‘What Does Quality of Care Mean from a Resident’s Perspective of Living in a care Home’?

‘A Qualitative Descriptive Study’.

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Contents

Abstract

Purpose: Despite substantial regulatory oversight, quality of care within the care home sector remains problematic. The aim of the research is to improve quality of care for residents by asking those who live in care homes what quality of care means to them. These findings will drive changes for commissioners in the collection of quality data from the care home sector. The research project will mark the start of a progression in partnership working to cultivate impetus, clinical resources and guidance that will support the commissioners and providers in improving the experience and the quality of care for residents residing in a care home, with the resident's voice playing a central role to any potential changes in current practice. When individuals move into a care home, they are essentially moving from one home to another. The word 'home' should mean something special; a place that is filled with hope, friendship, love, and laughter. Regardless of age, health condition, or the place we call home, we all desire a good quality of life, to be able to do the things that mean the most to us, and to feel appreciated and valued. This influenced the decision to study the quality of care from a resident's perspective in the place they should be able to call home (Goodman et al, 2015). Therefore, this study will support the evidence base by exploring how to enhance the quality of care and experience of people residing in a care home, understanding what quality means to them, and ensuring that the residents voice is heard.

This study will seek to understand the perceptions of quality of care within a care home from those residing in care homes. Chiefly, that the present performance outcome measures are based on our clinical outcomes, but there is little emphasis on engaging in 'what matters' to residents which is the purpose of this study. The aim is to explore and understand the experiences, perceptions, of residents, which will start to bridge this gap and outline meaningful fulfilment. The hope is to learn how to create opportunities that afford each resident more control over what constitutes quality of care by listening, reflecting, and trying to understand their personal interpretations.

Research Aim: Define what 'Quality of Care' means from a resident's perspective.

Research Objectives:

- To generate knowledge of what quality of care means to residents residing in a care home.
- To develop an evidence base of what matters the most to residents from a lived experience perspective.
- To generate knowledge to inform commissioners of resident's perspectives of the quality of care in care homes.

Research Question:

'What does quality of care mean from a resident's perspective of living in a care home? A qualitative descriptive study'.

Design and Methods: The study will employ a Qualitative Description (QD) methodology. A Literature search will be adopted to extract terms, characteristics, experiences, and outcomes from relevant literature not just those solely related to nursing practice, in relation to improving quality of care within the care home sector. Following on from the literature review, the researcher worked with a third party (Health Watch) to conduct semi structured interviews with residents to determine what quality care means to them; with the intention of comparing the findings from the literature review to formulate the discussion. Once the semi-structured interviews had taken place the data was analysed by adopting a thematic analysis approach as developed by Braun & Clarke, (2017), this method of analysis was chosen as it is an appropriate tool for analysing qualitative data, and provides structure and flexibility for the researcher, and offers a rich and detailed, yet complex account of acquired data.

Results to Date: In the UK, most of the long-term care for older people is provided by staff working within the care home sector. As older people with complex health care needs tend to require more intense care and support, which in the most is offered by care homes, these places should be considered their home in which their quality-of-life matters. In 2020, approximately 419,000 people were recorded as living in care homes (NIHR, 2020) although this population is projected to rise by 127 percent over the next 20 years. This represents 4 percent of the population aged 65 years and over, and 16 percent of those aged 85 or more (NIHR, 2020). There are more than twice as many people living in care homes in England and Wales than people staying in hospital. Yet, care professionals know far more about effective treatments in hospital and less about what works most effectively to improve care for older people residing in care homes.

According to NIHR (2021), the English care home market for the elderly comprises just over 9,500 care homes, which primarily aim to provide for those who live with dementia or the general population of older people (NIHR, 2021). Much of the supply comprises single home providers or small, multi-home organisations, although there are some large chains. Around 15 percent of the market is supplied by non-profit providers (Villaire & Walsh, 2017).

The challenge this brings to our region is that research has shown that those areas with the most care homes have a higher incidence of emergency hospital admissions for patients over the age of 75 (Laing & Buisson, 2023).

It is apparent that the voice of residents with regards to what quality of care means to them within the sector is usually not heard according to the literature. In fact, it emerged that when improving residents' experience and quality outcomes, the focus is on the perspectives of professionals, policy makers and relatives, rather than those of the residents who live in the care home. The political saliency of nursing home quality remains uneven.

Implications: Quality of care in care homes is a major issue for which there is no simple solution. There is variation in practice, oversight, monitoring, and assurance processes of the quality of care within care homes. The consequence of not capturing what matters the most to residents is that we fail to deliver meaningful, quality or care.

Chapter One

Background and Introduction to the Study

Background

> ‘When patients are harmed, it has an impact on them, their loved ones, our staff, and others who work in the healthcare system. It is crucial that all staff, whatever their roles, see safety and quality not just as a collective responsibility, but as a key priority in order to keep people safe. We all need to think differently about what patient safety and quality means and how we can make improvements.’
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> (Lewin et al, 2020, p 11).

Understanding the best ways to measure and monitor the quality of healthcare is at the core of assurance and improvement work. It is vital to collect data around quality and safety within healthcare organisation to highlight problems and concerns, such as poor patient experience, increases in avoidable harm, workforce challenges and reportable incidents. A failure to collect or use this information has resulted in some notable failures in care, for example Mid Staffordshire - Francis Report (2013), Winterborne View (2013), and most recently the Okendon Report (2022). These demonstrate the importance of monitoring quality, seeking the assurance of commissioned services, and responding quickly as issues are identified or emerge. Most importantly, they emphasise the need to listen to the voices of service users and their families or representatives. It is vital that professionals listen to people and take action when things go wrong, whilst also sharing learning when things go well.

However, existing definitions and approaches which measure the quality of health and social care often fail to address the complexities involved in understanding this quality. Indeed, perceptions of quality, rather than clinical indicators of quality and patient outcomes, drive the monitoring of quality and scrutiny of services (Hall et al, 2019).

According to Norton et al (2014), perceptions of quality, clinical indicators of quality, and patient outcomes are all important aspects of assessing the quality of healthcare, but they represent different perspectives and dimensions of quality.

Perceptions are based on judgements and are subjective and are influenced by many factors (Towers et al, 2015). Whilst perceptions can provide a valuable insight into resident experience, they are not always aligned with measurable, resident focussed outcomes (Dequanter et al, 2020).

In the last decade, a broad range of measures and initiatives on the part of commissioners, services, regulators, and organisations have focused on the quality of care delivered and received within care homes and effort has been devoted to furthering the development of quality and its measurement. Yet, because of the diversity of ideas, cultural and organisational approaches, and concepts and models, it has not been possible to create a uniform, generally accepted definition of quality that brings together various viewpoints to form a consensus (National Institute for Health Research (NIHR), 2021). Therefore, it is not surprising that the main emphasis of practicalities remains on the quality of structures and processes. While it is worthwhile monitoring and enhancing the framework within which services are delivered and assured as well as the functional and professional basis of delivery, the quality of results and outcomes remain challenging. As with healthcare services, it is still difficult to disentangle the different aspects to produce a specific outcome and agree upon a common framework and understanding.

Quality measurement and oversight is vital within healthcare as performance assessment influences quality standards in provision and informs patient outcomes. Insufficient healthcare oversight can impede progressive healthcare services, thereby rendering the overall quality of care inadequate and unreliable which directly impacts on patients (Towers et al, 2015).

According to reports from the CQC (2013, 2015, 2020), over 90 percent of adult care services are provided by independent providers. The remainder is provided 'in-house' by local authorities via residential care and domiciliary 'home' care providers (NIHR, 2021). In respect of residential care, there are approximately 8,000 providers, with the largest 159 organisations attracting approximately 40 percent of the market share (Cutting Red Tape, 2016). The care home market is largely comprised of small and medium-sized enterprises (Laing & Buisson, 2014, 2018). The vast majority of residential and domiciliary care is provided by the private sector (78 percent and 91 percent respectively), while the remainder constitutes a mixture of public and voluntary provision (Cutting Red Tape, 2016). The market is split between state and self-funded care: 49 percent of residential care is funded by local authorities with a relatively small amount of funding from the NHS (Laing & Buisson, 2023).

Attempts have been made over the last two decades to improve both the quality of care and the standards of care within the care home sector by giving local authorities and the Care Quality Commission greater powers. This change occurred as a direct result of the introduction of the Health and Social Care Act (2014), and the introduction of the Fundamental Standards (CQC, 2015). However, according to Nazaoko (2000), such change was essential as previous legislation was vague and open to interpretation that resulted in commissioners and regulators applying different quality and contractual standards, and left providers overwhelmed, overburdened and unsupported (British Geriatrics Society (BGS), 2013). As these legislative changes have only just occurred over the last couple of years, the effects of the previous systems are still apparent within the commissioner and provider landscape. Thus, both health and social organisations have called for an agreed, co-produced, joint contracting and monitoring system between health and social care commissioners to improve the quality of the care provided (Department of Health, Social Care 2018, CQC, 2020, Laing & Buisson, 2023).

According to the literature, a joint, co–produced contract and monitoring system is essential to reduce duplication, variation, and the burden upon the care home sector (CQC, 2012, Laing & Bussian, 2014, 2018 & NIHR, 2021). As part of the researcher’s role (CCG, Chief Nurse) an audit was undertaken as part of the care home collaborative engagement sessions and the range of agencies identified as working with care homes was found to be considerable, inequitable, and uncoordinated. These services include primary care, community services and acute services. There are also authorities enforcing standards including the Care Quality Commission, Health and Safety Executive, Environmental Health, and Public Health England. In addition, providers contract with both health and local authorities, which could include more than one (NIHR, 2021).

Measuring quality of care has its challenges as the concept is so varied and conveys diverse meanings to those receiving it, as well as to loved ones, staff, organisations, and the wider public. Thus, the definition of quality in care homes can generally be separated into two distinct elements: 1) quality of care and 2) quality of life (Hall et al, 2019). The former are the technical aspects of care which the care home delivers by looking after the resident (Spilsbury et al, 2011). The latter is individual-based and concerned with residents’ satisfaction with life, including their level of control, privacy, interactions, safety, ability to carry out daily living activities, etc. (Goodman et al, 2015, Kerr et al, 2019 & Villaire & Walsh, 2017). Quality of care will be directly influenced by the competency and quality of care home staff and, whilst more subjective in nature, quality of care will be indirectly influenced by care home staff. Thus, staff and staffing characteristics in long-term care have an impact on satisfaction (Harrington, et al, 2012) and the perceived quality of service (Smith et al, 2015).

Quality of care is a fundamental goal for policymakers in the social care sector. At the same time, the social care sector is highly labour intensive and care home staff have a large bearing on the quality of care that residents receive. There is some evidence from the USA which suggests that staffing factors impact quality outcomes, but there is little evidence of this for the UK (Gilbert et al, 2020). However, no single person or organisation can improve the quality-of-care homes. Rather, everyone who uses, provides, commissions, oversees, or supports care and support services must play a part (Skills for Care, 2016).

However, 'quality', is a difficult concept to capture solely as an outcome measure (Villaire & Walsh, 2017). Resident or provider outcomes are often used as a proxy for quality and tend to emphasise clinical outcomes. Few studies take a wider view of resident outcomes, such as quality of care measures and social indicators. As such, a joint, co–produced contract and monitoring system is essential to reduce duplication, variation and the burden upon the care home sector (CQC, 2020, Laing & Bussian, 2023).

The Care Act (2014) aims to improve people's independence and wellbeing. It stipulates that local authorities must provide or arrange services that help to prevent people from developing needs for care and support, or that slows down their deterioration and thus their need for ongoing care and support. The NHS's *Five Year Forward View* (2021) sets out a shared vision for its future. It describes priorities for reducing unwarranted variation and enables more people to experience high-quality care. It also highlights the importance of engaging people in their own care and working with the wider community. The report by CQC (2019), entitled '*Distinctive,* *Valued and Personal – Why Social Care Matters'* sets out the particular role and value of social care in the 21st century. It highlights the actions required over the next five years to ensure services and systems are up to date, so that the right care and support can be offered in the right place at the right time. In addition, the Social Value Act (2013) requires organisations who commission public services to consider how they can also secure wider social, economic and environmental benefits in order to provide high quality care home provision.

Commissioners statutorily mandated to monitor and assure the quality, safety, effectiveness, and experience of the services provided. To achieve this, there are core data sets, NHS standard contract indicators, and performance targets which need to be addressed. Providers need to assure that the services they provide are fit for purpose, follow best practice, are evidence based, and do not cause harm.

In relation to the care home market, such indicators and statutory data sets are absent, leaving decisions about quality monitoring and oversight to local authorities and health commissioners (Kings Fund, 2019). However, the Care Quality Commission (CQC) (2019), as the regulator, mandates key lines of enquiry which are tried and tested tools to quality assure the provision of services.

Prior to COVID-19, locally agreed processes were in place to monitor bed capacity within the care homes which enabled communication with care home providers. This focused on the contractual and quality monitoring aspects of care and care home placements, and the need to share supportive information to inform and direct quality improvements. This area has required continuous review and refinement to obtain information that adds value, reduces variation, and improves the quality of care whilst reducing the burden on providers to assure numerous regulators and commissioners of the quality of care provided within their establishment.

However, the onset of COVID-19 highlighted a gap in the approach to monitoring and supporting the care market's ability to support their care staff and residents/service users, and to providing requested information on a local and national basis (NIHR, 2021). COVID-19 changed the landscape in which systems operate. It was acknowledged that statutory services need joint support from care providers - both residential and domiciliary - and should ensure that care providers are part of the health and social care system, meaning they are included in systemic decision making and reform from the outset. It is no longer acceptable to only focus on the care home market when things go wrong, when there are delays in decision making which affect discharge, or when there is a need to request a change in provision to better support community and acute services (Davies & Gnanapragasam, 2019). The care sector market is integral to system working and to the delivery of care in the right place at the right time.

Furthermore, it is important to monitor and gain assurances of the care and treatment delivered, because the quality of adult social care matters. People who use health and social care services should be able to expect person-centred care that is safe, effective, caring, and responsive. This care should be supported by good leadership, a competent workforce, and a fair price for care, and sustained by the effective use of resources.

Throughout the COVID-19 Pandemic, all UK systems including local systems, have been significantly challenged. Such systems have mainly coped and survived mainly because of integrated working and leadership. It could be argued that this period has seen the greatest shift in leadership culture for a generation. However, despite enormous effort to manage the care system and keep the public socially protected and clinically safe, the system remains far too reactive. Thus, the care system and processing of care needs are predicated on the volume of demand, which - by definition - is always variable and volatile (Giebel et al, 2018). This causes system stress and fatigue and does not provide assurance for the public, care professionals, regulators, the operational system, or partnerships.

As elderly care becomes more expensive, more than two in three Britons fear becoming a burden in their old age (NIHR, 2021). The Government has previously warned the health care system is facing a ‘Time Bomb’ due to its aging population (DH, 2012). As such, it is important that the quality of care provided is of the highest standard and measured against a robust reporting system. Moreover, the demand for long-term care services is predicted to increase, primarily as a result of longer life expectancy, as people with existing long-term conditions live longer and more people survive into very old age (DH, 2014).

Care homes currently represent the most intensive type of support provided to some of the most vulnerable members of the population and it is vital that they receive effective, outcome-focused, high quality, and safe care (DH, 2018). However, the measurement of quality and definition of quality poses many challenges, particularly for those living in care homes. The research will consider how quality of care is measured and monitored in a care home setting. Improving ‘quality’ care in care homes is an ambition of the researcher, due to the significant challenges witnessed as part of their chief nurse role along with the findings by Goodman et al (2015) and Harrington et al (2012), which outlines the impact poor quality of care has on residents and the wider health and social care system. However, unless there is a commitment by all healthcare professionals that is supported by social services, NHS, regulators and independent care home staff, the Department of Health, and other interested agencies, the outcome of this research is unlikely to have a positive influence in the future for residents in care homes.

Whilst there is a genuine commitment to assuring and improving the quality of services in the absence of a central approach, local providers often develop ad hoc systems which respond to local needs and commissioning requirements and create significant risk within the system. This creates challenges for providers and commissioners, and limits comparability and usability from the perspective of someone using services. It may also affect this research, as it can prove difficult to measure ad hoc systems or introduce a health economy wide system that all providers can utilise.

With a shift towards high quality outcomes for people who use social care services and increasing focus on value for money, there is an urgent need for these goals to be supported by high quality intelligence and reporting systems, which this research will identify. However, leadership is key to achieving any change within the NHS and social care.

Introduction to the Study

When individuals move into a care home, they are essentially moving from one home to another. The word ‘home’ should mean something special; a place that we hope would be filled with friendship, love, and laughter. Regardless of age, health condition, or the place we call home, we all desire a good quality of life, to be able to do the things that mean most to us, and to feel appreciated and valued. This influenced the decision to study the quality of care from a resident’s perspective in the place they should be able to call home (Goodman et al, 2015). Therefore, this study will support the evidence base by exploring how to enhance the quality of care and experience of people residing in a care home, understanding what quality means to them, and ensuring that the residents voice is heard.

The move into a care home for many individuals is a significant life event, particularly for those with multiple co-morbidities or those nearing the end of life. This move necessitates a holistic approach to care and treatment which addresses not only physical health needs, but consideration must also be given to emotional wellbeing, social and spiritual wellbeing (Razavi, 2016). Holistic or resident centred care, alongside principles derived from the hospice movement, plays a crucial role in ensuring that residents receive compassionate, individualised care during this transition along with the continuation of providing a home from home experience (James, 2013).

This study will seek to understand the perceptions of quality of care within a care home from those residing in care homes. Chiefly, that the present performance outcome measures are based on our clinical outcomes, but there is little emphasis on engaging in ‘what matters’ to residents, which is the purpose of this study. The aim is to explore and understand the experiences and perceptions, of residents, which will start to bridge this gap and outline meaningful fulfilment. The hope is to learn how to create opportunities that afford each resident more control over what constitutes quality of care by listening, reflecting, and trying to understand their personal interpretations.

In response to the NHS Long Term Plan, Integrated Care Systems (ICS) are expected to develop ambitious plans to respond to the health and wellbeing challenges faced by local communities and to make best use of available resources. A key component of the proposed ICS System Reform Plan is the continued focus on Mental Health, Learning Disabilities and Autism services (alongside all social care provision), with a particular focus on care home settings. The proposed new legislation set out in The Health and Care Bill (2022), offers an opportunity to further align partners across systems, building upon lessons of the pandemic, recommendations from quality failings, learning from safeguarding alerts, and feedback from patients and service users.

Each Integrated Care System will be required to develop an ‘Integrated Care Strategy’. Developing system strategies for care home provision in an integrated fashion will allow for the agreement on a clearer framework with a shared purpose and vision for the quality of care for the population.

The researcher currently leads a care home collaborative as part of the role as commissioner and chief nurse. This is a forum to bring care home managers, leads and partner health professions (from the acute and community sector) together to create a community of practice. A space for sharing of information, policies, good practice, along with learning from incidents. This is held monthly and provides a valuable space for bringing the system together to make a difference to residents and improve relationships between sectors. This is essential to ensure residents who require a hospital admission or care within the community experience a seamless encounter across sectors and between health professionals. It also supports the concept of appreciative learning between health professionals working in various roles.

Within the care home collaborative, additional thoughts, and views of areas for improvement are often shared by providers within the care home market, which included the following (Source – Care home collaborative session):

- No single organisation can do everything.

- A long list of possibilities needs to be prioritised due to resource constraints.
- Once agreed, all partners need to focus efforts on those priorities.
- There is a need to recognise the importance of local/place strategies and how links are made with system wide strategies to ensure value is added, and there are no duplications or distractions.
- It must add value for the taxpayer.
- There needs to be parity of access to health and social care.
- It is essential that high quality care is available for all.

Part One: The 'Why'

For the purposes of this research, the adopted description of the care home sector is that homes '*offer accommodation and personal care for people who may not be able to live independently. The care and nursing home sector delivers a crucial service, supporting those who need residential or nursing care in a place other than their own home*' (CQC, 2015 pg. 11).

Nursing and residential care homes have a duty to provide residents with quality care in a mutual and safe environment, where staff know their residents and residents know the staff. Residents, their families, and carers should be involved in the care provided, and feel that their opinions are sought and respected. The report produced by NHSE (2016*), Enhanced Health in Care Homes Framework – New Models of Care* (EHCH) (NHSE, 2016), found that person-centred care (PCC) is critical, which is a stance I promote to make meaningful improvements in the workplace. Yet, PCC is still not widely reflected and is lacking robust evidence despite the publication of the framework (DH, 2018).

The aim of the research study is to generate knowledge which will inform practice; this will be achieved by interviewing residents on what quality means to them and by comparing these findings to the literature review. The findings will provide an evidence base to consider if change is required by commissioners and providers through the collection of data on quality from care home residents. The data will be meaningful, add value, be resident-centred, and evidenced-based.

The linguistic variables mean that ‘quality of life’ and ‘quality of care’ (focus of the study) are difficult concepts to operationalise with multiple meanings and paradigms, as each party brings different perspectives and delivery-expectations. For example: providers define their expectations of service delivery, commissioners or regulators set metrics to be measured and achieved, and residents come with expectations of quality care, (Griffiths, 2008, Levy, 2015). I agree with Fossey (2014), that quality of care is a key concept whether we can accurately define it or not, and a robust mechanism is required to capture and monitor what is important to the population, particularly those we serve as practitioners.

As a practitioner currently working within the field of commissioning, with direct experience of the impact of a failing care home due to quality failings, I have a desire to make a valuable change to quality improvement within the care home sector. This desire has underpinned the research aim. One objective of this study has been to generate knowledge to inform how commissioners use quality metrics within a care home setting to assure quality of care within a care home setting. The study considered whether the right quality metrics, measurements and indicators were utilised to understand quality of care outcomes from a resident’s perspective.

This study aimed to ascertain what quality of care means to the residents in care homes, to ascertain if commissioners and regulators are monitoring and measuring the true, meaningful indicators of quality, which add value and improve patient outcomes. It was therefore vital that appropriate methods were identified and applied to this study, to enable insight, greater understanding and change for the populations residing in a care home. The design reflected the aim of the thesis and the methods employed served to illicit the richest data and transparency at every step and is outlined in (Table 5 and Figure 2).

Researching quality indicators from a care home perspective is not just a matter of academic curiosity; it is a fundamental necessity according to Smith et al (2015), with profound implications for the well-being of residents, the efficiency of care delivery, regulatory compliance, staff training, and broader public health considerations. The rationale for researching quality indicators from a care home resident perspective explores the myriad reasons why such research is not only important but also essential to the care home industry and social care market shaping agenda (Hinsliffe – Smith, 2020).

At the heart of any care home's mission, is the commitment to provide the best possible quality of care for its residents. Researching quality indicators from a resident perspective is a means to achieve an understanding from those with a lived experience to make a difference to residents residing in a care home. Researching quality indicators from a resident perspective is a means to achieve an understanding from those with a similar lived experience (i.e. other residential home life recipients) in order to make a difference to residents inhabiting a care home.

By investigating various aspects of care, from the physical environment to the interactions between staff and residents, along with reviewing quality indicators and guidelines, care homes can tailor their services to create an environment that prioritises resident and staff well-being.

Quality indicators research helps inform how providers, commissioners and regulators can structure measures to ensure that residents are not just cared for but are truly at the centre of the care home's operations. It supports the identification of areas where improvements can be made to enhance residents' physical, emotional, and psychological health, ultimately leading to a better quality of life.

One of the core principles of quality improvement is that it displays elements of ongoing continuous iterative cycling of the improvement process, to refine and compound positive aspects (Patterson et al, 2010). Care homes are no exception to this rule. Without ongoing assessment and monitoring of key quality indicators, it is challenging to identify areas where improvements are required (Oliver et al, 2014).

Many countries have stringent regulations and standards that care homes must adhere to (CQC, 2015 and Moore & Hanratty, 2013). These regulations are designed to ensure the safety and well-being of residents are paramount. Researching quality indicators is essential for care homes to meet these regulatory requirements whilst improving the care and treatment delivered.

According to Croft (2017), researching quality indicators within a care home can ensure that they are adhering to all relevant laws and regulatory standards. This includes everything from infection control protocols to fire safety measures. Failure to meet these requirements can have severe consequences to life, including fines, the suspension of operating licenses, and damage to the reputation of the care home and those who contract with them, such as health commissioners. (CQC, 2015).

Researching quality indicators often includes assessing resident satisfaction. This aspect of research is particularly crucial because it emphasises the importance of tailoring care to meet individual needs and preferences.

When care homes actively seek feedback from residents and their families, they gain insights into what is working well and what could be improved. This feedback loop allows care homes to provide a more personalised experience for residents, which is essential for their well-being and overall satisfaction. This, according to Schenk et al (2013), supports regulators and commissioners to make informed decisions when it comes to contracting with care home providers for them to commission care on their behalf.

Care homes are only as good as their staff, according to Kemp (2019), and Hinsliffe - Smith (2020), as the home is only a building and the care is always nuanced, and as suggested by the word care, relies on the abilities, motivations, and diligence of those employing the care (Spilsbury et al, 2011). The quality of care provided is directly linked to the knowledge, skills, and attitudes of the care home's workforce. Researching quality indicators from a care home resident perspective can shed light on areas where staff training, and development improvements are required to improve standards of care.

Efficiency is a critical concern for care homes, especially in a healthcare landscape where resources are often limited. Researching quality indicators can support care homes and commissioners to optimise their operations by identifying areas where resources are underutilised or overburdened, especially in a post pandemic landscape.   The arrival of this set of circumstances thrust upon the world has created previously unforeseen and unplanned challenges. There has been an impetus to innovate and break the inertia to approaching problems with a new perspective and vigour, without the traditional bureaucracy. This was primarily brought about by necessity which meant making decisions quickly and purely on the merits as they occurred, rather than on the long held rigid pathways, which has reaped unexpected successes in rapid time, contrary to normal circumstances where the transition of new best practices into common use is reported to take an average of 17 years (Kerr et al, 2019). Taking note of quality may enhance our decision making and not reduce it down to quantitative detail (Dequanter et al, 2020).

Researching quality indicators allows care homes, commissioners, and regulators to benchmark their performance against standards and the performance of other care homes. This comparative data can be a powerful driver of excellence when monitors, assured, achieved, and delivered well (Forder & Fernandez, 2011). Should the measures remain the same, they are useful within a limited paradigm of comparison and standards, but this has the inherent danger of negating the vital component that allows innovation within improvement, namely that of looking at new dimensions.

When care homes have access to data that shows how they measure up to their peers, they can set realistic and achievable goals for improvement. This competitive spirit encourages care homes to continually strive for higher quality care and better outcomes for their residents (Dequanter et al, 2020). Beyond this though, this study wants to generate knowledge to support measurements being correctly aligned. In particular, aligning the focus to the service of the individual from the perspective of the individuals wishes, who are living in residential care. Thereby, achieving a meaningful dimension to quality of care, rather than relying on the perspective of service providers and commissioners assumed quality of care outcomes.

Transparency is a cornerstone of a culture of quality in care homes. Research on quality indicators promotes accountability by encouraging open communication and reporting of performance data.

According to Kim et al (2017), care homes that engage in quality indicator research are more likely to take responsibility for their actions and outcomes. They are also more likely to proactively address issues when they arise, knowing that transparency is key to maintaining trust with residents, families, and regulatory authorities.

Transparent reporting of quality indicators also helps residents and families make informed decisions when choosing a care home. They can use this data to assess the quality of care provided and select a facility that aligns with their expectations.

Improving care quality can lead to cost savings in the long run. Preventable adverse events, such as hospitalizations due to poorly managed health conditions or infections resulting from inadequate hygiene practices, can have significant financial implications for care homes and commissioners alike (Bowers et al, 2016).

Research on quality indicators helps care homes identify areas where proactive measures can prevent these adverse events. By investing in prevention, care homes can reduce healthcare costs and enhance the overall financial sustainability of the organisation. Cost savings can be redirected towards improving care delivery, investing in staff development, and enhancing resident services.

Researching quality indicators from a resident perspective is not merely an academic exercise; it is a critical component of providing high-quality care and ensuring the well-being of residents. It serves as a continuous improvement tool, facilitates compliance with regulations, enhances resident satisfaction, improves staff training, optimises resource allocation, builds trust within the community, drives excellence through benchmarking, fosters a culture of quality, promotes transparency and accountability, and ultimately leads to cost savings. According to Neergaard et al (2009), care homes that prioritise quality indicator research are better equipped to fulfil their mission of providing the best possible care, but it is also vital that the metrics that are formulated are carefully created to direct accurately to the ends they intend to support. Therefore, a metric that is to measure quality of care on behalf of a resident which does not involve in its formulation what the resident thinks quality of care is, risks making the error of negating itself, and worse could in fact be counterproductive to realising the ends which it suggests it upholds.

Part Two: The Aim

The aim of the study was to understand what quality means from a resident's perspective to inform if quality data gathered from the care home sector was meaningful and truly resident focussed. This study is particularly relevant to providers, commissioners and regulators of care, as current figures show that, despite growing demand, more care homes are closing than opening (NIHR, 2021). Therefore, it is imperative a solution is found by first understanding the issues, particularly those relating to the quality of care, data, and market shaping (Laing & Buisson, 2014, 2023). Even though this was stated 10 years ago, this call to action is still relevant and important today. Without this deeper understanding, and due to the absence of robust, evidenced-based monitoring systems, home closures and failings will continue to become the norm.

