affairs.

Fuller, A. (2007). Critiquing theories of learning and communities of practice. *In:* Hughes, J., Jewson, N. & Unwin, L. (eds.) *Communities of Practice: Critical Perspectives.* Abingdon: Routledge, 17-29.

Gabbay, J. & May, A. (2004). Evidence based guidelines or collectively constructed "mindlines?" Ethnographic study of knowledge management in primary care. *British Medical Journal,* 329(7473), 1013.

Garfinkel, H. (1967). *Studies in Ethnomethodology,* Englewood Cliffs, NJ: Prentice-Hall.

Geertz, C. (1973). *The Interpretation of Cultures,* New York, NY: Basic Books.

Gherardi, S. (2009). Knowing and learning in practice-based studies: An introduction. *The Learning Organization,* 16(5), 352-359.

Gherardi, S., Nicolini, D. & Odella, F. (1998). Toward a social understanding of how people learn in organizations: The notion of situated curriculum. *Management Learning,* 29(3), 273-297.

Giddens, A. (1984). *The Constitution of Society: Introduction of the Theory of Structuration,* Berkeley and LA: University of California Press.

Giddens, A. (1999). Risk and responsibility. *The Modern Law Review,* 62(1), 1-10.

Gimlin, D. (2007). What is 'body work'? A review of the literature. *Sociology Compass,* 1(1), 353-370.

Glasgow, R. E. & Emmons, K. M. (2007). How can we increase translation of research into practice? Types of evidence needed. *Annual Review of Public Health,* 28, 413-433.

Glucksmann, M. (2006). Developing an economic sociology of care and rights. *In:* Morris, L. (ed.) *Rights: Sociological Perspectives.* New York, NY: Routledge, 55-72.

Goffman, E. (1961). *Asylums: Essays on the Social Situations of Mental Patients and Other Inmates,* London: Penguin Books.

Golsorkhi, D., Leca, B., Lounsbury, M. & Ramirez, C. (2009). Analysing, accounting for and unmasking domination: On our role as scholars of practice, practitioners of social science and public intellectuals. *Organization,* 16(6), 779-797.

Goodrick, E. & Reay, T. (2011). Constellations of institutional logics: Changes in the professional work of pharmacists. *Work and Occupations,* 38(3), 372-416.

Graham, I. D., Logan, J., Harrison, M. B., Straus, S. E., Tetroe, J., Caswell, W. & Robinson, N. (2006). Lost in knowledge translation: Time for a map? *Journal of Continuing Education in the Health Professions,* 26(1), 13-24.

Grahame, P. R. (1998). Ethnography, institutions, and the problematic of the everyday world. *Human Studies,* 21(4), 347-360.

Green, J. (2009). Is it time for the sociology of health to abandon "risk"? *Health, Risk & Society,* 11(6), 493-508.

Green, L. W., Ottoson, J., García, C. & Robert, H. (2009). Diffusion theory and knowledge dissemination, utilization, and integration in public health. *Annual Review of Public Health,* 30, 151-174.

Greener, J. (2011). *The Bottom Line: An Ethnography of For-Profit Elderly Residential Care.* PhD Thesis, University of Nottingham.

Greenhalgh, T. (2010). What is this knowledge that we seek to "exchange"? *Milbank Quarterly,* 88(4), 492-499.

Greenhalgh, T., Robert, G., MacFarlane, F., Bate, P. & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: Systematic review and recommendations. *Milbank Quarterly,* 82(4), 581-629.

Grenfell, M. (ed.) (2008). *Pierre Bourdieu: Key Concepts,* Durham: Acumen Publishing Ltd.

Gruneir, A. & Mor, V. (2008). Nursing home safety: Current issues and barriers to improvement. *Annual Review of Public Health,* 29, 369-382.

Gubrium, J. F. (1997[1975]). *Living and Dying at Murray Manor,* Charlottesville, VA: University of Virginia Press.

Gubrium, J. F. & Holstein, J. A. (1999). The nursing home as a discursive anchor for the ageing body. *Ageing and Society,* 19(5), 519-538.

Guillemin, M. & Gillam, L. (2004). Ethics, reflexivity, and "ethically important moments" in research. *Qualitative Inquiry,* 10(2), 261-280.

Hancock, R., Wittenberg, R., Pickard, L., Comas-Herrera, A., Juarez-Garcia, A., King, D. & Malley, J. (2007). Paying for Long-Term Care for Older People in the UK: Modelling the Costs and Distributional Effects of a Range of Options (PSSRU Discussion Paper 2336/2). London: Personal Social Services Research Unit, LSE Health and Social Care.

Harrington, C., Choiniere, J., Goldmann, M., Jacobsen, F. F., Lloyd, L., McGregor, M., Stamatopoulos, V. & Szebehely, M. (2012). Nursing home staffing standards and staffing levels in six countries. *Journal of Nursing Scholarship,* 44(1), 88-98.

Hartig, M. T. (1998). Expert nursing assistant care activities. *Western Journal of Nursing Research,* 20(5), 584-610.

Heidegger, M. (1962). *Being and Time,* Oxford: Basil Blackwell.

Helfrich, C. D., Damschroder, L. J., Hagedorn, H. J., Daggett, G. S., Sahay, A., Ritchie, M., Damush, T., Guihan, M., Ullrich, P. M. & Stetler, C. B. (2010). A critical synthesis of literature on the promoting action on research implementation in health services (PARIHS) framework. *Implementation Science,* 5(1), 82.

Henderson, A. (2001). Emotional labor and nursing: An under-appreciated aspect of caring work. *Nursing Inquiry,* 8(2), 130-138.

Hersey, R. B. (1932). *Workers' Emotions in Shop and Home: A Study of Individual Workers from the Psychological and Physiological Standpoint,* New York, NY: Amold Press.

Hillman, A., Tadd, W., Calnan, S., Calnan, M., Bayer, A. & Read, S. (2013). Risk, governance and the experience of care. *Sociology of Health & Illness,* 35(6), 939-955.

Hinman, M. R. & Heyl, D. M. (2001). Influence of the Eden Alternative™ on the functional status of nursing home residents. *Physical & Occupational Therapy in Geriatrics,* 20(2), 1-20.

Hochschild, A. (1983). *The Managed Heart: Commercialization of Human Feeling,* Berkeley: University of California Press.

Hodson, R. (2004). A meta-analysis of workplace ethnographies. *Journal of Contemporary Ethnography,* 33(1), 4-38.

