Supporting older people living in care homes:
A qualitative network approach

Jennifer Marie Ferguson

University of Stirling

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Supervisory Team:
Professor Alison Bowes & Dr David Griffiths
Faculty of Social Sciences

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Abstract

In Scotland, older people living in care homes are becoming increasingly frail and in need of more specialised care and support. Additionally, demand for care home services will likely increase due to a growing ageing population. Care approaches being applied in care homes, such as person-centred care and relationship-centred care, emphasise the importance of relationships and community. Despite this, little research has explored how the support networks of older people living in care homes are structured or composed, and thus, where support may be lacking for residents. This study seeks to understand how residents utilise their support networks and how this support affects their experience in the care home, as well as their wellbeing.

This thesis uses an egocentric network approach to construct the support networks of residents, and a critical realist approach to qualitative data analysis in order to identify mechanisms which may impact a resident's network and wellbeing. Staff members and visitors were also interviewed in order to identify additional barriers to support in care homes.

The findings describe the support networks of 36 older people living in care homes and residents revealed that there were a number of barriers to receiving support. Most notably, negative relationships with staff and an inability to make meaningful connections with fellow residents made making relationships in the care home difficult. Staff discussed organisational and administrative burdens that limited their ability to provide better support and highlighted resources which could result in better support. Additionally, patterns of support emerged through network and qualitative analysis, which formed the basis for developing a typology of support networks for residents. Residents who made connections with staff and allowed their families to integrate with staff members were more likely to have a better experience in the care home, as well as better wellbeing.

Together, these findings inform care home practice, as well as approaches to care and support, by identifying gaps in resident support and factors that can contribute to better relationships within care homes.

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Chapter 1 Introduction

1.1. Research context

> **Care home definition**
>
> Care homes are places that provide accommodation and personal care for people who need extra support in their daily lives (Age UK 2019a). Care homes can be referred to as residential homes and as nursing homes. Residential homes typically offer accommodation and personal care; whereas nursing homes offer these services in addition to more advanced nursing care. A care home can also be dual-registered, where they offer both residential and nursing care. Throughout the care literature, the term 'care home' is used for residential, nursing and dual-registered homes (Office for National Statistics 2014). In this thesis, the term 'care home' encompasses residential, nursing and dual-registered homes.

In Scotland, the care home population is becoming increasingly frail and requires more support and specialised care (Froggatt *et al.* 2009) and this is due to several compounding reasons. Firstly, the UK has an ageing population, which has resulted in people living longer (Age UK 2019a). However, life expectancy has increased at a faster rate than healthy life expectancy, which is the number of years lived without disability and in good health (PHE 2018). This means that more people are living with a disability, or without good health, for longer and are more likely to require social care and nursing at the end of their lives (PHE 2018). Additionally, older people are delaying their move into a care home and this is also resulting in a frailer care home population. This can be partly attributed to the stigma surrounding care homes and the promotion of care-at-home policies.

The stigma attached to care homes is likely to lead to older people resisting moving into a care home until there are few other options, which further delays their moving into a care home. Care homes are increasingly regarded as a 'last resort' for people with the highest need for care at the end of life (Lievesley *et al.* 2011, p. 3). A recent literature review has found that the people who live in care homes are now doing so because they

can no longer live independently at home due to their high physical and mental care needs (Wild and Kydd 2016). Therefore, it could be argued that, increasingly, care homes are becoming a place not just for care, but also for specialised care (Alzheimer's Society 2019), particularly for people living with dementia as, in the UK, around 70% of people in care homes have dementia (Alzheimer's Society 2020).

Additionally, the Community Care and Health (Scotland) Act 2002 helps older people live in their own home for longer by paying for personal and nursing care (Scottish Government 2002). This care at home policy has resulted in older people being able to receive nursing and personal care at home, at no direct cost to them, therefore allowing older people to live at home for longer (Bell and Bowes 2006). However, this has resulted in older people living at home until they are no longer able to manage at home with carers and therefore results in moving into a care home much later in their journey.

This delay in admission, combined with an ageing population, has increased the average age of the care home population (Banks *et al.* 2006), which has also resulted in residents in care homes having increased cognitive impairment (Mozley *et al.* 2000; Knapp *et al.* 2007) and level of frailty (Gordon 2014) and a greater number of diseases (Froggatt *et al.* 2009). Thus, the care home population requires the highest level of care and is becoming increasingly dependent and marginalised within society (Froggatt *et al.* 2009). This means that people who live in care homes are at a higher risk of lower wellbeing, as dementia and disability have both been highlighted as key factors in reduced social interaction and social networks, which could have a negative impact on wellbeing (Grenade and Boldy 2008; Pinquart and Sorenson 2001). As such, the care home industry is seeing an increase in the care needs of older people and, further, residents now need more support in order to maintain their wellbeing.

The Care Inspectorate, which is the regulator for all care homes in Scotland, evaluates care homes on a quality framework which is based around six questions; the first of which is; 'How well do we support people's wellbeing?' (Care Inspectorate 2019). The National Institute for Health and Care Excellence (2019, p. 1) states in their quality standard for care homes for older people that:

A decline in mental wellbeing should not be viewed as an inevitable part of ageing. […] By focusing on the needs of each person, care providers can ensure that people can keep active and access health and social care services that keep them as mentally and physically well as possible.

Thus, one of the main goals of care homes is to maintain and improve the wellbeing of older people. Research suggests that there is a relationship between social support and wellbeing in older people (Tajvar *et al*. 2016; Golden *et al*. 2009) and that social isolation and loneliness can be detrimental to the wellbeing of an older person (Dickens *et al*. 2011). Care home research has focused on how specified relationships can improve the wellbeing of older people. For example, how the staff-resident relationship can maintain and improve wellbeing (Canham *et al.* 2017).

However, there is a lack of research exploring what support looks like for individual residents, and how the supportive relationships that surround a resident may coordinate to improve wellbeing. This thesis will address this gap in the literature by explicitly exploring the support provided to older people living in care homes through their support networks.

Additionally, social network literature explains that, although an individual's personal connections can provide support, organisations are also important for providing resources and support as well. Organisational ties are the connections an actor can draw upon to gain social capital, resources, information and material goods from an organisation (Small 2006). The concept of organisational ties allows the exploration of how residents are supported through the care home specifically, and how the care home is not only a wealth of knowledge and resources for residents, but how it can also broker resources from other well-resourced sources. This study aims to explore the impact of organisational ties on the wellbeing of residents within older peoples care homes.

Thus, this thesis has three core aims:

1.2. Aims and objectives

1. To better understand the support networks of older people living in care homes.

2. To better understand how care homes support older people.

3. To explore the relationship between support and wellbeing, in the context of care homes for older people.

1.3. Overview of thesis

Chapter 2 explores the gaps and drawbacks of previous research concerning how older people in care homes are supported. Explicitly, it explores current care policy and describes the current and future challenges of Scottish care homes. It establishes that there is a lack of research in care homes in general, and, more aptly, that there is a lack of research looking at how support is perceived by older people living in care homes. Essential to this review are concepts of social networks, social support and social capital. These concepts are key to the theoretical underpinnings of this project and are used to show how analysing the support networks of older people can help inform care home policy in how to better support residents in care homes. Throughout the review, consideration is given to how concepts of social networks may have an impact on wellbeing, and how previous studies have approached this question. Lastly, the literature review discusses frameworks and measures of subjective wellbeing and how this will be conceptualised in the present study. An outcome of Chapter 2 is the emergence of gaps in the knowledge concerning the support networks of older people living in care homes, leading to the definition of the research questions, as follows:

1a. *How are the personal networks (ego-nets) of older people living in care homes structured?*

2a. *How do care home staff feel they support older people and what are the barriers to this support?*

2b. *How do residents, and their visitors, feel they are supported in care homes and what are the barriers to receiving this support?*

3a. *Are there types of support networks of older people living in care homes, and if so, how can they be characterised?*

4a. *What is the relationship between the personal networks (ego-nets) of older people living in care homes and their wellbeing?*

4b. Do different types of personal networks (ego-nets) affect wellbeing more than others?

4c. What mechanisms underline the wellbeing of older people living in care homes?

Chapter 3 outlines the research design and methodological choices made in this thesis. This thesis adopts both a critical realist and relational sociology approach to the research, which emerged from the research questions. The ontological approach of relational sociology acknowledges a subjective and an objective perspective on reality. Further, critical realism does not polarise quantitative and qualitative methods and thus allows the use of a combination of both egocentric network analysis and qualitative methods of analysis. Thus, the use of both relational network data and qualitative interview data was deemed appropriate to explore both perspectives on reality, while adhering to this critical realist approach. The chapter outlines the sampling process adopted for data collection with residents, visitors and staff of the care home. It describes the aims of interviewing each group of participants and the ethical considerations made to complete this project. It discusses the use of egocentric network analysis, descriptive statistics, and a critical realist approach to qualitative data analysis, and how these methods were used in each empirical chapter to answer the research questions. Lastly, the limitations of the project are discussed in detail.

There are four findings chapters; each of which aims to answer one or more of the research questions outlined at the start of the project.

Chapter 4 uses egocentric network analysis and descriptive statistics in order to describe and analyse the structure and composition of the support networks of older people living in care homes. Here, relational network data are visualised and measures of structure and composition are highlighted to better understand who supports residents living in care homes in Scotland. This chapter plays a key role in introducing what the support networks in the project look like and highlights key themes that continue throughout the thesis.

Chapter 5 identifies key mechanisms which may drive or deter the support that is being provided to residents. This chapter analyses the perspective of the residents and their families separately from the perspective of the staff. Thus, it identifies the mechanisms

underlining the support provided by the care home (organisational tie) which are highlighted by both parties. This chapter uses a critical realist approach to qualitative data analysis to analyse the interview data from all three groups.

Chapter 6 creates a typology of support networks for older people living in care homes. It uses both the relational network data and the qualitative interview data to establish patterns of support among the sample of care home residents. This thesis will argue that main dimensions driving differences in support networks are the inclusion of a staff member in a resident's network, and having multiple groups of people to promote support. This analysis allows the exploration of compositional and structural patterns of support between types of support networks and a development of qualitative understanding behind how residents feel supported by different types of people.

Chapter 7 explores the impact of network structures and composition on the wellbeing of older people living in care homes. It uses quantitative methods to explore the association between network measures and the wellbeing score of residents. Further, it explores whether there are differences in wellbeing between older people who have different types of support networks, as defined by the typology in Chapter 6. Finally, it uses qualitative network data to identify relational mechanisms which may affect the wellbeing of older people living in care homes.

The eighth, and final, chapter offers a discussion of each empirical chapter while comparing the findings of this thesis to previous research, theoretical understandings and policy and practice perspectives. Thereafter, conclusions are made in the form of recommendations for care home policy and practice, as informed by the empirical work completed in this thesis. Finally, it will clearly state the original contributions to knowledge made by this research, which stem from this thesis exploring the support of older people living in care homes from a novel qualitative network approach and describe what steps should be taken next in order to fully support older people living in care homes in Scotland.

Overall, this thesis will argue that, by using an egocentric approach, a better understanding of how residents are supported in care homes can be achieved. Further, it will argue that, although there is evidence of supportive relationships in care homes, there

are barriers to receiving support at an organisational level, as well as at a personal level. Finally, by exploring the relationships between support and wellbeing, this thesis will argue that the composition of an older person's support network has a larger effect on wellbeing than structural measures of support network.

Chapter 2 Literature review

Chapter 2 Outline

This chapter presents the findings of a literature review that was carried out in order to establish the current state of knowledge on the support of older people living in care homes and the effect of this support on their wellbeing. The chapter will first establish the process that I followed to complete the review of literature, before discussing the approaches to care frameworks which care homes employ in order to maintain the wellbeing of older people. It critically assesses the concepts of social networks, social support and social capital, while discussing how these concepts have been used in previous literature to explore their effects on wellbeing. The review then explores the use of organisational ties and how this concept can be applied to care homes to further understand how older people receive support in care homes. The chapter will show how previous research has created typologies of social networks in order to better understand the factors that influence networks and what this can offer to the exploration of support in care homes. Finally, it will outline the theoretical understandings of subjective wellbeing and how the concept will be conceptualised in the thesis. This review further refined the research questions and narrowed the focus of the analysis.

2.1. Review process

The primary purpose of the literature review was to provide a comprehensive account of the topics that this thesis explores, identifying the relevant gaps in the knowledge in order to determine the research questions (Cronin *et al.* 2008). As such, a narrative approach to the literature review was adopted where relevant concepts were identified and explored within the literature (Ferrari 2015). Where systematic reviews aim to include the most relevant literature by following set search procedures which can be replicated by others, narrative reviews aim to identify and summarize previously published work on a topic(s). These differing aims, allow narrative reviews to include a wider range of literature from differing disciplines, whereas systematic reviews can often be confined to limited search parameters (Hammersley 2001). A narrative review was chosen, over a systematic literature review, in order to explore a broader and wider literature base (Bryman 2016).