Commissioners have established metrics to measure and monitor quality within care homes. However, in my experience many aspects of what residents report are not captured within these metrics and are gathered incidentally by the inspector's intuition and by conversation during an on-site visit.

These gossamer threads would be lost by the untrained or inexperienced eye. Yet, this ethereal understanding is the pinnacle of the lived experience and crucial for understanding, and consequently striving for quality improvement.

The essence of this study is to generate new knowledge in understanding of concepts which may have been left unexplored by the utilisation of the current quality measurement tools. Therefore, the intention of the study is looking to fill the gaps of what is currently not being monitored by commissioners or stop monitoring care homes based on assumptions of what is classified as valuable and significant to residents.

In conclusion, the important distinction of asking the views of residents before the formulation of the assessment of services seems to be the more logical approach to seeking assurance, rather than the traditional approach of pursuing feedback on an already established set of quality indicators. This traditional approach poses the risk of residents providing views in a biased context, such as confirmation bias and therefore can be a risk as it negates the important narrative of what matters to residents and the purpose of service delivery. Another consideration of biased views, in quality monitoring from a resident’s perspective, can refer to instances where the judgement of quality may not accurately reflect the needs of the resident. There may also be an element of institutional policies and practices, such as poor staffing levels or limited social activities which can impact on the overall experience of the resident. If these factors are not seen to be adequately addressed in quality monitoring, it can lead to a biased assessment of care from the resident’s perspective (Giebel et al, 2018).

Part Three: The Impact of Poor-Quality Care

The poor quality of care found or reported in care homes can lead to restrictions or suspensions (CQC, 2019). This means that admissions to homes reduce or cease, which not only has an impact on the care homes financial viability, but on the wider system as the number of beds available for patients will be reduced, which results in delayed hospital discharges (NIHR, 2021). According to Goodman et al (2015), poor quality of care impacts on residents living within the home who experience an increase in footfall as assurances of resident safety become the focus for regulators and commissioners. The workforce is also affected, particularly the manager, as the request for data submissions and evidence requests increase due to this greater scrutiny (Kim et al, 2017). Again, this adversely impacts on care and the treatment of residents as staff are taken away from their day jobs leaving less time to care (Croft, 2017).

Furthermore, according to Castle & Anderson (2011), if improvements are not realised, and assurances of safety are not obtained, this can result in care home closures which those concerned want to avoid. The closure of nursing and residential care homes causes significant distress amongst residents, relatives, the local community, and the workforce (Kemp, 2019). Closures also place additional pressure on an already over-stretched and recovering health and social care system, which potentially defers problems and places residents at risk of poor-quality care and outcomes (Bardsely, 2010, Duppen et al, 2020 & Griffiths et al, 2017). In recent years, several cases of care home have been closed due to quality failings meaning the total number of care homes has reduced by 25 percent at a time when the impact and aftermath of the pandemic has created challenges for the sector (CQC, 2019). Therefore, it is paramount that a change in focus takes place quickly for not only residents but both commissioners and providers.

COVID-19 exerted additional severe challenges on the nursing home population and its workforce (Stevenson & Cheng, 2021). Both internal and external factors predisposed nursing homes to an increased propensity of spread. Numerous strategies were employed to mitigate the negative impacts, and substantial learning has occurred to aid future pandemic preparedness and improve the quality of care for nursing home residents (Daly, 2020). According to Heneghan et al (2022), such strategies include accelerated improvement programmes and the implementation of recommendations from this learning.

According to Hall et al (2019), care home failings and struggles should seldom occur without the prior knowledge of those who can potentially help to support, respond to issues, and maintain quality. However, this is not always the case, which raises questions as to how commissioners monitor services, seek assurance, and respond to the quality concerns identified (CQC, 2019). It is also necessary to establish where professional accountability and responsibility lies by visiting professionals who witness and experience poor practice. The response does not have to be financial, but should be focussed with a bespoke, proportionate response to the concerns uncovered and supported by the Integrated Care System (ICS) (Godden, 2001, CQC, 2013, 2019 & NHSE, 2021).

There have been a number of high-profile safeguarding and provider failures in recent years which have impacted on viability and credibility of the care home sector. When coupled with increased regulation, the health and social care economy saw a reduction in care home provision for the first time in a decade (NIHR, 2021), furthermore, this national picture is reflected locally. As a commissioner, the capacity within the local system for care home beds has reduced by 144 in 3 years and the impact can be seen in the daily delayed transfers of care reported by hospitals, increases in primary care and community referrals, and the number of residents in their second or third home due to closures or quality concerns.

This is a hugely important and integral sector that is currently very vulnerable. To live within a care facility is an incredibly important decision that is taken by or on behalf of individuals who are often extremely vulnerable. The nature and quality of care have massive impacts on a person's happiness, health, and longevity and - as professionals working in health and social care - we have a duty to ensure quality care and treatment every time, all the time (Towers et al, 2015). As such, this research will support commissioners and providers by improving the experience and quality of care of residents in care homes, with the resident's voice playing a central role to any potential changes in current practice.

Part Four: Background and Overview of the Regulated Care Sector

In the UK, most of the long-term care for older people is provided by staff working within the care home sector. As older people with complex health care needs tend to require more intense care and support, which in the most is offered by care homes, these places should be considered their home in which their quality-of-life matters. In 2020, approximately 419,000 people were recorded as living in care homes (NIHR, 2020), although this population is projected to rise by 127 percent over the next 20 years. This represents 4 percent of the population aged 65 years and over, and 16 percent of those aged 85 or more. There are more than twice as many people living in care homes in England and Wales than people staying in hospital. Yet, care professionals know far more about effective treatments in hospital and less about what works most effectively to improve care for older people residing in care homes.

According to NIHR (2021), the English care home market for the elderly comprises just over 9,500 care homes, which primarily aim to provide for those who live with dementia or the general population of older people (NIHR, 2021). Much of the supply comprises single home providers or small, multi-home organisations, although there are some large chains. Around 15 percent of the market is supplied by non-profit providers (Villaire & Walsh, 2017).

The challenge this brings to our region is that research has shown that those areas with the most care homes have a higher incidence of emergency hospital admissions for patients over the age of 75 (Quality Watch Smith et al, 2015). There are other challenges that do not currently have a robust, evidence-based system in place to monitor or review the following:

- The size and complexity of a home in comparison to their emergency admissions and standard mortality ratios.
- Enhanced intelligence on end-of-life care pathways and the link to excess emergency admissions.
- Those residents who are high service users, the reasons why and mechanisms to challenge care homes whose residents have frequent short stays.
- Why homes cannot currently meet or sustain quality standards.

The population of care home residents has changed dramatically over the last five to ten years, to include people living with severe frailty and illness. The average care home resident is likely to be female, aged 85, and have a life expectancy of 12-30 months (NIHR, 2021). She may have six or more diagnoses, taking seven or more medications and live with physical disabilities and mental health problems in addition to physical health complaints. Some residents with severe and complex health care needs are wholly funded by the NHS by means of continuing health care (CHC) or are partly funded through nursing care contributions (FNC). Others are self-funded, with their care paid for by the local authority (LA), or a mixture of NHS and LA. Meeting the health and care needs of this vulnerable group of older people is a significant challenge for the NHS, local authorities, and care home providers.

However, care home providers are facing complex challenges that, in turn, risk negative impacts on the people who rely on them for care and support. According to Castle & Anderson (2011), & Hall et al (2019), and Jansen et al (2019), These include:

- Rising needs from an ageing population with increasingly complex conditions.
- Rising costs to providers of adult social care.
- Restricted public funds to meet those costs and a strain on the resources of those who pay for their own care.
- Serious challenges in recruiting and retaining good quality, competent staff.
- Impact of COVID-19 (PPE, testing regimes and environmental changes).
- Negative public perceptions of the social care market.

The recent changes in demographics within the care home population have partly arisen because of a policy shift towards maintaining older people’s independence for as long as possible and improving the care provided to people in their own homes or within the community (often referred to as ‘home first’) (Croft, 2017). Therefore, entry into a care home is delayed until older people’s health problems have become difficult to manage at home, or where the safe ceiling of care in the community has been met. People whose care is paid for by a local authority or trust may go into a care home at a later stage than those who self-fund, which poses an ethical question of parity (Laing & Buisson, 2023). At the same time, the long-term management of conditions that affect older people, including heart disease, dementia, and other long-term conditions, has improved.

Across all these areas of research activity, supporting partnership working between care homes and the NHS - at individual, organisational and system levels - is key to achieving outcomes that matter to residents and their relatives. Research has helped to explain why such partnerships sometimes work well and sometimes fail. Both policy documentation and research studies have started to explore, in earnest, the pivotal role of the care home manager in creating a culture in homes that enables change (Levy, 2015 & Duppen et al, 2020). New studies (examined in Chapter Three) are addressing the important question of what kind of workforce is required to deliver the best quality of care.

There is relatively little evidence of the development and utilisation of lived experience quality indicators when commissioners monitor care homes, particularly in the UK; these gaps were identified in the literature review.

While conducting research to improve care, some researchers have recognised the importance of the care home context, and that research works best when informed by the expertise, values and priorities of residents, relatives, and front-line staff. The most successful research projects involve a partnership approach to their work, and steps to ensure everyone involved is enabled and supported. This means ensuring residents have their say, that care homes benefit from their participation, and researchers have the support they need to work in this setting.

Part Five: The Residents

Care home residents are under-represented in research studies (Davies & Cripacc 2008). Funders, providers, and researchers have, in the past, incorrectly assumed that they have nothing to say or that it is too difficult to include them. However, they are the experts in this field and their contribution is key to making improvements to the care that they receive; thus, it is important their voices are heard.

The findings from research studies can be instrumental in helping to raise standards of care in care homes. Providing the evidence needed to encourage changes in practice and develop new ways of working from residents’ perspectives is key to quality assurance and improvement. Research has the potential to lead improvements in the quality of care or wellbeing of residents and care teams. Given the current sustainability and quality crisis within the care home market, this represents an opportunity for further research to make a difference, especially from a service user perspective. Moreover, people in care homes and their families may want to be involved in research for a variety of reasons, such as the desire to give them a voice, a greater sense of purpose, increased self-esteem, more control or choice, and improvements in residents’ experiences.

It is important to ensure that there are opportunities for care home residents to participate in research studies. They may have different ideas about what quality of life or care means which are critical to elicit when trying to establish what quality of care really means to them. Research provides an opportunity to develop the evidence base to guide best practice in care homes, essentially from user and carer perspectives where there are clearly identifiable gaps in the literature. Whilst there are mechanisms for resident feedback which appear as satisfaction surveys and have proved valuable in making some improvements, we need to build on these and include the issues that matter the most from those who matter the most.

As the aim is to understand what quality of care means from a resident's perspective, findings from the literature review were compared to residents’ views about important quality outcomes and what commissioners and regulators should be measuring.

These were evaluated to identify the true indicators and measurements of quality within a care home setting. The carers' perspectives did not form part of this study, as there are currently other mechanisms to capture this feedback; however, this area needs further consideration although it lies outside the priority for this study, which is to understand residents' views.

Part Six: What is Quality?

Quality of care is found to be a significant predictor of mortality, physical dependence and service utilisation among older people (Lewin et al, 2020, Gilbert et al, 2021 & Chadborn et al, 2021). Care home residents are more likely to experience a reduced quality of life due to deteriorated health conditions, changes in their living environment, inflexible daily routines and altered social interactional patterns (Oliver et al, 2014). Thus, promoting better quality is acknowledged as the goal of regulated care from a health and social care perspective (Blood, 2010, Moore & Hanratty, 2013 & Hinsliff et al, 2020).

It could be anticipated that care quality is variable, and this diversity does not just relate to the care home sector as variation can be seen across NHS services and organisations.   While there are many good care homes, there are also some unacceptable and unreliable providers, which have a profound impact on residents and their loved ones and undermines public confidence in the sector as a whole.

Part Seven: The Impact of Closures

The statement of intent addresses the reasons why care homes are failing to deliver high quality care and what can be done to address this to improve the care home experience for residents and sustaining the market for future provision. This study is of relevance to providers, commissioners and regulators of care as current figures indicate that more care homes are closing than opening despite, the growing need for this service (NIHR, 2021).

Although, in a market-based system, closures should naturally remove the weakest firms from the market, the closure of care homes is important as this can lead to supply issues (which affect current and potential residents). The closure of care homes (both nursing and residential) has the potential to cause significant distress amongst residents, relatives, and a workforce already under increased pressure. Closures also create tensions for an over stretched health and social care system which have the potential to place patients at risk of poor-quality care, including delayed episodes of care, delayed discharge, and negatively impacted patient flow within the health and social care economy (Castle et al, 2019 & Hall et al, 2019). There have been a number of cases of care home closures within the North of England over the course of this study, due to quality failures, meaning it is paramount that commissioners and providers change their priorities when it comes to responsiveness, assurance mechanism and contract management.

This research study marks the start of a progression in partnership designed to cultivate impetus, clinical resources, and guidance to support commissioners and providers by improving the experience and quality of care of residents in care homes. Thus, residents’ voices play a central role to any potential changes in current practice.

Part Eight: Workforce Challenges

Integrated care systems face significant and urgent workforce challenges across health, and social care. The inability to recruit, retain and equip the workforce for the changing world of social care and health, threatens the ambition to deliver good quality services and outcomes. Without a stable, good quality and developing workforce, costs will increase, quality will reduce, and a risk will arise that the growing and changing needs of the population will not be met.

The Integrated Care Systems (ICS) in its current form, has a People Board in place, although it was designed for a different purpose and comprised predominantly NHS organisations. There is a drive to include social care providers as key stakeholders within decisions and planning, which is designed to encourage integrated systems rather than silo organisations. It is evident that, by not addressing workforce challenges, the system relies on an unstable, transient workforce that increases the risks to patients and the sustainability of the system (Heneghan et al, 2022).

Within my area of work, collaboration between social care and the NHS has worked well during the pandemic, and there are examples of best practice in all areas of the workforce across the system. However, these have largely been responsive and operationally led. Tackling the scale of the workforce challenges will require a strategic approach with multiple partners operating at scale (and implementing in places), and a systemic approach to disseminating best practice (Stevenson & Cheng, 2021). There is a drive to capitalise on size to spearhead a collaborative approach to work that drives change. This includes working with higher education authorities to prioritise the development of roles in this sector that are attractive, credible, and valued. There needs to be an agreement on how the system provides employment for the breadth of people who live within each integrated care system across the country.

Findings from the ICS’s were as follows (NHSE, 2021):

- Some posts remain stubbornly difficult to recruit to, e.g. domiciliary carers, therapists, mental health, and general nurses.
- Costs are incurred in having to continually recruit, alongside the cost and risk associated with agency use and unfilled roles.
- Poor CQC ratings are apparent in health and in care services (inadequate or requiring improvement).
- Pay terms and conditions are a significant barrier for recruitment and retention.
- Agreements by organisations are sometimes transacted without any accountability.
- Competition between the sectors, i.e., between the NHS and local authorities, and between care and retail/hospitality, impedes retention and stability.
- Progression routes not always clear or available and deter people from joining or staying.
- Diversity in the workforce does not always reflect communities and neighbourhoods.
- This is an aging workforce that faces difficulty in attracting younger, new recruits.

The challenges we face as a system are complex and cannot be resolved in the short term. Thus, to make a difference, we need our collective energy and commitment with a clear set of actions and deliverables. We need clear agreements, shared accountability, and processes to ensure that decisions which are agreed are transacted. The newly formed People Boards need clear lines of accountability to the Integrated care Board (ICB), Integrated Care Partnership (ICP) along with links to place.

The following outlines the research aim, objectives, and question for this study.

Research Aim:

- Define what ‘Quality of Care’ means from a resident’s perspective.

Research Objectives:

- To generate knowledge to inform how commissioners use quality metrics within a care home to gain assurance of the quality of care being delivered.

- To generate knowledge of what quality of care means to residents residing in a care home.
- To develop an evidence base of what matters the most to residents from a lived experience perspective.

Research Question:

‘What does quality of care mean from a residents’ perspective of living in a care home: A qualitative descriptive study’.

Chapter Two

Literature Review

Introduction

This chapter is divided into two parts; the first presents the research question and the literature search that was undertaken to inform the study, while the second presents the findings from the literature review which are presented in themes.

Part One: Overview and Literature Search

Overview

A systematic search of the literature published between (2010 – 2020) was undertaken to identify research evidence on the quality indicators used by commissioners for people living in care homes. A further review of the literature was undertaken due to a break in academic studies as a consequence of the global COVID-19 pandemic. Therefore, a further literature search was undertaken for 2020-2022 which identified two further studies.   Information on the study setting, sample characteristics, and key findings were extracted for comparison and integration.

This time period of 2010 - 2022 was chosen due to changes within CQC regulations, the formation of clinical commissioning groups (now Integrated Care Boards ICBs), and the publication of the NHS long term plan. An overview of the inclusion and exclusion criteria is presented alongside the search strategy.

The literature for this qualitative discussion (QD) was sought using a systematic approach and by conducting a comprehensive search of relevant databases (Neergaard et al, 2009 & Sandelowski, 2000). According to Kim et al, (2001), this approach allows for the production of a systematic narrative, a clear presentation of themes, and the synthesis of findings.

Method

The search strategy for investigating the quality of care in care homes from a resident's perspective involves evaluating the approach used to identify relevant literature, potential biases or limitations in the selected sources, and considerations for ensuring the inclusivity and comprehensiveness of the research findings.

It was important that the residents voice was captured within the studies as this is a critical aspect of the research, therefore the key word selection was crucial for capturing the relevant literature which is required to inform the study. The key words reflected the resident experience, such as 'resident perspective', 'resident view or 'patient view'. Only results in English and from peer-reviewed journals were considered for this review.

Care homes serve a diverse population of residents with varying backgrounds, needs, and preferences. Therefore, the search strategy aimed to include studies that reflect the diversity to ensure the findings where representative and applicable to a wide range of residents.

There may be a tendency for published literature to focus more on objective measures of quality of care, rather than subjective experiences from the resident's perspective. It is important to critically evaluate potential publication bias and consider grey literature, unpublished studies, or reports from advocacy groups that may offer valuable insights.

A critical appraisal of the selected studies was undertaken, along with a focus on ensuring ethical consideration. By critically evaluating the search strategy and considering these factors, a further enhancement of the rigor and validity on quality of care in care homes could be assured.

A systematic search of the literature published between 2010 – 2019 was initially conducted, which was followed by a further search for 2019 – 2023. The literature search was undertaken to identify research evidence on the quality indicators of care of residents residing in a care home from a commissioner's perspective. Nineteen publications were identified following the search strategy and a search of the selected databases (Table 2) which met the inclusion and exclusion criteria.

The full search inclusion and exclusion criteria are presented in (Table 3), while a range of electronic databases were searched for articles from 2010 - 2019 and 2019 – 2023 (as listed in Table 1). These were: Cumulative Index to Nursing and Allied Health Literature (CINAHL), The Cochrane Library, CINAHL, Pubmed, and Medline. A search strategy was developed using the terms outlined in (Table 2) to ensure a comprehensive review of the six databases, and synonyms of these words were subsequently used, as well as the Boolean operators AND/OR.

Table 1: Databases Searched

Medline
Cumulative Index to Nursing and Allied Health Literatures (CINAHL)
Pub Med
The Cochrane Library

Table 2: Keyword Search Terms

Quality of care
Or - Quality measures
Or - Quality indicators
And
Residents' perspective
Or - Patient perspective
Or - Resident view
Or - Patient view
And

Care home. Or – care setting Or residential home

Table 3: Research Literature Inclusion Criteria

CRITERIA	RATIONALE
Studies conducted from 2010 onwards	To review findings relevant to current practice and care with consideration to changes in government regulation.
English language research from Canada, United Kingdom, United States, Europe, Australia, and New Zealand	As a vast amount of research into quality of care from a commissioner's perspective has been conducted in other countries, it is important to include such literature. However, caution must be used in interpreting the findings because of potential differences in commissioning arrangements, residential care delivery, care levels and definition of quality between other countries. This review was limited to studies in the English language.
Research with a focus on evaluation. Quality indicators from a resident's perspective. Residing in a care home	To focus on studies which have investigated the contribution of nursing to residents' quality of care (measured by commissioners on resident outcomes).
Research conducted in a care home.	The transferability of research from other settings, such as acute care/hospitals, rehabilitation centres, retirement centres, and/or assisted living facilities may be limited due to differences in care levels and quality metrics.
Research focusing on care of the elderly, age 65 upwards (children's residential care excluded)	The focus of the research is quality of care in care homes for the elderly due to the researcher's area of work (commissioning).
Only studies published in peer reviewed journals have been included (unidentified studies, newsletter articles, newspaper articles, etc have not been included). Policy documentation was restricted to the introduction and background.	To focus on the most credible data sources. Nonetheless, literature which falls into a 'grey' area, that is it is not from a peer reviewed source, may provide useful information. Government agencies, policy institutes and research units have released numerous reports that are not included in journals, but provide credible, comprehensive, and current information on valuable research findings and evidence based best practice guidelines.

	These findings have been restricted to chapter one.

A Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) flow chart can be seen in Figure 1 and has been used to present the process used to select high quality relevant literature throughout the stages of the review. The PRISMA flow chart depicts the total number of papers identified in the literature search process, it shows the point at which the search papers were identified, included, or excluded from the search. Figure 1 demonstrates the process adopted to identify and screen the literature, followed by the assessment of eligibility for inclusion and the studies included in the review.

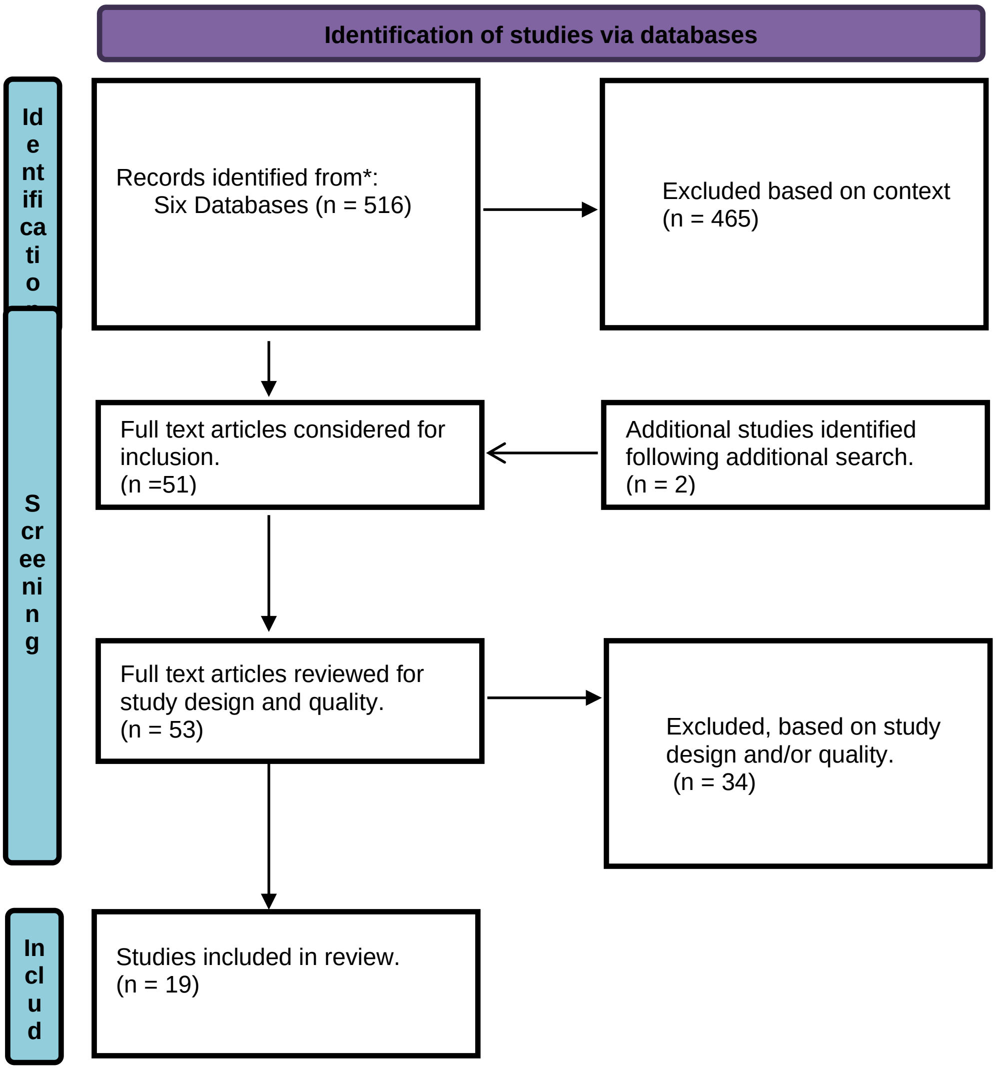


Figure 1: PRISMA (2020) flow diagram. (Page et al, 2021)

A systematic approach was undertaken to extract terms, characteristics, practice from the literature. Each article was critically appraised utilising the, Preview, Question, Read and Summarise (PQRS) method proposed by Cohen (1990), and the synthesised findings are listed in (Table 4).

Table 4: Synthesis – Findings

Researcher (year; country)	**Title**	**Data Source**	**Study Design**	**Quality of Care Measurement**
Aguwa, C. et al (2021)	Voice of the customer: Customer satisfaction ratio-based analysis	Primary	Mixed	Power ratings, quality perception, marketing tools, and customer satisfaction. Achieving improvements by asking those who matter.
Bail, K., Gibson, D., Hind, A., Strickland, K., Paterson, C., Merrick, E., Gibson, J., Kozlovskaia, M., O'Dea, A., Smith, B., & Redley, B.	'It enables the carers to see the person first': Qualitative evaluation of point-of-care digital management system in residential aged care.	Primary	Qualitative evaluation	A strong emphasis on co-design with care staff in developing and implementing the digital care system contributed to a system that supported nursing and care work, facilitated reporting and documentation, and improved resident care and

(2023)				well-being including identification of missed care.
Blood, I. (2010)	Older people with high support needs: how can we empower them to enjoy a better life?	Secondary	Evidence Review	Affordability, navigating the system, dementia and mental capacity, social isolation, recruiting and retaining a skilled workforce, involving and supporting carers, end-of-life care.
Burhans LM, Alligood MR (2010).	Quality nursing care in the words of nurses. Journal of Advanced Nursing.	Primary	Phenomenology	Human needs through caring, empathetic, respectful interactions within which responsibility, intentionality and advocacy form an essential, integral foundation
Castle, N & Fergurson, J (2010).	What Is Nursing Home Quality and How Is It Measured?	Primary	Quantitative research	Report cards, pay for performance, market-based incentives, and policy developments in the certification process, assurance, and oversight
Castle, N. & Anderson, R. A. (2011).	Quality improvement in long-term care settings: a scoping review of effective strategies used in care homes	Primary	Scoping Review	A scoping review of quality improvement in care homes. We aimed to identify participating occupational groups and methods for evaluation and monitoring. Secondly, we aimed to describe resident-level interventions and which outcomes were measured.
Davies, S. et al. (2011).	A systematic review of integrated working	Secondary	Systematic review	Integration, skilled workforce, cost, staff and resident satisfaction. Quality

	between care homes			measures.
Forder J and Fernández J-L (2011)	Length of Stay in Care Homes	Secondary	Longitudinal study	Length of stay. Effect of funding on length of stay. Cost of care. Quality metrics
Fossey J, Masson S, Stafford J, Lawrence V, Corbett A and Ballard C (2014)	The disconnect between evidence and practice: A systematic review of person-centred interventions and training manuals for care home staff working with people with dementia.	Secondary	Meta-analysis of Randomised Control Trials	Person centred, trained staff, training manuals, inductions. Impact on residents and monitoring.
Gilbert, A (2021)	Aged Care Residents' Perspectives on Quality of Care in Care Homes: A Systematic Review of Qualitative Evidence	Primary	Systematic review	Quality improvement. Care homes. nine key themes describing factors influencing quality care: staffing levels, staff attitude, continuity, routine, environment, decision-making and choice, dignity of risk, activities, and culture and spirituality. While many themes were consistent across studies, residents' prioritization of them varied.
Hinsliffe - Smith - Smith, K (2020)	Improving the quality of care in care homes using the Quality Improvement Collaborative approach: lessons learnt	Primary	Empirical study	Staff training and behaviour. Lack of interactions. Quality ratings. Staff attitude. Staff competencies. Management leadership.

	from six projects conducted in the UK and the Netherlands.			
Hughes, L. J., Daley, S., Farina, N., Tabet, N., & Banerjee, S. (2022)	Care home staff perceptions of implementing a quality-of-life instrument into routine care practice: A qualitative study	Primary	A qualitative study	Measuring quality of life as a part of care practice improvements in resident quality of life, staff knowledge and understanding and care practices. The findings suggest that routinely measuring quality of life as a part of normal care could also have more far-reaching effects on the provision of person-centred care provided by care staff.
Jeffs L, Beswick S, Martin K, Campbell H, Rose DN, Ferris E (2013)	Quality nursing care and opportunities for improvement insights from patients and family members	Primary	Qualitative	Insights from residents and family members. Nurse leaders to enhance nurses' therapeutic relationships with patients and family members, and patient-centred care within their organizations. Culture, relationships, leadership & choice.
Killett, A., Hyde, P., Burns, D., Gray, R., & Poland, F. (2013)	How organizational factors interact to influence the quality of care of older people in the care home sector	Primary	Participatory observation-based study	Analysis provides empirical insights into how and why similar sector-wide changes to care provision have differential effects at the care home level. It indicates the situated and unpredictable ways in which

				organizational factors interact, implying the need for locally contextualized quality assessment and improvement actions.
Lewin et al, H (2020)	Evidence for the long-term cost effectiveness of home care reablement programs. Clinical Interventions in Aging.	Primary	Quantitative research	Restorative, older adults, community dwelling, service costs. Commissioner metrics
Moore D and Hanratty B (2013)	‘Out of sight, out of mind? A review of data available on the health of care home residents in longitudinal and nationally representative cross-sectional studies in the UK and Ireland’,	Secondary	Cross-sectional study	Policy, monitoring, quality of care, inconsistencies in data collection. Lack of resident involvement.
Oliver R, Foot C, Humphries R (2014)	Making our health and care systems fit for an ageing population	Secondary.	Systematic review	Helping people to live well. Access to universal services. Competent staff in LTC and EoLC. Good discharge planning and post-discharge support. Choice and control. Integrated care. Support for relatives. Healthy, active ageing and supporting independence. Continuity, and risk stratification. Telehealth. Resident and relative

				involvement. Regulation and monitoring.
Schenk, L. et al., (2013).	Quality of life in nursing homes: results of a qualitative resident Survey	Primary	Qualitative Survey	Social contacts, self-determination and autonomy, privacy, peace and quiet, variety of stimuli and activities, feeling at home, security, health, being kept informed, and meaningful/enjoyable activity. Oversight and assurance. Regulation
Smith, P, Johnson, C, Ariti, C & Bardsley, M (2015)	Focus on hospital admissions from care homes.	Secondary	Quantitative	Increased hospital admissions. Poor access to universal services. Inequalities. Choice and control. Independence. Skilled staff. Care at home. Commissioning and patient involvement. Risk stratification. Access. Measurement of quality.