Hoeffer, B., Talerico, K. A., Rasin, J., Mitchell, C. M., Stewart, B. J., McKenzie, D., Barrick, A. L., Rader, J. & Sloane, P. D. (2006). Assisting cognitively impaired nursing home

residents with bathing: Effects of two bathing interventions on caregiving. *The Gerontologist,* 46(4), 524-532.

Hofland, B. F. (1994). When capacity fades and autonomy is constricted: A client-centered approach to residential care. *Generations,* 18(4), 31-35.

Horlick-Jones, T. (2005). Informal logics of risk: Contingency and modes of practical reasoning. *Journal of Risk Research,* 8(3), 253-272.

Horowitz, A., Silverstone, B. M. & Reinhardt, J. P. (1991). A conceptual and empirical exploration of personal autonomy issues within family caregiving relationships. *The Gerontologist,* 31(1), 23-31.

Hughes, C. M. & Lapane, K. L. (2006). Nurses' and nursing assistants' perceptions of patient safety culture in nursing homes. *International Journal for Quality in Health Care,* 18(4), 281-286.

Hughes, E. C. (1962). Good people and dirty work *Social Problems,* 10(1), 3-11.

Hughes, J., Bagley, H., Reilly, S., Burns, A. & Challis, D. (2008). Care staff working with people with dementia: Training, knowledge and confidence. *Dementia,* 7(2), 227-238.

Hughes, J., Jewson, N. & Unwin, L. (eds.). (2007). *Communities of Practice: Critical Perspectives,* Abingdon and NY: Routledge.

Hummert, M. L., Garstka, T. A., Shaner, J. L. & Strahm, S. (1994). Stereotypes of the elderly held by young, middle-aged, and elderly adults. *Journal of Gerontology,* 49(5), P240-P249.

Hunter, C. L., Spence, K., McKenna, K. & Iedema, R. (2008). Learning how we learn: An ethnographic study in a neonatal intensive care unit. *Journal of Advanced Nursing,* 62(6), 657-664.

Innes, A., Macpherson, S. & McCabe, L. (2006). *Promoting person-centred care at the front line,* York: Joseph Rowntree Foundation.

Institute of Medicine. (1986). Improving the Quality of Care in Nursing Homes. Washington, DC: National Academy Press.

Institute of Medicine. (2001). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academy Press.

James, N. (1989). Emotional labour: Skill and work in the social regulation of feelings. *The Sociological Review,* 37(1), 15-42.

James, N. (1992). Care = Organisation + physical labour + emotional labour. *Sociology of Health & Illness,* 14(4), 488-509.

Janes, N. (2010). Making context work in aged care. *In:* Kent, B. & Mccormack, B. (eds.) *Clinical Context for Evidence-Based Nursing Practice.* Oxford: Wiley-Blackwell, 156-177.

Janes, N., Sidani, S., Cott, C. & Rappolt, S. (2008). Figuring it out in the moment: A theory of unregulated care providers' knowledge utilization in dementia care settings. *Worldviews on Evidence-Based Nursing,* 5(1), 13-24.

Jenkins, R. (2002). *Pierre Bourdieu (Revised Edition),* London and NY: Routledge.

Jones, T. L. (2010). A holistic framework for nursing time: Implications for theory, practice, and research. *Nursing Forum,* 45(3), 185-196.

Kane, R. L. & Kane, R. A. (2005). Ageism in healthcare and long-term care. *Generations,* 29(3), 49-54.

Kanter, R. M. (1977). *Men and Women of the Corporation,* New York, NY: Basic Books.

Kapp, M. B. (2003a). "At least Mom will be safe there": The role of resident safety in nursing home quality. *Quality and Safety in Health Care,* 12(3), 201-204.

Kapp, M. B. (2003b). Resident safety and medical errors in nursing homes. *Journal of Legal Medicine,* 24(1), 51-76.

Kayser-Jones, J. S. (1981). *Old, alone, and neglected: Care of the aged in Scotland and the United States,* Berkeley: University of California Press.

Kitson, A. (2009). The need for systems change: Reflections on knowledge translation and organizational change. *Journal of Advanced Nursing,* 65(1), 217-228.

Kitson, A., Rycroft-Malone, J., Harvey, G., McCormack, B., Seers, K. & Titchen, A. (2008). Evaluating the successful implementation of evidence into practice using the PARiHS framework: Theoretical and practical challenges. *Implementation Science,* 3(1), 1.

Kittay, E. F. (2008). The global heart transplant and caring across national boundaries. *The Southern Journal of Philosophy,* 46(S1), 138-165.

Kitwood, T. (1993). Towards a theory of dementia care: The interpersonal process. *Ageing and Society,* 13(1), 51-67.

Kitwood, T. (1997a). *Dementia Reconsidered: The Person Comes First,* Buckingham: Open University Press.

Kitwood, T. (1997b). The experience of dementia. *Aging & Mental Health,* 1(1), 13-22.

Kitwood, T. & Benson, S. (eds.). (1995). *The New Culture of Dementia Care,* London: Hawker Publications.

Kohn, L. T., Corrigan, J. M. & Donaldson, M. S. (2000). *To Err is Human: Building a Safer Health System (IOM Report),* Washington, DC: National Academy Press.

Kontos, P. C. (2004). Ethnographic reflections on selfhood, embodiment and Alzheimer's disease. *Ageing & Society,* 24(6), 829-849.

Kontos, P. C. (2005). Embodied selfhood in Alzheimer's disease: Rethinking person-centred care. *Dementia,* 4(4), 553-570.

Kontos, P. C. & Martin, W. (2013). Embodiment and dementia: Exploring critical narratives of selfhood, surveillance, and dementia care. *Dementia,* 12(3), 288-302.

Kontos, P. C., Miller, K. L., Mitchell, G. J. & Cott, C. A. (2010). Dementia care at the intersection of regulation and reflexivity: A critical realist perspective. *The Journals of Gerontology: Series B,* 66B(1), 119-128.

Kontos, P. C. & Poland, B. D. (2009). Mapping new theoretical and methodological terrain for knowledge translation: Contributions from critical realism and the arts. *Implementation Science,* 4, 1.

Korczyk, S. (2004). Long-term workers in five countries: Issues and options. Washington, DC: AARP Public Policy Institute.

Koren, M. J. (2010). Person-centered care for nursing home residents: The culture-change movement. *Health Affairs,* 29(2), 312-317.

Kornadt, A. E. & Rothermund, K. (2011). Contexts of aging: Assessing evaluative age stereotypes in different life domains. *The Journals of Gerontology: Series B,* 66(5), 547-556.