Over the course of this project, literature was continuingly being read and investigated, however, there were two main search time-points where the literature review was first conducted (October 2016–June 2017) and then updated (September 2019–November 2019). In order to collect and refine appropriate literature criteria to search for literature was established. Firstly, from my initial research and interest in the support of older people in previous studies, I had accumulated a knowledge important concepts in the field. This knowledge informed my initial list of key concepts and disciplines to search for literature, however these concepts were refined through further reading and discussions with other researchers. The searches used Boolean search methods, (e.g., "care home" AND "nursing home") in order to refine the number of papers identified by the search engines. Peer-reviewed papers published in the last 20 years (1996–2016) were identified using the key concepts and search engines described in Table 2.1. Although the literature searches were restricted to the past 20 years, if these papers cited relevant literature which was older or of particular interest, then these papers were also read. This process was repeated in the second search time-point, however, this was limited to include publications from 2016–2019 in order to update the literature review.

Table 2.1. Search terms and search engines

Search terms	Search engines
Older people, elderly, elderly people, older adults. Care home*, residential home*, nursing home*, care facility*. Social network*, social capital, social support, social tie*, support network*, supportive tie*, support, care, communit*. Friendship tie*, friend, family tie*, family member*, care home staff, care home worker*, care home manager*, carer*. Wellbeing, well-being, quality of life, hedonic wellbeing, eudaimonic wellbeing. Organisational tie*, organisational culture, organisational support. Person-centred care, relationship-centred care, task based care. Typolog*, type. Scotland, Scottish, UK, United Kingdom, British.	Web of Science/Knowledge, ASSIA, Google Scholar.

Although the search prioritised peer-reviewed journal articles, a range of sources have been accessed to obtain a thorough overview of the topics of interest. Grey literature was acquired from stakeholders in social care and ageing. These stakeholders included; Age UK, Age Scotland, Scottish Government, Care Inspectorate (regulator), NHS Scotland, and Help the Aged. The relevance of these grey literatures to care homes, support, older people and wellbeing was assessed by critically examining the wider literature (Saunders and Rojon 2011) and therefore I came to an informed decision on whether grey literature was relevant and informative (Bryman 2016).

The majority of literature examined stemmed from disciplines such as social gerontology, social networks and social care. However it should be recognised that social work literature also discusses many overlapping concepts used in this study and, in particular, explores the use of relationships centred care. One example from social care literature was 'The Better Life' programme which produced a wealth of evidence to support what works to improve the quality of life for older people living with high support needs, their carers and other supporting participants (Andrews *et al.* 2015). Although learning, especially in reference to care frameworks, could have been drawn from social work, a choice was made to restrict literature to social care in health facilities or studies particularly exploring social networks.

As such, the results of said searches have been grouped into five main sections which discuss the main concepts of the research. These sections identify the relevant research that added to my understanding of supporting older people living in care homes, and identified the gaps in knowledge which this thesis aims to fill.

2.2. Approach to care frameworks

In the UK, person-centred care is synonymous with good-quality care (Brooker 2003). It is included in key frameworks for care in the UK, such as the National Service Framework for Older People (DoH, 2001), which required all health and social care services for older people to assess whether they are meeting the standard of person-centred care. Kitwood (1997) argued that the aim of person-centred care is to maintain personhood. Personhood is a "status that is bestowed upon one human being, by another,

through the medium of social relationships" (Kitwood 1997, p. 8). Thus, the aim of person-centred care is to design and develop care and services based around the person and their individual needs (DoH 2001). The VIPS framework (Brooker and Latham 2015) included in UK care policy, which was developed from a person-centred approach, has four essential elements, as follows:

V: A **V**alue base that asserts the absolute value of all human lives regardless of age or cognitive ability.
I: An **I**ndividualised approach, recognising uniqueness.
P: Understanding the world from the **P**erspective of the person living with dementia.
S: Positive **S**ocial psychology in which the person living with dementia can experience relative wellbeing.

The approach, and framework, aimed to help carers of people with dementia to recognise the individuals they are caring for (Kitwood 1997) and acknowledge their personality and life experience, thus improving the older person's wellbeing (Baker 2015).

However, in recent years, these ideas have been further developed and built upon. Holstein and Minkler (2013) argue that person-centred care often tries to promote independence and autonomy, which are synonymous with ideas of successful ageing. This can be problematic when ideas of successful ageing are based around avoiding disability and disease, having high cognitive function and living an active/engaged lifestyle (*ibid.*). Arguably, this would label many older people living in care homes as being *unsuccessful* in their ageing, which is problematic as well as ageist and ablest. Further to this, it may condemn many older people living in care homes as living in the 'fourth age'. Where the 'third age' is characterised through a healthy, productive, post-working later life, the fourth age is defined by dependency, an inability to hold power and bad health (Higgs and Gilleard 2015). Thus, it could be argued that person-centred care could become problematic for older people living in care homes if it begins to promote elements of successful ageing.

Further, Nolan *et al.* (2006, p. 8) argues that person-centred care has become "lost in common usage" and is now only focused on services that are user-orientated, rather than exemplifying a complex model of care that care homes often follow. For example, they

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claim that everyday use of person-centeredness can overlook the reciprocal nature of a care relationship and the acknowledgement that care homes are communities. Thus, the emergence of more relationship-centred care has become prominent in UK and Scottish care policy.

Relationship-centred care is an approach in which care is collectively produced by the residents, their families and carers, therefore, the whole person must be appreciated *within the community context* (Tressolini *et al.* 1994). Thus, relationship-centred care goes further than person-centred care, as it not only acknowledges that understanding the individual is important for care, but it also considers how the interdependent relationships (between staff, residents, visitors and other practitioners) created in the care environment is important for understanding and supporting all individuals. Nolan *et al.* (2006) suggest that interdependent relationships are key to this, and, as such, they developed a framework to help produce these relationships in care. The Senses Framework (Nolan *et al.* 2012) argues that, to produce interdependent relations in care environments, all participants should feel a sense of security (to feel safe), continuity (to experience connections), significance (to feel that you matter), achievement (to make progress in your personal goals), purpose (to have goals that you aspire to) and belonging (to feel that you are a part of something). The framework was developed through an evidence-based approach and the senses used have been found to be important for residents, their families and staff (Nolan *et al.* 2002; Nolan *et al.* 2006; Brown-Wilson 2009). For example, Nolan *et al.* (2006) found that involving residents in care decisions could lead to a sense of significance because the person felt that their contribution was valued and supported by staff.

Ultimately, these developments have led to informing care practice in Scotland. In 2013, the initiative 'My Home Life' was formally established in Scotland, which is informed by a relationship-centred approach (My Home Life Scotland 2017). This initiative is led by the University of the West of Scotland, in partnership with Age Scotland and Scottish Care, and aims to improve quality of life for everyone living, dying, working and visiting in care homes. Importantly for this thesis, My Home Life, and relationship-centred care in general, argue that positive relationships between residents, relatives and staff are key to providing best practice in care homes (Help the Aged 2007). Thus, care should not only be focused on the needs and wants of the resident, but also on the community of care

homes, and every person who is involved in the care experience must have their needs heard and be involved in decision making (Nolan 2013).

These approaches to care frameworks establish that relationships matter for the care and wellbeing of older people living in care homes. However, despite this acknowledgement of the importance of relationships and community in care, there is very little research on what these communities look like for individual residents.

Past research has explored how residents make and maintain relationships with staff (Canham *et al.* 2017; McGilton and Boscart 2007; Berdes and Eckert 2007), with other residents (Abbott and Pachucki 2016; Hubbard *et al.* 2003; Mattiasson and Andersson 1997; Powers 1996) and with family and friends (Cook *et al.* 2006; Davies and Nolan 2006; Cook and Brown-Wilson 2007). In particular, this research shows that family and friends can help maintain a resident's sense of identity through helping the staff get to know their loved one (Davies and Nolan 2006; Cook 2006). Furthermore, staff who voiced 'family-like' feelings toward residents and believed they knew them personally, were able to build stronger, more positive relationships with residents (Canham *et al.* 2017). However, few studies explore how these relationships co-operate together to support residents. One of the few examples is Brown-Wilson (2007, 2008), whose research establishes that reciprocal relationships between staff, residents and families are important for improving the care of residents. Although her findings are insightful and important, they do not establish how these communities are negotiated by individual residents and how the support networks of residents coordinate to support them as individuals. This gap in knowledge will be addressed by the current study by employing an egocentric network methodology to explore the support networks of individuals. This will aid the development of the relationship-centred care framework by showing, from the residents' perspective, where they feel their network coordinates and to whom they rely on most for support. However, to fully explore this method of analysis, concepts which underpin network science, such as social networks, support and capital, must also be discussed.

2.3. Social networks, support and capital

Social networks can be defined as a "*specific set of linkages between a defined set of social actors*" (Mitchell 1969, p. 2). Underpinning network science is the assumption that individuals are embedded in social relations and interactions (Borgatti *et al.* 2009; Lewis 2011). For this thesis, a network approach is appropriate as it goes beyond the single relationship between staff and resident, or family and resident. Instead, it tackles the 'embeddedness' of social relations (Granovetter 1985) by exploring how multiple relations interact and integrate (Hollstein 2014). This is important to the aims of this thesis, as how a resident embeds themselves into a care home may be important for their support, and for their wellbeing.

Although a social network may exist around an older person, that older person may not consider all actors as supportive, and, therefore, perceived support may have a larger effect on wellbeing (Bowling 1994; Wenger 1987). Thus, this thesis focuses on how older people perceive the support they receive and from whom this support comes. Social support is described as a potential function of a social network (Wellman 1981), where a social tie can be supportive or not. Thus, social networks precede social support, as social networks provide the structure to allow potential support (Stephens *et al*. 2011).

Types of social support can be distinguished (Perry *et al*. 2018) into three different categories; instrumental support (ties that provide resources, money or assistance), emotional support (ties that offer love or nurturing), and informational support (ties that provide knowledge, advice and information) (House and Khan 1985). Therefore, different types of support may be provided by different actors in a network. However, if social support is a potential function of social networks, then social capital is a potential product of social networks. As Kritsotakis and Gararnikow (2004, p. 46) argue:

> *Social support refers to relations a person develops in his/her social environment, while social capital breaks away from this individualistic approach to address more effectively the influence of the society to the individual.*

'Social capital', as a concept, is widely used, and debated, in the social sciences. Generally, social capital is a concept which acknowledges the importance of social

networks, or as Field (2008, p. 1) states, the concept implies that "relationships matter". Bourdieu and Wacquant (1992, p. 119) argue that:

> *Social capital is the sum of resources, actual or virtual, that accrue to an individual, or a group, by virtue of processing a durable network of more or less institutionalised relationships of mutual acquaintance and recognition.*

Thus, social support is a potential function of a tie between two actors within a network, which can add to a person's social capital, whereas social capital is the accumulative resources embedded within social networks and individuals need to engage with others within a network to be able to capitalise on potential social capital (Lin 1999). Social capital has been highlighted in several studies as having a positive effect on wellbeing, and this relationship has proven to be especially strong among older people (Forte 2009; Pinquart and Schiller 2000). Forsman *et al.* (2013) showed, in a systematic literature review, that quantitative studies have found that having more social capital, such as having adequate social networks and increased social engagement, has a positive impact on an older person's wellbeing/quality of life.

The distinction between social networks, support and capital is important for residents because, although they may interact with many people while living in a care home, they may not perceive all these interactions as part of their social network, or indeed, as part of their support network. Further, what these supportive actors provide accumulatively can affect what social capital residents have to draw upon to support them, and to improve their wellbeing.

2.3.1. Types of social capital: bonding social capital

Commentators distinguish between bonding and bridging social capital (Putnam 2000). Bonding social capital refers to trusting and co-operative relationships which are similar to each other in terms of social identity (Woolcock 2001). Bonding social capital occurs among homogenous groups, and the benefits of this social capital, such as emotional support and assurance of identity, can be harnessed internally by the people among the

group (*ibid.*). This type of social capital is normally provided by close friends and family, who are closely connected.

For older people, several studies suggest that close friends and family are particularly important for wellbeing (Forsman *et al.* 2011; Cook 2006; Cummings and Cockermouth 2004; NHS Health Scotland 2004). However, one study suggested that the frequency of social contact with friends has a higher association with subjective wellbeing for older people than the frequency of contact with their adult children (Pinquart and Schiller 2000). This is further emphasised by Barnard *et al.* (2001) whose research explored the changing support networks of older people living in the community. They found that three quarter of actors in older people's support networks were kin, however that due to the increasing geographical dispersion of 'blood relatives', close lifelong friends had become equally important to older people's support.

Forsman *et al.* (2011) found that ties to close friends and family provided social support, mutual trust and a sense of security, which, for older people, was far more important than formal ties in organisational life. They posited that this meant that social capital might have a different meaning for older people when compared to younger people (*ibid.*). However, this may also suggest that the aspects of social capital that affect the wellbeing of younger people may affect older people differently. For example, having emotional support in later life may be more important for an older person's wellbeing than having ties that can provide resources for "getting ahead" (Putnam 2000, p. 23), whereas "getting ahead" may be a higher priority for younger people. For many older people, bonding social capital may be more important in order to maintain established social relationships which they can rely on or, in Putnam's words, "get-by" with.