Part Two: Literature Review

For this study, a narrative overview was developed for the literature review (Hart, 2018). This enabled the synthesis of findings from the literature. The narrative review identified evaluative criteria which covered the field rather than focused on specific studies and theories, linked to the intended research (Green et al, 2006). According to Grant & Booth (2009), this approach is appropriate for the chosen study as an understanding of the concepts around quality of care within the care home sector was sought to inform the study. Understanding concepts of quality of care need to be clarified and described by providers, commissioners, and importantly by residents themselves. According to Haase et al (1993), and Walker & Avant (2011), the strength of a narrative review is its flexibility that enables emphasis on specific phrases during the analysis process. It supports the clarification, description, and explanation of key nursing concepts by analysing how the selected concept has been used within the discipline itself and other health related sciences (Colorafi & Evans, 2016). Therefore, in developing a narrative review, it is not possible to simply summarise theoretical or empirical publications.

According to Penrod & Hepcey (2005), a narrative review enables the researcher to develop an in depth, critical insight into the concept, rather than simply provide a descriptive task, as noted in the work of Walker (2011). It also allows experiential knowledge to play a key part in the development of concepts and enables a greater understanding of the research topic. However, according to Walker & Avant (2011), there are limitations to a narrative review as there are no set rules and their proximity to the paradigm may lead an inexperienced researcher to inappropriate conclusions (Dunken et al, 2007 & Walker, 2010).

Flexibility was key to sourcing empirical data from a variety of fields, as it helped to identify research concepts and key terms (Hoase et al, 1993, Hasse, 1993, Huberman, 2014 & Walker, 2011). Five concepts, of which are seen as a measurement of quality, which impacts on the quality of care within the care home sector were identified from the literature review. These were: 1) staff competencies, training and development; 2) the role of the registered manager; 3) commissioning (joint monitoring, joint contracting arrangements, and data collection); 4) staff involvement; and 5) resident involvement.

Literature Review Findings

Six concepts where identified, which are perceived as a measurement of quality by Health and social care commissioners. The reviewed literature tells a story of unmet need, unacceptable variation and often poor-quality care from the NHS, local authorities, and the private sector, which affects the estimated 400,000 older vulnerable people currently residing in care homes within the UK (Blood, 2010, Lewin et al, 2020 & Schenk et al, 2013). From the literature review, it became apparent that the voices of residents within the sector are usually unheard or quantified by those measuring and assuring quality. In fact, it emerged that, when improving residents' experiences and quality outcomes, the focus is placed on the perspectives of professionals, policy makers and relatives, rather than residents who live in the home (Blood, 2011 & Oliver, 2014). This early finding supports the decision to adopt a qualitative methodology with the intention of conducting semi-structured interviews with residents within the care home sector.

The *measurement* of quality provided a focus on structure, process, and outcome (Oliver, 2014), while the *structure* of the home includes its characteristics (e.g. size, staff mix) and the characteristics of the residents (payer-type, mix). *Process* refers to the delivery of care, whilst *outcome* is the result of the care process, in terms of both health outcomes and satisfaction.

Studies by Jeffs et al (2013), Blood (2010), and Gilbert et al (2021), have described what should and could be done to improve the quality of support and clinical pathways to care home residents. They have also emphasised access to equitable services provision and have called for national action by policy makers and local action by the NHS and local authority commissioners, providers and clinical services.

However, according to Blood (2010) and Burnhans & Alligood (2010), there is a critical need to collaboratively develop and nurture joint professional leadership amongst the health, social, and care home sectors, statutory regulators, and patient advocacy groups. However, this cannot be achieved independently, but rather requires a multi-agency approach (Forder & Fernandes, 2011).

The quality of social care and the impact of staff behaviour on the quality of social care provision are critical international policy themes (Blood 2010, Chadborn et al, 2021 & and Smith et al, 2015). Generally, the level of quality in social care in England is well maintained and regulated, but this does not prevent high-profile cases of abuse (Castle and Anderson, 2011). As outlined in the study by Smith et al (2015), Local authorities (LAs) in England are tasked by the Care Act 2014 to shape social care markets in which the continuous improvement of quality is encouraged and where the workforce can deliver high quality services. As such, staffing is an important aspect of social care and impacts on the quality of the service provided. Despite this, there is little quantitative evidence as to the importance of staff in quality provision within social care in England.

Theme One: Commissioning & Contracting

Excessive bureaucracy from commissioners was acknowledged in the study by Kilet et al (2013), which noted it was widely recognised that regulatory burden took providers away from the delivery of frontline care and this is a key area of concern. This was also reflected within discussions with providers and identified as a consistent characteristic when reviewing and evaluating the care homes which are failing to provide quality care or have undergone home closures.

According to Blood (2010), and Castle and Ferguson (2010), agencies involved with supporting the sector need to work collaboratively and in a coordinated way to avoid duplication of effort, which can result in a lack of clarity for homeowners and impact on residents' health, safety and wellbeing.

According to Moore and Hanratty (2013), and Jeffs (2013), system errors and failures may arise when locally agreed measures and communication are conducted in isolation and partnership working is limited or ambiguous. This often results in limited meaningful information gathering, poor information sharing and missed opportunities to identify substandard practice early, which all reduce the effectiveness of the home (Davies, et al, 2011 & Gilbert, 2021). According to Jeffs (2013), a lack of local leadership and oversight by one lead organisation has shown to reduce effectiveness in developing and sustaining a consistent and coherent quality monitoring process across local health and social care pathways. As observed in practice, this limits the responsiveness and availability of expert advice when required.

There is also a need to collaborate across health and social care to improve data collection, monitoring and reporting for the regulated care sector. A study by Bail et al (2023) of provider quality and sustainability for older people, recommended the careful assessment and option appraisal of existing shared reporting platforms to support market oversight, quality assurance and quality improvement.

Moreover, Hinsliffe - Smith et al (2020), and Kilet et al (2013), asserted that it is important not to rely on one single means of quality assurance but to triangulate information from different sources in order to evaluate the effectiveness of partner organisations and the partnerships surrounding the regulated care sector.

Providers should not be overburdened by additional requirements to those relating to registration and regulation. It is therefore important that commissioners work to ensure that all monitoring activity is aligned as much as possible. To inform their work, commissioners should gather information from all stages of the commissioning process and all activities carried out by stakeholders. Commissioners should also effectively utilise and coordinate the many monitoring and quality assurance activity strands to assure service quality and good safeguarding practice.

The better integration of services for older people has long been promoted as improving the quality of care and potentially reducing costs. Local circumstances, legal contexts, funding streams, and procedural and structural arrangements affect integration, as does collaborative culture. Multidisciplinary reviews also indicate such benefits (Davies, 2011 & Oliver et al, 2014). However, according to Blood (2010), Hughes (2022), and Jeffs et al (2013), a more formal systems approach that identified the organisational and environmental characteristics associated with more successful nursing homes has, to date, demonstrated limited value.

Quality improvement interventions include monitoring the quality of care, strengthening the care-giving workforce, and building organisational capacity (Davies, 2011 & Hughes et al, 2022). Simply providing nursing homes with comparative quality performance feedback, access to training, and staff performance incentives does not appear to lead to significant improvements (Fossey et al, 2014 & Schenk, 2013). Additional real-time feedback of adherence may produce improvements, although these are not always sustainable. Quality improvement is more likely to be successful in homes with a culture that promotes innovation and staff empowerment and is supported by the wider health economy (Moore & Hanratty, 2013).

According to the literature many care homes are owned and managed by independent providers, yet the local authorities and CCG’s who contract their services have equal responsibility to ensure the safety of residents in these care homes (Jeffs et al, 2013). Nevertheless, evidence suggests that many individuals residing in a care home are not having their needs properly assessed and addressed (Kilet et al, 2013 & Smith et al, 2015). As a result, residents often experience unnecessary, unplanned, and avoidable admissions to hospital, and sub-optimal care (Fossey et al, 2014). A thorough review of the literature was undertaken regarding the quality of care and resident experiences within the care home sector. It became apparent that the voices of residents within the sector are not sought as a consistent quality metric by commissioners, which is also reflected within the literature reviewed (Castle, & Fergurson, 2010 & Jeffs et al, 2013). In fact, it emerged that, when improving residents’ experiences and quality outcomes, the focus is on the perspectives of professionals, policy makers and relatives, rather than residents who live in the home (Blood, 2011 & Oliver, 2014).

This early finding reflects the views of Hughes et al (2022), & Smith et al (2015), who advocated the adoption of qualitative methodologies; thus, the primary data collection for this study involved semi-structured interviews with residents within the care home sector. This will enable a comparison with the key quality indicators noted in the literature against those noted by residents, and inform the work of commissioners, providers, and regulators to determine the quality of care within a home.

Although according to Hughes et al (2022) there are approximately 400,000 people living in a care home with 8,000 care home providers in existence nationwide (employing significant numbers), the sector is still seen as the ‘Cinderella service’

(Oliver et al, 2014). A study by Kilet et al (2013), raised concerns that the fragility of the adult social care market is now beginning to impact both the people who rely on these services and the performance of NHS care, including its performance, flow, and targets. The combination of a growing and ageing population means that more people with long-term conditions living longer, and a challenging economic climate means greater demand on services and more problems for people in accessing quality care. Now is the time for radical change with a focus and priority on the regulated sector (Chadburne, 2021).

Theme Two Joint: Quality Monitoring and Contracting

Attempts have been made over the last two decades to improve the quality and standards of care within the care home sector, such as giving local authorities and the Care Quality Commission more powers. These actions were taken as a direct result of the introduction of the Health and Social Care Act (2014) and Fundamental Standards (CQC 2015). According to Lewin et al, (2020), this change was essential as previous legislation was vague and open to interpretation which resulted in commissioners and regulators applying different quality and contractual standards which left providers overwhelmed, overburdened and unsupported (Hinsliff et al 2020). Although these legislative changes have only occurred over the last decade, the effects of previous systems are still apparent within the commissioner and provider landscape which now require an agreed co-produced, joint contracting and monitoring system between health and social care commissioners to improve the quality of care provided.

According to Davies (2011) there are a considerable range of agencies supporting care homes, which can often be inequitable and uncoordinated and as a result adds unintended risk to the quality of care provided. These services include primary care, community services, social care, and acute services, but there are also authorities enforcing standards, including the Care Quality Commission, Health and Safety Executive and Environmental Health and Public Health England (Goodman et al, 2015). These are in addition to the commissioners contracting with care homes from both health and local authorities. According to Blood (2010), agencies involved with supporting the sector need to work collaboratively and in a coordinated way in order to avoid the duplication of effort that can result in a lack of clarity for homeowners and impact on residents' health, safety and wellbeing.

According to Moore and Hanratty (2013) and Jeffs (2013), system errors and failures may arise when locally agreed measures and communications are conducted in isolation and partnership working is limited or ambiguous. This often results in limited, meaningful information gathering, poor information sharing and missed opportunities to identify substandard practice early, which reduces the overall effectiveness of the home (Davies et al, 2011 & Lewin et al, 2020). According to Jeffs (2013), a lack of local leadership and oversight by one lead organisation has shown to reduce the effectiveness in developing and sustaining a consistent and coherent quality monitoring process across local health and social care pathways. This, in the researcher's experience, limits the responsiveness and availability of expert advice when required.

This finding is echoed by Moore and Hanratty (2013), who emphasised the inconsistency of General Practitioner care for residents, a lack of timely access to primary care services, and poorly commissioned pathways. The reports noted that these result in a lack of ownership across the care home sector and the provision of sub optimal care to some within the most vulnerable population. It is clearly outlined by Hinsliff et al, (2020), that providing co-ordinated, organised services has become an essential task for health and social care commissioners. According to Jeffs et al (2013) if this is not actioned swiftly residents will ‘bump along’ between silos of well-meaning but poorly organised, uncoordinated services. Moore and Hanratty (2013) state that residents require structured and pro-active approaches to their care which are built upon clearly defined and commissioned pathways, with co-produced teams working together (Burhans and Alligood, 2011 & Kilet et al, 2022).

In addition, Castle & Fergurson (2010), concluded there is no consensus across primary care groups about what services older people living in care homes need or how services should and could be provided. This leaves vulnerable adults at risk of receiving inadequate care and with inequitable access to NHS services. Although these findings follow a decade of research and professional debate which have repeatedly highlighted the health care needs of care home residents, to date this is still a poorly commissioned area for clinical commissioning groups (Oliver et al, 2014 & Smith et al, 2015).

Nevertheless, in times of austerity across both the health and social care economy it is important to work collaboratively to share resources, reduce inefficiencies and focus on what really matters (Forder & Fernandez, 2011 & Moore & Hanratty, 2013). This will have the biggest impact for residents.

Theme Three: Resident Involvement

Older people have championed the importance of choice and control over the care that they receive and the life they want to live (Castle & Ferguson, 2010). Although this is echoed in government policy across all four nations in the UK, there still appears to be challenges and a lack of understanding amongst commissioners when describing what this looks like and how it can be measured to obtain meaningful information (Blood, 2010 & Castle, 2010). All policy documents over the past decade outline the importance of greater service user involvement and of giving a voice to the sector that experiences the care (Schenk et al, 2013 & Smith et al, 2015). However, Blood (2010) states that lip service is often paid within the care home sector and is not given the in-depth focused analysis it deserves in order to develop accurate insights into the quality of care experienced by residents (Davies, 2011). Moreover, Oliver (2014) states that whilst the importance of customers' views has gained acceptance across developed western communities, few studies have been dedicated to the exploration of care homes residents' voices, and the importance of capturing this softer intelligence. However, literature recognises the key part it plays in capturing the quality of care provided (Oliver, 2014 & Davies et al, 2013). The literature on improved care focusses primarily on the quality of clinical care (Bail et al, 2023). According to Hinsliffe - Smith (2020), there is a paucity of quality-of-life measures reflecting residents' voices.

Literature regarding residents' experiences within care homes, revealed that the voices of residents are almost unheard or absent (Castle & Anderson, 2011, Oliver et al, 2014 & Smith et al, 2015). The adoption of quality improvement tools with a customer feedback focus has fallen behind those used successfully in other industries (Schenk, 2013 & Oliver, 2014). However, a focus on this measurement of quality will have a significant impact on the care that is provided and improve the experiences of residents.

According to the literature, there is little evidence to suggest that quality of care requirements differ from those residing in care homes compared to those who reside elsewhere (Castle, 2010). Nonetheless, to obtain a true reflection of the standard of care received, generalisations of experiences and living contexts will need to be explored when reviewing the quality of care for residents. According to Bail et al (2023) and Moore (2013), quantifying care home outputs has historically been the focus when measuring the quality of care, while the vital role that of residents' voices is rarely evidenced. The research suggests that if residents' voices were heard in a formalised, consistently applied manner then commissioners and providers would receive meaningful information that could be utilised to formulate action plans and interventions to improve and maintain standards of care (Castle, 2010, Castle & Anderson, 2011 & Schenk, 2013).

Theme Four: Staff Involvement

There is considerable debate about the relationship between quality of care and quality of life as joint, but not necessarily competing, measures of quality. Research indicates that residents' perceptions of nursing and care staff are a good indicator of quality of care (Lewin et al 2020, Hughes et al, 2022 & Oliver, 2014). There are currently no agreed national, regional, or local standards for the number of staff per resident ratio within the regulated care sector, which poses challenges when setting standards to meet. This results in a lot of variability in the system which in turn reduces the effectiveness of a whole system approach to monitoring, measurement, and improvement. Fundamental standards in the regulations include no specific requirements for the number of staff or the ratio of skill mix required in English care homes.

To address this issue there is a call for action from UK governments to ensure that regulators set and monitor standards for the minimum staffing levels that care homes are required to meet. It also stipulates that local authorities and CCG's must work with providers to agree practicable staff to resident ratios (Lewin, 2020).

Staff support may also address the problem of staff turnover and retention, which poses a challenge for providers and commissioners. There is continuing apprehension over an on-going shortfall of social care staff (Bail, 2023). This shortfall suggests an 'unmet delivery of care to meet peoples' needs, and the high turnover suggests that recruitment practices are not robust in finding and retaining staff that hold the right values and beliefs, to sustain them in their role.' (Bail, 2023, p.12). Both factors have an influence on the quality of care provided to residents as staff turnover also costs money in recruitment and agency staff to fill the gaps.

According to Blood (2010), the mixture of low morale and extreme work pressure has a negative impact on the workforce. This is critical to recognise and understand, as morale is directly linked to the quality of the output that a workforce delivers (Oliver et al, 2014). If the challenges that care homes face are ignored year on year, it is likely that the morale of its workforce will continue to deteriorate. This has disquieting implications for the quality of care that staff can deliver and could result in a further reduction in the workforce as more staff leave. This would further compound existing problems and, in turn, have a detrimental impact on the quality of life and care of residents whose lives are impacted by repeated change and disturbance.

To ensure that care homes are the best they can be, a regulated care workforce must be seen as a professional national asset and therefore valued and supported to provide truly person-centred care (Jeffs et al, 2013). It is clear, however, that this is not the case: care work currently has a particularly low social status that is reflected by its low pay, long working hours, poor working conditions, and a lack of opportunities for professional development and career progression (Aguwa et al, 2021 & Kilet et al, 2013). Similarly, a care home can be an isolating environment and a place with limited access to peer support. According to Schenk et al (2013), the regulated care workforce also experiences poor working relationships with the NHS workforce, which again poses risks to resident care and outcomes. This has been witnessed by the researcher and measures have been implemented to mitigate this risk.

Although there has been a drive to monitor and measure staffing numbers, such activities have been conducted in isolation. However, according to the literature and from experience there is more to focus on (Blood, 2010, Davies, 2011 & Smith, 2015). Other factors to consider include the use of agency staff, which impacts on the continuity of care and residents' abilities to build and maintain therapeutic and meaningful relationships. Variability in skill mix and training along with staff turnover and workforce stability are also indicators of the ineffectiveness of service delivery which studies indicate leads to poor resident outcomes (Blood, 2010 & Castle, 2010).

However, there is no economic evidence on the cost-effectiveness of nurse staffing in care homes. Further emphasis and agreement are required to determine the combination of skill levels required to enable a good quality and cost-effective contribution (Laing & Buisson, 2014). For example, according to Hughes et al (2022), and Schenk (2013), knowing how a resident likes their cup of tea, or explaining why lunch is a little bit late today can make a big difference. Notably, the group emphasised that the ways in which staff conduct themselves, rather than their qualifications, matters to them (Smith et al, 2015). Dependability, the creation of trust, and making people feel comfortable were not the sole preserve of the registered nurse. If people living in the home feel safe, protected and loved, it is unsurprising that this leads to a better experience of care. Nevertheless, as outlined by Fossey et al (2014) the lack of time was recognised as both the enemy and friend of staff pursuing quality care.

Theme Five: Staff Training, Development and Competencies

Another concept identified within the literature pertains to the relationship between staffing levels and the quality of care provided. Many of the studies evidenced that the importance of well-staffed homes, with appropriately skilled staff have a direct impact on the standard of care provided (Castle, 2010 & Castle & Anderson, 2011). However, according to Hughes et al (2022), and Schenk (2013), the impact of skill mix requires further clarity and further research is required to fully understand the appropriate staffing levels, skill mix, and influences these have on quality outcomes.

The literature further detailed that all staff employed by registered providers must receive training and support to carry out their duties and offer opportunities to build qualifications in the role in which they work. In practice, care homes must have a clear plan as to the staffing levels/mix present in their care home (Hinsliff et al, 2020).

The quality of social care and how staffing will have an impact on the quality of social care are critical policy themes (Jeffs, 2013 & Oliver, 2014). Generally, the level of quality in social care in England is well maintained and regulated, but this does not prevent high-profile cases of abuse. Local authorities (LAs) in England are tasked by the Care Act 2014 to shape social care markets in which the continuous improvement of quality is encouraged and where the workforce is expected to deliver high quality services (Oliver et al, 2014). As such, staffing is an important aspect of social care that is likely to impact the quality of services provided. Nevertheless, there is little quantitative evidence for England as to the importance of staff in quality provision within social care (Blood 2010 & Castle & Anderson, 2011).

Due to the nature of the role, notwithstanding terms of employment and low salaries, this sector in particular experiences a significantly high turnover of staff (Bail et al, 2023) and a workforce that falls behind the expected standards of an NHS-employed member of staff due to poor, inconsistent access to training and development opportunities (Anderson, 2011 & Schenk, 2013). However, due to the vulnerability, dependency, and frailty of this population, high staff turnovers can be problematic and have negative outcomes for residents (Blood, 2011 & Castle, 2010). Several studies identified that a high staff turnover and increased vacancy rates, especially within management and senior roles, has a direct impact on the quality of care delivered and exerts a significant negative financial effect on the care home (Gilbert, 2021).

Whilst social care staff face a range of pressures in carrying out their day-to-day roles, they are largely doing the best they can under extreme pressure (Jeffs, 2013). Indeed, Blood (2010), stressed that poor care is not deliberate; however, it is noted that a greater culture of support is needed to improve conditions. This is unequivocally acknowledged by the work of Jeffs (2013), and Lewin (2020), who suggest that although staff are typically hardworking and committed to delivering respectful care that promotes independence, this was often undermined by workload pressure. Moreover, Kilet et al (2013), and Moore (2013), concluded that the good treatment of staff would likely result in the good treatment of those for whom they care', particularly fair reward systems, a culture of trust and openness and the management of workload pressures.

Therefore, it is acknowledged within the literature that a good quality indicator is the monitoring of staffing levels, availability of training and development, agency usage, and the number of substantive posts; this is in addition to the monitoring of the home manager’s position (Spilsbury, 2011 & Jeffs, 2013). Nevertheless, research is limited when identifying a dependency tool within the care home sector to establish a safe staffing regime; again, this sector has been given little priority by National Health Service England (NHSE) to articulate meaningful, safe staffing levels. Hughes et al (2022), articulated the importance of appropriate staffing levels and the direct correlation between poor staffing levels and care delivery. They further stress the importance of cross sector working with NHS providers to reduce variation. This, again, is an area that requires drive, commitment and integration across sectors and systems (Gilbert, 2021)

Training and development opportunities for staff are recognised within the literature as a good indicator of quality, as these opportunities can be utilised as an incentive in the absence of salary increases. The research also evidenced the impact of training and development on staff morale and the correlation with staff retention rates and quality of care delivered (Fossey, 2014). Goyder et al (2011), also indicated that a detailed review of the available literature suggested that staff training is a potentially valuable method of improving care quality and residents’ experiences; however, poor quality evidence and inconsistent findings make it difficult to draw firm conclusions. The research outlined that the availability of training opportunities for nurses and health care assistants is vast, yet the uptake is uneven, and quality is variable; however, regulation within this domain is tight and prescriptive, which can leave providers at a disadvantage at inspection. Nevertheless, a solution is essential as a well-trained workforce has a direct correlation with resident safety and the delivery of care (Blood, 2012 & Fossey, 2014).

This leaves the sector in turmoil as to where to source training opportunities of a high standard, at a low cost which are easily accessible for an underpaid workforce. This also requires the engagement of an underpaid, under resourced workforce with a low morale to value and learn from such training opportunities and improve the quality of care for residents (Burnhans, 2010 & Chadborn, 2021). Yet, education is crucial to ensure staff have the right knowledge, skills, and competencies to consistently deliver a high standard of safe and effective care (Blood, 2010 & Jeffs et al, 2013). Nevertheless, whilst training and development opportunities are essential within the care home sector, initial findings indicate the importance of raising the profile and status of care homes and acknowledging the value and importance of attending to the needs of all those who live, work, and visit care home settings (Castle, 2010, Blood, 2011 & Fossey, 2014).

Theme Six: Role of the Registered Manager

Organisational culture and the care home environment are perceived to be important influences on both the quality of care for residents and staff well-being and safety (Aguwa et al, 2021). According to Castle (2010), and Kilet et al (2013), these concepts are ill-defined and largely not addressed in UK literature. However, there is focus on the role of the care home manager, and its importance as a static position, with minimal change over a long period of time. According to Hinsliffe - Smith (2020), while care home managers are perceived to have an important role in leadership, and providing support and development opportunities to staff, there are wide variations in the extent to which they fulfil this aspect of their role, and a lack of clear guidance through best practice. The care home manager's enthusiasm and engagement influence the success of any new initiative introduced and taken up by nursing and care staff which can directly impact on the residents (Fossy et al, 2011).

In many countries, care homes are subject to strict regulations and standards. The registered manager is responsible for ensuring that the care home meets all legal requirements, including health and safety regulations, staffing ratios, resident assessments, funding and quality of care standards set by regulatory and commissioning bodies (Moore & Hanratty, 2013). The appointment of a registered manager is seen as a quality metric which is monitored via commissioners. However, as stated within the literature, the quality lies within the delivery of the role rather than just an appointment to the role (Moore & Hanratty 2013 & Schenk, 2013).

The role of the registered manager is an identified quality metric within the literature as they oversee the day-to-day operations of the care home, including staffing, training, and resource management (Davies, 2011, Castle & Anderson, 2011 & Hinsliffe – Smith, 2020). Their leadership ensures that staff are properly trained, motivated, and equipped to provide high-quality care to residents. It is noted that the absence of such a role leaves the care home and residents vulnerable, due to the lack of oversight, management, and leadership. It has been recognised as one of the main contributing factors of failing care homes within the literature and experienced by the researcher (Bail et al, 2022).

The registered manager is accountable for the overall quality of care delivered in the care home. This involves monitoring and evaluating care practices, implementing quality improvement initiatives, and addressing any issues or concerns raised by residents, their families, or regulatory authorities. Therefore, the absence of such a role model leaves the care home non-compliant with contractual and regulatory requirements, due to the high value of such a position (Davies, 2011).

According to Castle & Anderson (2011), a skilled registered manager understands the importance of person-centred care, which focuses on meeting the individual needs and preferences of each resident. They promote a culture of respect, dignity, and compassion within the care home, ensuring that residents receive personalised care that enhances their quality of life (Smith et al, 2015).

The registered manager according to Lewin (2020), serves as a liaison between residents, their families, staff, and external stakeholders. Effective communication channels ensure that concerns are addressed promptly, feedback is solicited and acted upon, and residents' rights are upheld. They also advocate for residents' needs and preferences within the care home and in interactions with external agencies including commissioners (Hinsliffe – Smith, 2020).

Operating a care home involves inherent risks, including health emergencies, safeguarding issues, and financial challenges. The registered manager is responsible for identifying and mitigating these risks, implementing robust policies and procedures, and ensuring that the care home operates in a safe and secure environment for residents and staff alike (Hinsliffe – Smith, 2020 & Smith et al, 2015).