Kovach, C. R., Logan, B. R., Noonan, P. E., Schlidt, A. M., Smerz, J., Simpson, M. & Wells, T. (2006). Effects of the Serial Trial Intervention on discomfort and behavior of nursing home residents with dementia. *American Journal of Alzheimer's Disease and Other Dementias,* 21(3), 147-155.

Kovach, C. R., Morgan, S., Noonan, P. E. & Brondino, M. (2008). Using principles of diffusion of innovation to improve nursing home care. *Journal of Nursing Care Quality,* 23(2), 132-139.

KT Clearinghouse. (2011). *Glossary* [Online]. [Accessed 7 April 2011].

KUSP. (2011). *Glossary* [Online]. Edmonton, AB: Knowledge Utilisation Studies Program. [Accessed 6 April 2011].

Landivar, L. C. (2013). Men in Nursing Occupations. Washington, DC: U.S. Census Bureau.

Lapadat, J. C. & Lindsay, A. C. (1999). Transcription in research and practice: From standardization of technique to interpretive positionings. *Qualitative Inquiry,* 5(1), 64-86.

Latimer, J. (2008). Introduction: Body, knowledge, worlds. *Sociological Review,* 56(s2), 1-22.

Lau, R. W. K. (2004). Habitus and the practical logic of practice: An interpretation. *Sociology,* 38(2), 369-387.

Lave, J. (1996). Introduction. *In:* Chaiklin, S. & Lave, J. (eds.) *Understanding Practice: Perspectives on Activity and Context.* Cambridge, MA: Cambridge University Press, 3-34.

Lave, J. & Wenger, E. (1991). *Situated Learning: Legitimate Peripheral Participation,* Cambridge, MA: Cambridge University Press.

Lawler, J. (2006[1991]). *Behind the Screens: Nursing, Somology and the Problem of the Body (re-issue),* Sydney: Sydney University Press.

Lee-Treweek, G. (1997). Women, resistance and care: An ethnographic study of nursing auxiliary work. *Work, Employment & Society,* 11(1), 47-63.

Levenson, S. A. & Morley, J. E. (2007). Evidence rocks in long-term care, but does it roll? *Journal of the American Medical Directors Association,* 8(8), 493-501.

Levinson, D. R. (2008). Memorandum Report: Trends in Nursing Home Deficiencies and Complaints, OEI-02-08-00140. Washington, DC: DHHS.

Lewis, G. H., Vaithianathan, R., Hockey, P. M., Hirst, G. & Bagian, J. P. (2011). Counterheroism, common knowledge, and ergonomics: Concepts from aviation that could improve patient safety. *The Milbank Quarterly,* 89(1), 4-38.

Lievesley, N., Corosby, G. & Bowman, C. (2011). The Changing Role of Care Homes. London: Bupa and the Centre for Policy on Ageing.

Lin, M. K. & Kramer, A. M. (2013). The Quality Indicator Survey: Background, implementation, and widespread change. *Journal of Aging & Social Policy (Special Issue: Nursing Home Policies)* 25(1), 10-29.

Lincoln, Y. S. & Guba, E. G. (1985). *Naturalistic Inquiry,* London: Sage Publications.

Local Government Association, NHS Confederation & Age UK. (2012). *Delivering Dignity: Securing Dignity in Care for Older People in Hospitals and Care* [Online]. London: NHS Confederation. [Accessed 1 August 2012].

Loveday, B. (2013). *Leadership for Person-Centred Dementia Care,* London and Philadelphia: Jessica Kingsley Publishers.

Madison, D. S. (2005). *Critical Ethnography: Method, Ethics, and Performance* Thousand Oaks, CA: Sage Publications.

Manley, K. (2000). Organisational culture and consultant nurse outcomes, Part 2: Nurse outcomes. *Nursing Standard (Royal College of Nursing),* 14(37), 34-38.

Mann, S. & Cowburn, J. (2005). Emotional labour and stress within mental health nursing. *Journal of Psychiatric and Mental Health Nursing,* 12, 154-162.

McColgan, G. (2005). A place to sit: Resistance strategies used to create privacy and home by people with dementia. *Journal of Contemporary Ethnography,* 34(4), 410-433.

McCormack, B. (2001). Autonomy and the relationship between nurses and older people. *Ageing and Society,* 21, 417-446.

McCormack, B. (2004). Person-centredness in gerontological nursing: An overview of the literature. *International Journal of Older People Nursing in association with Journal of Clinical Nursing,* 13(3a), 31-38.

McCormack, B., Kitson, A., Harvey, G., Rycroft Malone, J., Titchen, A. & Seers, K. (2002). Getting evidence into practice: The meaning of "context". *Journal of Advanced Nursing,* 38(1), 94-104.

McDaid, D., Oliveira, M. D. & Jurczak, K. (2007). Moving beyond the mental health care system: An exploration of the interfaces between health and non-health sectors. *Journal of Mental Health,* 16(2), 181-194.

McDermott, R. P. (1996). The acquisition of a child by a learning disability. *In:* Chaiklin, S. & Lave, J. (eds.) *Understanding Practice: Perspectives on Activity and Context.* Cambridge, MA: Cambridge University Press, 269-305.

McDonald, R., Waring, J. & Harrison, S. (2006). Rules, safety and the narrativisation of identity: A hospital operating theatre case study. *Sociology of Health & Illness,* 28(2), 178-202.

McKeown, J., Clarke, A., Ingleton, C., Ryan, T. & Repper, J. (2010). The use of life story work with people with dementia to enhance person-centred care. *International Journal of Older People Nursing,* 5(2), 148-158.

McKibbon, K. A., Lokker, C., Wilczynski, N. L., Ciliska, D., Dobbins, M., Davis, D. A., Haynes, R. B. & Straus, S. E. (2010). A cross-sectional study of the number and frequency of terms used to refer to knowledge translation in a body of health literature in 2006: A Tower of Babel? *Implementation Science,* 5, 16.

McLean, A. (2007). *The Person in Dementia: A Study of Nursing Home Care in the US,* Peterborough, ON: Broadview Press.

McLeod, S. A. (2008). *Person Centred Therapy* [Online]. [Accessed 22 August 2013].

McWilliam, C. L., Kothari, A., Ward-Griffin, C., Forbes, D., Leipert, B. & SW Community Care Access Center Home. (2009). Evolving the theory and praxis of knowledge translation through social interaction: A social phenomenological study. *Implementation Science,* 4, 26.

Mead, N. & Bower, P. (2000). Patient centredness: A conceptual framework and review of the empirical literature. *Social Science & Medicine,* 51, 1087-1110.