A number of studies also found that family members can play a crucial role in enabling people living with dementia to remain socially involved, especially when supporting them to continue to feel useful in day-to-day tasks and in maintaining their identity (Genoe *et al.* 2010; Keller *et al.* 2010; Phinney *et al.* 2007; Phinney 2006). Harris (2012) found that, in the early stages of dementia, friends played a key role in keeping a person living with dementia socially connected. Having peers who could relate to their situation was especially important as they were able to see that "there is life after a diagnosis of dementia" (Clare *et al.* 2008, p. 21). This peer support gave a sense of belonging and re-

engagement with life as they felt less lonely and isolated (Keyes *et al.* 2016; Clare *et al.* 2008; Fung and Chein 2002). In this sense, friends and family have additional importance to residents who are living with dementia and may make friends and family even more important for people living with dementia.

Additionally, relationships which provide bonding social capital, such as close friends and family, can also harbour tension and disagreement. In this sense, close ties can be ambivalent were ties are not simplified by only being harmonic or conflicting, but are nuanced by acknowledging closeness while having tension between two people (Luscher 2002). Studies such as Pillermer *et al.* (2007) and Hillcoat-Nalletamby and Phillips (2011) explored how relationships between older people and their families may be important for support, but they may also hold feelings of indifference or tension within these relationships. In particular these ambivalent relationships can expose how structural factors may influence these relationships. For example Hillcoat-Nalletamby and Phillips (2011) explored one such relationships where an adult daughter felt the social expectation of having to care for her mother, however their relationship was uneasy and often difficult. Thus, by acknowledging ambivalence we can unpick how the social expectation of the daughter to care for her mother at a macro level leads to an ambivalence were mother and daughter need to spend time together, despite their mixed feelings. As Luscher (2002: 586) states:

Acknowledging ambivalence helps to overcome the simplistic idealization of family relations. [...] Ambivalence is not necessarily negative but rather implies a task of structuring relationships that is more or less created by structural, situational, and personal conditions.

As such, the present study must acknowledge that not all close relationships, in particular family relationships, will be without tension. In particular if residents do not want to live in the care home, and families may have made this decision for them. As such, this may affect how residents access support from these relationships and others in their support network. Furthermore, the benefits of these strong, homogenous bonds may also be limited because of their lack of ability to introduce new resources to the network.

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2.3.2. Types of social capital: bridging social capital

Putnam (2000) argues that, although bonding capital is good for "getting by", bridging capital is required for "getting ahead" (p. 23). Bridging social capital differs from bonding social capital because it refers to the connections between people who are unlike each other, and Putnam (2000) suggests that this type of social capital can provide access to other forms of capital. Links between heterogeneous networks can encourage the exchange of resources and information that homogenous networks would not be able to access on their own.

Bridging social capital within a care home, from a resident's perspective, can refer to many different types of ties, including to staff and other residents. In one of the few studies which used a network approach to explore the relationships of older people living in care homes, Cheng (2009) looked at how many people were in the support networks of older people living in care homes in Hong Kong. Cheng (2009) found that residents nominated an average of 2.6 people in their network from whom they felt they could receive support, and who were important in their lives. Most of these were family and close friends, however, out of 72 nursing home residents, only a fifth nominated another person in the nursing home, and most of these nominations were the staff. This suggests that, despite the company of staff and 'peers' with whom residents could potentially make ties, they did not feel that they could receive support from them, or that they were important in their lives (*ibid.*). Clearly, due to the location of this study, there is the caveat that cultural differences will occur between Hong Kong and Scotland, however, it does beg the question: what do the social networks of care home residents in Scotland look like and how important are staff and/or other residents to the wellbeing of people in care homes?

Although there are few examples of the staff–resident relationship being analysed from a network perspective, the 'quality' of these ties has been explored through research regarding person-centred and relationship-centred care. By aiding the carers of people living with dementia to recognise the individual they are caring for (Kitwood 1997) and acknowledge the individual's personality and life experience, the carer can improve a person's wellbeing by providing care in a person-centred care approach (Baker 2015). Nolan *et al.* (2004) argue that relationship-centred care goes beyond person-centred care

as it acknowledges all of the relationships that may affect the care relationship between person and carer, and thus, encourages not only the celebration of the person's attributes but also encourages a reciprocal relationship. Research suggests that staff members who carry out person-centred, or relationship-centred care, in their everyday working practices, improve the wellbeing of residents (Brooker and Wooley 2007; Wilson and Davies 2009; Kelly 2010; Talbot and Brewer 2016). This suggests that, within care homes, staff who carry out these types of care may be more valuable to the wellbeing of residents. Thus, staff may have a substantial effect on the wellbeing of residents through their relationships in their work.

In the context of social capital, it could then be argued that person-centred and relationship-centred approaches to care may mean that staff are more likely to offer bonding social capital, as well as bridging social capital, as person-centred and relationship-centred care encourages personalisation and meaningful relationships between staff and residents (Brown-Wilson and Davies 2009). However, in reference to the care home, these 'approaches to care' (relationship-centred, etc.) may reflect the practices (or policies) of the care home. It is thus suggesting that the 'quality' of bridging ties may be affected by the organisation itself.

This thesis operationalises the concept of social support (the potential function of a social connection) through name generators which will elicit the names of supportive actors which provide particular types of support. Further social capital is operationalised by the collective resources described by the residents through name generators and qualitative interviews. Bonding and bridging social capital was not explicitly captured during data collection. However through compositional and structural measures (such as closeness of tie, density and types of support provided) as well as qualitative descriptions of relationships (whether residents and supportive actors came from similar backgrounds i.e. family, community etc.) I was able to establish if the connection provided bonding or bridging social capital. Both the interview procedure and name generators which captured these concepts are discussed in section 3.3.1.

2.4. Organisational ties

After discussing the importance of bridging and bonding social capital, especially in reference to older people living in care homes, it is vital to discuss how the care home may have an impact on the support and wellbeing of residents. One of the aims of this project is to understand how the care home supports residents and therefore affects the wellbeing of older people living in care homes. To achieve this, the concept of organisational ties is considered.

Organisational ties are the connections an actor can draw upon to gain social capital, resources, information and material goods from an organisation (Small 2006). Small's (2006) study of childcare centres showed that having an organisational tie could provide a wealth of benefits to mothers and therefore improved their wellbeing. Drawing on this work, Figure 2.1 shows how an older person may benefit from being connected to a care home (the organisation). The organisational tie, in this project, is the tie to the care home, which has the potential to provide both bonding and bridging social capital. As the organisational tie provides access to many different types of new connections (e.g. staff, specialists, other residents), this could foster new sources of bonding (e.g. emotional support from new friends) and bridging social capital (e.g. new care/information from specialist staff).

Figure 2.1. Potential resources and social capital through care homes (organisational tie)
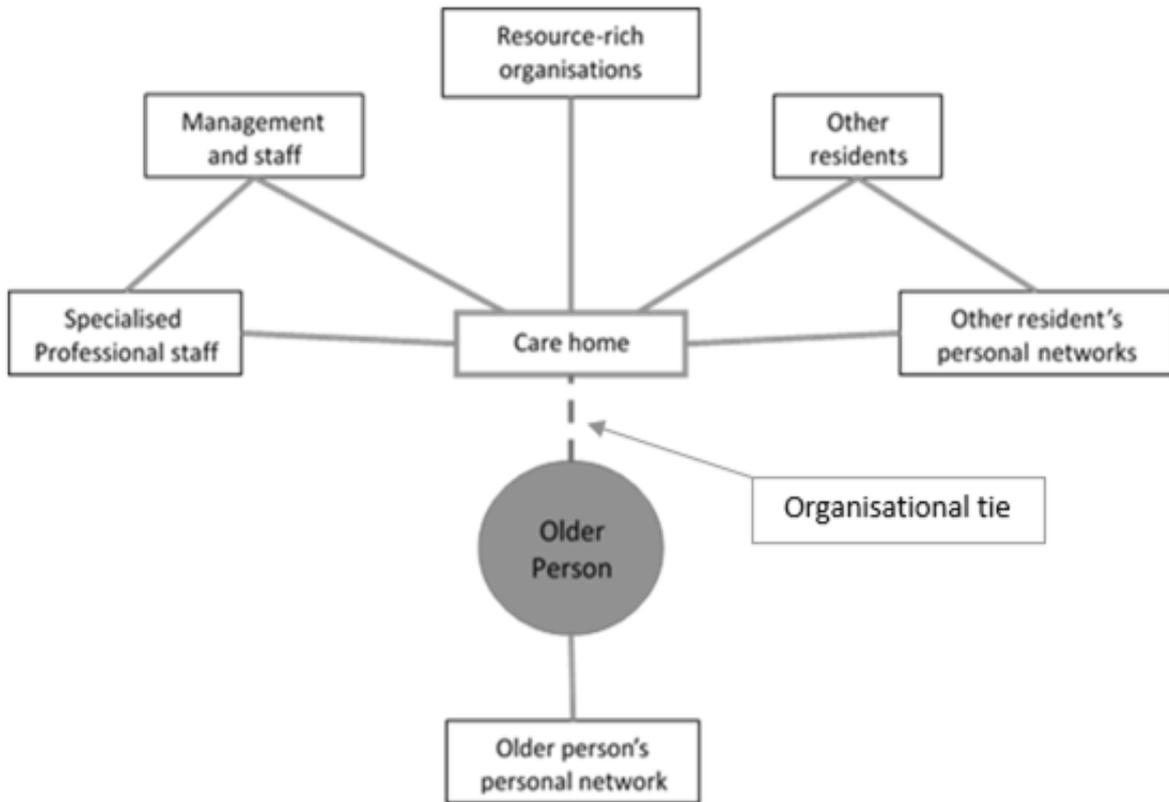
Small (2009) criticised past research which was mostly concerned with how people accessed resources, as most theories only focused on the social ties of individuals, rather than incorporating structural and organisational influences. He argues that, in a bureaucratic society, everyday goods and information are more likely to travel across formal ties, such as organisations and institutions, rather than social ties, which have less influence over the flow of resources and information in society, and which may influence wellbeing (*ibid.*). Small's work helps indicate how care homes can offer support and resources that an older person's network outside the care home may not be able to offer. Thus, this review explores how his work can be applied to care homes in order to better understand how support is provided to residents.

Formal Support

The formal support that organisations provide can offer resources, material goods, information and knowledge that a person would otherwise not be able to obtain (Small

2009). Similar to arguments made by Small (2009), more recent research suggests that care homes offer many direct benefits to their residents, including a wealth of resources, medical help and knowledgeable staff (Killet *et al.* 2016). As suggested in Section 2.3.2, a great amount of support could be provided by staff, and therefore they could play a significant role in maintaining the wellbeing of residents. However, previous research indicates that staff shortages and regular staff changes in care homes may impact negatively on the provision of care (Killet *et al.* 2016). Further, that some staff may have ageist views of residents (Wikström and Emilsson 2014) and therefore their relationships with residents may not be as positive and, thus, not as supportive. Therefore, although staff may be a main provider of support, barriers such as staff attitudes towards residents and inconsistency in staffing could have an impact on support.

Further to this, other research suggests that it is not only the support that staff provide directly, but how they coordinate with family and friends which is more important to the improvement of care (Van Beek *et al.* 2013). They argued that increased interaction between family members and staff improves the care the resident receives (*ibid.*). This would suggest that, rather than just the support of the staff directly, it may be the support of the community that is key for residents. A similar finding was suggested by Burge and Street (2010), who found that residents of assisted living facilities, which had regular contact with external social support, had better relationships with other residents who were already well connected in the assisted living facility. Similarly, residents who had regular contact with family were more likely to report positive relationships with the assisted living staff, when compared to those who did not have family contact. Thus, it could be argued that creating community between ties may have a greater effect on the positive experiences of residents than any one particular tie. This suggests that the quality and co-operation of ties may be instrumental in dictating the quality of support that a resident receives. However, these studies did not show whether this co-ordination benefitted a resident's wellbeing. Therefore, it is important not only to capture how the care home is directly supporting the resident, through staff and the other resources it provides, but also how the care home facilitates all of these people working together, and how that affects residents' wellbeing.

Informal Support

In addition to the formal support provided by organisations, Small's (2009) study found that informal support was also created, as the childcare centres made the contact details of other parents freely available and parents made informal support networks of their own. Living in a care home may result in the establishment of informal peer support with other residents and their families, which may also be encouraged through activities and social events organised by the care home. Friendship between residents has been observed in previous studies (Moyle *et al.* 2011), however, other research indicates that some older people living in care homes may also have negative attitudes towards each other, as they do not want to be associated with other people living with dementia (Abbott and Pachucki 2016; Hubbard *et al.* 2003). These mixed results indicate that there may be some companionship between residents, however, it is unclear whether this is deemed to be support by residents. Thus, although previous research has looked at informal support in other settings (i.e., childcare centres), looking at whether residents feel they are supported by one another is an under-researched area in care homes. Also, although care home research has looked at how residents interact, how the care home facilitates that informal support is an under-researched area. By looking at the support networks of residents, this research will explore the informal benefits of living in a care home, including the emotional support that other residents may provide.

External support

Small's (2009) study showed that organisations could potentially provide links to well-resourced external organisations. He described how childcare centres and external organisations could provide an array of resources, services, material goods and information to parents that could help overcome challenges of hardship and mental stress, which improved wellbeing (Small 2008). Figure 2.1 illustrates how residents may have access to external resources, such as specialised professional staff, as well as well-resourced external organisations, such as charities and local authority run initiatives.