While existing literature provides valuable insights into the experiences of residents in care homes, it is important to acknowledge the dated nature of some evidence. Many studies in this area were conducted several years ago, and the landscape of care homes has evolved since then. Furthermore, there is a noticeable lack of contemporary evidence, suggesting a gap in current knowledge regarding residents' perspectives on the quality of care within care homes. This study seeks to address this gap by exploring the experiences of residents in care homes using a qualitative approach, providing up-to-date insights into their perceptions and needs.

Chapter Three

Methodology & Methods

Methodological Approaches and Considerations

To summarise the background circumstances directing the rationale, it is clear from the literature that although much has been written on what could be perceived as indicators of quality within the care home setting, there remains little evidence of what these may be from a resident's perspective. Therefore, a fundamental perspective within the research design and methods was to ensure that residents views were captured effectively, reflecting their language, values, and beliefs. This chapter provides an overview of the research approach, methodology, and methods adopted to address the research aim. Personal philosophical assumptions are included and the rationale for the chosen methodology is included from an epistemological and ontological perspective.

The purpose of nursing research is to develop new knowledge or add to existing knowledge to improve outcomes for patients and populations (Gall et al, 1989). Two main approaches dominate healthcare research, namely quantitative and qualitative. According to Creswell and Poth (2016), qualitative research is a way of gathering evidence that tests and evaluates information within fixed parameters and fitting to a measurable context that is intent on testing ideas and theories. Qualitative methodological outlooks are an inquiry or exploration interested in contextual gaps that quantitative frameworks may miss, and deals with allowing the information to lead holistic understanding and conceptual premises (Creswell & Poth, 2016).

Although the research design for this study is qualitative, Edson (1986, p.13) asserts that '*there is no qualitative per se, only methods to gather information with which we* *construct our qualitative understanding*'. This is also acknowledged in the work of Merriam (1998, p.6) who defined qualitative research as '*an umbrella concept covering several forms of inquiry that help us understand and explain the meaning of social phenomena with as little disruption of the natural setting as possible*'. As valuable as this might be generally, for this study it was imperative that the residents did not feel any intrusion beyond asking questions they wanted to give voice to and answer which is why the study was designed to include Health Watch as this minimised any disruption to the residents' or the home and was a familiar occurrence.

Given that, qualitative research offers a variety of methods and opportunities to identify what really matters to patients, carers, and the workforce the opportunity to include a third party to obtain the data in this study meant that the research operated alongside a quality instrument where an intermediatory was already present. Working with a third party constituted a foundation that allowed any discovery of the challenges and barriers to changing performances and explore why improvements occur or fail to manifest. According to Kim et al. (2017), using qualitative data can help to better understanding of how to improve quality which is critical for the delivery of safe and effective care and treatment.

Research Paradigm

In contrast to natural science studies, which tend to adopt a positivist research paradigm that depend on strategies such as manipulation, hypothesis generation, experimentation and testing, this study followed an interpretivist paradigm. As the interpretivist paradigm concentrates on individuals by employing interviews, observations, and contextual analysis to develop a meaningful understanding of reality, an interpretivist paradigm was most appropriate for this study. The researcher recognises that reality is multi-layered and complex in nature and can result in multiple interpretations of that reality. Moreover, interpretivists see the world as constructed, interpreted, and experienced by people (Merriam, 1988, Bogden & Biklen, 1992, Guba, 1990 & Maxwell, 2006) and its purpose is to interpret and understand a particular phenomenon (Tubey et al, 2015). By adopting this perspective, the design of the methodology enabled a more rigorous understanding of the current reality of living in a care home. Thus, a holistic approach logically enables integration between ontology, epistemology, methodology and methods.

Thus, steps were taken to ensure this approach was applied to achieve a first-person perspective which is paramount for this study. By examining and understanding the world from those with a lived experience provided a more genuine understanding of the world from the residents' perspective on the quality of care, which reciprocity provided the richness and value the researcher was seeking. A true understanding of the participants' lived experience was obtained by undertaking semi-structured interviews, a method which is supported by applying the interpretivist paradigm as it relied on a dialogue between the researchers and their participants to negotiate, collaborate, and develop a meaningful understanding of reality.

According to Colorafi & Evans (2016), interpretive nature of QD gives a voice to the groups of residents who are seldom-heard; it was used to create an understanding of what influences residents' values and behaviours; it was also used to create an understanding of how a person's social and cultural position can influence their health. It allowed residents to use their own words to express their realities.

Reflexivity, Ontological and Epistemological Assumptions

A person’s philosophical assumptions or research positionality frames their motivations, aims, methods and methodology (Creswell & Poth, 2016). By exposing a greater awareness of how the researcher understands their own reflexivity and personal position, comprehension of the epistemology can strengthen the clarity, relative veracity and rigour of the research and provide justifications for the methodological approach and how participants were involved.

Reflexivity refers to the process of reflecting critically on the self as a researcher of practitioner. It involves being aware of one’s own biases, assumptions and influences on research of practice. Reflexivity is important in research and health care as being reflexive allows practitioners to acknowledge and account for their biases and assumptions, leading to a more transparent and credible findings within research. It promotes ethical awareness and encourages healthcare professionals to understand lived experience of patients, leading to more compassionate and holistic care. By embracing reflexivity, healthcare professionals an researchers can enhance the validity, ethics and effectiveness of their work, ultimately contributing to better health outcomes and therefore leading to more equitable care (Sileo, 2017).

Reflexivity prompts researchers to recognize and acknowledge their own subjectivity, biases, assumptions, and values that may influence their interpretations of data and construction of knowledge. By critically examining my own positionality, a better understanding on how my perspectives shaped the research process and the knowledge produced could be tracked (Sileo, 2017).

Having spent many years visiting care homes to monitor and inspect the quality of care provided, I witnessed varying levels of care being provided to some of the most vulnerable individuals in society. This included from the exceptional to the inadequate, which led to residents being removed from their homes during the night without any warning. Having led the closure process of a care home, it was key that everything humanly reasonable would be done to ensure this would not occur again due to quality failings. This means not being reactive but developing improved standards not just from the point of the commissioners, but for all stakeholders in the care home sector. The most glaring disparity, and therefore the emphasis of this study, was advocating for the residents.

This provided the rationale for choosing to look at quality of care within a care home but from a resident's perspective as it is those experiences which should matter the most, not what we as professionals deem to be a good quality indicator. It is paramount that an understanding of the reality of the care home environment is understood from those who live there and experience every aspect of it. To really understand and appreciate the reality from those with a lived experience is paramount in order that we can learn and make the required improvements to improve the quality of care provided with a focus on things that matter the most to residents.

Since the quality of care is dependent on residents' perceptions, it is also essential that the workforce, commissioners, and regulators also understand these perceptions to improve the care and treatment provided and to meet the needs of the residents they care for (Croft, 2017). A Qualitative Description (QD) analysis within the field of nursing adopts different ontological perspectives from the realism of provision, constructivism of community and individuals, to the phenomenology emphasising empathetic observation of the lived experience. Although its nursing philosophical basis lies in understanding the lived experience, general health, and the wider healthcare arena, the eclectic nature of this requires and values different standpoints and is made stronger by drawing upon multiple ontological perspectives, recognising the complex interplay.

This is the inherent problem with complex multifaceted systems and requires regular, stepping back and taking stock and advocating for all groups involved. Therefore, according to Siles-González & Solano-Ruiz (2015) using the principals of critical theory it is important to merge all the above stances to truly capture a holistic understanding of the delicate interplay of realism and relativist states in order to leave no one behind. It was by looking at the systems through experience that the researcher felt there was a need to readdress the systems at play in the nursing homes by capturing the perspective of those fully emersed in the lived experience. Therefore, the ontological stance in this study evokes values of interpretivism by raising the voice of those who the service is there to care for.

The ontological and epistemological foundations are acknowledged within the methodological principles of qualitative description by focusing on the opinions and desires of the residents with open exploration of their perspective. A deeper understanding was enabled through giving them a valued expansive way to express themselves. This opinion is not always apparent as QD studies have been critiqued for lacking clarity on their philosophical underpinnings (Colorafi & Evans, 2016 & Dowling & Cooney, 2012). However, according to Greenwood (1994), a descriptive approach centres on the views of the person with lived experience of the phenomenon studied, and the collection of rich information concerning how things appear in their world. These characteristics confirm this research assumes the existence of polycategorial ontologies to allow values to be developed primarily by an epistemological outlook most readily approximating interpretivism.

The thesis is underpinned by a lifelong desire (and a career informed by working as a care assistant in a care home at the age of 16) to give dignity, meaning, happiness and respect to some of the most easily neglected or overlooked (sometimes without advocate and therefore underrepresented) members of society, who can be at the most vulnerable, destabilising, and at a challenging stage of their life as mortality looms. This, combined with a contextual drive within practice to understand, develop, and use research of the participants' world, meant the researcher was able to provide a richness to the findings and tailor the interview questions to obtain a deeper understanding of the phenomenon along with ensuring the questions would be suited to the participants. This meant collecting and comparing different views of the world resulting in a range of experiences of the same intervention.

Furthermore, consideration must be given to how this knowledge arises (epistemology) for which there are several philosophical bases. For example, my own ontological position was that I wanted to gain a deeper insight into the social and cultural context of care homes from the resident's perspective. By having a sound ontological stance and indicating the epistemology of position, allows for the development of the research question through framing the situation, and development of further understanding through the methodology, which is required to deliver the aims and objectives. QD supports the interpretivist epistemology paradigm, as it is designed to capture, analyse, and interpret data relevant to people's concepts and experiences of their social world. This is the richness the researcher was looking for to give credibility to the findings and the recommendations. Viewing the actions, norms, and values of the residents from a holistic standpoint was the desired emphasis. The aim was to uncover meanings that are not ordinarily revealed from other forms of research, by directly giving a voice to the desires and viewpoints of residents.

Therefore, the epistemology paradigm within QD should re-evaluate our basic understanding of how to view human existence and experience within care homes is from a very important direction (that of those people it most pertains to) and looks at how knowledge was constructed and what was accepted as valid evidence, which is largely dependent on the study design and the quality of information collected (Braun & Clarke, 2017), but then also returns to inform the ontological stance when being interpreted.

Qualitative Descriptive Method

This study can be classed as ‘organisational and empowering’ as it identifies the problems to be solved in terms of patient viewpoint, staff empowerment and organisational development, to inform and embrace change (Neergaard et al, 2009). A qualitative descriptive (QD) approach offers opportunities for an ‘insider researcher’ as is the case of this study to become immersed in the study to observe behaviours and listen to what is being said. It enables the examination of practice by focusing on the problems encountered for a deeper understanding to be achieved. According to Sandelowski (2000), QD is designed to solve immediate and practical problems that may require quick decision making with limited resources which can make services more responsive and cost effective/efficient and more rewarding for all involved. It also embraces the voices of participants and allows for the findings to be presented in their language which enables greater authenticity and deeper meaning, further enhancing the intrinsic value of the service for all stakeholders (Kim et al, 2017).

Qualitative description (QD) is increasingly utilised within the field of health and has been recommended by the DH as a valuable approach for public health research (DH, 2002 & Stanely, 2015). Essentially, QD is used to create an understanding and generate knowledge, which supports a focused approach to minimise wasted time and resources for researchers and clinicians. This is even more important when there is pressure on multiple complex services that are part of an even larger highly stressed system, and timely solutions are required or when resources are restricted, such as time and access to participants. In the experience of the researcher, nurses and healthcare professionals often must use clinical questions to fill in the gaps that often aren’t measured by traditional metrics. Clinical questions that aim to fill in the gaps not addressed by traditional metrics can help provide a more comprehensive understanding of patient experiences, outcomes, and preferences. This can be in the guise of ensuring individuals feel heard and respected, inclusion in all decision making and trying to ensure continuity of care. Thus, building therapeutic relationships which enable individuals to feel safe and cared for.

They have to do this to adapt services for many individuals which means extra work and diligence for the professional, which may have negated these steps being standard. This would make the service far more efficient and less wasteful. These questions may often be suitable to a qualitative approach, but in the researchers experience staff are afforded little time to develop an exhaustive compilation of qualitative methodological approaches, let alone employ them. This study hopes to assist these dedicated and caring workers by providing additional and meaningful metrics of quality to assure quality of care, whilst also giving a voice to the resident.

These qualities support the section of QD as a method for this study (Bradshaw et al, 2017). According to Collorafi and Evans (2016), QD research is sometimes described as a less refined approach for epistemological reasons as explored below. Another challenge when considering QD design is differentiating qualitative description from other qualitative approaches.

A QD process of data collection, analysis, and reporting works directly with practitioners or patients so that findings can be rapidly formulated to continually develop practice (Duncan et al, 2007). Hence a key benefit of QD is that it can be used with residents as participants rather than as subjects, because unlike other studies it allows residents to generate the topics rather than pre-categorising topics from a researcher perspective, and therefore, loading the bias to only inform towards or away from viewpoints already held. This creates a wealth of directions that could have been missed by not giving the residents free reign of discussion before the topic formulation stage (Kim et al, 2017). Hart (2018), reiterates this by describing QD as an informal, qualitative, formative, subjective, interpretive, reflective, and experiential model of inquiry in which all contributors are knowing and contributing participants. QD has the primary intent of providing an understanding for qualitative investigations by practitioners and researchers.

QD is characterised by the constraints and strengths of the given research paradigm (Qualitative) as discussed earlier in this chapter, but as demonstrated this methodology is applicable and appropriate for use within the health care professionals. Kim et al (2017) recognised that the adoption of QD helps to identify practice-theory gaps by focusing on participative group processes to address conflict, crisis and change within organisations. More recently, QD has gained popularity in the fields of nursing, education, and psychology.

In addition, Sandelowski (2000) recognised that researchers who choose a qualitative descriptive methodology are drawn by the opportunity to stay close to the data and to the meaning of words and events. QD designs are typically expansive in ideas by being eclectic in combining the sampling, data collection, analysis, and re-presentation techniques. Such studies aim to understand the knowledge of those wanting to take a forensic analysis into a phenomenon.

Although literature tends to acknowledge the complexities of QD (Neergaard, 2009), core principles guide the process. Eden and Huxham (1996) state that the question to be researched must be of benefit to the participants or the process will fail. Collaboration between the researcher and stakeholders is recognised as key to the success of the study suggesting that the result of QD is the co-generation of knowledge, and the articulation of a rationale or philosophy of practice that leads to collaborative change. QD engages participants who guide the outcomes and evaluation of the project in dialogue and ‘the process’. (Kim et al, 2017).

Rationale for a Qualitative Description (QD) Approach.

Qualitative description (QD) is a label used in qualitative research for studies which are descriptive in nature. It is particularly utilised when examining health care and nursing-related phenomena (Polit & Beck, 2010). QD is a widely cited research tradition and has been identified as important and appropriate for research questions focused on discovering the who, what, and where of events or experiences (Neergaard et al, 2009). Also noted was, QD is implemented to gain insight from informants on a poorly understood phenomenon that required further interrogation from those with lived experience of the subject. QD was the method of choice when an overview of a phenomenon is sought, or information is needed to develop and refine interventions (Colorafi & Evans 2016). Both above papers also noted that, QD is typically selected when resources are limited such as the researcher's or participants' time or where access to interviewees is limited or restricted. This method added value and facilitated flexibility in its approach which is an important feature when engaging residents as participants.

It can be seen by the methodological perspective of the QD approach that it provides an opportunity to explore participants' attitudes and beliefs first hand thereby enabling a greater understanding of quality and the differences in perceptions. My intention was that by employing QD this would provide a rich understanding of residents' experiences and the structures of their worlds. QD therefore supported an understanding of meanings and experiences which means it is a valuable tool for generating knowledge on quality assurance and for unpacking some of the complex issues inherent to a greater understanding of quality improvement.

Reliability refers to the consistency of the research instrument and is linked to replicability i.e. the extent to which the study is repeatable and produces the same outcome under similar circumstances and conditions (Parahoo, 2014). Holloway and Wheeler (2003) believe replicability is not possible in qualitative studies as the researcher is the main research instrument within the study and their characteristics and background may influence the research. They further argue that QD, being context bound (i.e. the findings must consider the context in which it takes place), does not necessarily mean that the findings of one study cannot be applied in other contexts, or that theoretical advances are not useful in other settings.

The data gathered during any study (including QD) must be credible, reliable, and trustworthy. Murphy (2001) criticises QD, finding it deficient in elements of validity and rigour whilst Tukett (2005) previously stated that these values are inherent to all research. According to Parahoo (2014), a method is valid when it measures what it sets out to measure, such as what is a measurement of quality of care from a resident's perspective, whilst Castle et al (2019), cautioned that the credibility of observations depends upon the reliability and validity of the interviews. I recognise that within QD, there is a potential threat to validity through bias due to insider research involvement. A more useful approach as opposed to the quantitative concept of bias is the proposal of Kim et al (2009), which requires the researcher to adopt a reflexive stance on their own practice and assumptions, although Parahoo (2014) stressed that researchers must not allow their prejudice to influence actions, or the decisions taken. Conversely, Rolfe (1996) argues that QD by insider researchers bridges the practice-theory gap and questions previous deeply held assumptions. My perspective is that all arguments represented above display the ontological stance of each author is open to various interpretations and even how each argument is reached will be based on how the information was researched. This does not mean it is invalid, but that it is reached with inherent impact from and often because of a bias, and that may have value and be important in informing how we see the world (Penrod & Hupcey, 2005). Further to this, bias, always plays a part in research from the very inception of any question or hypothesis. In quantitative research avoiding these biases or mitigating for them makes a lot of sense as it can corrupt the outcome, but in qualitative research it is often bias that is seen as the important factor that give richness or context that raw figures can miss (Kim et al, 2017).

Despite some criticism, it is believed that the employment of QD, which is most applicable to the original context, to this study will help to develop a greater understanding of quality metrics within the care home sector from residents’ perspectives, where problems require solutions and actions, and current thinking needs improvement (Kim et al, 2017).

Methods

In a qualitative descriptive (QD) study interviewing residents on the quality of care in a care home, the sampling strategy plays a crucial role in ensuring the study's credibility, transferability, dependability, and confirmability (Kim et al, 2017).

Purposeful sampling was utilised to select participants who could provide rich, detailed insights into their experiences with the quality of care in the care home. This approach ensures that the sample represents a diverse range of perspectives and experiences among residents.

Twenty residents aged 65 and over were interviewed across four care homes (those that had come forward as interested and for practicality had a visit planned by Healthwatch) and were equally split between two Clinical Commissioning Group (CCG) localities.

The rationale for the number of residents and homes was based on the researcher’s time, residents’ focus, and the avoidance of information overload which had the potential to impact on the analysis and risked overlooking rich data.

In the first instance, all care homes were contacted in writing with a request for their participation in the research. This stage was undertaken prior to identifying resident participants.

The homes which were included within the study expressed an interest and where due visits by Health Watch imminently so therefore it reduced the burden on staff and residents by reducing the number of visits undertaken by professionals. All four homes were located within Central Lancashire, with two representing the Greater

Preston CCG and two representing the Chorley, South Ribble CCG. All four homes provided both nursing and residential care and did not have residents who had a dementia diagnosis. All four homes were registered with the care quality commission (CQC) and had a rating of ‘good’ or ‘requires improvement’.

Residents were selected on a first come first served (FCFS) basis, with oversight from the registered manager of the home to ensure that consent was obtained by patients with the mental ability to do so. Moreover, it was essential that residents needed to have full capacity to consent to participate in the research. Therefore, the manager in this study identified people with the capacity to consent.

The researcher selected FCFS as it enhances transparency and objectivity in participant recruitment by establishing clear criteria for inclusion in the study. It minimizes bias and the perception of bias in the selection process, as decisions are based solely on the order in which individuals express interest or meet set eligibility criteria (Fergusson et al, 2013).

According to John and Millum (2020), efficiency and expediency can be considered a positive of FCFS selection as it streamlines the participant recruitment process by simplifying decision-making and reducing the need for subjective evaluations or deliberations.

It enables researchers to quickly fill available slots or reach target sample sizes, particularly in studies with time constraints or limited resources, such as this study (John & Millum 2020).

FCFS selection is straightforward to implement and requires minimal administrative overhead, making it practical for studies with limited staffing or logistical support.

According to John and Millum (2020), FCFS facilitates efficient communication with potential participants, as individuals can be notified of their selection status promptly after expressing an interest which is important for the sample required. However, as with any method there are limitations which need to be considered and mitigated against. According to Fergursson et al (2013), the FCFS approach can result in a non-representative sample. It can reduce diversity and variation and can raise ethical concerns related to equity and fairness. The researcher role ensured that by visiting each home potential participants were given the necessary information, to answer any questions they had, and to gather consent. This approach was selected to ensure all residents were offered the same opportunity with the support of the care home manager. Prior to commencement, it was agreed that if too many residents wanted to participate, a focus group would be considered to enable a range of semi-structured interviews, however this was not required.

The use of semi structured interviews enabled data collection to challenge existing knowledge and/or identify that knowledge is lacking or invalid (Attride-Stirling, 2001). Each interview was unique and new knowledge gained, meaning they informed the findings and recommendations of the study. However, rigour in QD derives from how data are generated, gathered, explored, and evaluated, and how events are questioned and interpreted (Greenwood, 1994 & Eden and Huxham, 1996). In keeping with the methodological nature of this research, the researcher decided to utilise qualitative data collection methods.

To ensure that participants were able to help meet the aim of the study, inclusion and exclusion criteria were developed. These criteria are summarised below along with the steps taken to engage and select participants.

Promotional information along with the resident information sheet was shared with interested parties and, after reviewing the provided information, residents self-selected to participate in the study. The interested parties were checked against the eligibility criteria by the care home manager before confirmation of participation was given. For each of the four homes which participated in the study, the manager provided the details of the five residents. No other resident details were shared, therefore the need for a further focus group was not required.

The process for the recruitment of care homes is outlined as follows:

- Invitation letters sent out to the care home manager.
- Follow up invitation letters were sent, and a phone call made to the care home manager.
- The letter and telephone call stipulated: the amount of time, resources and involvement required of staff. They also estimated the level of disruption that participation in the study could cause.
- The researcher highlighted the benefits of being involved in the study.
- A description was given regarding the incentives (included within the ethics application) for care home participation in the study (for residents, the organisation, and staff).
- Anonymity and confidentiality were discussed.
- The interview questions were discussed in advance with the Health Watch researcher.
- The care home was provided with assurances that Health Watch had Criminal Record Bureau/Disclosure and Barring Service checks if needed, that they were insured, and that requirements for immunisation could be requested.
- The researcher checked whether anyone else in the organisation needed to be contacted to agree to care home participation e.g. the owner or CQC nominated individual.

The legal framework for informed consent was as follows:

- Consent was given by those with the mental ability to do so.
- Sufficient information was given to the participant.

  - Informed consent was freely given.

The process for recruiting residents was conducted as follows:

- A poster was developed and shared with the home manager to attract willing participants (residents who lived within the care home); the poster outlined the inclusion and exclusion criteria.
- The poster outlined that a very small sample (five in total from each home) of residents were required; therefore, appropriate participants would be selected on a ‘first come first served’ basis.
- Residents had to have the capacity to provide informed consent to participate. Residents self-selected their participation with the support of the registered manager where appropriate. Where any serious safeguarding issues were uncovered, confidentiality could no longer apply, and such concerns were reported to the Care Home Manager or other appropriate professional dependent along with the safeguarding team.
- If numerous residents elected to participate, a focus group was offered to include their input so as to not disappoint interested parties. This offered a further opportunity to engage with residents who did not automatically come forward. Capacity was reviewed throughout the research via the Mental Capacity Framework (MCA) 2005. Its primary purpose is to provide a legal framework when acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves.
- Once potential interviewees were identified, a presentation was given about the research and the role of the participant.
- A leaflet was produced and given to participants which included emphasis on resident consent to the interview process and outlined the right to withdraw at any time.
- Health Watch Lancashire undertook the interviews as part of their ‘Enter and View’ visits.
- Semi structured interviews were undertaken on a 1:1, face to face basis within the care home and each interview was recorded and transcribed.
- Findings will be shared with the care home for onward circulation to residents and families.

The following inclusion criteria were applied to resident recruitment:

- Individuals should currently reside in a care home.
- Individuals must be able to consent to participate in the study.

In addition, the following exclusion criteria were applied:

- Residents who were deemed to lack the capacity to consent (under the Mental Capacity Act (MCA).

Data Collection

Due to the potential impact on residents of multi-professional visits within their home, it was decided that the most appropriate approach for the semi-structured interviews was to engage Health Watch as a third party. This had the benefit of being more prudent timewise and cost effective, allowing the information to be gathered efficiently and without great outlay of money employing members of a new team and costly implementation time to training. This also bypasses the need for tackling hurdles presented by the practicalities of implementing new pathways such as safeguarding checks.

Introduction to Health Watch

Health Watch is the public voice for health and social care and exists to make services work for the people who use them. It was established following the introduction of the Health and Social Care Act in (2012) and has statutory responsibilities to help local people examine the standard of care on offer and whether services can and should be improved. Part of their remit is to meet with local people and groups to gather information on their experiences of local care services and make information known to the people who run, pay for, and monitor these services.

Legislation allows local Health Watch organisations to undertake ‘Enter and View’ visits, which allow the team to interview residents to obtain a view of services from individuals in receipt of care and treatment.

The researcher has an already established working relationship with the organisation due to both having roles in quality monitoring of the care home sector. Health Watch organisations and Clinical Commissioning Groups (CCGs) play distinct but complementary roles within quality oversight and assurance. Healthwatch organisations focus on gathering and representing the views of patients and the public, while CCGs are responsible for planning, commissioning, and monitoring healthcare services to meet the needs of local populations (CQC, 2019). Both organisations play a crucial role in driving improvements in the quality, accessibility, and effectiveness of health and social care services through the lens of the individual with a lived experience.

As part of my role, I set up meetings with a dedicated member of the Health Watch team monthly to provide an overview of visits which have taken place and report on the findings. During my research phase, I created opportunity to provide feedback from CCG visits to the care homes, in order that a triangulation of the findings could be undertaken to provide a report to the respective quality boards.

During one of the meetings, I took the opportunity to provide an overview of the intended research, to discover the aims and objectives were shared with all in attendance. Given the burden on the care sector with regards to quality monitoring and oversight, an agreement was made that the Health Watch representative would be willing to carry out the interviews on behalf of the researcher as they had planned several care home visits over the coming months. This would benefit not only the care home provider, but it would also reduce the number of interviews that residents would need to participate in, providing better utilisation of resources as the Health Watch team were already familiar with the homes, managers and more importantly the residents.

At a subsequent meeting my questions were shared with the Health Watch representative who compared these to their own questions and confirmed that they were almost identical to their own or would enhance their set of questions further. Therefore, consequently the health watch representative agreed to conduct the interviews with the questions the researcher had prepared (Appendix 1, ethical approval obtained).

The Health Watch team planned to undertake visits and agreed to ask residents the researcher semi structured questions. It was also agreed that the interview findings would be shared as these were developed in collaboration.   Therefore, the study utilised qualitative primary data gathered by a secondary source (Health Watch).

Health Watch interviewers may introduce biases that differ from those of the researcher, potentially impacting the validity and reliability of the data. However, ensuring consistency and adherence to interview protocols was made explicit. It is to be noted that these interviewers are trained to undertake such interviews and have an already established relationship with the home and the residents.

Ensuring participants fully understand the purpose, risks, and benefits of the study may be more challenging when a third party is involved in the data collection process and maintaining the confidentiality and privacy of participants' responses may be more difficult, when data are collected by individuals outside of the research team. Health Watch is a regulatory body whose core business is to ‘enter and view’ homes to assure quality from the views of residents, families, and advocates. Therefore, the researcher believes that this approach would make the process more rigorous, also noting they are more experienced in this field than the researcher.

There are benefits and pitfalls to obtaining primary data from a third party, however following an appraisal of these, the researcher remained confident that this was the most effective option for the study. According to Morse (2015), the benefits of outsourcing to a third party is that it can provide an opportunity to access expertise and specialism in many areas such as interviewing techniques, data management and storage. It is noted that they can bring valuable skills and experience to the research process, particularly within complex or sensitive research contexts (Miles et al, 2013). Efficiency and timeliness were also a positive of working with a third party to obtain the data in that they tend to have dedicated resource, which was the case for Health Watch (Johnson et al, 2019).

Where patients are vulnerable and resources limited, using secondary data can be cost effective and valuable regarding knowledge and insight (Mason, 1994). The credibility of the source is an important indicator of quality which supports the validity and reliability of the data. Furthermore, because Health Watch are externally governed and validated, quality assurance processes are guaranteed (Babbie, 2020 & Mason, 1994).

It can be argued that Third-party interviewers may lack the insider perspective and contextual understanding of the care home environment that researchers who are directly involved in the study possess (Morse, 2015). It can also be argued that consequently, interviewers who are not immersed in the research context may miss subtle nuances or overlook important factors that could impact the interpretation of the data (Miles et al, 2013). The researcher does not believe this argument applies within this study, given the expertise and core business of the third-party interviewers.

It was crucial that the researcher and Health Watch representative had a robust communication plan in place, as miscommunication or misunderstandings can lead to discrepancies within the data, which can compromise the validity and reliability of the research (Patton, 2014).