Meerabeau, L. (1992). Tacit nursing knowledge: An untapped resource or a methodological headache? *Journal of Advanced Nursing,* 17(1), 108-112.

Meijers, J. M. M., Janssen, M. A. P., Cummings, G. G., Wallin, L., Estabrooks, C. A. & Halfens, R. Y. G. (2006). Assessing the relationships between contextual factors and research utilization in nursing: Systematic literature review. *Journal of Advanced Nursing,* 55(5), 622-635.

Merleau-Ponty, M. (1962). Phenomenology of Perception. London and New York: Routledge.

Messinger-Rapport, B. J. (2004). Evidence-based medicine: Is it relevant to long-term care? *Journal of the American Medical Directors Association,* 5(5), 328-332.

MetLife. (2012). *MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs* [Online]. [Accessed 30 September 2013].

Milne, A. & Dening, T. (2011). Introduction *In:* Dening, T. & Milne, A. (eds.) *Mental Health and Care Homes.* Oxford: Oxford University Press, 1-5.

Mitchell, S. A., Fisher, C. A., Hastings, C. E., Silverman, L. B. & Wallen, G. R. (2010). A thematic analysis of theoretical models for translational science in nursing: Mapping the field. *Nursing Outlook,* 58(6), 287-300.

Mitton, C., Adair, C. E., McKenzie, E., Patten, S. B. & Perry, B. W. (2007). Knowledge transfer and exchange: Review and synthesis of the literature. *Milbank Quarterly,* 85(4), 729-768.

Moran, A., Enderby, P. & Nancarrow, S. (2010). Defining and identifying common elements of and contextual influences on the roles of support workers in health and social care: A thematic analysis of the literature. *Journal of Evaluation in Clinical Practice,* 17(6), 1191-1199.

Morgan, S. & Yoder, L. H. (2012). A concept analysis of person-centered care. *Journal of Holistic Nursing,* 30(1), 6-15.

Moriarty, J., Kam, M., Coomber, C., Rutter, D. & Turner, M. (2010). *Research Briefing 34: Communication Training for Care Home Workers: Outcomes for Older People, Staff, Families and Friends,* London: SCIE.

Morse, J. M., Barrett, M., Mayan, M., Olson, K. & Spiers, J. (2008). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods,* 1(2), 13-22.

Moyle, W., Hsu, M. C., Lieff, S. & Vernooij-Dassen, M. (2010). Recommendations for staff education and training for older people with mental illness in long-term aged care. *International Psychogeriatrics,* 22(7), 1097-1106.

Munn, N. D. (1992). The cultural anthropology of time: A critical essay. *Annual Review of Anthropology,* 21, 93-123.

Murphy, E. & Dingwall, R. (2007). Informed consent, anticipatory regulation and ethnographic practice. *Social Science & Medicine,* 65(11), 2223-2234.

Mutch, A. (2003). Communities of practice and habitus: A critique. *Organization Studies,* 24(3), 383-401.

MyAmego Healthcare Ltd. (2013). *http://www.myamego.com/* [Online]. [Accessed 6 September 2013].

Mykhalovskiy, E. & Weir, L. (2004). The problem of evidence-based medicine: Directions for social science. *Social Science & Medicine,* 59(5), 1059-1069.

National Patient Safety Agency. (2010). NHS to Adopt Zero Tolerance Approach to Pressure Ulcers. London: NPSA.

Navarro, V. & Schmitt, J. (2005). Economic efficiency versus social equality? The US liberal model versus the European social model. *International Journal of Health Services,* 35(4), 613-630.

Nay, R. (2003). Evidence-based practice: Does it benefit older people and gerontic nursing? *Geriatric Nursing,* 24(6), 338-342.

NHS Confederation. (2012). *Use NHS Constitution in Right Way to Make it Effective* [Online]. [Accessed 18 September 2013].

NICE/SCIE. (2006). NICE Clinical Guideline 42: Dementia: Supporting People with Dementia and Their Carers in Health and Social Care. London: NICE/SCIE.

Nicolini, D. (2009). Zooming in and out: Studying practices by switching theoretical lenses and trailing connections. *Organization Studies,* 30(12), 1391-1418.

Nicolini, D. (2011). Practice as the site of knowing: Insights from the field of telemedicine. *Organization Science,* 22(3), 602-620.

Nicolini, D. (2013). *Practice Theory, Work, and Organization: An Introduction,* Oxford: Oxford University Press.

Nicolini, D., Powell, J., Conville, P. & Martinez Solano, L. (2008). Managing knowledge in the healthcare sector: A review. *International Journal of Management Reviews,* 10(3), 245-263.

Nolan, M., Brown, J., Davies, S., Nolan, J. & Keady, J. (2006). The Senses Framework: Improving Care for Older People Through a Relationship Centred Approach. Sheffield: University of Sheffield.

Nolan, M., Davies, S., Brown, J., Wilkinson, A., Warnes, T., McKee, K., Flannery, J. & Stasi, K. (2008). The role of education and training in achieving change in care homes: a literature review. *Journal of Research in Nursing,* 13(5), 411-433.

Nonaka, I. (1994). A dynamic theory of organizational knowledge creation. *Organization Science,* 5(1), 14-37.

Nursing and Care Quality Forum. (2012). Recommendations to Prime Minister on Treating Patients and Service Users with Respect, Dignity and Compassion. London: DOH.

Nussbaum, J. F., Pitts, M. J., Huber, F. N., Krieger, J. L. R. & Ohs, J. E. (2005). Ageism and ageist language across the life span: Intimate relationships and non-intimate interactions. *Journal of Social Issues,* 61(2), 287-305.

Nutley, S., Walter, I. & Davies, H. T. O. (2003). From knowing to doing: A framework for understanding the evidence-into-practice agenda. *Evaluation,* 9(2), 125-148.

O'Connor, J. S., Orloff, A. S. & Shaver, S. (1999). *States, Markets, Families: Gender, Liberalism and Social Policy in Australia, Canada, Great Britain and the United States,* Cambridge: Cambridge University Press.

OECD. (2005). Ensuring Quality Long-Term Care for Older People. *OECD Policy Brief.* Paris: Organisation for Economic Cooperation and Development.

OECD. (2011). *Help Wanted? Providing and Paying for Long-Term Care* [Online]. Paris: Organisation for Economic Cooperation and Development. [Accessed 9 August 2013].

OECD. (2013). *A Good Life in Old Age? Monitoring and Improving Quality in Long-term Care* [Online]. Paris: Organisation for Economic Cooperation and Development. [Accessed 9 August 2013].