For example, residents can be referred by the care home to specialists for specific needs. Medical experts, such as dementia specialists, would be readily available to support residents- especially during declining health. This access to specialist staff may become more or less important for a resident's wellbeing, depending on the types of needs an older person has in the care home. There may be times when the resources, knowledge

or specialisms that these staff provide are more important for wellbeing because an older person's need for specialised care is greater than their need for emotional comfort or socialising.

Organisational ties and wellbeing

Despite the wealth of resources that organisational ties could provide, Small (2009) found that these resources did not affect the wellbeing of well-connected or non-poor mothers (because non-poor mothers already had access to numerous resources through their other networks), but they had a definite effect on the wellbeing of poor mothers, and those who were more socially isolated (*ibid.*). Therefore, organisational ties benefitted those who had less social capital because the organisation could help improve their access to resources to which they could not gain access within their own personal networks.

Those with more social capital may also have access to other capitals that allow them access to better-resourced organisations. Bourdieu (1984) argued that the individuals who were able to gain the most social capital were those who also had the most financial and cultural capital. Cultural capital can be considered as the cultural symbols or marks of distinction that groups may adopt to signal their position in society (Bourdieu 1984), for example, tastes in certain foods, music and activities. Bourdieu (1984) argued that cultural capital can, and often does, mirror financial capital, as sometimes these foods and activities can be particularly expensive, and thus wealth may dictate the cultural capital that people accumulate. However cultural capital, to some extent, can operate on its own by compensating for lack of money as a part of an individual's, or a group's, strategy to pursue power and status (Robbins 1999). Although each element can add to a person's position in society, it is the accumulation of financial, cultural and social capital which has the potential to create the most privilege in a group or individual. This could result in residents who come from more advantaged backgrounds being able to draw on their social capital to gain more support in the care home (family being able to more effectively negotiate with staff). Or indeed, being able to afford to live in a care home that costs more to live in, and which is better resourced and staffed. In reference to care homes, this could mean that living in a well-resourced care home could improve or maintain a person's wellbeing more effectively because they have more resources to support the residents.

A recent study looked at how socio-economic disparities between nursing homes were reflected in the quality of staff–resident interaction in different nursing homes in the USA (Ryvicker 2011). The study found differences in approaches to care between a nursing home serving a mainly white middle-class community and a nursing home serving a low-income Hispanic and black community. The nursing home, which served the middle-class community, delivered a much more person-centred approach to care, while the care home, which served the lower-income community, supplied a more tasked-based approach to care. In this case, the author argues that the nursing home in a higher income area was able to supply better-trained and qualified staff when compared to the lower-income community. Thus, the socio-economic disparities between these nursing homes changing the quality of care the residents received. This suggests that, although care homes will supply care, resources and information to their residents, there may be disparities between the care homes themselves, which will affect the wellbeing of residents.

The work of Small (2009) suggested that these informal and formal networks mainly benefitted those who were not well connected outside of the childcare centre or those from poorer backgrounds. However, theories of social capital and care home research would suggest that people who have more social, cultural and financial capital may have an advantage in accessing better-resourced care homes.

In short, the concept of organisational ties provides this thesis with underlying assumptions about how care homes may be able to benefit residents by providing direct support and resources, as well as informal and external support. However, care home research and theories of social capital suggest there may be barriers to these supports, which may have an impact on the wellbeing of residents. As such, this thesis will explore what impact the care home may have on providing support, as well as what barriers there are to providing this support.

2.5. Typologies of social networks

Arguably, researchers of networks have not only been analysing the structures of networks for decades, but they have also been exploring the *systematic patterns* of these

networks and what factors can explain these recurring patterns. One way in which these patterns of support can be explored is through identifying a typology of support networks.

> *Identifying a typology of egocentric networks has been at least an implicit task in social network analysis since its early years. (Giannella and Fischer 2016, p.17)*

Antonucci (2001) argues that the composition and overall quality of a person's network is systematically affected by personal and situational factors. This suggests that capturing these systematic patterns through typologies is "not only viable, but theoretically meaningful: (Li and Zhang 2015, p. 60), and analyses of how these patterns in networks may be related to other external factors can be carried out. Despite the theoretical evidence that typologies of networks could lead to a better understanding of the systematic factors that affect a person's social network, there have been few studies which have characterised such networks in older populations. Moving beyond specified relations to individualistic approaches could provide a more nuanced methodology. This would arguably be beneficial for analysing the support networks of older people in care homes, because it would lead to a better understanding of the patterns of support that exist, and, thus, may show what factors are influencing the provision of this support.

2.5.1. Typologies of the social networks of older people

The social networks of older people have been grouped into types in previous studies. Often the types of networks created include a family-based, restricted and diverse type of network, with some studies adding network types such as religious-based or friend-based networks. Generally, the network typologies in these studies show that older people who have more restricted and less diverse networks are generally worse off when considering health and wellbeing outcomes (Litwin 2001; Fiori *et al.* 2006; Li and Zhang 2015; Sohn *et al.* 2017; Ayalon 2019). Thus, exploring whether this pattern also emerges in the support networks of older people living in care homes will be of great interest to care practice and whether these patterns affect wellbeing.

Support networks are not the whole social network, but a sub-network which only takes into account supportive ties (Wellman 1981). These previous studies aimed to outline the full personal network of older people, and thus, looking at typologies of *support* networks will most likely produce differing networks. Further, these typologies only use quantitative data, which, if such methods were applied in this study, would disregard rich qualitative data, which also characterises said support networks.

Most studies looking at the social networks of older people have used quantitative data to create a typology through cluster analysis (Litwin 2001; Fiori *et al.* 2006; Li and Zhang 2015; Sohn *et al.* 2017; Ayalon 2019). To the best of my knowledge, only one study, Wenger's (1991), has created a typology of *support* networks specifically for older people with both network and qualitative data. Although past research has looked at the networks of older people that could be considered supportive (e.g., collecting data on family, friends, etc.), these studies have not set out to collect data on only supportive ties. Furthermore, although studies have created typologies of supportive networks, they have not created these typologies through data gathered with older people, who will most likely have differing supportive networks to younger people.

Wenger (1991) used a longitudinal survey for older people (*n*=525 at first wave, *n*=197 at final wave) living in Wales, which collected the characteristics of their support network (size, composition, and function) over four years, and a smaller number of older people involved in the survey were also included for more in-depth interviews (*n*=30). Wenger used McCallister and Fischer's (1978) approach of collecting supportive ties that provided companionship, advice, help or care. Using both network data and qualitative interview data, Wenger (1991) developed a typology of support networks specifically for older people which included 5 types;

1. Family dependent
2. Locally integrated
3. Local self-contained
4. Wider community-focused
5. Private restricted

Wenger found that more 'family dependant' networks were usually smaller than other types of networks and that the ego was more likely to be older (over 80) than those with other types of support networks. 'Wider community focused' networks were also likely to provide frequent contact with family, but were larger networks in general (8+ supporting alters) as they also had contact with community organisations, while private restricted networks were more likely to be smaller with infrequent contact with relatives, neighbours and community organisations. Locally integrated networks had many connections to friends, family and neighbours, while also being actively involved in the community, whereas locally self-contained networks were reliant on local supports, such as neighbours, but were not involved in the community.

Wenger created these typologies by assessing both the network and qualitative data, focusing on three main factors; proximity to their alters, the proportions of family, friends and neighbours, and the level of interaction between the ego and their supportive ties. This typology has also been applied to other older populations in later studies (Santini *et al.* 2015; Golden *et al.* 2009) through applying said typology to quantitative data and exploring how the structures of each type affect other factors. Wenger found that most support network types remained stable over four years. However, on average, a small percentage (2.5%) of support ties altered from year to year, which was often due to the changing health status of the older person who needed alternative support, or previous supportive alters passing away.

However, the typology was created from a sample of older people living in the community in the 1970/80s, and this means that their care needs are very different from older people in this research sample. For these reasons, applying this typology to the data at hand would not be appropriate. However, using a methodological approach which combines both network and qualitative data would be advantageous in the present study.

One of the main aims of the thesis is to better understand the support networks of older people. By creating a typology of support networks for older people, this will help create a more nuanced understanding of support in care homes, as it allows the exploration of support from the individual perspective, rather than from a specified relationship (e.g., only the staff–resident relationship). Furthermore, creating a typology also highlights

patterns of support and indicates whether there are key factors that are driving or discouraging support inside care homes.

2.5.2. Typologies of the social networks of older people in residential care

Only two studies looked at creating a typology of the social networks of older people living in residential care (Ayalon 2019; Powers 1992). However, the residential care described in these studies is not synonymous with how residential care is defined within UK contexts, although each type of care facility will be described below.

Ayalon (2019) looked at the social networks of older people in continuing care retirement communities in Israel. Ayalon describes the people living in these facilities as "more affluent adults who are independent in the activities of daily living" (2019, p. 1), which is quite different to the majority of older people moving into care homes in Scotland (care homes in Scotland usually have mixed funding statuses for residence, and many would not be independent in some activities of daily living, e.g., personal care, continence, eating). However, Ayalon (2019) did find that these networks were grouped into two types: child-based and friend-based. This indicates that people who live in continuing care retirement communities in Israel can be characterised by those who have a higher proportion of ties to the family (child-based) or to friends (friend-based). This study used latent profile analysis to cluster the types of support networks with six indicators: the size of the network, proportion of friends and family, proportion of the spouse when compared to the number of all social ties, the average frequency of contact, and the average level of sharing secrets. Despite the two groups not having a significant difference in wellbeing, they did find that those people with child-based networks were more likely to be older. This study, although relevant, used only clustering methods, which could not be used in the present sample due to its size and would not take into account rich qualitative data. Further, the cultural differences between Scotland and Israel are significant and, as such, may yield different types of social networks.

Powers (1992) used a mixed-method approach to create a typology of the social networks of older people living in long-term institutionalised care in the USA in the 1980s. Sixty-nine residents were interviewed between 1984 and 1986, aged between 55 and 97 years.

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The creation of the typology was completed through the comparison of network characteristics (composition and structure) and the analysis of interview transcripts. Although it must be noted that the description of the steps taken to create this typology is vague. Powers found four types of social networks present in the sample; institution-centred, small cluster, kin-centred and balanced. Institution-centred networks were generally small in size and, proportionally, had fewer ties from outside of the institution. Interestingly, this type of network was the most common (27 out of the 69 people sampled), with balanced (19), kin-centred (18) and small cluster (5) following, respectively. People with institution-centred networks were also more likely to self-label as 'loners' and would limit their social contact with people to the bare minimum tasks. Kin-centred networks varied in size; however, kin ties always equalled or exceeded institutional ties. The people who had this type of network often depersonalised, and did not have emotional connections to, staff. Alternatively, balanced networks were the largest networks on average, and this reflected the residents' ability to negotiate multiple types of relationships. Often with this type of network, the resident would not only have a relationship with staff but have a friendship with a staff member. This was often an indication that the resident had the social skills to be able to navigate the hierarchy of institutional life, if they needed support, and maintain a personal connection from outside the care home. However, despite this paper having a very similar demographic to the present study and sharing a similar aim of looking for organisational differences in network patterns, the paper was written nearly 30 years ago and was based on US residents. Thus, although it was helpful to inform the analysis of the current study, it still leaves a gap in the current knowledge.

These two studies, which produce two different typologies of networks for older people in residential care, showcased two things. Firstly, the typologies created vary greatly. This could be due to a number of reasons, although the difference in geography, time and culture will play a part in this. Despite this, their limited number shows that there is a need for more research in this area due to the difference between the two typologies.

Secondly, these papers showed that types of networks could have an effect on the experience that a resident will have in the care home. In particular, Powers (1992) showed how people who had more integration with care home staff seemed to have more positive relationships – which could lead to better wellbeing. Thus, exploring whether a typology of support networks exists for residents in Scotland, may highlight interesting patterns of

support and indicate how more positive relationships emerge. Further, it could be beneficial to examine whether having a different type of support network could affect the wellbeing of a resident. To the best of my knowledge, no such studies have examined the support networks of older people living in care homes, which, as suggested previously, comprise a population with a growing need of support and, thus, warrant exploration.

2.6. Definition and framework of wellbeing

This literature review has explored a number of ways in which a resident's wellbeing may be affected by social support and social capital. The review has discussed that, when care homes use approaches to care which focus on positive and meaningful relationships, this can have a positive impact on the wellbeing of residents (Baker 2015; Brown-Wilson and Davies 2009, Nolan *et al.* 2006). Organisational ties can provide a wealth of resources and social capital through formal and informal support, as well as through external sources, which could improve the wellbeing of the people connected to the organisation (Small 2009).

Increased social capital can result in improved wellbeing in older people (Forsman *et al.* 2011); however, bonding and bridging social capital may have different effects on the wellbeing of residents. Research suggests that close friends and family are particularly important for the wellbeing of older people (Cook 2006; Cummings and Cockermouth 2004; NHS Health Scotland 2004), however, having contact with a friend compared to a family member may have a larger effect on wellbeing (Pinquart and Schiller 2000). Family and friends might also be particularly important for people living with dementia as they enable the person to continue to feel useful in day-to-day tasks, maintain their identity and therefore improve their wellbeing (Genoe *et al.* 2010; Clare *et al.* 2008). Furthermore, the typology of networks literature suggests that older people with less diverse or more restricted networks are more likely to have worse health outcomes, such as poorer wellbeing (Litwin 2001; Fiori *et al.* 2006). Although the literature shows an overall positive relationship between social support/social capital and wellbeing, it is by no means linear, nor without complexities. Thus, to explore this relationship in care homes, the definition of wellbeing must be conceptualised and measured.