Methods of data collection

The selected methods for the data collection must deliver against the aims and objectives and align with the chosen methodology. The most common data collection methods for QD are interviews, focus groups, questionnaires, or action learning sets (Kim et al, 2017). Semi structured interviews were the chosen method for this study as they enabled a focus on the topic whilst providing the required autonomy to explore relevant ideas that emerged during the discussion. Interviews are a crucial tool for capturing thoughts and feelings of individuals which is critical when seeking to understand a phenomenon that involves lived experiences. The use of this method therefore leads to a deeper understanding of the subject matter. According to Parse (2001), any form of interview within QD provides rich data and an insightful picture of how individuals experience their world.

Because of the researcher’s senior role, any power differential between the researcher and the resident needed careful and sensitive consideration. By using secondary data via Health Watch, residents could speak openly about quality in their home and not feel their responses needed to be influenced by what they thought I wanted to hear. Primary data gathered by a secondary source helped to protect against the effects of researcher bias so that selective reporting, personal or professional biases (either consciously or subconsciously), could be ameliorated. As no primary or secondary data analysis is conducted completely without bias, an important role for me as the researcher, was to determine the sources and structure of any biases. The researcher was familiar with Health Watch and its aims and motives; therefore, I would be aware of any need to adjust for them in my analyses. As noted earlier, the aims of this research and Health Watch were well calibrated from the outset. Moreover, the public availability of comprehensive reports on quality from Health Watch ‘enter and view’ visits meant that such information was in the public domain and likely to be accurate. The direct quotations from the Health Watch interviews will be published as part of the wider ‘enter and view’ care home reports (X4), however the thematic analysis and findings will not be in the public domain.

An interview guide was developed outlining the core questions and associated prompts with the aim of guiding the discussion. This promoted the optimal use of time as the interviews could only be held once (DiCicco-Bloom, 2006). According to Mason (1994), semi structured interviews within qualitative research create a thinking space for the researcher and participants to explore a concept or phenomenon. According to Austen and Sutton (2015), undertaking interviews gives researchers the opportunity to put themselves in another person’s shoes and understand the subjective experiences of participants. Although questionnaires were considered as a data collection method, anecdotal evidence shows that many residents would require support with the completion and would welcome the opportunity to engage with the researcher rather than complete a questionnaire in isolation. It was also felt that this was a less personable approach, and answers could be omitted and did not afford an opportunity to prompt or ask follow-up questions. According to Parahoo (2014) and Polit & Beck (2010), one of the significant challenges of questionnaires is the potential for a low response rate which has been reported within the care home sector. Residents enjoyed the one-to-one interaction when asked about care and treatment, as this was fed back to Health Watch interviewers. This better enables the sharing of potentially sensitive data including personal thoughts, feelings, and experiences.

The research process utilised the following steps, as illustrated in Figure 2 (Gall et al, 1989).

Figure 2 – Research process

Interviews

This equated to five resident interviews per care home and each interview lasted approximately 1.5 hours. Semi structured interviews were undertaken by Health Watch with residents who resided within the care homes.

Prior to initiating the interviews, six questions with prompts were designed and shared with the Health Watch researcher. This enabled a discussion on the aim of the research, and the expectations of the researcher. It provided an opportunity for the Health Watch representative to familiarise themselves with the questions and to seek any points of clarity. Semi-structured interviews were chosen over structured interview as they offered sufficient flexibility to interview individual residents in different ways while ensuring the required data was collected. All interviews were held in the resident’s bedrooms (with consent) as this provided a sense of privacy, familiarity, and comfort. It was also a method with which residents were familiar as they participated in interviews or feedback sessions regularly with Health Watch, commissioners, and regulators as part of the regulatory or contractual inspections. However, the option to undertake the interview in a different room within the home was offered to each resident.

The interview questions were aligned with the study’s aim and objectives, and worded so that residents could easily understand them, meaning they were free from jargon and assumptions, and allowed space for residents to describe their thoughts, feelings and experiences as openly as possible - both positive and negative (Roberts, 2020). The interviewers sought to allow and promote a range of response and avoided guiding or manipulating answers (Brinkmann & Kvale, 2015).

The questions utilised are listed in (Table 6) including the prompts to support the third-party interviewer and participants. The questions were split into three parts to allow the residents to take a break, share any reflections or terminate the interview.

The interview questions outlined in (Table 6) were discussed with the Health Watch researcher prior to the interviews. Health Watch shared the goal of seeking to understand what quality meant to residents. This added strength to their questions and reduced duplication and over burden on the residents who were interviewed, as the questions I had prepared matched or enhanced Health Watch questions.

Table 6: Semi-Structured Interview Questions and Prompts

Part 1 - Introduction
Q: Thank you for agreeing to this interview. Can we start by asking how long you have been a resident here?
Q: Where did you live before residential care?
Q: What does care mean to you?
Q: What does quality of care mean to you?
Prompt: Let the interviewee tell you what they understand quality care to be
Part 2 - Give participants the definition of quality in care
Q: Tell me about your experiences of quality of care
Prompt: Ask them to relate experiences since living at the care home
Q: Can you give me examples of good quality of care?
Prompt: Ask them to relate experiences
Q: Can you give examples of poor-quality care?
Prompt: Ask them to relate experiences
Part 3 - Changes requested by resident
Q: What can the care home staff do that would help them to provide a quality service to you (Nursing and Health care Assistants)?
Prompt: Ask them to give suggestions that may help the care team to meet these needs

Interviews were offered on a number of dates when Health Watch planned to visit the home, and participants chose a time most appropriate for them, namely 9am – 12pm or 2pm – 5pm. However, all participants opted for a morning interview. Interviews lasted approximately 1.5 hours. Of the 20 participants, 12 were female and 8 males, and all participants were aged over 65 (ranging from 68 to 97). All residents had lived in their current home for more than two years, with the longest stay recorded as six years. The interviews were carried out by the same Health Watch representative over a two-week period. Twenty residents were interviewed across four care homes which equated to five resident interviews per home and were split equally between two Clinical Commissioning Group (CCG) localities.

Reflexivity

The Health Watch interviewer was asked for their reflections on the process as this adds further rigour to the process and supports the findings. Reflexivity is vital when reviewing and analysing the findings along with enhancing the methodology.

The researchers own beliefs enabled the scrutiny of, and judgements during the research process and how these may influence the research outcomes. Reflexivity provided a way to turn the problem of subjectivity in research into an opportunity. It could be argued that personal and methodological reflexivity should be included as an element of every research study both for qualitative or quantitative research methodologies and that without it, the rigour of the research could be questioned. Reflexivity involved the researcher questioning their own assumptions. Essentially, it involved drawing attention to the researcher as opposed to ignoring the position and pretending that they did not have an impact or influence over the findings. According to Finlay, (1998) it requires openness and an acceptance that the researcher is part of the research.

I am very experienced when it comes to interviewing residents who live in a care home. I have been undertaking ‘enter and view’ visits for two years and each one is very different however what does remain a constant is how willing and open residents are to share their experiences. The semi structured interview questions certainly led to a different dialogue with a real focus on the quality agenda. As an organisation we will be looking to incorporate some of these questions going forward to add strength to the findings and outcome. I had to use the prompts with each resident to allow for a richer conversation. Resident’s true focus is how staff make them feel and does it feel like a home to them. They want to come across as independent whilst requiring a little support. Most importantly they want their voices heard and be respected. This is what good quality care would look like to them. I found the interviews to be powerful and certainly gave me food for thought.

Health Watch Interviewer

Data Storage, Communication and Retention

All data use, storage and communication adhered to General Data Protection Regulation (GDPR) guidelines. Audio recordings were only used for analysis by the research team, and data was only used for the stated intended purpose. All materials were stored on an encrypted computer that was backed up by an encrypted hard drive and securely stored in a locked room. The Health Watch representative gave the researcher the paper copies of the interviews in order that a thematic analysis of the findings could be undertaken. Again, these where anonymised with a unique code assigned to each.

To ensure their identity remained anonymous and confidential, all participants were given a unique research code known only to the third-party interviewer. The names and contact details of the participants were stored on a Health Watch password protected computer. Creswell and Poth (2016) emphasised the researcher’s obligation to consider ethical implications when gathering data for analysis. They stipulated this is essential in protecting participants from harm or the disclosure of identifiable information. To this end, participant names were redacted from transcripts and replaced with codes, for example ‘R1’, R2’. All interview notes were anonymised and coded by the Health Watch interviewer and the codes shared with the researcher.

All participants were informed of the nature of the interview process and that, by its very nature, could be intrusive. Communication was shared with all participants on what to expect in the interview process, the role of Health Watch, the types of question likely to be asked, and the assurances on confidentiality. Questions were carefully constructed to ensure they were only applicable to the area of study.

Data Analysis

On completion of the semi-structured interviews a thematic analysis (TA) approach was adopted to elucidate the findings (Braun & Clarke, 2017). The theoretical framework and methods chosen aligned with the aim and objectives of the study. There are no universally accepted rules for qualitative data analysis (Polit & Beck, 2010), and several QD processes have been developed (Sandelowski, 2000).

A thematic analysis (TA) of the findings was conducted that followed Braun & Clarke's (2017) method for identifying, analysing, and reporting themes found within the data. This is known as one of the most common forms of analysis used within qualitative research (Miles et al, 2014). Themes are identified patterns which emerge across the data sets and are critical to an accurate description of the phenomenon. TA supports the organisation of the collected data and provides a rich narrative. According Kim et al (2009), TA goes further than simply identifying patterns as it also interprets various aspects of the research topic making it a valuable data analysis tool. It allows for flexibility in the choice of theoretical framework; indeed, Tuckett (2005) states that TA can be used with any theory. It enabled the generation of themes in relation to the phenomenon and the differing ontological and epistemological positions. This improved the validity and credibility of the findings. The findings were compared to the themes identified within the literature review to inform the discussion, thus enabling triangulation.

The themes for the QD were identified within the six thematic analysis stages as a ‘step-by-step guide’ (Braun & Clarke, 2017) (outlined in Table 7). Following these steps ensured the process was clear and rigorous. These accumulated outcomes were confirmed or rejected as the researcher moved from one participant to another, with the ultimate purpose to arrive at a greater understanding of the phenomenon studied.

Figure 7: Braun and Clarke’s Six Stages of Thematic Analysis

Braun and Clarke’s Six Stages of Thematic Analysis	
Phase 1	Familiarising yourself with your data
Phase 2	Generating initial codes
Phase 3	Searching for themes
Phase 4	Reviewing themes
Phase 5	Defining and naming themes
Phase 6	Producing the report

According to Neergaard et al (2009) thematic analysis is best suited to new researchers and is a common form of analysis in QD. It provides a flexible, cyclical approach and provides the opportunity to report on experiences, meanings and realities which are important for the outcomes of this study. Similarly, Tuckett (2005) stress that the process of TA is not linear but dynamic, and steps may be repeated before the process is complete. Indeed, Cresswell and Poth (2018) describe TA as a dynamic process that is cyclical or spiral-shaped in nature, rather than fixed and linear.

Braun and Clarke’s (2017) approach to TA also circumnavigates the potential limitations posed by a wide range of other research methodologies. However, it is important to consider the six-phase process as a set of guidelines, rather than rules to apply; this enabled a flexible approach that fits the data and research question. Furthermore, each of the steps can be used multiple times in a cyclical fashion (Braun & Clarke, 2012, 2017).

According to the literature, thematic analysis is one of the most widely used data analysis methods for novice researchers. Thematic analysis refers to ‘a method for identifying, analysing and reporting patterns (themes) within data’ (Braun & Clarke, 2012, p. 79). Thus, it is viewed as the foundational data analysis method for most qualitative studies as it ‘… provides core skills that will be useful for conducting many other kinds of analysis’ (Braun & Clarke, 2012, p. 78 & Sandelowski, 2010). The approach to data analysis has been used widely in health care studies exploring patients and carers experiences (Wilson & Davies, 2009).

Hence, it was deemed a suitable technique to analyse the data in this study that focused on residents’ experiences (Wilkinson, 2016). The data analysis approach appeared to fit in with my interpretive worldview and drive to adopt a holistic approach to study how residents viewed and described quality of care in a care home environment (Towers et al, 2015).

Braun and Clark’s (2006, 2013) thematic framework, was chosen and adapted because it gave a clear systematic process and added depth to each stage, including the use of reflexive researcher notes. This provided a robust and clear trail of evidence from not only the data collection but also my reflexivity as a researcher along with reflections from the Health Watch representative, which enhances transparency and rigour within the project.

Thematic Data Analysis Process and application (Braun & Clarke, 2012)

Thematic Data Analysis

Stage 1 – Familiarise myself with my data.

- Triangulate interviews with literature search findings
- Describe the case and its context.
- Document theoretical and reflective thoughts – Health Watch researcher and my personal accounts.
- Document thoughts about potential codes/themes.
- Store raw data in well-organised archives.
- Store data safely following IG code of conduct

Stage 2 – Generating initial codes.

- Debriefing with Health Watch representative
- Reflexive accounts
- Creating codes
- Create and organise files for data analysis.
- Verbatim transcriptions of interviews reviewed.
- Documentation of coding per care home and resident

Stage 3 – Searching for Themes

- Highlighting possible themes and use of post-it notes
- Diagramming to make sense of theme connections.
- Linking of themes and subthemes
- Read through texts, made margin notes, and highlighted texts that are interesting and repetitive.
- Clear documentation of thoughts, hierarchies, concepts, and themes
- Reflexive notes of the researcher
- Further debrief with Health Watch representative

Stage 4- Reviewing of Themes

- Review of themes and authenticity check with Health Watch representative.
- Themes and sub-themes with Health Watch representative

Stage 5 – Defining and Naming Themes

- The naming of themes and sub-themes agreed with Health Watch representative.
- Documentation of discussions and meetings with the Health Watch representative where themes were discussed.

Stage 6 – Producing the Report

- Sense checking for authenticity with the Health Watch representative.
- Further debrief.
- Described the process of coding and analysis in sufficient details.
- Clear Description of content with verbatim quotations

- Triangulation with literature
- Document justification for theoretical, methodological, and analytical choices throughout the entire project.
- Health Watch prepare own report and publish following factual accuracy checks by care home manager.

The discussion meetings allowed for reflexivity and the reduction of bias to ensure the data strongly reflected the residents voice and experience. The application of Braun and Clarke's (2006) TA framework with regards to steps taken within each of the 6 steps can be seen below.

Application of Thematic Analysis

Stages of TA	**Application of TA**
Stage 1 – Familiarise myself with my data. • Triangulate interviews with literature search findings • Describe the case and its context. • Document theoretical and reflective thoughts – Health Watch researcher and my personal accounts. • Document thoughts about potential codes/themes. • Store raw data in well-organised archives. • Store data safely following IG code of conduct	• Immersed myself in the raw data via re-reading transcripts & notes from the semi structured interviews. • Highlighted keywords on the scripts & made notes. • Use of post-it notes (small affixable memo sheets) • Transferred notes electronically for ease of storage & sharing. • Information governance rules applied. • Record of participants and care homes • Demographics recorded. • Code assigned to participant interview transcript. • Debrief with Health Watch representative. • Notes of meeting taken • Reflective account documented
Stage 2 – Generating initial codes. • Debriefing with Health Watch representative • Researcher Triangulation • Reflexive accounts • Use of coding framework • Create and organise files for data analysis.	• Shared notes with Health Watch representative and discussed possible themes. • Notes recorded of discussion. • All meetings took place at Health Watch base. • Arranged further meetings following

Transcriptions of interviews reviewed. Documentation of all meetings with the Health Watch representative Dates of all interviews recorded. Documentation of coding per care home and resident recorded.	deeper TA of scripts and highlighting themes. Health Watch representative shared draft report
Stage 3 – Searching for Themes Highlighting possible themes and use of post-it notes Diagramming to make sense of theme connections. Linking of themes and subthemes Read through texts, made margin notes and highlighted texts that are interesting and repetitive. Clear documentation of thoughts, hierarchies, concepts, and themes Reflexive notes of the researcher Further debrief with Health Watch representative	Keywords highlighted, documented, reviewed and re checked. Diagrams of themes made. Further examination of the themes and comparison with Health Watch representative to check for validity or missed data. Reflections documented on each stage. During this phase, I noted down any thoughts, observations, and reflections I had while reading the interviews. These notes included any repeated expressions or words and any questions I had about what was happening. These annotations were done on the left-hand margin of the transcripts. Texts that were repeating themselves or interesting words/sentences were highlighted with different colour highlighters and post it notes with potential theme were applied.
Stage 4- Reviewing of Themes Review of themes and authenticity check with Health Watch representative. Themes and sub-themes discussed and agreed. Review and triangulation of Health Watch report.	Once broad-ranging themes were identified these were listed in a separate document and keywords were checked against the raw data for frequency. Themes were then grouped as appropriately linked. Themes and sub-themes were then checked with Health Watch representative for validity. Health Watch report shared with care home managers for factual accuracy checks. Coding was done manually, as I felt that data analysis software packages like NVivo would. interrupt the connection I had with the data and would not account for the contextual issues that were an integral part of the data. Manual coding also enabled me to continuously interrogate

	the data and visualise the relationships between data sets and compare and contrast the information gathered.
Stage 5 – Defining and Naming Themes • The naming of themes and sub-themes agreed with Health Watch representative. • Documentation of discussions and meetings with the Health Watch representative	• Names of key themes were developed and shared with Health Watch representative to seek agreement. • All notes of meetings with the Health Watch representative were documented and the timeline for clarity and validity. • Reflections documented. • Feedback from each care home manger returned to heath watch for inclusion within their report.
Stage 6 – Producing the Report • Sense checking for authenticity with the Health Watch representative. • Further debrief. • Described the process of coding and analysis in sufficient details. • Clear Description of content with verbatim quotations • Triangulation with literature • Document justification for theoretical, methodological, and analytical choices throughout the entire project. • Health Watch prepare own report and publish following factual accuracy checks by care home manager.	• This framework enabled the themes to be generated which was enhanced by the inclusion of reflective accounts and comparisons with the Health Watch report. • Meetings and timelines recorded. • Health Watch published reports for each care home visited as per their methodology. • Ratings provided to each home.

Ethics

It was necessary to explore the ethical implications prior to commencing the study. The guidelines set by the NMC (Nursing and Midwifery Council), and the University were considered, and an outline sent to the ethics committee and employing organisation. All ethical principles were considered, and informed consent was obtained from the residents recruited to this study. Detailed communication to patients ensured that they were aware of the study's title, the subject of the research, and that any participation was voluntary meaning they could withdraw at any time.

On gaining ethical approval from the University, the individual anonymity of participants was ensured. The organisational information gathered for this study was in the public domain and therefore organisation anonymity was not required. Key ethicists in the field of research (Beauchamp and Childress, 2019) view ethics as a generic term for both understanding and examining moral life. They emphasise a framework of moral norms that encompass principles, rules, rights, virtues, and moral ideas. They outline four main principles to this framework - respect for autonomy, non-maleficence, beneficence, and justice - which were all considered within this study.

Autonomy

Ensuring informed consent, respect for privacy, and the confidentiality of any information shared was important for participants' safety and confidence in the research. Informed consent lies at the heart of ethical research (DH, 2001) meaning those involved were informed in advance of the reason for the study and how the data collected would be used. Furthermore, permission was gained from participants so that their views could be used (McNiff, 2013). It was vital that openness and honesty were ensured throughout the study so that individuals were able to make informed decisions regarding their participation/withdrawal from the group. According to Hart (1998), confidentiality can prove problematic in semi structured interviews, as participants may choose to discuss findings outside the pre-arranged interview sessions.

Researcher veracity was stated and maintained throughout to develop understanding and enhance mutual fidelity, enhancing an atmosphere of respect for privacy and confidentiality thereby forming a basis for trust.

Fidelity and veracity were maintained through the shared understanding that the maintenance and respect for privacy and confidentiality would form the basis for trust (Sileo, 2017). Autonomy was discussed and reinforced at the beginning of each interview to ensure that all participants were fully aware that any information shared was not for disclosure in any other setting.

Beneficence

From the outset, all participants agreed that the interviews would be beneficial to any future understanding of what quality meant to people residing in care homes. Consequently, they also agreed that it would benefit all stakeholders as new ways of working and best practice may in consequence be identified to inform change.

Nonmaleficence

To ensure no harm, it was important to be aware of the potential for any psychological upset amongst participants during their interviews; thus, the researcher needed to be aware of the possibility that participants could feel uncomfortable or raise safeguarding concerns. Another potential problem was the time taken away from the normal day to day, commissioning, and quality monitoring role of the researcher along with the additional burden on care home staff and residents; therefore, it was necessary to involve an independent, third-party organisation to undertake the interviews (Fowler, 2008). These individuals were already engaging with care home residents and staff as part of their regulatory obligations.

Justice

To demonstrate the relevance and advantages of the study to the organisation, it was essential to collaborate with partners and stakeholders to develop an overview of the aim of the study. Participants, managers, Health Watch and commissioners are identified as key stakeholders, who were advised that the purposes were: to improve quality care outcomes, understand residents' experiences, and enable potential resource savings.

Social justice within care home research focusses on ensuring fairness, equity, and respect for all residents, particularly vulnerable populations like the elderly. This approach and consideration seek to address and rectify power imbalances, provide inclusive and respectful care, and ensure the voices of marginalised group are head, considered and valued.

By adopting a social justice framework, researchers can ensure that care home research studies are ethical, inclusive, and respectful, ultimately leading to better outcomes and equitable care. partic

Summary

The analysis of the data collected from the participants during the interviews identified the themes that influenced the experiences of residents living in a care home. The data was synthesised through the recursive movement between the codes and themes, until final themes were established. I was able to look for meaning in single instances and repetition of phenomena. These strategies supported the relationship between the meanings participants attached to their experiences and the contextual complexity. Overall, combining the broad principles of Braun & Clarke's (2012) thematic analysis approach provided a sound, systematic method of data analysis to enable the production of findings to support the report.

Table 5: Overview of the Research Steps Taken

Steps	**Rationale** →	**Techniques** →	**Rigour** ↓
Step 1: Qualitative Description ↓	• Focused on attitudes, lived experiences and beliefs. • Supports nursing research. • Cyclical in nature • Relies on interactions. • Flexible in approach • Supports when resources are limited.	• Purposeful sampling • Participant driven data collection. • Data collection by 3rd party • Secondary data collection • Semi structured interviews • Interviews conducted as part of pre-arranged 'enter and view' visits. • 3rd party data collection utilising researcher questions.	• The authenticity of data transcripts • Authenticity checks with transcripts. • Notes reflecting on researcher bias.
Step 2: Thematic Approach ↓	• Robust Approach • Increases rigour in QD. • Provides a clear framework for data analysis	• Utilising recognised framework (Braun and Clark, 2012) • Dual role in analysis – facilitator to check authenticity and accuracy (triangulation of data) • Clear audit trail • Reflexive researcher notes • Ability to theme findings.	• Clear transparency of data • Authenticity checking with the facilitator. • Notes reflecting on researcher bias.
Step 3: Defining Themes and Write up ↓	• Robust approach • Use of Braun & Clarke's (2012) framework. • Reflects authenticity	• Identification of themes and subthemes • Cross-check raw data and field notes. • Documentation of any meetings and discussions with the facilitator • Theme names authentic	• Review of themes (triangulation). • Clear audit trail • Report all rationale for choices made throughout the data analysis and interpretation.

		to data	

Chapter Four

Findings

Introduction

This chapter presents the findings of the 20 semi structured interviews which were transcribed, analysed, and themed according to a thematic analysis approach. Study participants were referred to using a personal identification code that comprised a capital letter and a number, for example R1 meant resident number one. An overview of the demographic details of the participants is provided in (Table 8).

Table 8: Resident Coding and Demographic Details

Resident Code (R)	Care home Number (CH)	Age of Participant	Gender: Female (F) Male (M)	Clinical Commissioning Group (CSR OR GP)
R1	CH1	68	F	CSR
R2	CH1	88	F	CSR
R3	CH1	78	F	CSR
R4	CH1	69	M	CSR
R5	CH1	97	F	CSR
R6	CH2	92	F	CSR
R7	CH2	83	F	CSR
R8	CH2	74	M	CSR
R9	CH2	77	M	CSR
R10	CH2	93	M	CSR
R11	CH3	69	F	GP
R12	CH3	70	M	GP

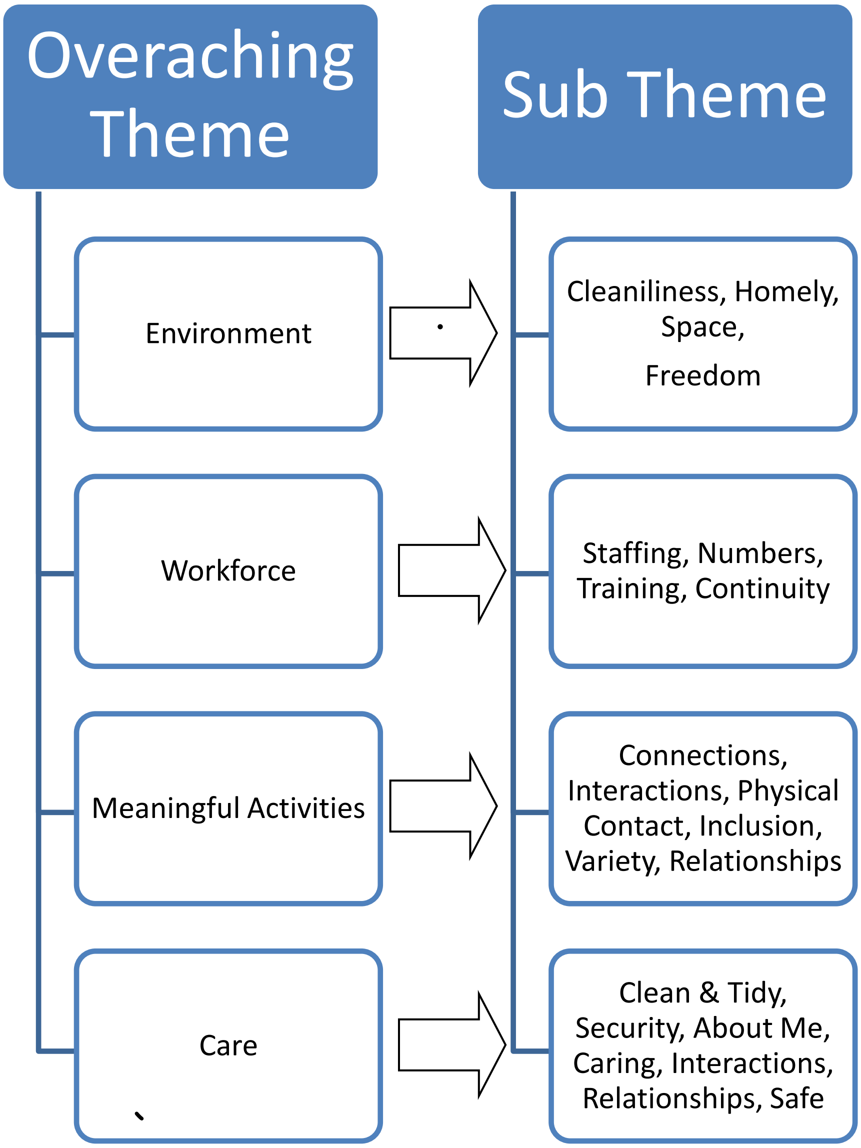
R13	CH3	94	F	GP
R14	CH3	91	F	GP
R15	CH3	83	F	GP
R16	CH4	74	F	GP
R17	CH4	69	M	GP
R18	CH4	73	F	GP
R19	CH4	88	M	GP
R20	CH4	85	M	GP

The themes identified are presented and discussed is this chapter. Excerpts from the transcripts are used to highlight significant statements and examples from participants’ answers.

Thematic Analysis

The thematic analysis of the semi structured interviews identified the following five overarching themes and sub themes:

Figure 3: Themes and Sub-Themes



Reflection from Health Watch Interviewer

I have undertaken many interviews with care home residents and staff however the questions did prove difficult for many of the residents, even when prompts were utilised. The quality concept was difficult for them to understand. Not all of the semi structured questions were answered by all the participants which reduces the number of responses and impact on the overall findings.

Health Watch Interviewer

The following provides further analysis of each of the five themes identified from residents' responses.

Theme 1 – Environment

When asked what quality of care (Q4) or care (Q3) meant to residents most commented on the environment within the care home and how it impacted on their day. Environment was noted as an important choice of care home but also the room they inhabited within the care home. Participants provided examples of what they deemed to be poor quality, which again included environmental examples. There is a common perception that moving into a care home involves a loss of independence and autonomy. However, while communal living may involve some compromise, it should not mean residents have to relinquish the elements of their lives they enjoy that are fundamental to their identity. When people are left to sit for most of the day with little movement or stimulation a number of detrimental physical and psychological changes occur which impact on their independence.