Orlikowski, W. J. & Yates, J. (2002). It's about time: Temporal structuring in organizations. *Organization Science,* 13(6), 684-700.

PHI. (2009). Facts: Who are Direct-Care Workers? New York, NY: Paraprofessional Healthcare Institute.

Picker Institute. (2013). *Principles of Patient-Centered Care* [Online]. [Accessed 30 September 2013].

Pioneer Network. (2004). Getting Started: A Pioneering Approach to Culture Change in Long Term Care Organizations. Rochester, NY: The Pioneer Network.

Pioneer Network. (2013). *Mission, Vision, and Values* [Online]. Rochester, NY: The Pioneer Network. [Accessed 30 September 2013].

Piven, M. L., Anderson, R. A., Colón-Emeric, C. S. & Sandelowski, M. (2008). Certified nursing assistants' explanatory models of nursing home resident depression. *Western Journal of Nursing Research,* 30(6), 653-672.

Polanyi, M. (1966). *The Tacit Dimension,* Garden City, NY: Doubleday/Anchor.

Pontusson, J. (2005). *Inequality and prosperity: Social Europe vs. liberal America,* Ithaca, NY: Cornell University Press.

Poole, N. (2008). Using consciousness-raising principles to inform modern knowledge translation practices in women's health. *Canadian Journal of Nursing Research,* 40(2), 76-93.

Pope, C. (2003). Resisting evidence: The study of evidence-based medicine as a contemporary social movement. *Health,* 7(3), 267-282.

Post, S. (2000). The concept of Alzheimer's disease in a hypercognitive society. *In:* Whitehouse, P. J., Maurer, K. & Ballenger, J. F. (eds.) *Concepts of Alzheimer Disease: Biological, Clinical, and Cultural Perspectives.* Baltimore, MD: Johns Hopkins University Press, 245-256.

Prasad, P. & Prasad, A. (2009). Endless crossroads: Debates, deliberations and disagreements on studying organizational culture. *In:* Buchanan, D. A. & Bryman, A. (eds.) *The SAGE Handbook of Organizational Research Methods.* London: Sage Publications, 128-142.

Prochaska, J. M., Prochaska, J. O. & Levesque, D. A. (2001). A transtheoretical approach to changing organizations. *Administration and Policy in Mental Health and Mental Health Services Research,* 28(4), 247-261.

Proctor, E. K. (2004). Leverage points for the implementation of evidence-based practice. *Brief Treatment and Crisis Intervention,* 4(3), 227-242.

Prout, A. (2000). Childhood bodies: Social construction and translation. *In:* Williams, S. J., Gabe, J. & Calnan, M. (eds.) *Health, Medicine, and Society: Key Theories, Future Agendas.* London and New York: Routledge, 109-122.

Quinlan, E. (2009). The 'actualities' of knowledge work: An institutional ethnography of multi-disciplinary primary health care teams. *Sociology of Health & Illness,* 31(5), 625-641.

Rabinow, P. (1985). Discourse and power: On the limits of ethnographic texts. *Dialectical Anthropology,* 10(1), 1-13.

Rahman, A. N. & Applebaum, R. A. (2009). The Nursing Home Minimum Data Set Assessment Instrument: Manifest Functions and Unintended Consequences - Past, Present, and Future. *The Gerontologist,* 49(6), 727-735.

Rahman, A. N. & Schnelle, J. F. (2008). The nursing home culture-change movement: Recent past, present, and future directions for research. *The Gerontologist,* 48(2), 142-148.

Rahman, A. N., Straker, J. K. & Manning, L. (2009). Staff assignment practices in nursing homes: Review of the literature. *Journal of the American Medical Directors Association,* 10(1), 4-10.

Reay, T. & Hinings, C. R. (2009). Managing the Rivalry of Competing Institutional Logics. *Organization Studies,* 30(6), 629-652.

Reckwitz, A. (2002). Toward a theory of social practices: A development in culturalist theorizing. *European Journal of Social Theory,* 5(2), 243-263.

Reed-Danahay, D. (2001). 'This is your home now!': Conceptualizing location and dislocation in a dementia unit. *Qualitative Research,* 1(1), 47-63.

Reimer-Kirkham, S., Varcoe, C., Browne, A. J., Lynam, M. J., Khan, K. B. & McDonald, H. (2009). Critical inquiry and knowledge translation: Exploring compatibilities and tensions. *Nursing Philosophy,* 10(3), 152-166.

Resnick, B., Keilman, L. J., Calabrese, B., Parmelee, P., Lawhorne, L., Pailet, J. & Ouslander, J. (2006). Nursing staff beliefs and expectations about continence care in nursing homes. *Journal of Wound Ostomy and Continence Nursing,* 33(6), 610-618.

Rhynas, S. J. (2005). Bourdieu's theory of practice and its potential in nursing research. *Journal of Advanced Nursing,* 50(2), 179-186.

Robert, G., Greenhalgh, T., MacFarlane, F. & Peacock, R. (2010). Adopting and assimilating new non-pharmaceutical technologies into health care: A systematic review. *Journal of Health Services Research & Policy,* 15(4), 243-250.

Roberts, E., J., R. & Seymour, L. (2002). Old Habits Die Hard:Tackling Age Discrimination in Health and Social Care. London: King's Fund.

Robinson, J. (2000). Managing urinary incontinence in the nursing home: Residents' perspectives. *Journal of Advanced Nursing,* 31, 68-77.

Robison, J., Curry, L., Gruman, C., Porter, M., Henderson, C. R. & Pillemer, K. (2007). Partners in caregiving in a special care environment: Cooperative communication between staff and families on dementia units. *The Gerontologist,* 47(4), 504-515.

Rodgers, V., Welford, C., Murphy, K. & Frauenlob, T. (2012). Enhancing autonomy for older people in residential care: What factors affect it? *International Journal of Older People Nursing,* 7(1), 70-74.

Roethlisberger, F. J. & Dickson, W. J. (1947). *Management and the worker: An account of a research program conducted by the Western Electric Company, Hawthorne Works, Chicago (with the assistance and collaboration of Harold A. Wright),* Cambridge, MA: Harvard University Press.

Rogers, E. M. (2003[1962]). *Diffusion of Innovations,* New York, NY: Free Press.

Ron, P. & Lowenstein, A. (2002). In-service training of professional and para-professional staff in institutions for the aged. *Educational Gerontology,* 28, 587-597.

Rosher, R. B. & Robinson, S. (2005). Impact of the Eden Alternative on family satisfaction. *Journal of the American Medical Directors Association,* 6(3), 189-193.