This review will establish the key literature surrounding the concept of wellbeing and the model of wellbeing that will be used in this project. 'Wellbeing' is a multifaceted, dynamic construct (Diener 2009; Michaelson *et al.* 2009; Forgeard *et al.* 2011; Linton *et al.* 2016), which includes emotional, social, and functional components, however, it still remains undecided which components should be included in a valid theory and measurement of wellbeing (Diener *et al.* 2003).

Wellbeing research has primarily been dominated by two distinct strands of thought; hedonic and eudemonic wellbeing (Vahoutte and Nazroo 2014; Ryan and Deci 2001). The following section will outline the definitions of hedonic and eudemonic wellbeing, as well as how past research has measured these concepts. How this study will measure subjective wellbeing is discussed in the research design section, where I will describe the three measures used to capture subjective wellbeing.

Figure 2.2 below gives an overview of subjective wellbeing and how the literature links each of the concepts. This study will follow this structure and will measure each facet of subjective wellbeing.

Figure 2.2. Model of subjective wellbeing
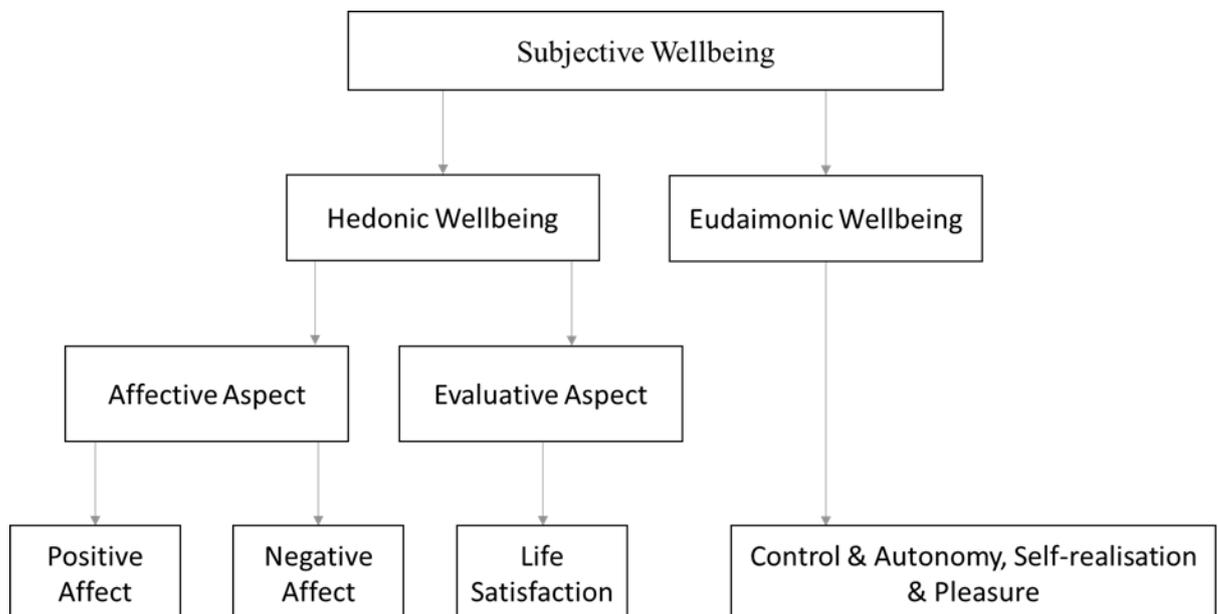
2.6.1. Hedonic wellbeing

Until the 1980s, hedonic wellbeing and subjective wellbeing were considered one and the same (Kahneman *et al.* 1999) until later research clearly illustrated that subjective wellbeing is a multi-faceted concept, which includes the facet of hedonic wellbeing (Keyes 2006). Hedonic theories of wellbeing argue that, by minimising suffering and maximising pleasure, a person can achieve higher wellbeing (Vanhoutte 2014, 2012). Hedonic wellbeing can represent the subjective element of wellbeing, where it distinguishes mood or feeling, from any evaluation of one's life overall (Vanhoutte and Nazroo 2016). Thus, hedonic wellbeing can be split into two separate components; evaluative and affective aspects of hedonic wellbeing, which distinguish between feeling and evaluation (Diener *et al.* 1985).

The affective aspect of hedonic wellbeing can be represented through the emotions a person feels (Tinkler and Hicks 2011) and includes emotions that are both positive and negative (Vanhoutte and Nazroo 2014). Thus, within the affective aspect of hedonic wellbeing, both positive affect (PA),when a person feels emotions such as enthusiasm, high energy and alertness, and negative affect (NA), when a person feels negative emotions such as guilt, anger or fear, are captured (Vanhoutte 2014). Equally, measures should capture the lack of a PA and NA, where a lack of PA can resemble a lethargic or sad mood, and a lack of NA may be seen as a state of calm (*ibid.*).

The evaluative aspect of hedonic wellbeing can be defined as an appraisal of a person's life (Jivraj *et al.* 2014) and is often evaluated through the life satisfaction a person feels, which is determined through their own criteria (Pavot and Diener 1993).

Therefore, high wellbeing, in the hedonic view, would comprise of high life satisfaction (evaluative aspect), as well as a high PA with little or no NA (affective aspect) (Diener *et al*. 1985; Watson *et al*. 1988).

2.6.2. Eudemonic wellbeing

The eudemonic wellbeing approach argues that, in order to have high wellbeing, a person needs self-fulfilment and personal development (Ryff and Keyes 1995). Thus, in contrast to hedonic wellbeing, eudemonic wellbeing is not just about happiness or satisfaction, but also consists of a person's assessment of their psychological wellbeing (Keyes 2006). Vanhoutte and Nazroo (2014) suggest that eudemonic wellbeing is often measured through variables that capture autonomy, fulfilment and personal growth, and this can be seen in measures such as Ryff and Keyes' (1995) Psychological Well-Being (PWB) measure. Hyde *et al.* (2003) specifically look at this concept in older populations and have developed a measure of eudemonic wellbeing for older people that was informed by four ontologically derived domains; Control, Autonomy, Self-realization, and Pleasure. This theoretically informed measure will be explored further in Section 3.3.1, where the measures of subjective wellbeing used in this study will be discussed.

2.6.3. Summary of subjective wellbeing

Keyes (2006) argues that the field of subjective wellbeing has now recognised that both hedonic and eudemonic wellbeing need to be considered in order to define and measure subjective wellbeing, while Vanhoutte and Nazroo (2014) argue that, as well as accounting for both sides of subjective wellbeing, it is also essential to separate affective and evaluative aspects of hedonic wellbeing, because they represent different parts of subjective wellbeing. Thus, all three facets of wellbeing contribute to the concept and, to gain a greater understanding of subjective wellbeing, a measurement should be taken of each facet in order to adequately measure an outcome of subjective wellbeing. The full measure of subjective wellbeing is included in Appendix 1, as well as being fully explained in the research design section.

2.7. Conclusion

The Scottish care home population is becoming older, increasingly frail and in need of more support. Care homes aim to adopt approaches to care which not only acknowledge the person's needs and wishes, but also the relationships which surround them (Brooker

and Latham 2015; Nolan 2013). Despite acknowledging the importance of the supportive relationships surrounding residents during their time in the care home, there is very little research on what this support network looks like, or what it is about this network that is particularly helpful in supporting residents.

This is where concepts of social capital and organisational ties could be helpful in exploring how care homes support residents in Scotland. This review has established a link between social capital and wellbeing among older populations. However, it showed that this relationship is underexplored among older people living in care homes and that this group is missing key supports for residents such as staff and other specialist staff. Despite there being an overall positive relationship between increased social capital and wellbeing, the research acknowledges that the relationship between social capital and wellbeing may not be linear. In the literature, bonding social capital has been given more attention, however, both bonding and bridging social capital could have an effect on a person's wellbeing, especially in a care home, where residents may need a great deal of support and resources to maintain their wellbeing. This chapter also established the underlying literature and theoretical framework surrounding subjective wellbeing. These will be discussed extensively in the methodology chapter.

Small's (2009) study shows the resources and social support that organisational ties can provide are especially beneficial to the wellbeing of people who are less well-connected or people of a lower socio-economic position. However, this has not been examined within care homes for older people. There has been little network research done in care homes, however, some studies have shown that the social networks of older people living in care homes may have fewer social ties, as an individual's health worsens over time, which may result in reductions in social capital. Furthermore, research shows that the co-ordination between staff, families, friends and residents may be important for promoting a positive experience for residents in the care home.

Analysing patterns of networks and creating typologies of networks can lead to a better understanding of the systematic factors which may shape a person's social network. This study aims to understand what factors may influence the support of residents in Scottish care homes. Few studies take this typology approach, and even fewer have completed this type of analysis in care homes for older people. The following chapter and subsequent

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findings chapters will elaborate on network methodologies and will examine their benefits and limitations for promoting better understanding of support provision in care homes.

This chapter has established that, despite the adoption of a relationship-centred care approach, there is a lack of research in the supportive relationships within care homes. There is a need to establish what the support networks of older people living in care homes look like and how they are structured. Concepts such as social capital and organisational ties, which have been shown to have an effect on wellbeing, are rarely explored in research on care homes for older people. Therefore, the following research questions were composed:

> 1a. *How are the personal networks (ego-nets) of older people living in care homes structured and composed?*
>
> 2a. *How do care home staff feel they support older people and what are the barriers to this support?*
>
> 2b. *How do residents, and their visitors, feel they are supported in care homes and what are the barriers to receiving this support?*
>
> 3a. *Are there types of support networks of older people living in care homes, and if so, how can they be characterised?*
>
> 4a. *What is the relationship between the personal networks (ego-nets) of older people living in care homes and their wellbeing?*
>
> 4b. *Do different types of personal networks (ego-nets) affect wellbeing more than others?*
>
> 4c. *What mechanisms underline the wellbeing of older people living in care homes?*

Chapter 3 Methodology

Chapter 3 Outline

This chapter presents the methodological rationale for the thesis and is comprised of six main sections. Section 3.1 establishes the epistemological and ontological standpoint of the study as informed by the research questions. Section 3.2 reports the methods used for data collection, including the sampling of care homes, residents, staff and visitors. Section 3.3 describes the interview process and how both network and qualitative data were collected. Section 3.4 outlines the ethical issues faced within this project, which include issues of consent, capacity and risk. Section 3.5 details the methods used for analysing both network and qualitative data, while Section 3.6 describes the main limitations of the study and provides some reflections and suggestions of how the study would be conducted in hindsight. The final section will discuss all of the key limitations of this study before moving on to the first findings chapter.

3.1. Research questions and their ontological and epistemological stance

Research questions have their own ontological and epistemological underpinnings, which, when considered, will extend into "informing the methodology and thus providing a context for the process and grounding its logic and criteria" (Crotty 1998, p. 3). Therefore, the epistemological underpinnings of the research questions outlined in Section 2.7 are considered.

Bellotti (2015) offers 'Relational Sociology' as an appropriate ontological perspective which can capture why network research must use both a subjective and objective perspective on reality. Relational sociology offers a pragmatist's view of agency and social agents, by arguing that actors are 'agentic': individuals are producers as well as products of social systems, and thus, this perspective allows for an interpretive analysis of action and agency (*ibid.*). For relational sociology, 'agency' is defined as:

> *A temporally embedded process of social engagement, informed by the past (in its habitual aspect), but also oriented toward the future (as a capacity to imagine*

alternative possibilities) and towards the present (as a capacity to contextualise
past habits and future projects within the contingencies of the moment).
(Emirbayer and Mische 1998, p. 963)

Therefore, relational sociology addresses the concept of agency by arguing that action and identity are revealed temporally through social events, as well as spatially, through different social circles (Bellotti 2015). Relational sociology, whilst acknowledging that agents have an identity, also argues that these identities only come into place through social interaction, and therefore, do not exist without social interaction. For example, dyads represent the interactions of two individuals and therefore "the attributes of dyads cannot be reduced to the ones of the individuals: wives are only wives when matched with husbands, and there can only be slaves with masters, teachers with pupils, buyers and sellers" (Bellotti 2015, p. 44). Therefore, not only do the interactions of individuals define the attributes of the dyad but in turn, the features of the dyad will shape the characteristics of the individuals within the dyad (*ibid.*). Thus, a network cannot be purely defined as the sum of its components, because it is constituted by the pattern of elements, as well as the attributes, at the individual and dyadic level (Brandes *et al.* 2013; Bellotti 2015).

In sum, by adopting a relational sociological perspective, the subjectivity of the agent, and their choices is acknowledged. However, it also allows the exploration of objective perspectives in which 'the network' and structure can be explored.