> *'I chose this home to live in as it is around the corner from where I used to live. I have lived in this area for almost 50 years. This home is well known around here.* (R5)

> *'I have the best room in the building as it looks out over the garden, and I can watch the birds. My son has put a bird table there for me.'* (R3)
>
> *'The rooms are okay. I enjoy helping with the gardening including mowing the lawn, makes me feel like I'm still in my own home. I also plant seeds in pots in my room before re-potting outside'.* (R2)
>
> *'I must do (like it here) I've been here for years.'* (R17)
>
> *'The room is lovely, it is big enough and it is spotless.'* (R4)
>
> *'I like my little flat, it is neat and tidy. I put it right if it isn't right. They work hard this lot (staff). I can't fault them. It is a right mixture here. It is just like a family. I like cleanliness and hoovering. I can't knock the food. There's not a lot of choice but they do ask what you like.'* (R6)
>
> *'We can decorate it if we like, my grandchildren make pictures'* (R1)

The size of the home and layout was important to residents when asked about what they deem to be good quality care, while the sense of belonging was also a significant factor. Moreover, participants described why the environment was central to their experience; this is supported by the findings from Castle & Furgurson (2010) who indicated that the environmental layout of the home is a key feature when encouraging and promoting meaningful interactions and promoting patient-centred care. This will be expounded on in the following chapter. Common words and phrases recurred, namely: '*it is got everything*', '*it is comfortable*,' '*having my own room makes a difference*,' and '*they look after me*.' When prompted further on what they meant by '*it is comfortable*', one participant said:

> *'It is like having my own little flat in a block of flats. I have all my own things from home so that makes it liveable, home comforts. That's what I mean. It is the little things that make it feel like home, like all my pictures and trinkets'* (R6)

Other participants provided different examples of why the environment was a factor in providing quality care (Q6). Participants gave mixed feedback about the bedrooms provided within the homes when giving examples of quality of care (Q6). One resident told the interviewer, '*I feel comfortable here. I can watch my TV in my room, or I can go there for quiet time, and I've got a big, comfy sitting chair which is good*.' Two of the residents indicated they would prefer a bigger bedroom, with one commenting '*It is not that big - about the limit in size*' and another explaining '*I'd prefer it bigger but it is completely adequate, but nothing like home*' adding that there was '*big enough wardrobe space, so that's good*.'

The level of lighting in the rooms when trying to read was an example of poor quality of care for four residents, especially during the darker months, but they were happy for the interviewer to feed this back to the registered managers, who said they would look to see if they could rectify this. Residents were happy that bedrooms were cleaned daily by staff, '*I'm happy for the staff to come into my room and clean, I had a cleaner at home so it is nice*' and managers explained that deep cleans happen once a week as many residents find this an area of significant importance in relation to quality. Mapping these findings to themes 2 & 3 of the literature tells a story of the importance of having a visible workforce and the impact that this has on resident experience of care received. Although privacy was observed by the interviewer during the care home visits, six residents did not think they had the ability to lock their room while they were out of the building and were concerned that other residents could potentially have access to their room. They missed having their own key to their 'home'.

> *'It is a big place. I get lost sometimes. I like the big lounge and the big tele'.* (R8)
>
> *'I love it, the home is perfect'* (R13)
>
> *'I like my own space, my tv, my own bath, my kitchenette'* (R17)

> *'It is okay. At first, they gave me a small room, then they changed it to a larger one'* (R8)
>
> *'It is got everything I need; I have brought my own bed'* (R3)
>
> *'It is alright in here, I'd like the room to be a bit bigger'* (R12)
>
> *'I don't like being here. I like her [staff member]'* (R20)
>
> *'It is not my scene – it is not what I thought it would be or what I expected so I'm leaving'* (R14)
>
> *'It is comfortable. It is an old-style building but I'm old and so is the other residents. It is an interesting cosy rabbit warren.'* (R2)
>
> *'I have settled in. I have got friends, no bills and heating, no gas bill to worry about paying for, and I get my meals made.'* (R19)
>
> *'I would like my own door key, that's important to me. Doesn't feel like a true home without it'* (R17)

Some residents commented that not having real ownership or power over their environment was difficult. Choice and independence over their living space was captured in the interviews when asked about examples of good and bad quality (Q6 & Q7). Reliance on others was a factor they deemed to be poor quality in terms of workforce responsiveness. Findings by Jeffs et al (2013) and Gilbert (2021) have shown the importance of the care home environment feeling like a home; this could be in the sense of smelling homely, as the environment is strongly linked to wellbeing.

> *'My room needs a lick of paint; I have to wait for them to do this. I don't like it looking untidy when my family comes to visit.'* (R6)
>
> *'I don't like where my room is as the man next door shouts all night. I can't have another room, but I am on a waiting list'.* (R17)
>
> *'I've been waiting two weeks for a new bulb, it is not like being at home where you just get it done'.* (R15)

Overall, many participants were happy with their surroundings within the care homes. One resident described their room as '*beautiful with the best view*' and another described the environment as '*very pleasant and immaculately clean!*' One resident thought that their room was quite small but also explained that this could be because the bigger rooms were for two people sharing. Another resident shared that they had been able to bring ornaments from their flat to put in their room to make it feel more like home. This was reiterated by six other residents who used the phrase '*very homely*'.

Residents commented about the importance of the wider surrounding community facilities and access to these. The outside space was also an important factor when expressing what quality meant to them (Q4, Q6 & Q7).

> '*I like having a flutter on the horses but there isn't a betting shop round here and there isn't a bus stop near either'.* (R11)
>
> *'I like going to the library, but I don't think there is one local to here. I like reading'.* (R19)
>
> *'I like to sit outside in the sunshine when it is warm.'* (R3)
>
> *'Go into the garden when it is nice. I'm not involved in the gardening as there's a gardener.'* (R2)

Theme 2 - Food

Most residents commented about the food provided within the care home when asked about the quality of care and what quality meant to them (Q3 & Q4). The examples and experiences (Q5 & Q6) shared about food were mixed albeit clearly indicating a key theme. Some residents liked the variety of food on offer while others did not like the food menu. Many people who move into care homes have varying and specific dietary needs. When providing food and drink, care homes are obliged to account for the needs, preferences, allergies and cultural and religious backgrounds of all residents in order to fulfil the requirements of their regulators. However, diet and fluid should be seen as essential basic care and a fundamental focus of care home providers (rather than just an obligation) whereby residents have the right to make their own choices. This was not a theme identified within the literature, and therefore an area which is not routinely captured or highlighted as an area of capturing good quality care. According to Norton et al (2014) and Oliver et al (2014) quality indicators are areas of highlighting where there are failings or to identify where there are areas for improvement. However, if areas of significant importance to residents aren't realised then this makes it impossible to truly provide good quality care.

An inadequate diet that lacks nutrition is known to cause poor health and poor quality of life, particularly for residents residing in a care home. It is important that social care providers have an oversight of diet and fluid as older people are at higher risk of malnutrition than younger people. Furthermore, care home residents are at higher risk of malnutrition than older people living in their own homes. Participants provided examples (Q5 & Q6) why food is a quality marker to them.

> *‘Quality is very good, there’s variation in the food offered. The menu changes weekly’* (R1)
>
> *‘I don’t eat the food, I don’t like it, my friend has to bring me food’* (R6)
>
> *‘Yes, I like soup. They make it just how I like it.’* (R17)
>
> *‘I like steak and kidney pie and jelly fruits! Every day is mash potato and chips’* (R11)
>
> *‘I like bacon sandwiches and big fat cakes! I will eat what no one else wants, I like my own company, so I eat in my room. This is important and means quality of care as they listen to what I want and need’* (R13)

> *'It could be better; I wouldn't give people in wheelchairs [the food] because they can't work out'* (R5)
>
> *'I select the food I like to eat. I can't believe how they cater for so many people so well.'* (R8)

Many residents spoke about staff accommodating their individual needs and preferences. Choice over the food offered was important to the interviewees who used phrases such as '*varied menus*', '*they listen to what I like to eat*', '*I can bring my own food in*' or '*family and friends can provide my food*'. It is necessary for homes to know how to ensure good nutritional care and to comply with CQC's fundamental standards advice. Inspectors look for evidence that shows how people are supported to have enough to eat and drink, have a balanced diet that promotes eating for good health (healthy eating), participate in decisions about what residents eat and drink, and measuring how residents' nutritional needs are identified, monitored and managed in a personalised way. However, it is difficult to marry this importance of this to the literature review findings to these specific areas of quality of care.

Several participants referenced the importance of choice and being treated as an individual when it came to diet and fluids which comply with the regulatory quality standard.

> *'If I go and buy steak, they will cook it for me, they're accommodating'* (R9)
>
> *'I don't like spices. I don't like what is on the menu, but they will make me something else. They make baked potatoes and beans on toast'* (R15)
>
> *'The food is alright. I wouldn't say its quality'* (R17)
>
> *'I enjoy lunch, they have a choice.'* (R1)
>
> *'Quality care is about having some good grub. Sometimes it is very good. It was Sunday roast lamb this week.'* (R3)

> *‘There is a choice of two meals, I like that.’* (R13)

When asked what quality of care meant (Q3 & Q4) to them, another significant factor to residents was the link between food and home. Again, when personal preferences were heard and catered for, this touched on a feeling of belonging and being recognised as an individual, as reflected in the literature (Castle, 2011 & CQC, 2019). Appetising food provided in a positive and caring environment that meets individual needs, is a key aspect of high-quality care. Providing a nutritious balanced diet and regular drinks is essential to prevent malnutrition, maintain a healthy weight, keep hydrated, and encourage interest in and the enjoyment of food**.** Interviewees highlighted the importance of having control over their food as they would in their own dwellings. Examples and experiences (Q5 & 6) included:

> *‘Pretty good on the whole – some good and bad options but then it depends on what you like, they do listen to what I like, sometimes.’* (R15)
>
> *‘I wouldn’t have any hesitation on saying its pretty good, just like food I cooked for myself and children at home. I’d love to be able to get in the kitchen though’* (R4)
>
> *‘I don’t like cereal, so we have bacon instead on toast. It is important to us that we don’t all have to have the same’* (R2)
>
> *‘I feel like I eat as I would at home.’* (R16)
>
> *‘We don’t need to be fed so much food – we just keep stuffing ourselves. My food*
>
> *is brought to me, it is very kind.’* (R6)
>
> *‘It is a whopping breakfast – toast and cereal. If we want, we can have bacon. We have a chef, it is great. No washing up for me anymore, I love it’* (R20)
>
> *‘Feed you too much: full meal at both dinner and tea. I was used to just a sandwich before. They don’t listen though, so it just gets left’ (R9)*

The food was described as ‘very good’ and ‘good’ and one resident explained they had really enjoyed ‘*ham, egg, chips and beans for dinner*.’ Another was pleased there were plenty of choices for breakfast such as ‘*toast and cornflakes or porridge*.’ This was echoed by one resident who said, ‘*I like Weetabix and hot toast with marmalade!*’ The interviews showed the importance of having snacks available throughout the day; one resident said they looked forward to the biscuits and explained, ‘*We have biscuits after our meal - I love them!*’

When asked what quality and quality of care means to interviewees, negative experiences were considered equally important in building an accurate understanding of what matters to residents in care homes. This also helped to meet the study aim.

> *‘At one time you used to get a full cooked breakfast on a Saturday, but they have knocked that off – you get just bacon now, it is disappointing not to be consulted with as this was a routine for me and my husband.’* (R17)
>
> *‘If I went out for a beef burger and half a lager then that would suit me and feel like home.’* (R15)
>
> *‘They give you what you like. It is what you would eat at home, chicken, fish and veg, plenty of variety, so that’s good quality care.’* (R4)
>
> *‘I like my dinner best, and egg and bacon and porridge first thing just like home. It is starting to feel like home now they know what I like, when I like it’ (R6)*
>
> *‘The food is very good it is like homemade which is important to me’* (R2)

When asked about experiences or examples of quality (Q5 & Q6), some residents referenced the involvement of family and friends as important, as they helped with the choice of diet and fluids and decisions. Food is a fundamental part of life in a care home where it is not only vital for health and well-being but also provides a structure to the day and supports orientation to time and place while promoting social interaction. Involving family and friends is a vital element in ensuring care is individualised and enables a greater insight into residents' needs and wants.

> *'If I went out for a beefburger and half a lager then that would suit me, my son does this once a week. It is the day I most look forward to'* (R1)
>
> *'Dave (son) makes me chilli con carne it is my favourite meal.'* (R11)
>
> *'My son brings me tripe every Friday for my dinner. He makes sure there is plenty of vinegar on the table'.* (R18)
>
> *'Including my family in my care is good as I forget all the food I like. They know and they have told the staff and chef. I can tell as I always get a poached egg and crackers for my supper'.* (R12)
>
> *'It is a BBQ today and that's brilliant! It is for my birthday. Makes the day a bit different as it can feel like the same day over and over again'.* (R13)
>
> *'I get my own food brought in, it is the best way. The staff don't mind as it is important to me and it is my home at the end of the day'* (R7)
>
> *'My carer brings food for tea because I don't like it much here.'* (R3)

Residents provided rich insight into what they believe to be examples of poor-quality care (Q7 & Q8).

> *'They tell you what you've got, and they come with plenty of tea and biscuits.'* (R1)
>
> *'Breakfast is alright, I could make it better. Others just leave it and don't eat all day. That's not good.'* (R6)
>
> *'Food, on the whole, is alright. Not much choice and nothing really offered if you don't like it.'* (R16)
>
> *'There's a lot of repetition, each choice is worse than the last.'* (R20)
>
> *'Yoghurt or ice cream all the time, I could scream!'* (R17)
>
> *'Just like hospital food. It is warm and you get three choices. No choice of desserts, usually just yoghurt or ice cream, and I don't like either. I keep telling them, but it doesn't make a blind bit of difference.'* (R19)

> *‘If you can’t eat it nine times out of ten you will be offered toast.’* (R14)
>
> *‘We get fed up with yoghurt and ice cream if it is on the menu for both meals.’* (R8)
>
> *‘The food is absolutely shocking. That’s not what I would describe as quality of care, is that what you asked me?’* (R2)
>
> *‘The food is absolutely awful. My family bring me food, so I use a lot of my own. They are happy for me to do this.’* (R16)
>
> *‘If there was nothing, I liked there was nothing they could make me other than toast.’* (R9)

Comments about the food were positive overall, although it appeared that residents were not always clear if they could choose what they wanted to eat and the responses they gave were varied. One participant explained that they had been involved in deciding what was on the menu but were not sure what they were having to eat that day. Another said when asked about quality (Q6), ‘*I think we’re having hotpot, very homely*.’ When asked about the quality of the care, one resident explained that it was ‘very good’ although another said, ‘it varies’. When discussing the choice of meals, one resident did not think they were able to choose and thought it was quicker to serve everyone if they all had the same, which meant that the dining room was ‘not as packed’. This does not reflect the findings of Aguwa et al (2021) and Griffiths et al (2017) who highlight the importance of individualised care and residents feeling that their individual needs and preferences are known, understood, and delivered.

Theme 3 - Workforce

Working in a care home means that the workforce needs to have excellent clinical and interpersonal skills to be able to look after people who frequently have complex care needs. Many older people do not want to go into hospital and want to stay in the care home for their care and treatment. The staff within a care home are fundamental to all aspects of health, care and well-being whilst aiming to provide a homely living environment. As outlined in the literature review, evidence suggests that care can be improved with strong leadership, effective care home teams, a focus on continued quality improvement and a culture that gives staff time to listen to residents and meet their needs with compassion. When asked what care and quality of care meant to residents (Q3 & Q4) a clear theme emerged in the form of the workforce.

> *'The home work around my routines. The staff are amazing.'* (R14)
>
> *'The girls are great. I'm comfortable here.'* (R7)
>
> *'On the whole I feel looked after and most of the staff are really nice.'* (R20)
>
> *'There is always someone available if you need them, it is good to know.'* (R15)
>
> *'I think they are good. I've only just moved in, and it already feels like a big family'.* (R10)
>
> *'They look after me, it is not the same as having your own family around you, but I'm getting used to it'.* (R19)
>
> *'Yes, they do look after me, they are ever so good'* (R8)
>
> *'I'm just glad I came here; they look after me like my family does'.* (R10)
>
> *'I have a shopping list and the carers order it for me, they will do anything. That's important if you want to know examples of quality of care.'* (R19)
>
> *'The staff get everything we need. There is always someone available if you need them, that's caring.'* (R6)
>
> *'On the whole the care is good. They (staff) encourage you to be independent and help you get yourself washed and dressed so it is helping me.'* (R20)
>
> *'Staff treat you with respect. Sometimes I think I'm not so sure but then I leave it. The boss herself is very good.'* (R3)

> *‘Staff are good. They are easy to get on with and talk to.’* (R6)
>
> *‘It is great they’re very good.’* (R16)
>
> *‘They do what you ask them to do. If they can manage it, they will. They know everything about you, and they are up to date.’* (R12)
>
> *‘I want to feel seen and heard, it is important that I feel I belong’* (R6)
>
> *‘I dress and wash myself, but I have to let someone take me down the stairs and they carry my things for me. That’s important it stops me from falling’* (R11)
>
> *‘I need hearing aids and glasses, but I do get out walking even though I can fall. Everyone looks out for me, and I still get to go out.’* (R10)
>
> *‘I am looked after very well. The staff here treat me like I’m one of their own. They all really care about me; I feel loved which makes me happy’* (R4)
>
> *‘Its important the carers know what matters to me’* (R12)

All interviewees were extremely complimentary towards staff. One participant explained, ‘*We get on well with all of them*’, and another added ‘*They’re lovely, they are*’. Another participant explained that they had cared for others throughout their life but explained that now, ‘*I’m being cared for, and I can put my feet up!*’ Two residents commented on individual staff members who happened to be walking by, saying, ‘*She’s fantastic!*’ and ‘*She’s lovely. They really are good*.’ Another resident said, ‘*I have a nice life*’. One resident explained that they were not always able to recall the names of the staff and wondered if it could help to have name badges.

The following reflection from the Health Watch interviewer described interactions between staff and residents.

Reflection from Health Watch interviewer:

Interactions between staff and residents were observed to be both caring and professional, with all residents appearing settled in the environment at the time of the visit. All five residents spoken to during the visit expressed that they were happy at xxxxxxx. Two residents when asked about quality of care conveyed how pleased they were with the changes since the new manager had taken over and explained, ‘It was good before but now it is fantastic!’ and ‘Look - tablecloths, flowers on the table. It is made a difference.’ It was made clear to me that there was a weekly menu and activity schedule. However, residents were not consistently aware of choices, and even though this information was displayed, it was quite small and not very prominent. One resident did not think they were able to go out enough, although they thought that this was largely due to the impact of the staffing. However, feedback regarding staffing levels was variable. Some residents felt there were times when it could be difficult to provide person centred care. The new manager explained that staffing levels were adequate for the needs of the residents but that some days are busier than others. She confirmed that she planned to talk to the staff about this at their next meeting.

Health Watch Interviewer

Participants shared views (Q5) that the staff could be flexible and respond to the varying levels of care needed: ‘*We all have good days and bad days*’ and ‘*but they really do listen and note things down*’. One participant expressed that they all care about each other ‘*I do sit in the lounge and listen to other people, and they listen to me. I try to put myself in their shoes*’. Residents were happy with levels of care, support with mobility or with independence. One participant was very impressed at receiving freshly laundered bed linen and having their room cleaned on a regular basis. More specific care needs appeared to be addressed on an individual basis. For example, many residents talked about visiting the dentist or seeing the chiropodist or attending hospital appointments which the staff in the home supported and which the residents appreciated and acknowledged.

It was clear from the interviews that residents wanted to feel seen and heard, in order that their individual care needs could be met, and that interventions were meaningful and added value to their day.

Interview evidence suggests that residents want staff to enable their wish for a 'home for life', therefore, enabling resident choice. However, they recognised this was not always easy to achieve. When asked to give examples (Q6) or share experiences (Q7) about the quality of care or what would be deemed poor care, the workforce featured heavily within the responses:

> *‘Sometimes I’m looked after well, the rest of the time you go dirty if there isn’t anyone around’* (R3)
>
> *‘They are alright. It isn’t always easy, they read about me and make notes, I don’t like that.’* (R14)
>
> *‘Staff try to get me ready for bed too early. They once tried to get me ready for bed around 5pm but I refused. They are leaving it a bit later now, but I would like to choose the time I get ready for bed.’* (R3)
>
> *‘One member of staff has upset me recently by a comment that I felt was unjustified, but this seems to have resolved.’* (R2)
>
> *‘If I was to share an example about poor care I would say being treated like a child at times. I’ve told my family and I think they have spoken with the boss. I’m sure they don’t mean to do it’* (R6)
>
> *‘I hate we all have to get up at the same time and go to bed early. I didn’t do this when I was at home. Wish I could look after myself and do what I wish’.* (R3)
>
> *‘I don’t fit in here at all. I feel like the odd one out. I don’t think the staff like me, I’m too much of a burden’* (R17)

> *‘I think they are understaffed. You can tell as the meals have been late and we don’t have any activities planned today which is a shame as I look forward to those. It makes the day go quicker’* (R13)

Theme 4 – Meaningful Activities

This theme relates to the descriptions and experiences of participants in relation to the importance of meaningful activities when describing quality of care. The skill of the staff within care homes lies in understanding the importance of activity and finding ways to encourage choice and engagement. Staff can ensure they are familiar with the key points of each resident’s biography, interests, and preferences. This will help them to understand whether it is appropriate to encourage individual residents to participate activities. Discussing what residents like to do with friends and relatives is paramount when providing and producing personalised care and this starts before admission to the home.

It is important not to force residents into an activity or event, but rather to see them as individuals with their own preferences. Care home staff can begin by fostering a culture of spontaneity when talking to residents and make the most of occasions when they can interact with them on a one-to-one basis.

Encouraging interaction in the local community, either independently or in groups supported by staff, was recognised as an important part of life for most of the participants interviewed. Participants spoke about enjoying trips out to Blackpool or Townley Park for ice-cream, proudly sharing ‘*We’ve got our own minibus!*’, whilst others shared (Q5) that they enjoyed ‘*the freedom to go out and come and go as I please*’. Several residents confirmed, ‘*as long as you sign out, tell them roughly what time you’ll be back it is fine, and I always have my mobile*’. They continued, ‘*In the summer, I walk for miles! It keeps me physically fit, and I get to see new things*’.

Other interviewees explained that they did not go out much and were not aware of any activity plans although it was an area of significance to them. When asked about quality of care (Q6), other examples included:

> *‘I like doing the jigsaws and go out with my family.’* (R1)
>
> *‘I like to sit outside when I can. It reminds me of sitting out at my son’s house’* (R17)
>
> *‘I like listening to the radio.’* (R8)
>
> *‘When it is nice I like to go into the garden.’* (R5)
>
> *‘People come in the afternoon. I do like that’.* (R19)
>
> *‘I’m not bothered about TV, but it is always on. The nurse comes into the lounge every morning and turns it on without asking what we would like. I like watching the news but it is never on’.* (R18)
>
> *‘I don’t know about any activities’.* (R6)
>
> *‘One of the carer’s children comes to visit me.’* (R10)
>
> *‘The carers get my newspapers. This passes my day especially the crosswords’ (*R12)

When asked about quality of care (Q6), several participants provided examples of activities. One resident described hobbies such as matchstick model making, and another referred to reading ‘*I love reading but my eyesight isn’t good. I have one or two audio books and the library send me the Burnley Express that I can listen to. They also got me a speaking clock, so I know what time it is!*’ (R10). One resident spoke about regular visits from the hairdresser and the fact that they enjoyed getting a manicure. However, a couple of the residents mentioned that no relatives or friends visited them. Some of the residents had lost touch with their family members for a variety of reasons prior to living at the home. When asked what care meant to them (Q3) or to share (negative and positive) examples and experiences (Q6, 7 and 8), a number of residents referred to family and friends.

> *'My son takes me out and I do crafts. He knows I like that.' (R3)*
>
> *'Radio programmes, music, TV – we don't have a lot of activities because we are always eating.' (R16)*
>
> *'I go out to get my hair done every week and my nails get done as well. My granddaughter takes me. We then enjoy a cup of coffee before we come back' (R14)*
>
> *'There are games we play; we can invite our family to the events.'* (R15)
>
> *'Chair based exercises today, my daughter comes in to help with these. I like listening to the music, and dominos games, and quizzes.'* (R17)
>
> *'We had a party yesterday for Halloween, all my family came, we had a great time.'* (R8)
>
> *'I can't do much. I've got my book, which my husband comes to sit and read with me.'* (R3)
>
> *'My family have brought me in some tapestry.'* (R2)

When asked about quality of care, some of the negative examples included:

> *'Yes, there are things to do like running away.'* (R9)
>
> *'There is nothing in particular to do. I was always doing something when I lived in my own house. I like arts and crafts; think I'll ask my niece to bring me some in'.* (R2)
>
> *'There are no activities in here that I can get involved in. I want to go out more but have to go out with a member of staff, so I hardly ever get to go out.'* (R6)
>
> *'I hate not being able to go out when I want to. You always have to ask someone to let you out. I've asked them to put more activities on in the garden or if they will take me to church on Sunday. Not happened yet'.* (R18)
>
> *'I don't like group activities I much prefer for someone to come and sit with me and chat'* (R6)

There were mixed comments regarding the activities arranged in the care homes, as some residents liked the activities on offer while others stated that there was nothing for them to do or that they had to entertain themselves. Several residents mentioned the lack of activities at the weekends:

> *'There's not a lot to do. They play records downstairs. We make our own fun'.* (R4)
>
> *'They play dominoes, but I don't know how. I'd rather be doing something like listening to music or listening to someone singing especially at the weekends.'* (R14)
>
> *'I haven't been mixing because my immune system has gone down. No one has been in to do anything or to say hello.'* (R20)
>
> *'I do word searches and I have the TV on. I've got puzzles to exercise my brain. Family and others visit me every day.'* (R2)
>
> *'I keep active by walking around. I walked outside but it was too cold, so I had to come back in.'* (R18)
>
> *'I get visitors which is great, I do the exercises and get my nails painted.'* (R9)
>
> *'I like getting my nails done – I can get them changed when I like.'* (R16)
>
> *'There is always something to do, lots of choice, even when I don't know what to do.'* (R12)
>
> *'They have a wine and cheese night'.* (R4)
>
> *'The weekends are boring'.* (R5)

Activities were often mentioned when asked about examples of quality of care and what it meant to participants (Q3, Q4 & Q6), and these tended to include 'Task Based Activities' such as ironing, dusting, hoovering to be given the opportunity to use the laundry or kitchen independently.

Some residents noted that, with proper precautions in place, helping out with the chores can be an important part of daily routines for some residents, and would improve the quality of care in homes. Indeed, according to The College of Occupational Therapists, residents should be encouraged to help in the kitchen, laundry or garden or work alongside domestic staff as they clean communal areas. Staff were urged to: '*ask residents to help – get them involved*', which is reflected in the interview responses:

> *'I've got the remote here and I can change the channel for people as some of them can't do that, it gives me purpose.'* (R16)
>
> *'An example of quality of care for me would be if they would allow me to hoover and clean my own room. I don't know why I can't?'* (R1)
>
> *'I would like to take my own clothes to the laundry; I miss not being able to wash my own clothes. Your clothes don't always come back.'* (R11)
>
> *'I would like access to the kitchen to prepare my own meals'.* (R18)
>
> *'My own kitchen would be ideal so I could prepare drinks and snacks for my grandchildren'.* (R20).
>
> *'Having the opportunity to wash the dishes and help prepare the meals is important to me. You aren't allowed to do that here; it is all done for you which is ok I suppose'.* (R13)

Participants spoke about enjoying '*lots of conversations*' with the staff along with other residents' friends and families. Some participants shared that sometimes they felt they were '*sat around not doing very much*'. Another resident spoke enthusiastically about having the '*opportunity to chat to people*' and added '*You're not alone here, you can talk to anyone, it is like an extended family*.'

> *'I don't mind exercises but not all the time, I know it helps me. The others enjoy them.'* (R17)
>
> *'I think I'm getting the treatment I need. I've got up and got the Zimmer and walked through the hall with the carer, that's improvement.'* (R1)

> *'Through the day it is a bit slow but evenings flash by. There is lots of visitors in the evening who all chat with me'.* (R13)
>
> *'I keep trying to run before I can walk. They're very understanding. They've even taken me for a walk outside.'* (R6)
>
> *'I like word searches. I'm limited as to what I can do. The carers and my family bring them in and sit with me when I need help.'* (R10)

Social contact and interactions are crucial to health and wellbeing and a contributory factor to remaining independent (Fessey, 2014). Interviews highlighted that many of the residents have little to no physical contact despite recognising its importance (Q3, Q4, Q5, Q6 & Q7).

> *'No one gives you a cuddle in here. I like cuddles, I have to wait for my family to visit to get one'.* (R20)
>
> *'I don't talk to many people here as I don't know them, like to keep myself to myself'* (R12)
>
> *'I like it when the staff sit and hold my hand, that's nice.'* (R10)
>
> *'It feels lonely here there is no one to interact with.'* (R8)

Theme 5 – Care

The delivery of care and treatment in care homes is of paramount importance. How residents are treated impacts on all aspect of their daily living along with their physical and mental health. The interviews describe why care is essential to how residents feel and how they live.