Routledge, M. & Carr, S. (2013). Improving Personal Budgets for Older People: A Review (Phase I Report). London: Think Local Act Personal (TLAP).

Rowley, E., Morriss, R., Currie, G. & Schneider, J. (2012). Research into practice: Collaboration for leadership in applied health research and care (CLAHRC) for Nottinghamshire, Derbyshire, Lincolnshire (NDL). *Implementation Science,* 7(1), 40.

Roy, D. F. (1959). " Banana time": Job satisfaction and informal interaction. *Human Organization,* 18(4), 158-168.

Rubenstein, L. Z. (1997). Preventing falls in the nursing home. *Journal of the American Medical Association,* 278(7), 595-6.

Ryan, A. (2003). Rights, risks, and autonomy: A new interpretation of falls in nursing homes. *Quality and Safety in Health Care,* 12(3), 166-167.

Ryan, B. & Gross, N. (1943). The diffusion of hybrid seed corn in two Iowa communities. *Rural Sociology,* 8, 15-24.

Rycroft-Malone, J. (2004). The PARIHS framework: A framework for guiding the implementation of evidence-based practice. *Journal of Nursing Care Quality,* 19(4), 297-304.

Rycroft-Malone, J. (2007). Theory and knowledge translation: Setting some coordinates. *Nursing Research,* 56(4), S78-S85.

Rycroft-Malone, J. (2008). Evidence informed practice: From individual to context. *Journal of Nursing Management,* 16(4), 404-408.

Rycroft-Malone, J., Harvey, G., Seers, K., Kitson, A., McCormack, B. & Titchen, A. (2004). An exploration of the factors that influence the implementation of evidence into practice. *Journal of Clinical Nursing,* 13(8), 913-924.

Rycroft-Malone, J., Kitson, A., Harvey, G., McCormack, B., Seers, K., Titchen, A. & Estabrooks, C. A. (2002). Ingredients for change: Revisiting a conceptual framework. *Quality and Safety in Health Care,* 11, 174-180.

Ryle, G. (1949). *The Concept of Mind,* Chicago: University of Chicago Press.

Ryvicker, M. (2009). Preservation of self in the nursing home: Contradictory practices within two models of care. *Journal of Aging Studies,* 23(1), 12-23.

Sabat, S. R. (2001). *The Experience of Alzheimer's Disease: Life Through a Tangled Veil,* Hoboken, NJ: Wiley-Blackwell.

Sackett, D. L., Rosenberg, W., Gray, J. A., Haynes, R. B. & Richardson, W. S. (1996). Evidence-based medicine: What it is and what it isn't. *British Medical Journal,* 312(7023), 71.

Sallaz, J. J. & Zavisca, J. (2007). Bourdieu in American sociology, 1980-2004. *Annual Review of Sociology,* 33, 21-41.

Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science,* 8(3), 27-37.

Sarton, M. (1973). *As We Are Now,* New York, NY: W.W. Norton & Company.

Savage, J. (2000). Ethnography and health care. *British Medical Journal,* 321, 1400-1402.

Savage, J. (2006). Ethnographic evidence: The value of applied ethnography in healthcare. *Journal of Research in Nursing,* 11(5), 383-393.

Scales, K. 2012. Time to Care. *Institute for Person-Centered Care Blog* [Online]. [Accessed 30 October 2013].

Scales, K. (2013). Translating Ideas and Evidence about Person-Centered Care to Nursing Assistants' Practice: The Importance of Context. Buffalo, NY: Institute for Person-Centered Care.

Scales, K. & Schneider, J. (2012). Social care. *In:* Baldock, J., Mitton, L., Manning, N. & Vickerstaff, S. (eds.) *Social Policy (4th edition).* Oxford: Oxford University Press, 285-314.

Schatzki, T. R. (2001). Introduction. *In:* Schatzki, T. R., Knorr Cetina, K. & Von Savigny, E. (eds.) *The Practice Turn in Contemporary Theory.* Abingdon and NY: Routledge, 1-14.

Schatzki, T. R. (2005). Peripheral vision: The sites of organizations. *Organization Studies,* 26(3), 465-484.

Schatzki, T. R., Knorr Cetina, K. & Von Savigny, E. (eds.). (2001). *The Practice Turn in Contemporary Theory,* Abingdon and NY: Routledge.

Schaufeli, W. & Bakker, A. (2004). Job demands, job resources, and their relationship with burnout and engagement: A multi-sample study. *Journal of Organizational Behavior,* 25(3), 293-315.

Schneider, J., Scales, K., Bailey, S. & Lloyd, J. (2010). *Challenging care: The role and experience of healthcare assistants in dementia wards. End of study report number 08/1819/222,* Southampton: National Coordinating Centre for the Service Delivery and Organisation (SDO).

Schön, D. A. (1983). *The Reflective Practitioner: How Professionals Think in Action,* London: Basic Books, Inc.

Scott-Cawiezell, J., Vogelsmeier, A., McKenney, C., Rantz, M., Hicks, L. & Zellmer, D. (2006). Moving from a culture of blame to a culture of safety in the nursing home setting. *Nursing Forum,* 41, 133-140.

Scott, S. D., Estabrooks, C. A., Allen, M. & Pollock, C. (2008). A context of uncertainty: How context shapes nurses' research utilization behaviors. *Qualitative Health Research,* 18(3), 347-357.

Scott, W. R., Ruef, M., Mendel, P. & Caronna, C. A. (2000). *Institutional Change and Oganizations: Transformation of a Healthcare Field,* Chicago: University of Chicago Press.

Secrest, J., Iorio, D. H. & Martz, W. (2005). The meaning of work for nursing assistants who stay in long-term care. *International Journal of Older People Nursing,* 14, 90-97.

Shilling, C. (2007). Sociology and the body: Classical traditions and new agendas. *The Sociological Review,* 55, 1-18.

Shura, R., Siders, R. A. & Dannefer, D. (2011). Culture Change in Long-term Care: Participatory Action Research and the Role of the Resident. *Gerontologist,* 51(2), 212-225.

Skeggs, B. (2001). Feminist ethnography. *In:* Atkinson, P., Coffey, A., Delamont, S., Lofland, J. & Lofland, L. (eds.) *Handbook of Ethnography.* London: Sage Publications 426-442.

Skills for Care. (2009). *National Minimum Data Set for Social Care Briefing, Issue 8 : Pay* [Online]. Leeds: Skills for Care. [Accessed 20 August 2013].