This relational sociology therefore has epistemological implications because network research does not fall neatly into either a quantitative or qualitative paradigm. Given this, Bellotti (2015) argues that network science aligns with a critical realist philosophical approach, as critical realism does not polarise quantitative and qualitative methods. Rather, it acknowledges the importance of both types of inquiry; where qualitative methods focus on contextualised and intersubjective perspectives, whilst quantitative methods concentrate on the social patterns in society, which may point to underlying social mechanisms (*ibid.*). Critical realism argues that qualitative data collected from the actors themselves give an account of 'demi-regularities', where actors are aware of their own social reality, but may not be aware of all that is surrounding them (Kemp and Holmwood 2012). However, their individual perspective does not diminish their account,

as critical realism acknowledges that valid explanations of social phenomenon are interpreted through social actors, which in turn point researchers towards plausible explanations of social reality (Bhaskar 1998). As such, there are three levels to this social reality (Danermark *et al.* 2002). The first is the empirical level, where actors experience events, which can be measured and explained through experience and interpretation. The second, is the actual level where events occur regardless of whether they are experienced or not, and finally, the third is the real level. This is where casual mechanisms exist, which are the "inherent properties in an object or structure" that impact or cause an event to occur, which is experienced in the empirical level (Fletcher 2017, p. 183). Thus, qualitative accounts of events can give insight into mechanisms that may be causing events to occur in the empirical level. Further to this, quantitative methods can illustrate regularities in social worlds. However, these regularities are only "spatially and temporally contingent" and therefore do not capture the full causal mechanism by which a social phenomenon may occur (Bellotti 2015, p. 34). Thus, the different perspectives that each approach offers has resulted in a call for methodological triangulation where quantitative methods explore patterns in social world and qualitative methods point towards why these social patterns may occur in a particular time and place (Downward and Mearman 2006).

Therefore, this study adopted a relational sociology and critical realist approach, which allowed the analysis of social worlds through an individual's perspective, as well as acknowledging the impact of structural factors.

3.1.1. Validity of mixed method network research

Ensuring that the data, results and findings of this thesis are valid was a key component of the overall project. Traditionally, qualitative and quantitative research are both able to ensure validity, but through different processes. That is, quantitative research aims to construct consistent tools and scores in order to reliably measure outcomes, and qualitative research uses multiple sources to cross-check data and interpretation (Creswell and Creswell 2017).

The concepts of reliability and validity were considered carefully throughout this project. Firstly, valid research tools were used to collect and analyse relational network data and quantitative data. The measures used in this project were chosen because they were "meaningful indicators of the construct" and therefore could be interpreted in a meaningful way (Creswell and Plano-Clark 2017, p. 217). For example, the use of standardised name-generator questions which were asked to all residents, Hogan *et al.*'s (2007) target method of collecting network data, and Vanhoutte and Nazroo's (2014) measure of subjective wellbeing, were all validated methods of collecting appropriate data for this project.

The results were also shown to be valid through triangulation. Triangulation in social science can be defined as the combination of multiple data sources and/or methods (Creswell 2009). This allowed the exploration different realities and, as such, confirm the observations described in one reality compared to the other. Here, the use of relational network data and qualitative interview data describe two different realities and thus, when compared, can confirm the findings of the other. Wald (2014, p. 79) states:

The integrated analysis of qualitative and quantitative data contributes to a better understanding and produces more valid results.

In this project, the use of relational network data will give the structure and composition, but the qualitative description can reveal the meaning and intent behind these connections. In particular, in egocentric network data collection, the use of name interpreters aid in the characterisation of relationships between the ego and the alter, but also between alter and alter as descriptions of these relations emerge (Marsden 2005). Thus, the qualitative data not only confirm the observed structures, but they also contextualise them, and thus, improve the interpretation of the network analysis results.

3.2. Sampling

This section outlines the sampling techniques utilised in this project, as well as the reasoning behind this choice of sampling. The sampling strategy for this study had three levels; level one selected care homes in the Scottish central belt which housed older

people, level two selected residents who have the capacity to consent and wanted to be part of the research, and, finally, level three selected staff and visitors who were connected to said residents through their support networks.

The research was carried out in the Scottish Central Belt to make the project manageable. Restricting the care homes to the Scottish Central Belt meant that I had the funds and time to make multiple visits to care homes, without going over the research budget assigned to me by the Economic and Social Research Council, and could finish the project within a reasonable timeframe. Therefore, the Scottish Central Belt was chosen as the region from which to draw the sample.

3.2.1. Sampling of care homes

The project aimed to identify a number of care homes in different areas of deprivation, and under different ownerships (e.g., local authority/not for profit/private), in order that the sampled care homes might represent varying access to resources, and that the sampled residents might be funded by different sources.

To identify care homes that would be willing to be included in the research, ENabling Research In Care Homes (ENRICH) was contacted. ENRICH is an organisation which has a network of care homes that have previously indicated that they may want to be a part of research, and which makes this list of care homes available to researchers (NIHR 2018). Identifying care homes through this organisation ensured that no undue pressure was being placed on care homes that did not want to take part in research. Inclusion and exclusion criteria for care homes were created in line with the study's sampling strategy, and these criteria were given to ENRICH to establish a list of eligible care homes. The criteria can be viewed in Table 3.1.

Table 3.1. Inclusion and exclusion criteria for care homes

Inclusion or exclusion	Criteria
Inclusion	• The care home is located in the Scottish Central Belt • The care home is registered as providing care for older people with the care inspectorate
Exclusion	• The care home's manager does not consent to the participation of the care home • The care home is located outwith the Scottish Central Belt

ENRICH returned a list of 14 care homes for older people across the central belt. The data included the address of the care home, ownership of the care home (private, local authority etc.), the manager's name and contact details, the number of residents and its registered care services (dementia, cancer, etc.).

Of the 14 care homes, 12 were contacted initially, and two were kept in reserve due to the distance it would take to travel to these care homes. However, these were never contacted due to the successful recruitment of other care homes. The 12 selected care home managers were contacted to discuss their potential involvement in the study. These care home managers were given an information sheet about the study (Appendix 2), and were given time to ask questions about what the study would entail.

Of the 12 contacted, two managers chose not to participate from the start due to the workload of the care homes, three others suggested that they were over-worked and asked whether I could attempt to recruit other care homes first before returning to their care home (because of the success with the recruitment of other care homes, I did not need to approach these care homes again). Thus, in total, seven care homes agreed to participate in the study (Table 3.2). These were situated in a variety of areas in the Central Belt, over different SIMD levels.[1]

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[1] The Scottish Index of Multiple Deprivation (SIMD) ranks small areas (called data zones) from the least deprived (level 10) to the most deprived. For more information on how the scale is made please consult here: https://www2.gov.scot/Resource/0050/00504809.pdf

Table 3.2. Care home sample

Care Home	SIMD	Size (no. of beds)	Wider Area
1	7	68	Greater Glasgow
2	9	35	Lothian
3	6	62	Lanarkshire
4	5	80	Lanarkshire
5	10	35	Lothian
6	9	63	Lothian
7	1	66	Greater Glasgow

3.2.2. Sampling of residents

Before research commenced, many managers wanted to inform visitors, staff and residents that the care home was participating in the study. In three care homes, I was invited to attend a 'relatives' meeting', which was a meeting of visitors and select staff where any changes or events in the care home would normally be discussed. At these meetings, the aims and methods of the research was explained, and all were given the opportunity to ask questions. These meetings included a very select group of people (usually dedicated volunteers and new visitors who wanted to know more about the care home). This meant that the meetings never included all of the next of kin for the residents who would eventually participate. While managers included a description of the research in the meetings' minutes so that other visitors and staff, who could not attend, could be informed via email or a newsletter, these might not have been read by all relatives.

In other care homes, staff and visitors were informed about the study through newsletters, or in staff meetings. Therefore, when approaching potential residents, an information sheet was left with the resident for families to read in case they wanted to contact me. Further, it was clear that many staff were not informed of the research, as I was often approached by care home staff who asked, 'Who are you?' and 'What are you doing here?' In these situations, I explained the aims of the research to the staff and invited them to ask questions. All staff members were happy with this explanation, especially

when it was mentioned that the managers, other staff and the families of the residents were aware of the ongoing research.

Managers were given the inclusion and exclusion criteria for residents (Table 3.3). Care home managers had different approaches to identifying residents who could potentially participate in the study. Some managers prepared a list, consisting of residents they believed would be able to participate before the first care home visit, and other managers provided a full list of all residents and room numbers on arrival, allowing me to talk to all residents. Additionally, some mangers indicated the residents who would definitely not be able to participate in the study on arrival.

Table 3.3. Inclusion and exclusion criteria for participants

Participants	Inclusion or Exclusion	Participants
Residents	Inclusion	• Residents must have the capacity to consent to the study • Residents will have to be able to speak and understand English • Residents must be living in a care home within the care homes sampled
	Exclusion	• Residents who have the inability, or loss of ability, to provide informed consent at study outset.
Staff	Inclusion	• Staff must be working in a care home which is part of the study • Staff must be able to give informed consent
	Exclusion	• Staff without English language skills
Visitors	Inclusion	• Visitors must be a visitor of a resident who is participating in the study • Visitors must be able to give informed consent
	Exclusion	• Visitors without English language skills

All managers were asked not to ask residents if they wanted to participate before I had initially met with the resident. This was to ensure that they were being given the choice to participate, and also to ensure that they could consent to their participation. However, despite asking this of care home managers over the phone and in emails, this was not adhered to in two care homes. In these cases, it was made clear with residents that this was a voluntary activity and they did not need to participate if they did not want to, even if they had already agreed to participate with the manager. Further, they were informed that it would not affect their care in any way if they did not want to participate. In other care homes, I approached all the residents to whom the manager provided access for an initial meeting.

In the initial meeting with residents, a Mental Capacity Assessment (MCA)[2] was carried out to ensure that they had the capacity to consent to their participation, and thus adhered to the first criteria of the exclusion and inclusion criteria.

The process for the initial meeting for recruiting participants, and the MCA, was as follows; invite resident to come talk to me (usually in a private lounge, or if appropriate, in their bedroom), have a short conversation about their day (to gauge whether they were situated in time and place), explain what the research was about and its purpose, ask them what they think the research is about (to gauge whether they could retain information about the research), invite them to ask any questions about the research (ensuring that they were able to process the information and make an informed decision), and, finally, gauge whether they might be interested in participating. This process allowed me to explain the research, gauge whether they would be interested in participating, whilst also carrying out a mental capacity assessment. This is a validated method for assessing mental capacity approved by the Social Care Institute for Excellence. This is detailed in the Mental Capacity Protocol in Appendix 3, which was used as a guide in the meeting. Simultaneously, during the initial meeting, I would be trying to gauge whether the resident would like to be part of the study.

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[2] Social Care Institute for Excellence (SCIE) and Continuing Professional Development (CPD) accredited training to carry out mental capacity assessments was completed by Jennifer Ferguson. Information on the training can be sought at: https://www.scie.org.uk/e-learning/mca

Where the manager had provided a list of all residents, many more Mental Capacity Assessments were carried out in the care home, but this also meant that most people were given an opportunity to be part of the study if they had the capacity and agreed to be part of the study. Table 3.4 shows the breakdown of how many people I had an initial meeting with mental capacity assessment included.

Table 3.4. Reasons for inclusion or exclusion of residents

Care Home Number	Initial meeting and MCA	Declined	Without Capacity/ loss of capacity	Not Well/ dropped out due to illness	Agreed with Capacity
1	8	1	1	0	6
2	25	4	13	2	6
3	9	3	1	0	5
4	19	3	10	1	5
5	19	6	3	2	8
6	4	0	0	0	4
7	3	0	1	0	2

If the resident did not have the capacity to consent, they were not asked whether they wanted to be part of the research at the end of the initial meeting. They were told that they might see me in the care home and if they wanted to say hello, they could. I would usually carry on a short conversation with them and then suggest a walk to a lounge (where they could get a cup of tea), back to their bedroom or sometimes the resident would indicate that they wanted to leave themselves. All residents were met with a staff member or escorted back to their bedrooms after the initial meeting.

If the resident did have the capacity to consent, they were given an information sheet to take away. Each resident was told that I would be back to visit them and, if they would like to participate in the study, they should indicate this at the next meeting, which was always *at least* a day afterwards to allow the resident to read the information sheet or tell a loved one that they might participate. Some residents, who had the capacity to consent, did not want to participate, and in this case they were thanked for their time and told that

they might still see me visiting other people in the care home, but that they would not be bothered about the study from now on. A breakdown of all the residents considered in each care home is presented in Table 3.4, including the reasons why they were included or not included in the study.

Residents who did want to participate and had the capacity to consent, were asked to either sign a consent form or audio record their consent at the following meeting. The sampling technique outlined resulted in 36 residents being recruited across seven care homes. The spread of residents sampled over the seven care homes can be seen in Table 3.5.

Table 3.5. Number of residents, staff and visitors sampled per care home

	Care Home Number						
	1	**2**	**3**	**4**	**5**	**6**	**7**
Residents	6	6	5	5	8	4	2
Staff	3	2	4	3	3	2	3
Visitors	1	3	3	0	4	2	1

3.2.3. Sampling of visitors and staff

Visitors and staff were only approached after the majority of resident interviews within the relevant care home had taken place, so as to identify which people were important to the residents before interviewing. It was important to seek consent from the residents before I approached anyone in their network. At the start of the resident interview, residents were asked whether there was anyone in their life that they would *not* like me to contact, and again, at the end of the interview, residents were asked whether they would be happy for any people who they had mentioned in the interview to be contacted. When a resident mentioned someone who they did not want me to contact, this was noted on their consent form and these people were never contacted.