In general, participants provided positive comments about the care and treatment they received when asked (Q3, Q4 & Q5). Participants reported that the staff were friendly and caring and often took the time to chat with them. Several comments were made about staff being very busy, meaning they do not have the time to chat, care or spend much time with them, which was a significant factor (as outlined in theme 3).

> *'The girls are smashing. Very homely if you know what I mean. We have a laugh, and we have jokes. I can tell they care about me.'* (R3)
>
> *'You know sometimes when you click with someone. I click with my carer. They're all very nice and helpful but they're busy. At first, I used to think no one cared – no one says hello, it would be nice if they just bobbed in. They don't clean enough but my standards at home were much higher.'* (R12)
>
> *'They do as much as they can do. They go out of their way. There's always someone to help. It is frustrating not being able to look after myself.'* (R15)
>
> *'They are a brilliant team when everyone works together – they knew my whole story. I never have to tell them how I like things done. They just know.'* (R9)
>
> *'They are not always on time but that is because they are short staffed. They never rush me and always look after me like my family.' (R7)*
>
> *'They are very caring, there is always someone to talk to or go to. They do my hair and nails.'* (R17)
>
> *'I feel cared for and happy, the staff visit me often to have a chat and keep me company.'* (R4)
>
> *'I get along with some staff, but not all, but that's life.'* (R2)

When asked 'what quality' and 'quality of care' meant to interviewees, all responses focused on how care is perceived, given and what would be deemed poor care. One longstanding resident commented on the changes since the current managers had taken over a few years ago.

> *'The quality was not good before, when I first came. Standards have improved dramatically - staff, hygiene, going out, cooking, I get all my treatments on time.'* (R1)

> *'Staff here are brilliant! I don't have a problem with any of them. I always feel well looked after. My family would also agree the care here is excellent'* (R8)

Participants acknowledged the importance of staff flexibility and responsiveness to the varying levels of care and support needs. Nine residents pointed out that they all care about each other, with one stating (R7) '*I do sit in the lounge and listen to other people, and they listen to me. I try to put myself in their shoes*'. Participants reported feeling happy with levels of care, such as support with mobility, washing and dressing or with independence; one participant was extremely impressed with the freshly laundered bed linen and the regular room clean. More specific care needs appeared to be addressed on an individual basis. For example, one resident talked about visiting the dentist or seeing the chiropodist, while another mentioned going to the hospital for scans and could be heard by the interviewer asking staff to update them on their next appointment. Personalised care and treatment are a necessity when living in a care home environment and this was recognised by the interviewees.

> *'Staff are good, they take me to all my health appointments when my family aren't available.'* (R7)
>
> *'They help us any time we need.'* (R16)
>
> *'The banter I have with them is good. One came and sat with me after their shift was over just to have a chat, that's what is important to me feeling like I belong.'* (R10)
>
> *'They are alright really. One or two are better than others, they don't all care.'* (R3)
>
> *'Everyone treats me with dignity and respect.'* (R18)
>
> *'The staff look after me, they are really helpful. They are taking me to the dentist tomorrow'* (R9)

> *'Sometimes they're in such a rush with everything, why do they have to write everything down?'* (R11)
>
> *'They used to help you get dressed but they don't help you as much.'* (R20)
>
> *'Some treat me with respect but not all.'* (R9)
>
> *'I need hearing aids and glasses, but I get out walking even though I can fall. Everyone looks out for me, and I still get to go out.'* (R18)
>
> *'It is very good; I am helped to wash and dress, and the call bell is answered quickly at night'.* (R15)
>
> *'They are kind and I feel safe.'* (R2)

When asked to give examples of share experiences of quality of care (Q3, Q4, Q5 & Q6), interviewees highlighted the importance of being assisted with personal hygiene in a dignified manner:

> *'I get more rehabilitation because it is smaller here. They help me get washed and dressed but also encourage me to do it myself'.* (R1)
>
> *'I'm glad I'm here, it is one step closer to home. They help me to the dining room and bathroom but I'm getting better at this on my own'* (R8)
>
> *'The home work around my routines.' (R18)*
>
> *'On the whole I feel looked after and most of the staff are really nice. They don't rush me to get ready' (R14)*
>
> *'There is always someone available if you need them to help you get up and dressed or helped to bed.'* (R3)
>
> *'I think they are good'.* (R15)
>
> *'They look after me. They cook, clean, shower and dress me. I can't do it all myself anymore'.* (R5)
>
> *'I have a shopping list and the carers order it for me.'* (R18)
>
> *'The staff get everything we need. There is always someone available if you need them.'* (R8)
>
> *'I would recommend it to anyone. Always feel safe and respected'* (R13)

> *'On the whole the care is good. They encourage you to be independent and help you get yourself washed and dressed so it is helping me.'* (R12)
>
> *'I dress and wash myself, but I have to let someone take me down the stairs and they carry my things for me.'* (R16)

When asked about the quality of care they received, a number of interviewees stated that choice is an indication of quality, for example: '*Joanne helps me when I want a bath or a shower, I can pick*'. Another resident stated, '*I've got no grumbles. I just go with the flow; however, they always give me options!*' One resident spoke about sometimes having to wait for a member of staff to take them back up to their room but added, '*Everyone does their best*'.

There were examples of poor-quality care (Q7) which were key indicators of what residents need and want to feel they are receiving for high quality care.

> *'I don't fit in here at all.'* (R3)
>
> *'I think they are understaffed.'* (R6)
>
> *'I wouldn't say it was worse than being in hospital'.* (R7)
>
> *'Sometimes they're in such a rush with everything.'* (R16)
>
> *'They used to help you get dressed but they don't help you as much.'* (R20)
>
> *'Some treat me with respect but not all.'* (R17)
>
> *'A carer called me lazy, and I was tired. I told them not to send that carer to me again. My complaint was dealt with.'* (R19)
>
> *'I can't cope with young lads coming into my room at night when I need the toilet. this is private. I don't like it; I just don't like it. They don't look after me it awful'* (R9)
>
> *'It just depends on who you are talking about.'* (R10)

Whilst the aim of this study is to understand from a resident's perspective what quality of care means to them, in order that improvements can be made to quality assurance processes, it must be noted that whilst the themes identified provided a rich insight into the realty of living in a care home, it also highlighted that some residents are currently not experiencing quality of care within some of the identified themes.

Personal Reflection on Identified Themes from the Interviews

Having worked in care homes, managed them, and moved on to regulation and oversight I have never stopped putting the resident at the centre of all decision making.

It is so easy for staff to get into an institutionalised mindset that people forget to look at residents as individuals with their own wants and needs. A life lived to the full and with so much experience to share and stories to tell. As noted within the literature and within theme 2 & 3, many care home staff forget that every task counts and can be seen as an activity if done with care, attention and compassion in partnership with residents and families. Residents enter a care home and almost overnight their independence is removed, not always knowingly but how care homes are set up. Residential homes have become more and more risk averse over the years due to an increase in regulation and inspection. Poor media attention which is not a reflection of most care homes but nonetheless affects how they are perceived. It should go without saying that residents should be 'allowed' (when safe to do so) to hoover and dust their rooms and have access to the kitchen to make a drink or prepare loved ones a sandwich as they did when at home. We call these facilities care homes but do residents really see them as homes or a diluted version of a home. This viewpoint is reflected within the findings by Jeffs et al (2013), who suggests that by the very nature of living in a home is to experience those things we routinely associate with being in one's own environment, yet as discovered within the interviews these very basic activities of daily living are removed in many instances. Activities are vital for health and wellbeing, keeping people mobile and mentally astute. Reduces physical health complications such as falls, developing pressure ulcers along with other de conditioning complaints. Meaningful activities which are individualised give residents a sense of belonging; allowing them to share their lives and tell us what matters the most to them and their loved ones. Activities and interactions let them know they are heard, and they are important. Simply sitting in a lounge with a TV blurring in the background is not a meaningful activity and it is time we started to monitor activities as a key quality marker to improve standards and enhance the delivery of activities for all residents.

Intersections and Connections

Environment and Food:

Understanding the influence of physical environment and food on resident well-being, quality of care, comfort, and satisfaction involves considering various factors that contribute to residents' experiences within care home settings. It is important that the residents feel relaxed within their environment to feel comfortable when it comes to mealtimes. These connections came up several times throughout the interviews.

> ‘I *like my little flat, it is neat and tidy. I can’t knock the food. I feel comfortable*’. (R1)
>
> *‘The smell of homecooked food always makes me ready for my meals, it is important that you can smell food cooking at the home’* (R9)
>
> *‘I have settled into the home well, and the food is excellent and tasty’.* (R19)
>
> *‘Food always tastes nicer, when I feel relaxed within my room’.* (R16)
>
> *‘I wish I could make my own meals so that I feel like im still in my bungalow.* (R2)
>
> *‘Mealtimes breaks the day up and helps structure my day’.* (R14)

The importance of creating homelike, comfortable environments and providing nutritious, culturally appropriate meals was expressed by the residents as important quality factors and was also identified as part of the findings by Aguwa et al (2021). However, as noted within the literature review this creation of a homelike environment is not identified as a key theme on what quality of care is from a resident's perspective.

The environmental layout and food services were found to impact on how the residents felt, social interactions, and overall quality of care. One resident reported that *‘I feel healthy and happy when the dining room is clean and tidy, and the menus are on the table’ (R11). ‘I like to plan ahead.’ (R1) Whereas* another resident commented how important it was to feel ‘*relaxed at mealtimes in a pleasant environment*’.

Residents' described satisfaction with the physical environment influenced by factors such as cleanliness, maintenance, and aesthetics ‘*The food always tastes better when the dining room is clean and quiet*’ (R9). This was echoed by another resident who described the dining room as *‘where I feel most at home’ (R18).*

A well-maintained and aesthetically pleasing environment contributed to residents' overall satisfaction and quality of care within their living arrangements. Conversely, issues such as clutter or disrepair impacted on residents dining experience and promoted feelings of discomfort or dissatisfaction. According to Hall et al (2019) and Stevenson & Cheng (2021), It is well documented that one's environment can have a negative or positive impact on mental health, mood, and behaviours hence why it is so important that health and social care professionals monitor and assure the delivery of this from the perspective of those living in a care home environment.

Workforce and Activities:

The workforce was linked to meaningful activities for residents when asked about the quality of care and what good care looked like. Staffing levels, and visibility of manager and workload were key phrases used by the residents.

This highlights the importance of diverse and tailored activities that promote socialization, autonomy, and enjoyment for residents.

Care and Workforce

The links between care and the workforce in a care home are intricate and vital for the overall well-being of residents and the smooth functioning of the facility. They are essential for creating the ‘home from home’ environment which is so important to residents.

The workforce is directly responsible for providing care to residents within the care home. The quality of care is heavily dependent on the skills, dedication, knowledge of the residents and empathy of the workforce. Adequate staffing levels, good training, and support mechanisms are crucial for ensuring that residents receive the high-quality care they deserve.

Adequate staffing levels are essential for meeting the needs of residents in a care home. Insufficient staffing can lead to rushed care, neglect, and increased stress for both residents and staff. Conversely, a well-staffed facility can provide more individualised and holistic care, fostering stronger relationships between residents and carers.

In synthesizing the findings from various themes and their intersections, a comprehensive understanding of residents' experiences in care homes emerges. The intersection of themes, including environment and food, workforce and meaningful activities, and meaningful activities and care, serves as a lens through which to analyse the nuanced dynamics shaping residents' lives. These intersections highlight the interconnectedness of various factors influencing residents' well-being and the quality of care they receive from their perspective.

The theme of residents' voices emphasizes the importance of empowering residents to actively participate in discussions related to their care and treatment. By fostering open communication channels and valuing residents' perspectives, care home providers can ensure that individual preferences and needs are recognized, respected, and planned for accordingly.

Time to care emerges as a critical factor in providing high-quality care to residents. Adequate staffing levels and sufficient time for carers to attend to residents' needs are essential for promoting safety, comfort, and dignity. Moreover, the quality of care is intrinsically linked to the amount of time carers can devote to each resident, highlighting the need for workforce support and adequate resource allocation.

The role of the workforce extends beyond task completion to encompass the provision of meaningful activities that enhance residents' overall well-being and quality of care. Caregivers play a pivotal role in facilitating social engagement, stimulation, and recreational opportunities, which are essential components of a fulfilling life in a care home, as found from the interviews.

Assurance and oversight mechanisms are essential for maintaining accountability and ensuring the delivery of high-quality care. Regulatory frameworks, quality monitoring systems, and effective leadership structures contribute to fostering a culture of excellence and continuous improvement within care homes, which will be explored further within the discussion chapter.

A person-centred approach to care highlights the individual preferences, values, and dignity of each resident. The workforce plays a key role in implementing person-centred care practices, such as involving residents in decision-making, honouring their choices, and fostering meaningful social connections and activities. Staff continuity and consistency are important for building trust and rapport with residents as highlighted within the findings.

By integrating these themes into the discussion of residents' experiences, insights can be gained into the multifaceted nature of care provision and the complex interplay of factors influencing residents' quality of life from the lived experience. Moving forward, prioritising residents' voices, adequate staffing levels, meaningful engagement opportunities, and robust oversight mechanisms are essential for promoting resident-centred care and enhancing the overall well-being of those living in care homes.

Chapter 5

Discussion

In this chapter the themes identified in the findings chapter will be considered against those from the literature review findings as this enables a critical triangulation to inform the discussion. Findings will also be examined and considered in relation to the research question. The unique contributions of the study will be described. To support the discussion, the study aim, and outcomes are restated below:

Research Aim:

- Define what ‘quality care’ means from a resident’s perspective.

Research Objectives:

- To generate knowledge of what quality of care means to residents residing in a care home.
- To develop an evidence base of what matters the most to residents from a lived experience perspective.
- To generate knowledge to inform commissioners of resident's perspectives of the quality of care in care homes.

Emphasis on resident-centred care approaches empowers individuals to actively participate in decision-making regarding their own care. This approach fosters a collaborative relationship between health and social care providers and resident's, leading to more personalised and effective interventions (Schenk, 2013). It was clear from the findings that resident's want and need to be involved in all aspects of their care, feeling ‘heard’ and ‘seen’ were phases used frequently. Meaningful interactions, activities and care should be areas of focus when gaining an insight on what quality of care means from a resident's perspective along with acting as an indicator to gain assurance of the quality of care being delivered. Meaningful interactions allow residents to continue to embrace things that mean the most to them and provides them with reassurance that staff are listening to them and planning care accordingly.

This study includes what is important in in terms of primary need and social interaction (Wilson & Davies, 2009). Maslow's Hierarchy of Needs, for example illustrates how chemical and neurological processing, happiness, motivation, and self-image is controlled by perceptions of choice and interaction. The extent to which residents exercise choice and control has a direct influence on the relationships they develop within the home, with staff and each other. Studies from the literature review have examined the impact of involvement in decision-making at the macro level, for example making the decision to move into long-term care and choosing a care home (Bamford & Bruce, 2000). However, findings by Hinsliffe - Smith (2020), highlighted the importance of maintaining personal control in day-to-day activities as far as possible.

Making decisions for someone may make providers feel like they are caring, but these moves towards self-efficacy bridge the gap of residents' daily experience to that of the micro aspects that bring 'meaning' in life', and in the twilight years may form fulfilment to the macro concept of the 'meaning of life' (Batthyany & Russo-Netzer, 2014).

An understanding of the link between a resident's perceived real choice over aspects of their daily lives and the potential to prevent poor experiences in care homes is imperative and reflected in findings from the literature (Boyle, 2005). Findings from the interviews highlighted a sense of powerlessness amongst residents over their daily activities within the homes which reduced residents’ sense of control. Such powerlessness stemmed from the imposition of regimented routines, the restricted scope for decision-making, and a diminished sense of freedom.

The descriptive approach of this study allowed for a more contextual response from the residents, which demonstrated that people desire a ‘home from home’ experience. However, the concept of home is subjective and multifaceted, encompassing a complex interplay of personal, cultural, social, and environmental factors (Villaire & Walsh, 2017). According to Daly (2020), while there may be common themes or associations that people share regarding what constitutes home, individuals' interpretations and experiences of home are ultimately unique and deeply personal, hence the need for personalised care planning to be undertaken to provide good quality of care.

This brings forth a valuable contextual issue which may well permeate all areas of provision within a quality-of-care context, that of giving an opportunity for residents to be involved in decisions and allow them to express their own understanding of individuality. This can be clearly mapped, that the processes of involvement, self-expression and control can give micro moments of meaning ‘in’ life and contribute to many peoples’ macro-meaning ‘of’ life (Batthyany & Russo-Netzer, 2014).

This perspective can show why it is important and should be put to the forefront of consideration, as it is no longer a point of a good experience but reflects broader issues of purpose and significance of existence and by addressing these issues can restore meaning after change, loss, or upheaval (Markman et al, 2013).

Older people and their relatives want residential homes to offer a 'home for life'. However, as residents age, their health needs become more complex and varied.

Care home staff will need enhanced personal skills and support from healthcare professionals to meet these needs. The findings by Deqanter et al (2020), inform us that residents want a workforce that is competent and trained to meet their individual care needs. Coping with a shifting paradigm of individual care is a massive undertaking but may display a need to shift approach to one of flexible co-design of lifestyle for each individual and of finding ways to allow people to express individuality and meaning. A workforce that cares, respects them and recognises their individual care needs is paramount.

If thought about the issues at hand may not be one of extra provision but of control ownership of responsibility. Therefore, allowing residents to contribute and assist in their own lifestyle and listen to what is important to them from their perspective and lived experience will offer the most meaningful and fulfilling experience.

The findings from this study also emphasised the importance of the care workforce; it is noted that what really matters to residents are the individuals who look after them and how they make them feel. According to the literature review, the solution is to adopt a collective approach to support, quality improvement, and oversight as no one professional has all the answers. This will allow a consistent view of the workforce. Nevertheless, the residents' voices must be central to any decisions and improvements.

The CQC's (2020) report entitled the State of Health Care and Adult Social Care in England indicated that, 'The quality of health and social care has been maintained despite very real challenges. The majority of people are getting good, safe care with reported good resident experiences. However, future quality is precarious…' (CQC, 2020, pg.25) It added, 'The efforts of staff have largely ensured that quality of care has been maintained – but staff resilience is not inexhaustible…the entire health and social care system is at full capacity at a time when residents needs are at an all-time premium.' (CQC, 2020, pg.25). Therefore, there are still improvements that can be made, and by really understanding what is important to residents with a lived experience can go a long way to making these much-needed improvements. This is reflected in the findings within this study, both from a literature review, which highlighted broad themes to those from the interviews that provide the areas of significant importance to residents. As a commissioner and working with regulators these specifics are the areas that require monitoring and oversight to capture what is deemed good quality of care from a resident's perspective. By truly understanding and incorporating these residents focussed indicators may support better use of resources, reduce hospital admissions, reduce the burden on community services and therefore support better utilisation of stretched resources in an overburdened system, as reflected within the literature (Goodman et al, 2015 & Kings Fund, 2019).

According to the findings from this study, even though residents accepted standardised care, and some were comfortable with common routines in the care home, residents should not be responsible for creating a healthy environment for themselves due to a poor organisational culture or uncommitted workforce. According to the literature review, standardised care illustrated a corporate culture where care home residents were seen as *subject to* rather than *part of* the care home culture (Aguwa et al, 2021 & Blood, 2010). According to Forder & Fernandez (2011), institutional rules, procedures, environment, and a high degree of conformity to corporate culture can be obstacles to achieving good quality care for residents or providing a conducive working environment.

It is important to note that the literature review highlighted that the perceived quality of care not only includes relevant areas of life, but also intangible and collective values such as ‘freedom’, ‘justice’ or the degree of ‘autonomy’ experienced by the individual (Castle & Anderson, 2011). This is of particular importance for the quality of care that care home residents experience, whose scope for determining and influencing their own living environment is limited. Indeed, such limitations impact on how they perceive quality of care.

Although there is a clear need to shift the balance of decision-making power in care homes to include residents and their families more effectively as outlined in the findings. However, there is a parallel need outlined within the literature which is to ensure that all staff can contribute to decisions regarding providing individualised care and treatment (Oliver et al, 2014). The literature reviewed suggests that partnership working has the potential to strengthen relationships in care homes and promote positive experiences for all concerned, which correlates to the perceptions of those interviewed (Jeffs et al, 2013 & Smith et al, 2015).

Residents’ Voices

According to the literature, it is accepted that moving home is a stressful life event for individuals of any age even when the move is planned as a positive step (Croft, 2017 & Towers et al, 2015). The relocation of older people into a long-term care setting can be particularly stressful, meaning it may have adverse effects on health, well-being and survival. Therefore, it is imperative that residents have a strong voice, greater control over life decisions and power over their own life and surroundings. That is why it is imperative that the view of quality of care from a resident's perspective is understood in order that residents receive the care and treatment which adds value and is person centred and meaningful.

In the literature review, Davies (2011) writes about integration as a quality measure, but if health and social care professionals are to meet the challenges of integration for service users', providers, commissioners, and others involved in system planning and market 'shaping' need to work effectively together across a number of fault lines, namely organisational, professional, functional, sectoral, and ideological. Furthermore, Castle and Anderson (2011), discuss the quality of relationships and dialogue between system leaders is crucial when identifying and improving services. However, this study goes further by asserting that relationships must be built on trust and transparency with a firm focus on listening to those who use services. In response to the challenges across health and social care, supporting the development of new and innovative ways of working, means ensuring all sectors and professionals use those soft skills (such as listening), with maximum effectiveness for the benefit of residents.

According to the literature, the quality of relationships and dialogue between system leaders is crucial when identifying and improving services (Fossey et al, 2014 & Oliver et al, 2014). Quality in care homes oversight must be built on trust and transparency with a firm focus on listening to those who use services. Recent research, from Gilbert (2021), noted that regional environments are characterised by a plethora of health and social care initiatives. Yet what my research identifies is that these only weakly link to enduring and effective whole systems change and did not include or truly represent residents.

Health and social care professionals and commissioners know that 'business as usual' processes will not deliver the changes required and that there is a need to engage in cultural and real-world changes. The size of the task can seem overwhelming, but it is imperative that systems change to enable different ways of working in the future. It is time to begin to explore the key opportunities and barriers to better working in health and social care and to set out some priorities for ‘real world’ system change in the interface between health and social care. Interprofessional working creates opportunities, as shared perspectives and decision making supports a holistic overview which improves outcomes and enhances overall quality of care for residents which was a clear directive from the interview (Croft, 2017).

Time to Care

Overall, the findings identified that care homes should promote a positive culture and create a meaningful daily life and homelike environment [to emphasise] the importance of the care home as a home. Care homes are homes for those who live in them, and this is something that everyone, including NHS staff, must acknowledge and respect.

The current and future challenges in health and social care are regarded as unprecedented, which call for a different set of responses (Aguwa et al, 2021). The main purpose of collaborative working amongst system partners should be to place the individual concerned at the centre, which means first identifying what ‘good’ looks like from a service user perspective and thence working backwards. Moreover, to truly coordinate care, local system leaders must ensure there is a golden thread linking vision to delivery so that everyone involved can not only share the vision but see themselves as part of the team that delivers it.

The aim of the study was to define what ‘quality of care’ means from a resident’s perspective. Nursing and residential care homes should provide their residents with compassionate care in a safe environment. According to the literature, it is important

that homes are recognised as places where people live as opposed to hospitals or clinics (Aguwa et al, 2021). The literature emphasised the need for staff to know their residents and for residents to know their staff which was strongly echoed by participants during the interviews. Residents should feel comfortable, safe and well cared for at all times. Residents, their families, and friends should have their voices heard and acted upon. According to the findings care homes should be welcoming, friendly, stimulating, clean and safe environments where residents want to live.
The 'average' care home resident is an 85-year-old woman with a life expectancy of 12-30 months and who is deemed to have complex care needs (Daly, 2020). A recent study found that of the 18,700 older people living in care homes that 63 percent had some form of dementia (NIHR, 2021). Evidence suggests that 1.465 million elderly people feel that they have no control over what happens in their life, while 936 642 say their life rarely has meaning. Whilst this sample is not reflective of all residents living in a care homes, these issues were reflected within the views expressed by participants in the study (Ballard, 2014 & Hinsliff, 2020).

The above statistics demonstrate the complexity involved in providing good quality care for people residing in care homes. To provide a high standard of care and fully support quality of life, it is necessary to consistently consider residents' needs. As demonstrated in the findings, how residents are cared for is fundamental to how they perceive their home environment. How they are cared for matters to them and impacts their physical and mental wellbeing. Wellbeing is a broad term used to encompass all aspects of a resident's needs, and care homes who recognise and harness this concern enable improvements in their residents' quality of life. This was identified within the literature and described within the findings. Wellbeing activities include being able to take part in hobbies, having a choice over what activities to take part in and what food to eat, being treated with respect, and having a resident-centred caring practice and culture in place. Participants highlighted that wellbeing included a feeling of control over your own life, such as involvement in all decision making, and consistently meaningful interactions.

The physical environment is an important part of individualised care which was reflected within the interview and literature findings. Creating care environments tailored to the individual's needs is essential for high-quality care and is increasingly recognised as associated with improved health and well-being among older people. The literature and findings recognised that, today, care should be holistic and view the person behind the disease, which means taking that person's perspective and treating the resident as a unique individual (Chadborn, 2021). Despite the emerging focus on individualised care approaches, the physical environment is still not considered an integral part of care, and relatively little attention has been paid to environmental aspects. However, the physical environment has the potential to facilitate or restrict care processes in a broad range of care settings, not least in care homes. The interviewed participants viewed the environmental space and surroundings as a fundamental contributory factor to how they viewed quality and quality of care within the home.

Many of the experiences described during the study were characterised by needing help and support with basic care needs but not wanting to be perceived as a burden and as a result not always getting their care needs met. This indicates the significance of listening to and hearing the experiences of residents when making improvements which ultimately improve the quality of care. The findings painted a picture of residents wanting to feel part of a family, to belong and feel connected. At the heart of the findings was an implied key message: 'love' drives quality. Indeed, love, caring and being heard was seen as crucial within the interviews as it promoted friendship, security and trust and shaped how residents experienced and valued their home.

However, enabling a felt sense of love in a care home is not without its challenges. Love requires staff to openly demonstrate their kindness, care, confidence, and engagement with people living in the home and in some environments, this is not always easy (Hall et al, 2019 & Stevenson et al, 2021). The participants shared experiences and examples of staff who were genuinely interested in residents. This interest was often communicated through the smallest of gestures, for example simply chatting, asking questions, or taking an interest in their life, families, and friends. Such gestures nevertheless build a sense of trust and comfort as it was these 'little things' that made the biggest difference and led participants to link this with quality of care for them.

The findings from the studies promote quality as a softer concept that is subjective, but characterised as the workforce around residents being kind, dependable, trustworthy, and having the confidence to advocate for them (Gilber, 2021 & Towers et al, 2015). Staff who make the time to really get to know people living in the home and go 'the extra mile' to do the little things make a big difference to how people experience care home life. Firm, fair, and a flexible workforce who create a home ethos, which is focused on the person living in the home rather than tasks which support residents is key. They enable a focus on residents' quality of care and build confidence in the staff who work there. Indeed, sometimes the little things that help people to do the best job they can for residents matter the most.

According to Norton et al (2014) a root cause of poor-quality care in care homes is that the standing of adult social care is low compared to health services, and an unfair price is paid for care and the workforce. Yet according to the findings from the interviews, residents hold the workforce in high regard for achieving satisfaction and obtaining social integration. Residents rely on the workforce to deliver safe and effective care within a homely living environment.

It is noted within the literature review that health and social care organisations must seek to improve the culture in adult social care and increase trust and respect between each partner in the system in order that residents care remains central (Castle et al, 2019, Duppen et al, 2020 & Hall, 2014). Leadership skills, knowledge, competencies, and capabilities also need to be promoted (Daly, 2020). However, the residents were more focussed on the compassion and attention of the workforce rather than the qualifications. Professionals in other sectors tend to overlook the skills in adult social care, including nursing skills. This causes conflict between the sectors and reduces credibility which is unproductive in meeting the needs of care home residents.

Quality & Time to Care

For research on residents' quality of care, no uniform tradition of research was found; rather, the terms 'quality of care' or 'satisfaction' have been considered in various fields of research, but without integration into an overall conceptual understanding of what older people want from quality of care in care homes. The term 'quality of care' is also closely connected with 'welfare' and 'well-being' was which was reflected in the findings.

The British Geriatric Society (2011) noted a drive for leadership, partnership, integration, and quality improvement initiatives to improve residents' experiences of care in care homes. Whilst work has been ongoing in both health and social care since (2011), there remains a need for NHS and Local Authority commissioners and clinical services to improve the quality of support provided to care homes. There is also a need to build joint professional leadership from health, social and care sectors, statutory regulators, and patient advocacy groups to collaboratively find solutions, which cannot be achieved in isolation.

It is unclear whether the lack of understanding about residents' view of care quality stems from ignorance, ageism or the lack of appropriate incentives and sanctions to redress the situation.

People living in care homes should have the same opportunities to live a good quality, safe, happy, healthy life and as part of their wider community. Residents must feel at home and have a voice that is heard and acted upon when there are improvements to be made. Findings from the study suggest that residents should be able to have fun and enjoy life by engaging in meaningful activities which add value to their health and well-being. They should have personalised care and support plans which describe their needs, and those needs should be met by someone who understands them and is able to meet them in a competent manner.