Skills for Care. (2010a). *National Minimum Data Set for Social Care Briefing, Issue 12 : Vacancy and Turnover* [Online]. Leeds: Skills for Care. [Accessed 20 August 2013].

Skills for Care. (2010b). *National Minimum Data Set for Social Care Briefing, Issue 13: Regional Comparisons* [Online]. Leeds: Skills for Care. [Accessed 20 August 2013].

Skills for Care. (2011). *National Minimum Data Set for Social Care Briefing, Issue 14: Migrant Workers* [Online]. Leeds: Skills for Care. [Accessed 20 August 2013].

Slater, L. (2006). Person-centredness: A concept analysis. *Contemporary Nurse,* 23(1), 135-144.

Sloane, P. D., Hoeffer, B. & Somboontanont, W. (2006). Bathing without a battle: Providing more person-centered experiences for long-term care residents with dementia. *Research and practice in Alzheimer's Disease,* 11, 294-299.

Smaje, C. (2000). A place for race? Medical sociology and the critique of racial ideology. *In:* Williams, S. J., Gabe, J. & Calnan, M. (eds.) *Health, Medicine, and Society: Key Theories, Future Agendas.* London and New York: Routledge, 67-86.

Smircich, L. (1983). Concepts of culture and organizational analysis. *Administrative Science Quarterly,* 28(3), 339-358.

Smith, V. (2001). Ethnographies of work and the work of ethnographers. *In:* Atkinson, P., Coffey, A., Delamont, S., Lofland, J. & Lofland, L. (eds.) *Handbook of Ethnography.* London: Sage Publications 220-233.

Sole, D. & Edmondson, A. (2002). Situated knowledge and learning in dispersed teams. *British Journal of Management,* 13(S2), S17-S34.

Spilsbury, K., Hewitt, C., Stirk, L. & Bowman, C. (2011). The relationship between nurse staffing and quality of care in nursing homes: A systematic review. *International Journal of Nursing Studies*.

Stacey, C. L. (2005). Finding dignity in dirty work: The constraints and rewards of low-wage home care labour. *Sociology of Health & Illness,* 27(6), 831-854.

Stannard, C. I. (1973). Old folks and dirty work: The social conditions for patient abuse in a nursing home. *Social Problems,* 20(3), 329-342.

Stetler, C. B. (2001). Updating the Stetler Model of research utilization to facilitate evidence-based practice. *Nursing Outlook,* 49(6), 272-279.

Stolee, P., McAiney, C. A., Hillier, L. M., Harris, D., Hamilton, P., Kessler, L., Madsen, V. & Le Clair, J. K. (2009). Sustained transfer of knowledge to practice in long-term care: Facilitators and barriers of a mental health learning initiative. *Gerontology & Geriatrics Education,* 30(1), 1-20.

Stone, R. I., Reinhard, S. C., Bowers, B. B., Zimmerman, D., Phillips, C. D., Hawes, C., A., F. J. & Jacobson, N. (2002). Evaluation of the Wellspring Model for Improving Nursing Home Quality. New York, NY: The Commonwealth Fund.

Strauss, A., Fagerhaugh, S., Suczek, B. & Wiener, C. (1985). *Social Organization of Medical Work,* Chicago and London: University of Chicago Press.

Strauss, A., Schatzman, L., Bucher, R., Ehrlich, D. & Satshin, M. (1963). The hospital and its negotiated order. *In:* Friedson, E. (ed.) *The Hospital in Modern Society.* New York, NY: Free Press, 147-169.

Suhonen, R., Valimaki, M. & Leino-Kilpic, H. (2002). "Individualised care" from patients', nurses' and relatives' perspective: A review of the literature. *International Journal of Nursing Studies,* 39 645-654

Szczepura, A., Clay, D., Hyde, J., Nelson, S. S. & Wild, D. (2008). *Models for Providing Improved Care in Residential Care Homes: A Thematic Literature Review* [Online]. Coventry: University of Warwick.

Szulanski, G. (2000). The process of knowledge transfer: A diachronic analysis of stickiness. *Organizational Behavior and Human Decision Processes,* 82(1), 9-27.

Tabak, R. G., Khoong, E. C., Chambers, D. A. & Brownson, R. C. (2012). Bridging research and practice: Models for dissemination and implementation research. *American Journal of Preventive Medicine,* 43(3), 337-350.

Tadd, W., Vanlaere, L. & Gastmans, C. (2010). Clarifying the concept of human dignity in the care of the elderly: A dialogue between empirical and philosophical approaches. *Ethical Perspectives,* 17(1), 259-87.

Tarde, G. (1903). *The Laws of Imitation,* New York, NY: H. Holt and Company.

Teno, J. M., Mitchell, S. L., Kuo, S. K., Gozalo, P. L., Rhodes, R. L., Lima, J. C. & Mor, V. (2011). Decision-making and outcomes of feeding tube insertion: A five-state study. *Journal of the American Geriatrics Society,* 59(5), 881-886.

Teune, H. & Przeworski, A. (1970). *The Logic of Comparative Social Inquiry,* New York, NY: John Wiley and Sons.

Theodosius, C. (2012). Social divisions in formal healthcare. *In:* Gabe, J. & Monaghan, L. F. (eds.) *Key Concepts in Medical Sociology.* 2nd ed. London: Sage Publications, 164-9.

Thomas, W. H. (2006). *In the Arms of Elders: A Parable of Wise Leadership and Community Building,* St. Louis, MO: VanderWyk & Burnham.

Thompson, G. N., Estabrooks, C. A. & Degner, L. F. (2006). Clarifying the concepts in knowledge transfer: A literature review. *Journal of Advanced Nursing,* 53(6), 691-701.

Thorne, S. E., Kazanjian, A. & MacEntee, M. I. (2001). Oral health in long-term care: The implications of organizational culture. *Journal of Aging Studies,* 15(3), 271-283.

Thornton, P. H. & Ocasio, W. (2008). Institutional Logics. *In:* Greenwood, R., Oliver, C., Suddaby, R. & Sahlin-Andersson, K. (eds.) *The SAGE Handbook of Organizational Institutionalism.* Ventura, CA: SAGE, 99-129.

Thornton, P. H., Ocasio, W. & Lounsbury, M. (2012). *The Institutional Logics Perspective: A New Approach to Culture, Structure, and Process,* Oxford: Oxford University Press.

Tobin, G. A. & Begley, C. M. (2004). Methodological rigour within a qualitative framework. *Journal of Advanced Nursing,* 48(4), 388-396.

Tolson, D., Booth, J. & Lowndes, A. (2008). Achieving evidence-based nursing practice: impact of the Caledonian Development Model. *Journal of Nursing Management,* 16(6), 682-691.