A staff member from the management, and at least two staff members who worked 'on the floor' of each care home were selected for interview. These staff members could have been nurses, carers or activity co-ordinators. If a staff member was named directly by a

resident, I attempted to interview them, however, this was not always possible due to the staff being busy, or not being at work on the day I was there. Of the staff who were available, I asked the manager who would be available to interview, or co-ordinated with staff to set up an interview date in the future.

Visitors were more difficult to contact as their details needed to be obtained through the care home, or through the resident. Firstly, the permission of the resident was always sought to contact these people, as the reason they were being sampled was because they were connected to the resident and provided them with support (as explained in Section 3.3.2 below). After permission was given, I would try to contact the visitor, either through contact details given by the care home, through the contact details given by the resident, or through seeing the visitor in the care home. Not all visitors responded, and some visitors did not have the time to meet. Efforts were made to get in touch with one visitor per resident, however, this was restricted, as most of the time I had to ask the care home for the contact details, and this was nearly always the next of kin. Therefore, the sample of visitors was mostly restricted to the next of kin. However, this was almost always the person who knew the resident best and gave them a lot of support. Once contact was made, a suitable time and place was set up for the interview.

Staff and visitors who were interviewed were not told whether they had, or had not, been nominated in a resident's personal networks to ensure that the information given to me in the interview of the ego was kept confidential.

Furthermore, interviews with staff and visitors were only carried out if they fulfilled the inclusion/exclusion criteria (Table 3.3). The sampling technique outlined above resulted in 14 visitors and 20 staff being recruited to the study, details of which can be viewed in Table 3.5.

3.3. Data collection

As mentioned previously, interviews were used as the primary tool of data collection and were conducted with a number of different participants (residents, staff and visitors). Resident interviews contained multiple components. The following section will describe

the data collection tools used, as well as some of the methodological challenges that arose from this process.

3.3.1. Interviews with residents

Interviews with residents not only aimed to collect demographic and wellbeing data from residents, but also network data on who supported them and how residents used these networks. By collecting network data, I was able to build an understanding of what support and resources a resident may have access to, and by collecting qualitative data about these connections, I was able to produce a narrative around how residents use these ties. Thus, the research is considering both the individual's perspective on their support network and the structure of the network itself.

Semi-structured interviews with residents consisted of 5 parts;

1. Demographic Data
2. Wellbeing Measure
3. Egocentric Networks with Name Generators
4. Qualitative Network Data
5. Subjective Memory Assessment

This interview was never completed in one sitting, as residents and researcher would become too fatigued to complete this interview at once. The interviews were normally split into two parts; the first interview consisting of consent, demographics and wellbeing, and the second interview featuring the collection of network data and description of relationships. However, some interviews were carried out over three or four sittings. Breaks between interviews lasted between a day to a week. The first interview would consist of signing the consent form (or verbally agreeing), and collecting demographic and wellbeing data. The second interview would then encompass all of the network data, which was advantageous, as the resident did not need to remember any details from the first interview. Residents were informed from the start that the interview would be split into two parts and would require multiple visits, and all agreed to this.

3.3.1.1. Demographic data

The demographic questions included; age, gender, funding category (social class proxy) and length of time in care home (important for establishing how much time they had had to make friends and create a network around them in a new home). These questions are listed in the Resident Interview Topic Guide (Appendix 4).

3.3.1.2. Subjective wellbeing measure

To gauge the wellbeing of the resident, a wellbeing survey tool was used during the interview. Wellbeing was measured through Vanhoutte and Nazroo's (2014) model of subjective wellbeing which includes three facets of wellbeing which are established in the theoretical and methodological literature. Figure 3.1 outlines the three main components of subjective wellbeing and how they are measured in this study.

Figure 3.1. Subjective wellbeing and measures
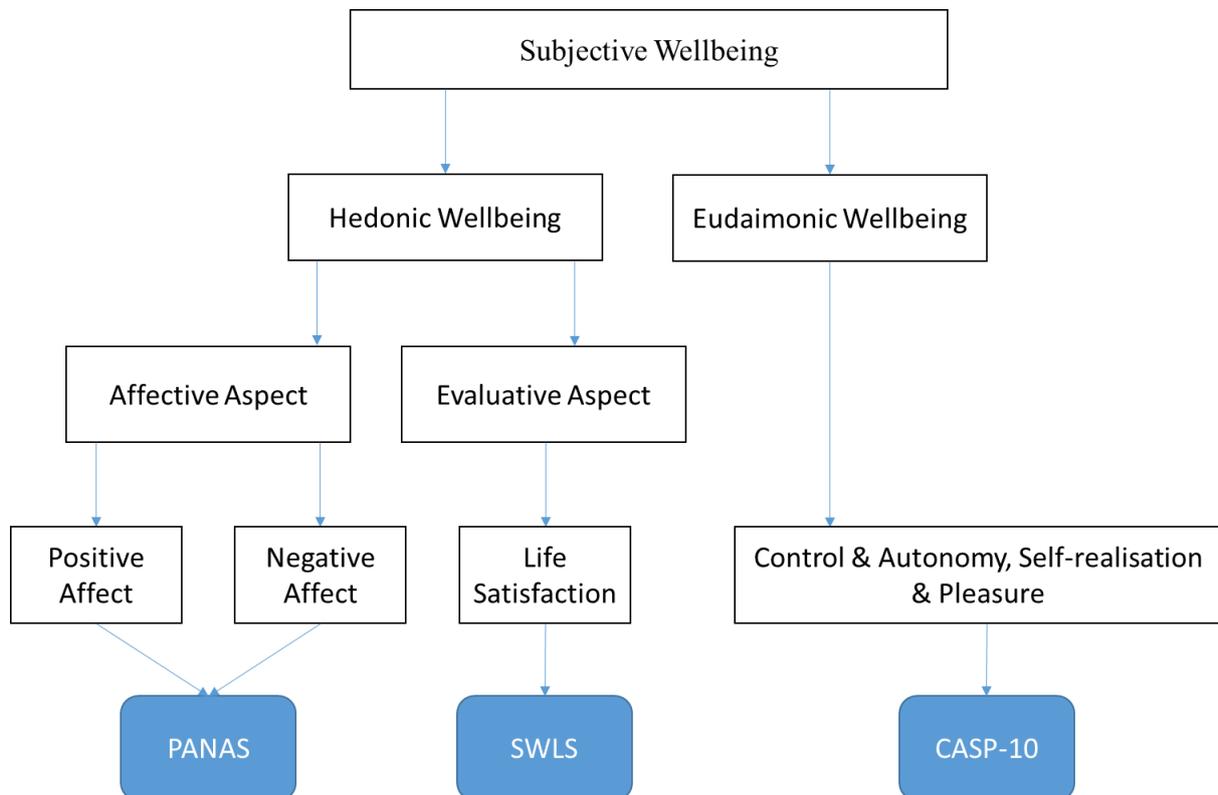
The three components of subjective wellbeing include;

The affective aspect of hedonic wellbeing

The Positive and Negative Affect Schedule (PANAS) was designed to measure both Negative Affect (NA) and Positive Affect (PA) components of the affective aspect of hedonic wellbeing (Watson *et al*. 1988). Further, the measure has also been shortened to a 10-item scale which has been shown to be appropriate and valid for older populations (Kercher 1992).

The evaluative aspect of hedonic wellbeing

The evaluative aspect of wellbeing is measured through life satisfaction, and one such measure used is Diener *et al*.'s (1985) Satisfaction with Life Scale (SWLS). Diener *et al*. (1985) developed the SWLS; a 5-item index on a 7-point scale from 1 'strongly disagree' to 7 'strongly agree', which asks respondents to rate their global life satisfaction.

Eudaimonic wellbeing

Researchers looking at older populations often use the concepts of Control, Autonomy, Self-realization and Pleasure (CASP) to measure an older person's eudaimonic wellbeing (Hyde *et al*. 2003; Jivraj *et al*. 2014; Vanhoutte and Nazroo 2016). CASP has been designed as a 19-, 15-, and 12-item scale (Hyde *et al*. 2003; Wiggins *et al*. 2004; Wiggins *et al*. 2008; Vanhoutte 2012) which measures eudaimonic wellbeing through these four concepts (Hyde *et al*. 2003). The 10-item scale is a newly formed scale which captures the four concepts within CASP and, due to the nature of the sample in this study, the 10-item scale was used for brevity.

Capturing these three facets of subjective wellbeing allowed the construction a wellbeing score which meant that residents with higher or lower wellbeing could be identified. These measures were selected, not only because they measure the appropriate facets of subjective wellbeing, but also for their brevity, and because they measured the three facets separately, they measured each facet with multiple questions and because of their appropriateness for use with older populations. As the sample of older people would have likely been frail and could potentially become fatigued quickly, it was important to keep the scale brief and ensure that it was appropriate for use with older people. Further, it was important to measure each facet individually, as the literature suggested that these facets may be affected differently in later life (Jivraj *et al*. 2014). For example, evidence

suggests that overall satisfaction with life becomes more positive as we age, although, objectively, circumstances may be worse (Ryff and Keyes 1995), whereas eudaimonic wellbeing may have more negative outcomes, as potential declining health in later life may act negatively on a person's feeling of control (*ibid.*). Therefore, by measuring each facet individually, these differences in each facet could be captured.

Other measures considered

Other measures, which matched the above criteria, were also considered, however, these were deemed not appropriate for a number of reasons. Both the Center for Epidemiologic Studies–Depression (CES-D) scale (Radloff 1977) and the General Health Questionnaire (GHQ) (Goldberg and Williams 1988) measurements of hedonic wellbeing were dismissed because they only measured the NA aspect of affective hedonic wellbeing, and not the PA aspect. Therefore, this would require a further measure of the PA aspect of hedonic wellbeing and therefore would be more time-consuming. Further, the Psychological Well-Being (PWB) (Ryff and Keyes 1995) and the Self Determination Theory (SDT) (Ryan and Deci 2000) scales were dismissed because their questions did not measure the 'pleasure' aspect of eudaimonic wellbeing. Vanhoutte (2012), and Ryan and Deci (2001), in a review of research on hedonic and eudaimonic wellbeing, argued that pleasure is an essential product of the fulfilment of needs, which is captured by eudaimonic wellbeing. Consequently, PANAS, SWLS and CASP-10 were chosen as the measures of the affective hedonic, evaluative hedonic and eudaimonic wellbeing, respectively, because they satisfied the criteria outlined.

3.3.1.3. Egocentric networks with name generators

As part of the interview, respondents were asked about the people who support them on a day-to-day basis, and whether those people knew one another. This allowed the visualisation of what a person's personal support network looked like and thus construct an ego-centric network (ego-net) for each resident. An ego-net starts with an individual (the ego) and their social connections to other people (alters). Furthermore, "it involves all other actors (alters) with whom the ego enjoys a specific type or types of tie (e.g. emotional closeness, information sharing) and all relations (of the same type or types)

between those alters" (Crossley *et al.* 2015, pp. 1–2). Therefore, an ego-net shows what connections a person has, and how they might utilise these ties.

Ego-nets can come from the standpoint of the individual and this can lead to the exploration of multiple social circles (Simmel 1955) and social domains (White 2008). Ego-net analysis allows the exploration of the ego's membership of multiple groups and therefore give a better representation of the multiple sources of resources that an ego can draw on (Crossley *et al.* 2015). This is especially important in this study because the resident may have ties to domains other than the care home. By moving outwards from the ego, the process used in this study highlighted different social circles in which the ego was connected and compared the different social domains that different residents were connected to. This allowed me to explore who had the potential to gain access to certain support, resources and information, which lie beyond the care home.

Ego-nets were created through name generators and visual aided methods. A name generator is a tool which asks respondents to nominate alters within their network (Robins 2015). A name generator usually involves three elements (Agneessens 2006):

1. Alters: the name generator collects information on ego's relevant alters
2. Structure: it collects information about relationships between these alters
3. Alter Attributes: it collects demographic information about alters

This information establishes the structure of an ego-net and means that, not only can a visualisation of this ego-net be produced, but also a sense of how connected and supported an ego is could be gained.