Role of the Workforce

The role of the workforce is a significant theme in both the literature and the findings from the interviews. This reflects the value placed on employing staff with the right knowledge and skills and the time to care. This was identified in several studies including the narrative review and the interviews (Horton et al, 2012, Kang et al, 2016 & Lee et al, 2017). Opportunities for staff to undertake training and education for their roles were noted in the interviews with care home residents through their desire for a skilled workforce (which was identified as a theme within the literature review 2 & 3) with the time to care and listen. Interviews also highlighted the need for staff to be visible and to avoid the impact of staff shortages on care and treatment. However, the reality of the situation which is well documented within the literature is that there is a staffing crisis within social care and the sector are heavily reliant on agency staff or homes being managed with under the recommended staffing numbers (Croft, 2017 & Towers et al, 2015). Therefore, according to Daly (2020) it is crucial that staff truly understand the needs of the residents to deliver care, which is meaningful and makes a difference, as by not addressing individual needs results in poorer outcomes which requires more resource as a consequence. It could be argued that the regulated care workforce is in crisis (Hinsliff 2020). Residents who may be deemed vulnerable are not being treated with the care and attention they deserve. Often, their only sources of support are exhausted, unable to plan their own lives through insecure contracts, and unable to spend sufficient quality time with residents. This has been further exacerbated by the impact and pressures of the COVID-19 global pandemic. Furthermore, there is a need to optimise the existing workforce, understand the additional skills needed to support the provision of care, secure support, and investment to develop skills, and recognise that silo working undermines collaboration and limits focus on the resident. There is a need to ensure that there are career opportunities within the care sector to promote recruitment, career progression and retention. However, it is also important to recognise the impact that current vaccination, long term use of PPE/testing and isolation continues to have on the social care workforce. This will need to be a focus if we are to meet the needs residents described within the interviews.

These factors are incompatible with the low level of resources that are afforded to many care homes. Until those who work closely with older people needing long term care are valued and rewarded in a way that recognises the complexity and skill involved, it is unlikely that the potential for ensuring optimal quality of care will be achieved. The following quote captures the essential elements of the community model:

> *‘Any group of people who live and work together develop a certain way of being, a commonly held set of values and traditions, essentially a culture. In an environment that accommodates vulnerable people, it is especially important that this culture is accepting, inclusive and positive… traditions evolve through celebrations and recurrent events. A sense of identity and role comes from individual and group responsibilities in various activities. This is the process by which a community is built. It is such an important function that it must include everyone, even the most impaired, in a positive and affirming manner.’*
> (Zgola, 1999, p.173)

To improve the capability of homes to deliver high quality care, it is necessary to review the nature and timeliness of training and support provided to staff working in care homes, as reflected within the findings and literature review (Ballard, 2014). In addition, there is a requirement to introduce new contractual frameworks for care home placements to enable the specification and efficient, effective, and proportionate monitoring of quality improvements with the intention of incorporating residents voice at every available opportunity to drive and improve the quality agenda.

Systems currently are at a critical stage in that current and forecasted demand are outgrowing capacity and further impacted by increased costs. In addition, the fragmentation of available services through non-uniform approaches will impact on the quality of care and available workforce. It is necessary to focus on marketing and influencing to promote the sector. This includes a consistent and co-ordinated strategic approach to communication, positive cross sector media messages to celebrate success and good news/good work to change perceptions, and the reward and recognition of staff to establish a culture change. The credibility of the sector has never been more crucial and a radical change to the public perception of the care home market is critical to sustain and grow with a competent and capable workforce.

Attention to recruitment and retention is paramount to ensure the right staff are employed with the right skills to provide safe and effective care and treatment. Sector led and partnership apprenticeships, values-based recruitment, reduced reliance on agency and locum staff, flexible working approaches, targeted recruitment campaigns, central portals to advertise posts, work experience, and joint pre-employment programmes will aid the credibility of the sector and reduce advertising costs. Training that focuses on meeting the needs of an increasingly complex cohort of people needing care is essential, as outlined within the researched literature.

Focus and attention on training and development, hands-on advice support and guidance will enable a more sustainable workforce. This means ensuring consistent, good quality, accessible training, the development of a joint career framework, and checking that employees are available to attend. Training and development need to be designed and delivered around staff and residents rather than the other way round; thus, training needs to be brought to the student/trainee.

The evidence presents a picture of what constitutes good quality care that is reflected in the findings. In terms of staffing, a low turnover of staff and a minimal need for agency staff were noted combined with the importance of engaging the right person in the Registered Care Manager role. The maturity of the workforce was noted along with the importance of bringing life experience. Moreover, the culture of the workplace was recognised as central to success.

Stable, professional leadership with a desire to prioritise residents and employees also emerged as a measure of success. Such leadership sets the tone for all aspects of the home, that includes meeting the needs of all residents in a personalised manner. The size and scale of the care home means that challenges which might in other circumstances be overwhelming remain manageable. It also enables a ‘homely’ and more intimate atmosphere.

As populations age, the role of the care home and the care home nurse will continue to become increasingly important. Thus, the findings from this study provide a platform for stakeholders (including commissioners, providers, care home managers, care home nurses, educators and researchers) to start conversations which consider the next steps towards change. After years of neglect, it appears that the role of the care home nurse is becoming the focus of political, practical, educational, and research agendas.

Assurance and Oversight

The Care Act 2014 stipulates that local authorities have the ultimate responsibility for the provision of care and support. NHS providers also have a statutory responsibility for the nursing and quality element of care and a statutory duty for the quality of any contract. In addition, the CQC have a statutory responsibility as the regulator for the Care Sector. Although safeguarding responsibilities lie with both health and local authorities, it is important to recognise that a significant percentage of care sector providers are private businesses. Furthermore, other regulatory bodies exist with which the care sector must comply, such as environmental health, fire and food hygiene.

The role of different public agencies is unclear to many providers and appears to involve a significant amount of overlap. There is a lack of clarity around the role and responsibilities of CCGs, and an apparent lack of coordination with local authorities and the CQC, leading to additional uncertainty and the duplication of activities. The overall burden of monitoring activities has a negative impact on care and the time staff can spend with residents. The overall burden of monitoring activities also risks a negative impact on the market. There is duplication of local authority contract monitoring requirements with CQC inspection requirements which results in overlaps in inspection visits and information requests.

There is an inconsistent approach between local authorities, which can lead to a lack of clarity about requirements and the collection of similar data in multiple formats. A number of different agencies are exploring improved approaches, but often these actions do not seem to be coordinated, suggesting a need to join up fragmented initiatives. Ensuring that residents receive high quality care relies on a complex set of interconnected roles, responsibilities and relationships between professionals, provider organisations, commissioners, system and professional regulators, and other national bodies including the Department of Health (DH), Association Directors of adult social services (ADASS) and the Local Government association (LGA.) The system’s collective quality objectives are to ensure that the essential standards of quality and safety are maintained and drive continuous improvement in quality and outcomes for residents.

> *‘Most safeguarding activity relating to care homes occurs as a result of poor practice and poor quality of service rather than malicious intent. The*

> *impact of poor practice and neglect can be just as significant as intentional abuse and yet it is arguably far easier to prevent'* (SCIE, 2016, pg. 12)

Evidence supports the development of a standard specification and contract for residential and nursing care homes to ensure a consistently high-quality service, and that people who use them can accurately compare similar services on quality and price. This supports equity and choice and provides transparency for those looking for long term care. Several of the interview responses referenced the lack of decision and choice when moving into long term care and how families have been the main decision maker when selecting a care home. Therefore, it is essential that all relevant information is available to support this major life choice and that it incorporates what residents think and feel about each care home facility to inform the decision-making process.

A focus on quality in care homes should never become an abstract concept or theoretical pursuit (Chadborn. 2021 & Lewin, 2020). A relentless focus on quality means a relentless focus on how we as system partners can positively influence and transform the lives of the people who use and rely on care home provision. In contrast, a failure to focus on quality and to make it a priority can result in lasting emotional and physical harm to patients, including death (Hinsliff, 2020). The failures at the Mid Staffordshire NHS Foundation Trust and at the independent hospital, Winterbourne View, provide stark reminders that when we fall short on our responsibilities for quality, residents, service users, and their families can suffer unnecessarily.

The need to create parity of esteem across system partners, and to encourage collaboration, trust, positive risk taking, and strengths-based approaches is paramount to influencing true integration and thereby reducing the need for monitoring and oversight. This was identified within the literature and recognised in the interviews. Health and social care professionals need to build relationships, provide system support, and work together in partnership to improve the quality of care within care homes by placing residents' voices at the forefront.

The COVID-19 pandemic accelerated the inevitable impact of the 'home first' culture. We have now seen a significant drop in occupancy levels within care homes. Moreover, financial viability issues are increasing meaning that home closures are occurring more frequently, and workforce recruitment and retention challenges are at a critical stage. This means that quality is a significant concern. Local systems need to ensure that effective provider and market shaping/management is in place as outlined in the literature to ensure we can consistently provide the care and treatment outlined in the interviews.

Through effective communication and engagement, there should now be a focus on working in partnership with care sector providers to achieve mutually beneficial outcomes that are in the best interest of the person, their family and/or carers. This means sharing perspectives, priorities and challenges, working as a system to build relationships, sharing learning, exploring opportunities to work together, and aligning priorities. Transformation and development programmes should be co-designed to ensure inclusivity. Moreover, robust care sector system data and intelligence should underpin and inform work programmes and delivery priorities without further burden on care home providers (as outlined in the literature).

The unnecessary burden from the duplication of quality visits and information requests from organisations with an interest in care provision has been a long-standing issue for providers. Several initiatives have addressed the issue over the years, and the latest report, *Cutting Red Tape: Review of Adult Social Care* (2016) confirm that more action is required. There is a view that previous initiatives have tended to be short-lived projects with short-lived effects. In addition, there is a consensus that improvements should be embedded within the actions and real work processes of organisations rather than as amendments to legislative and regulatory structures. With few strong national levers to enforce practice, actions will require a sector buy-in and supporting partnerships to ensure the delivery of high standards of care. Furthermore, not all bureaucracy needs to be burdensome. While it is vital to have robust regulation and enforcement across health and social care to protect patients and the public, there is scope for reforms to improve health and care provision. This would free up providers time to care for people, increase the value for money, and utilise limited resources effectively and efficiently. Figure 6 provides a listed summary of the benefits of joint intelligence approaches, and of coordinated/joint commissioning and contracting.

Benefits of joint intelligence approaches:

- Rapid sharing of good practice and learning.
- Sharing of intelligence and resources.
- Consistency, common tools and a common approach for monitoring.
- More robust monitoring information, with both a health and social care perspective.
- More specialist knowledge to support ‘gaps’ in delivery.
- Identification of performance challenges sooner through the multi-agency approach and information sharing.
- A risk-based approach for best use of resources.

Co-ordinated or joint commissioning and contracting:

- Opportunity for shared administrative support for contract management.
- Potential to reduce the number of contracts that need to be held, and in turn free up commissioner resources which can then be spent on managing quality.
- Shared team approach to managing and supporting quality and oversight – reducing duplication of effort and time.
- Ability to benchmark and provide targeted support to providers (across services & authorities).
- Synergy with existing legislation – (e.g. criteria cover all the KLOE's).
- Can help towards moving your area towards pan-STP working.

Figure 6: Benefits of joint intelligence approaches and coordinated/joint commissioning & contracting.

The literature provides evidence that commissioners should use existing powers better, rather than introduce new Acts or Regulations which ultimately safeguard residents. Better information about the state of the market is required, however commissioners should be mindful not to increase the burden on providers which ultimately impacts on the time available for staff to provide care and treatment.

The Association of Directors of Adult Services (ADASS, 2011, pg. 12) asserts that '*it is important not to rely only on single means of quality assurance but to be able to triangulate information from different sources to be able to evaluate effectiveness, both of partner organisations as well as the partnerships*.' This correlates with the purpose and findings from the study, the findings show that relying solely on a single means of quality of care can limit the depth, reliability, and comprehensiveness of evaluations, particularly when assessing the effectiveness of partnerships and what matters to residents from their perspective. Triangulating information from multiple sources is important for several reasons. Relying on a single source of information may provide a limited perspective on the quality of care provided in a care home. By triangulating data from multiple sources such as resident surveys, staff feedback, regulatory inspections, and independent assessments, a more comprehensive understanding of the care home strengths and areas for improvement can be detected. This multi-faceted approach helps paint a more accurate picture of the overall quality of care, by building in resident feedback adds further rigour.

Providers should not be overburdened by additional requirements relating to registration and regulation. It is therefore important that commissioners work to ensure that all monitoring activity is aligned as much as possible. Commissioners should gather information from all the stages of the commissioning process and all activities carried out by stakeholders should inform their work. Commissioners should effectively utilise and coordinate the many strands of monitoring and quality assurance activity to assure service quality and good safeguarding practice.

Quality improvement interventions outlined in the literature include monitoring the quality of care, strengthening the care-giving workforce and building organisational capacity. Simply providing care homes with comparative quality performance feedback, access to training, and staff performance incentives do not appear to lead to significant improvements. These also do not capture the experiences of residents which is essential for effective quality monitoring and identifying the most appropriate improvements when required. In addition, it is important to learn from and celebrate those homes where the quality of care is considered by residents as good.

Additional real-time feedback of adherence may produce improvements, although evidence shows these are not sustainable and add little value to the resident's experience. Quality improvement is more likely to be successful in homes with a culture that promotes innovation and staff empowerment, and prioritises decisions and initiatives based on feedback from residents and families.

According to the literature, most care homes are owned and managed by independent providers, yet the local authorities and CCGs who contract their services have equal statutory responsibilities to ensure the safety of residents in these care homes. The implementation of a quality monitoring system has been shown to enhance the quality monitoring process, saving time and resources which can then be used to help service providers improve the quality of the care they offer and spend valuable time with those in their care. This was also reflected in the interview and literature findings.

Preventing care home failure is a starting point for systems and providers. All have a duty of care to residents, so the whole system should work to support providers to continue to give a good service and make improvements where necessary. As highlighted within the literature review, closing care homes, or putting restrictions in place should be an extreme measure. However, prevention is key to making sure that residents’ welfare remains at the heart of all decisions and their home remains as such.

Although interviews highlighted the importance of feeling part of a family and having their needs met in a personalised manner, this goal cannot be achieved if care homes are in crisis or at risk of failing. We know from the literature that when homes are struggling with quality matters which attract regulatory or commissioner attention, recruitment and retention becomes fragile and challenging which leaves a care home short of staff. Again, this was a theme highlighted throughout the interviews when residents felt care and attention was lacking and staff visibility was minimal or felt rushed.

Along with consulting residents and families, systems should aim to avoid failures through prevention and learning from previous failings and listening to the views and experiences of residents. Providers should feel that all statutory partners want the provider to succeed and survive. This has a positive impact on the workforce which consequently leads to improved outcomes for residents (Norton et al, 2014). Care homes should be treated the same way as NHS providers, i.e. where failures are identified, a package of support is put around them in a 'Just Learning' culture (Smith, 2015). However, there is no clear process for improvement in adult social care; indeed, the perception is that organisations in other sectors come together much better when there are problems. Strategic resilience groups should involve the care sector (not just hospitals) to enable greater inclusivity and effectiveness. All statutory organisations with a quality scrutiny role should work towards a single shared view of quality so that providers are clear on what they need to achieve and this should be based on what matters the most to residents such as menus, workforce, delivery of meaningful activities, impact of the environment and care. The Health and Care Act (2022) may force some of these issues to be addressed, but the research aims and objectives also consider other contributing factors when understanding, measuring, and managing the quality of care.

Across the country, CCGs are leading projects undertaken under the guise of the Better Care Fund, and the Vanguard work stream as outlined within the *5-Year Forward View and Compassion in Practice*. These aim to improve outcomes for local populations including those residing in care homes although they have yet to demonstrate impact and spread at scale. There remains ongoing concern about the quality of care in care homes and more robust inspection by CCGs and regulators has highlighted areas of further development, as referenced within the literature. Furthermore, analysis of the winter resilience planning in 2018/19 highlighted that greater involvement was required from leaders to support the care home sector if it was to grow and become sufficiently resilient to support the overall health economy and provide quality service.

The sector is at a critical point due to years of underfunding, escalating costs and increasing demand which are impacting on capacity and quality. Systems will be facing an unmanageable crisis unless providers and commissioners openly and honestly work together on a whole-system solution now. Local authorities and health colleagues need to work at a formative stage with the independent sector across all levels, and not presume they have all the answers and only need to 'consult' as an afterthought. This includes working together to address the current workforce crisis. The quality of dialogue across the fault lines between health and social care is crucial and must be dealt with at a strategic level.

Regulation and quality monitoring should be modelled on 'appreciative enquiry' processes which focus on the outcomes and improvements to resident care and staff experience. Through a resident based appreciative inquiry, what quality and what home means to the individual can help facilitate actions such as hoovering, cleaning one's own room, and having access to facilities as one would when living in their own home (as some of the residents indicated).

People working in care homes must feel valued as part of the wider health and social care system, have the same level of respect and autonomy to make a difference, and equitable access to training and development opportunities.

Support and resilience planning across the health and social care sector is imperative if we are to prevent unnecessary admissions to hospitals, delayed discharges back home, poor quality and experience of care amongst residents with complex health care needs (including those with multiple long-term conditions, significant disability, and frailty). Care homes continue to be a significant and central component of care provision within the health and social care system but remain a ‘Cinderella’ service in the NHS according to the literature (Jeffs et al, 2013). Indeed, the care home sector has not previously been considered an integral part of the 'health and social care system' by statutory organisations. Often, they are considered part of the problem and there has been little effort to understand the reasons for this from the provider and resident perspective. People waiting for a place in their 'home of choice' contribute to delays in hospitals, which is a further consequence of not having a true integrated health and care system with care home providers adopting an equal role.

In recent national and local multi-agency reviews, findings highlight the need for a renewed focus amongst commissioners and leaders of health and social care to address the quality of provision in the care sector to ensure services are fit for purpose and meet the individualised needs of residents (Kings Fund, 2014). However, the sector is essentially a free market. If a company wants to build and operate a care home they can, but rarely discuss this with the main commissioners, population, or neighbourhood in which they plan to provide registered care. Moreover, there is an increasing number of homes with quality concerns, as referenced within the literature review and highlighted within interviews with residents residing in care homes. The literature provides a picture of struggling care homes or homes rated as unfit for purpose. Moreover, there is insufficient investment in new care homes at the current fee levels, which have worsened following the impact of COVID-19, which has raised questions about financial viability along with the impact of quality concerns on bed availability. This will result in a reduction in good quality provision which will mean that residents requiring long term care will have less choice and options, resulting in the potential of residents not having their needs met.

Some key questions for commissioners to consider based on the findings include:

- Has consideration been given for alternatives to care homes?
- Are commissioners proactively talking to providers about new investment?
- Are commissioners considering how risk management can be shared?
- Are commissioners looking at alternative sources of capital to build homes and contracting differently with care providers?
- Have commissions considered the consequences of parts of the market not able to meet needs or a significant provider failing?

It is noted from the literature review that frequently, independent sector providers are engaged as an afterthought, but there is now an opportunity to establish processes and individuals with the rights skills and competencies to engage in strategic change management. This reflects a unique set of opportunities for meaningful engagement to develop new and innovative solutions utilising the findings from what quality means form a resident’s perspective to guide improvements. This is considered essential if the potential within the sector is to be fully realised (Stevenson & Cheng, 2021). Whatever ideological differences may have existed in the past, it is necessary to set these aside in favour of working together for the maximum benefit of the people requiring services now and, in the future.

In understanding what quality of care means from a resident’s perspective within care homes, key themes emerged. Firstly, the quality of care provided significantly impacts residents' well-being and satisfaction. Studies consistently highlight the importance of person-centred care approaches in promoting residents' autonomy, dignity, and overall quality of life (Daly, 2020 & Castle et al, 2019).

The learning from the hospice movement must also be considered not only when identifying a home, but when commissioning care as a quality indicator. The hospice movement has significantly influenced the approach to holistic and end of life care by emphasising the importance of dignity, compassion and respect for individuals wants and wishes, which was a clear finding from the interviews (Harris, 2019). Holistic, individualised care and the application of the hospice principles can be a valuable tool for supporting transition into a care home for residents, particularly those with complex health needs or at the end of life. This approach ensures that all aspects of a residents well being are addressed, fostering a compassionate and individualised environment (Harris, 2019). Care homes adapting these principles could significantly improve the quality of life for their residents, ensuring that their final years are lived with dignity, respect, choice, comfort and meaning, along with noting the importance of acknowledging loss and bereavement (Brennan, 2015).

It is also paramount that commissioners also consider the transition into a care home as an indicator of quality by monitoring how providers manage this crucial transition given it is such a significant life changing event, often associated wit profound feelings of loss and grief. Whilst these feelings are often associated with death, they can also arise from non-death related losses often experienced by those moving into a care home (Marris, 2014).

Furthermore, the social climate within care homes plays a crucial role in residents' experiences according to the findings. Environments that foster social interaction, meaningful engagement and activities, and a sense of community contribute positively to residents' emotional and social well-being. Conversely, factors such as isolation or poor social integration can detrimentally affect residents' experience and overall satisfaction.

Additionally, the environment of the care home is a critical determinant of residents' experiences and how they perceive this as a crucial for assessing quality of care. The interviews demonstrated that interventions aimed at improving the physical surroundings, such as enhancing accessibility, safety, and aesthetics, can positively impact residents' quality of life and delivering a sense of home.

Overall, the findings stress the importance of having the residents voice central to quality improvement and understanding what quality of care is within a care home. By prioritizing residents' autonomy, dignity, and social connectedness, care homes can strive to enhance the overall well-being and satisfaction of those they provide care to.

Chapter 6

Conclusion, Contribution and Recommendations

This section will summarise the main findings of the study and the unique contribution of this research. The study sought to answer the question: ‘What are quality metrics from a residents’ perspective of living in a care home’. This study is the first of its kind in exploring what ‘quality’ and ‘quality of care’ means to residents currently residing in a care home. Very few studies have focused on understanding the needs of current care home residents living in the United Kingdom (Lewin, 2020 & Schenk, 2013). This study therefore addresses a gap in the body of knowledge relating to the perceptions of quality indicators amongst those who live in care homes.

Participants expressed their feelings very strongly and with emotion when describing their examples and experiences of living in a care home. This conviction highlights the importance of listening to the voices of those working and living in care homes, particularly during any management of change initiatives or local reform. Often, policies about care homes are written by policymakers and healthcare professionals and are based on little or no consultation with the people directly affected. The phrase ‘nothing about me without me’ is used liberally within the NHS and by advocacy groups; however, it must also be proactively applied to social care and with people living and working in care homes. Ambivalence about working within the independent sector remains a key challenge. In fact, reports repeatedly highlight the low margins of profitability amongst most care homes. However, this myth persists in tainting working relationships and affects residents’ access to health care and relationships with community providers, thereby resulting in discrimination and health inequalities.

One of the study objectives is to generate knowledge to inform the development of a resident-focused, evidenced-based quality monitoring system, which would produce meaningful outcomes for commissioners, regulators, and residents. Therefore, there should be clear and consistent plans to respond to care home quality concerns or resident feedback. These plans should provide direction on the activities to be undertaken when concerns have been identified, and before the situation escalates towards more urgent enforcement.   Therefore, evidencing the need for joint monitoring and oversight systems which highlight quality concerns or triggers in real time are critical for resident safety and the continuation of quality care. There are pockets of different practice in dealing with care home quality concerns across the country suggesting there is a need for these to be formalised and standardised.

The findings create a solution by identifying the need for standardisation, learning from the resident experience, highlighting best practices, informing policy development, advocating for change, and facilitating collaboration among stakeholders. By addressing the disparities in current practices and formalising standardised, resident led approaches, the research can drive meaningful improvements in the quality of care provided in care homes across the country.

The theses identified in the findings, environment, meaningful activities, food, time to care and workforce—from a resident's perspective, provide valuable insights into different aspects of quality monitoring in a care home.

By focusing on time to care from a residents' perspectives in quality monitoring can ensure that care plans are individualised, respectful, and aligned with residents needs and preferences. Regular assessments and feedback mechanisms, informed by residents' experiences, can identify areas for improvement and drive continuous quality enhancement initiatives.

Quality monitoring should assess the variety, relevance, and accessibility of recreational and social activities, along with the variety of food offered in care homes. Incorporating residents' feedback on the quality and enjoyment of activities can inform the development of engaging and person-centred activity programmes. Monitoring resident participation rates and satisfaction levels can also help evaluate the effectiveness of activity interventions.

Monitoring the competence and compassion of the workforce is essential for ensuring high-quality care delivery and ensuring residents feel a home form home environment. Quality monitoring mechanisms should include assessments of staff professionalism, empathy, and adherence to care standards. Providing ongoing training, supervision, and feedback opportunities can support staff development and enhance their ability to meet residents' needs effectively (Croft et al, 2017 & Kilet et al, 2013).

The themes provide a holistic approach to quality monitoring in care homes, encompassing different dimensions of resident experiences based on their personal perspectives. By incorporating residents' perspectives into monitoring processes and utilising feedback to drive improvements, care homes can enhance the overall quality of care, promote resident well-being, and create environments that prioritise dignity, autonomy, and happiness.

Chadburne (2020), stated in an earlier chapter that radical change is needed, but such change is often by small steps. Such is the value of this thesis which goes some way in accounting for that need via the personal voice of the resident.

Recommendations:

For Providers

- Providers to ensure a range of activities and an activity coordinator; provide trips and create opportunities for social contact to promote a sense of community within the care home and in the wider local community.
- Providers to allocate tasks according to time so staff can do their jobs efficiently in a caring manner.
- Providers to ensure the workforce have the resources to do their job.
- Providers to enable mechanisms for residents and relatives to influence what happens in the home, such as a Residents and Relatives Committee. The process for making comments or complaints should be clear and feedback should be welcomed and acted on.
- Care home providers should offer a kitchen facility to allow the preparation of food and drink for friends and family.

For Residents

- Care home staff to have good knowledge of each resident and how their needs may be changing and plan for how these can be met in a personalised way.
- Residents should be included in decision-making. There are numerous opportunities for negotiation and shared decision making within the care home, while involving residents in aspects of decision making, where possible, both empowers them and includes them in determining the culture of the care home in which they live.
- More visible management to staff, residents, and carers to offer good leadership to support the retention of the workforce.

- Care home Staff should be familiar with residents’ histories and preferences and have processes in place for how to monitor any changes in health and wellbeing.
- Care home Staff to offer quality, choice and flexibility around food and mealtimes. For example, homes offer a good range of choices and adequate support to help residents who may struggle to eat and drink. The social nature of eating should be reflected in how homes organise their dining rooms and accommodate different preferences.
- Care home staff to accommodate residents' personal, cultural and lifestyle needs.
- Residents should be supported to maintain their independence by encouraging the continuation of daily tasks such as ironing, laundry, cooking, and cleaning. These are seen as essential and should be considered as meaningful activities.

For commissioners

- Commissioners to work in partnership with care sector providers to achieve mutually beneficial outcomes and quality indicators which are reflective of the best interests of the resident, their family and/or carers through effective communication and engagement.
- Commissioners to capture resident led quality indicators to monitor quality of care within the care homes.
- Consideration or employing hospice movement principles as a quality measure.

In conclusion, the recommendation section underscores the paramount importance of quality indicators from a resident's perspective, encompassing various facets of care delivery within care homes. By prioritising these quality indicators, care homes can enhance resident satisfaction, well-being, and overall quality of care. It is essential that commissioners use these findings (care, environment, food, workforce, and meaningful activities) as a way of measuring and assuring quality of care within the care home by asking these questions during visits and monitoring.

The incorporation of resident-centred quality indicators, such as meaningful activities, food, quality, sufficient time for personalised care, a well-supported workforce, and a nurturing environment, is essential for promoting excellence in care homes. By embracing a holistic approach that prioritises the diverse needs and preferences of residents, care homes can cultivate environments that foster dignity, autonomy, and fulfilment. Implementing these recommendations not only enhances resident satisfaction and well-being but also ensures that care homes fulfil their fundamental mission of providing compassionate, person-centred care.

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Appendices

Appendix one.

SEMI-STRUCTURED INTERVIEW QUESTIONS

Q: What does care mean to you?

Q: What does ‘quality of care’ mean to you?

Probe: Let the interviewee tell you what they understand quality care to be

(Part 2) Give participants the definition of quality of care

Q: Tell me about your experiences of quality of care

Prompt: Ask them to give experiences since living at the home

Q: Can you give me examples of good quality of care?

Prompt: Ask them to give experiences

Q: Can you give examples of poor-quality care?

Prompt: Ask them to give experiences

(Part 3) Changes requested by resident.

Q: What can the care home staff do that would help them to provide a quality service to you (Nursing and Health care Assistants)?

Probe: ask them to give suggestions that may help the care team to meet these needs

(Part 4) FINALLY:

Thank you for your time. Are there any other points that you would like to make that you haven’t made already?