Tolson, D., Irene, S., Booth, J., Kelly, T. B. & James, L. (2006). Constructing a new approach to developing evidence-based practice with nurses and older people. *Worldviews on Evidence-Based Nursing,* 3(2), 62-72.

Train, G. H., Nurock, S. A., Kitchen, G., Manela, M. & Livingston, G. (2005). A qualitative study of the views of residents with dementia, their relatives and staff about work practice in long-term care settings. *International Psychogeriatrics,* 17(2), 237-251.

Tronto, J. (1993). *Moral Boundaries: A Political Argument for an Ethic of Care,* London: Routledge.

Tsoukas, H. & Vladimirou, E. (2002). What is organizational knowledge? *Journal of Management Studies,* 38(7), 973-993.

Twigg, J. (2004). The body, gender, and age: Feminist insights in social gerontology. *Journal of Aging Studies,* 18(1), 59-73.

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.

United Nations Department of Economic and Social Affairs - Population Division. (2002). World Population Ageing: 1950-2050 (report #ST/ESA/SER.A/207). New York, NY: United Nations.

van Maanen, J. (2006). Ethnography then and now. *Qualitative Research in Organizations and Management: An International Journal,* 1(1), 13-21.

van Weert, J. C. M., Janssen, B. M., van Dulmen, A. M., Spreeuwenberg, P. M. M., Bensing, J. M. & Ribbe, M. W. (2006). Nursing assistants' behaviour during morning care: Effects of the implementation of snoezelen, integrated in 24-hour dementia care. *Journal of Advanced Nursing,* 53(6), 656-668.

Vinje, H. & Mittelmark, M. (2007). Job engagement's paradoxical role in nurse burnout. *Nursing and Health Sciences,* 9, 107-111.

Vogus, T. J., Sutcliffe, K. M. & Weick, K. E. (2010). Doing no harm: Enabling, enacting, and elaborating a culture of safety in health care. *The Academy of Management Perspectives,* 24(4), 60-77.

Wacquant, L. (1989). A Workshop with Pierre Bourdieu. *Sociological Theory,* 7(1), 26-63.

Wacquant, L. (2005). Carnal connections: On embodiment, apprenticeship, and membership. *Qualitative Sociology,* 28(4), 445-474.

Wacquant, L. (2011). Habitus as topic and tool: Reflections on becoming a prizefighter. *Qualitative Research in Psychology,* 8(1), 81-92.

Waring, J. (2009). Constructing and re-constructing narratives of patient safety. *Social Science & Medicine,* 69(12), 1722-1731.

Welford, C. (2010). A concept analysis of autonomy for older people in residential care. *Journal of Clinical Nursing,* 19(9/10), 1226-1235.

Welford, C., Murphy, K., Rodgers, V. & Frauenlob, T. (2012). Autonomy for older people in residential care: A selective literature review. *International Journal of Older People Nursing,* 7(1), 65-69.

Wenger, E. (1998). Communities of practice: Learning as a social system. *Systems Thinker,* 9(5), 1-5.

Werner, R. M., Konetzka, R. T. & Polsky, D. (2013). The effect of pay-for-performance in nursing homes: Evidence from state Medicaid programs. *Health Services Research,* 48(4), 1393-1414.

Whyte, W. F. (1948). *Human Relations in the Restaurant Industry,* Oxford: McGraw-Hill.

Williams, G. & Busby, H. (2000). The Politics of "Disabled" Bodies. *In:* Williams, S. J., Gabe, J. & Calnan, M. (eds.) *Health, Medicine, and Society: Key Theories, Future Agendas.* London and New York: Routledge, 169-185.

Williams, S. J., Gabe, J. & Calnan, M. (eds.). (2000). *Health, Medicine, and Society: Key Theories, Future Agendas,* London and New York: Routledge.

Willis, P. & Trondman, M. (2000). Manifesto for ethnography. *Ethnography,* 1(1), 5-16.

Wilson, P. M., Petticrew, M., Calnan, M. W. & Nazareth, I. (2010). Disseminating research findings: What should researchers do? A systematic scoping review of conceptual frameworks. *Implementation Science,* 5(1), 91.

Wistow, G., Knapp, M., Hardy, B. & Allen, C. (1994). *Social Care in a Mixed Economy,* Buckingham: Open University Press.

Wittgenstein, L. (1958). *The Blue and Brown Books,* Oxford: Basil Blackwell.

Wittgenstein, L. (1998[1977]). *Culture and Value (Revised Edition),* Oxford: Blackwell Publishing.

Wolcott, H. F. (1999). *Ethnography: A Way of Seeing,* Lanham, MD: AltaMira Press.

Wolkowitz, C. (2002). The social relations of body work. *Work, Employment & Society,* 16(3), 497-510.

Wood, M., Ferlie, E. & Fitzgerald, L. (1998). Achieving clinical behaviour change: A case of becoming indeterminate. *Social Science & Medicine,* 47(11), 1729-1738.

World Health Organization. Bridging the "Know–Do" gap: Meeting on knowledge translation in global health. Meeting of the Knowledge Management and Sharing and Research Policy and Cooperation Groups, WHO, 2005 Geneva, Switzerland.

Wright, J., Varholak, D. & Costello, J. (2003). Voices from the margin: The nurse aide's role in pain management of institutionalized elders. *American Journal of Alzheimer's Disease and Other Dementias,* 18(3), 154-158.

Yanow, D. (2013 (forthcoming)). Interpretive Analysis and Comparative Research. *In:* Engeli, I. & Rothmayr, C. (eds.) *Comparative Policy Studies: Conceptual and Methodological Challenges.* Basingstoke: Palgrave Macmillan.

Yeates, N. (2004). Global care chains. *International Feminist Journal of Politics,* 6(3), 369-391.

Yin, R. K. (2009). *Case Study Research: Design and Methods,* London: Sage Publications.

Zickar, M. J. & Carter, N. T. (2010). Reconnecting with the spirit of workplace ethnography: A historical review. *Organizational Research Methods,* 13(2), 304-319.

Zimmerman, S., Williams, C. S., Reed, P. & Sloane, P. D. (2008). Obtaining evidence to inform practice and policy. *Alzheimer's Care Today,* 9(1), 9-17.

Zinn, J. O. (2006). Recent developments in sociology of risk and uncertainty. *Historical Social Research/Historische Sozialforschung,* 31(2), 275-286.

Zussman, R. (2004). People in places. *Qualitative Sociology,* 27(4), 351-363.