A 'Fischer approach' was used to collect ego-net data (Fischer 1982; McCallister and Fischer 1978). This approach is intended to highlight different supportive alters, who may offer different types of support to the participant. This type of approach leads to more clarity within the sample as the types of exchanges and support can be predefined and are less likely to be interpreted differently across the sample (Bailey and Marsden 1999). As the study is using a definition of support from the work of House and Khan (1985), as discussed in Section 2.3, the name-generator questions ask about informational, emotional and instrumental supports provided to residents. McCallister and Fischer

(1978) argue that people who provide regular or daily support can be considered an important subset of actors within an ego-net, however, they can also be over-emphasised in the network. Thus, by asking about different means of support, it could be established who in a person's network they rely on for particular resources or support, regardless of whether the ego is emotionally close to them. In this study, name-generator questions were restricted to five people per question so as to limit respondent fatigue (Abbott *et al.* 2012) and to therefore ensure that the respondents were able to fully participate in the description of their network. The following name-generator questions were used;

1. From time to time, most people discuss important personal matters with other people. Who are the people with whom you discuss matters that are important to you? (Kogovsek and Ferligoj 2005)[3]

2. From time to time, people socialise with other people, for instance, they visit each other, go out for an outing or for a meal. Who are the people you really enjoy socializing with? (Kogovsek and Ferligoj 2005)

3. From time to time, people ask other people for advice when a major change occurs in their life, for instance, a change in location or a serious accident. Who are the people you usually ask for advice when such a major event occurs in your life? (Kogovsek and Ferligoj 2005)

4. Could you name anyone who has provided you with help recently? (Abbott *et al.* 2012)

5. Please list anyone who is especially close to you who you have not listed in one of the previous questions. (Marin and Hampton 2006)

Each name-generator question was assigned a colour of post-it (e.g., Question 1 was assigned green post-its) and the alters nominated for that question were recorded by writing their name on the post-it of that colour. If an alter was nominated for multiple name generator questions, then the assigned coloured post-its were placed below the initial post-it with their name on it. After the names of alters had been established, I would

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[3] Although this name generator question is widely used, it must be noted that it has received recent criticism in Small's (2017) work in which he describes how although this question may collect data on strong ties, it does not explain why people may confide these important matters to strangers. Small (2017) purposes that this phenomenon may occur because when someone has an issue in their life, it quite often involves those closest to us. Therefore confiding in strangers gives the advantage of relieving ourselves of emotionally taxing burdens without the consequence of judgement or influence of those closest to us.

write the name of the resident on a different coloured post-it and place them in the centre of the target (i.e., concentric circles initially introduced by Kahn and Antonucci 1980). The target (Figure 3.2) was used to establish how close the ego felt to each of the nominated alters, which allows the exploration of whether residents are gaining support from closer or less close ties. Respondents were asked to place their alters on the target, with the alters the respondent felt closest to being placed on the inner concentric circles and those he/she felt less close to being placed on circles further out.

Figure 3.2. Target
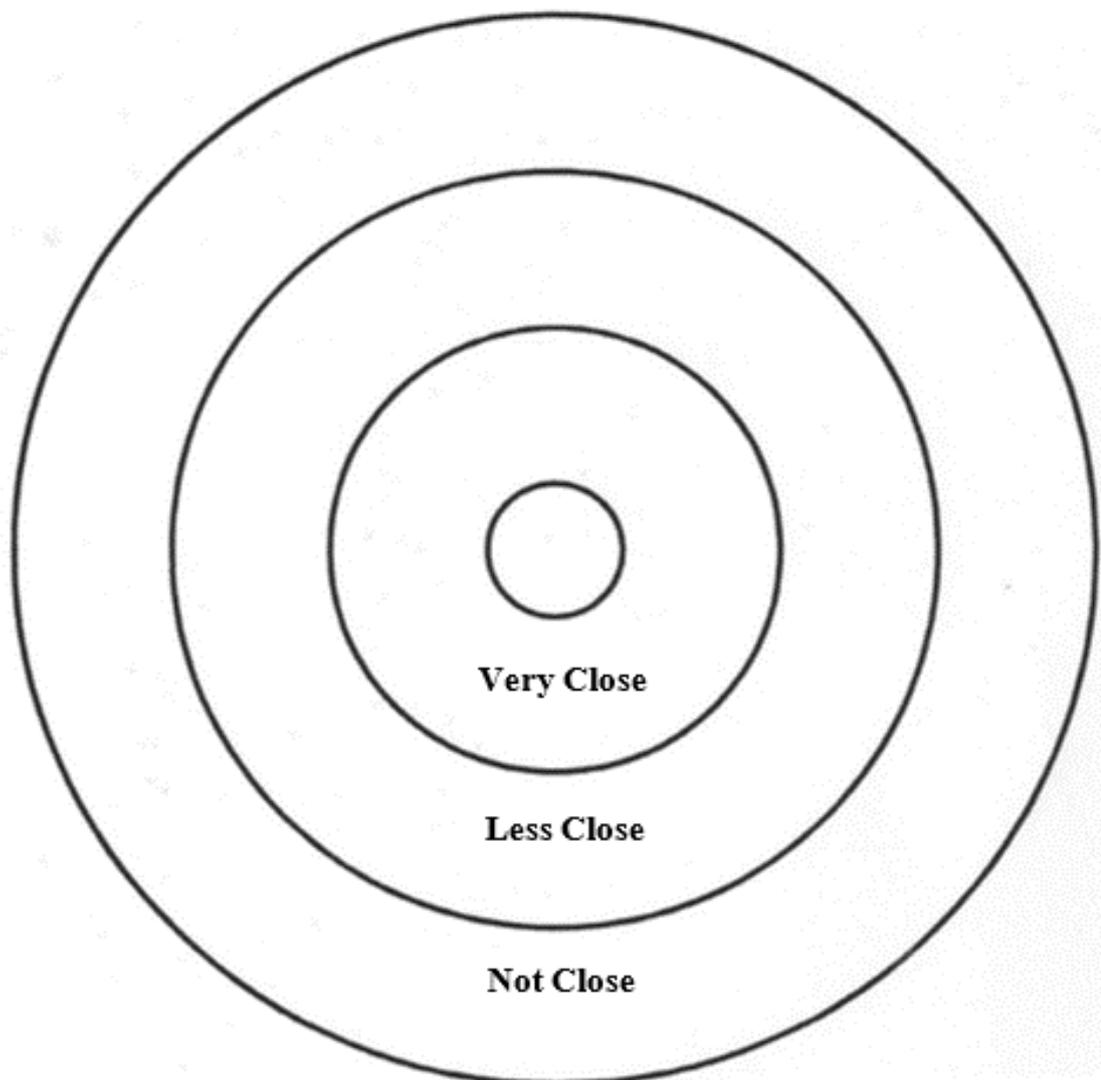
Although this technique was important for establishing who the ego was close to, the placing of certain alters became emotionally problematic for some residents. Dobbie *et*

al. (2018) describes this as 'problematic positioning', where participants may feel uneasy about placing alters in certain positions over others. During the data collection for this study, some residents found it difficult to position people who had been close to them in the past, or perhaps felt that they should be close to, but were not. For example, one resident felt guilty over positioning one daughter closer than another. This was also common among other residents who had maybe grown estranged from some people who had once been close to them at some point in their lives. The process of going through the name-generator questions and asking respondents to place their alters on an A3 board meant that often I was involved in the problem solving of where to place alters and how to justify their position, and so, often I was used as a sounding board in the placement of alters.

Hogan *et al.* (2007) advocated for the use of paper, pens and post-it notes in the target data collection process. They suggest that, as the respondent is naming alters and placing them on the target, the respondent is more likely to give extra information about alters more naturally, and without prompting. They claim that in their own research the participants had a lot of fun by placing their alters on the target, and in getting creative, especially when compared to traditional name generators. In the present study, it gave the participants insight into their own personal networks, but it also allowed egos to produce reliable structures as it gave them a more holistic view of their relationships. In Hogan *et al.*'s (2007) study, using paper, pen and post-it notes was less intimidating for those who did not like computers, or might have been overwhelmed with lots of questions concerning the attributes or closeness of their alters.

The data collection in this study benefitted from having a process which was not computer-based. Some of the residents were accustomed to computers, tablets etc. However, it was clear that many were not. Further, getting a laptop or tablet screen that was big enough to accommodate the eyesight of some of the residents would have been difficult. Although most residents found the big, clear board helpful, it was clear that a minority of the residents found the big board, colourful post-its and pens slightly patronising. When faced with this situation, I explained that it was for the benefit for other residents who may have eyesight problems, but this did mean that the rapport with these residents did need extra work and effort whilst carrying out this part of the interview.

Residents *did* want to give more detail as alters were placed on the target and they often elaborated on why they were placing certain alters in one place and not the other. Some even started telling stories of how some alters had 'gone the extra mile' for them, or how some alters had not, even though the resident felt they should have. Additionally, many residents enjoyed seeing their support network as a whole; but, for some residents, this activity was not as enjoyable. However, some residents had very few alters who supported them and, when they had finished placing the one or two alters they had nominated, the starkness of the board acted as a reminder of the lack of people in their lives. For some this was because they were a self-labelled 'lone wolf', but for others this was a reminder of people who had passed away or friends they had moved away from for the support of closer family. This finding is discussed in further chapters, but should be noted for other researchers exploring the social networks of more vulnerable groups in the future.

Overall, the paper, pens and post-its method was a good choice for collecting network data and worked well with a sample who had varied physical and cognitive ability to engage with the method. However, as noted, there were issues that arose from this data collection method that were emotionally taxing on the participants.

3.3.2.4. Qualitative network data

Following the quantitative network data collection, residents were given the opportunity to talk about their network more openly, if they had not already done so. Residents were asked questions about why certain alters had been placed where they were or what type of help certain alters gave. Other questions tried to gauge what the relationship was like between the resident and the nominated alter. The topic guide asked questions of all the types of ties: Family, Friends, Staff, and Others, and prompted discussion about why they would go to certain people for support and in what capacity they would see that person. For a full description of the Resident Interview Topic Guide which informed some of these questions please see Appendix 4.

3.3.2.5. Subjective memory assessment

The final part of the interview was a subjective memory assessment, where I assessed whether the resident had memory problems. This information was recorded in this way for a number of reasons. Firstly, Abbott *et al.* (2015) showed that the cognitive function of older people living in assisted living accommodation affected the support network of the person. Therefore, knowing whether an older person has memory problems is important to this study as it may affect the personal network of the individual.

However, it is well documented that diagnosis of dementia in care homes is not consistent and, therefore, accessing medical records would not be helpful in this study as some residents may not have been assessed for dementia or memory problems. Further, asking the resident whether they have memory problems may also be problematic for a number of reasons. Firstly, not all residents will be comfortable with the question, and they may become upset if they are asked if they have memory problems or dementia because of the stigma associated with dementia (Herrmann *et al.* 2018; Hellstrom and Torres 2013). Further they may not know whether they have been assessed for dementia in the time that they have been in the care home. Also, by asking this question, it may compromise the researcher/participant relationship that has been built up, because the participant may feel that they are now labelled as having dementia/memory problems. After consultation with colleagues in the care home industry and fellow dementia researchers, a decision was made that a subjective memory assessment would be the best way to assess memory problems rather than;

- Relying on inconsistent diagnosis of dementia in medical records by consulting the medical records of residents, of which, many residents may not have a diagnosis, or may have a diagnosis that is out of date.
- Risk upsetting the resident and compromising the researcher/participant relationship by asking the resident about their dementia diagnosis.
- Risk obtaining inconsistent evidence of memory impairment by asking the participant whether they think they have had any memory loss, as some people with memory loss may not want to disclose their memory loss due to the stigma surrounding dementia or they may not consider themselves to have memory problems (Abdulrab and Heun 2008).

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- Risk inconsistent assessments of which residents have 'memory problems' by staff from different care homes who may have different definitions of what memory problems are, including associating this with a diagnosis of dementia.

By carrying out a subjective memory assessment, memory problems were assessed consistently across the sample of participants and between care homes without risking the researcher/participant relationship. Memory problems were assessed by noting whether the resident had;

1. Very few problems remembering details, names, places and times.
2. Many problems remembering details, names, places and times.

3.3.2.6. Last meeting

At the final meeting, it was explained to the resident that this was the final meeting and discussed how the data collection would help the research. I then allowed the participant time to discuss any remaining questions or thoughts on the research and, if appropriate, stayed to have a cup of tea with the resident. The participant was presented with a thank-you card, which acted as a gesture of appreciation, and a physical prompt to aid the participant in remembering that the data collection stage of the research was over. This meeting usually happened on the last day that I was present in the care home.

3.3.2. Interviews with visitors and staff

Visitor interviews were used to explore their relationship with the ego, what they did with their loved one and how often this occurred. Furthermore, it was important to ask who they thought their loved one relied on and for what purpose they relied on them (i.e., for gaining resources and receiving emotional support). They were asked what they thought the care home did to support their loved one, and how they thought staff helped to improve the wellbeing of residents. Overall, these interviews helped contextualise the personal network of residents, and provided more information about how the residents utilised their organisational ties, as well as other important ties.

Similarly, interviews with staff were used to investigate their perceptions of their interactions with residents and visitors, as well as what measures they put in place to improve residents' wellbeing. A particular emphasis was placed on which other organisations were used to help the running of the care home, and what resources the care home received from these external parties to improve wellbeing. These interviews were used to help understand interactions and activities that had been discussed by the residents and sometimes the visitors of residents. Thus, interviewing staff aided the understanding of the running of the care home and how different relationships between staff, visitors and residents may benefit a resident's wellbeing. For a full interview topic guide of staff and visitor interviews please see Appendices 5 and 6.

The interview data included approximately 150 hours of audio recordings from residents, relatives and staff members. Resident and family interviews were manually transcribed by Jennifer Ferguson, while staff interviews were transcribed by an approved company.

3.4. Ethical approval and considerations

Ethics approval of this project was granted by the University of Stirling General University Ethics Panel on the 15th January 2018 (Appendix 7). The ethics approval process was extensive and included a detailed description of my methodological choices whilst providing all relevant documentation (e.g., consent forms and information sheets). The ESRC (2015) 'Framework for Research Ethics' was consulted throughout the design of this project. At this stage, it is important to highlight a number of key ethical considerations.

3.4.1. Informed consent

In particular, it is important to discuss the process that I followed to ascertain whether a person had the capacity to consent to the research, gaining informed consent and how consent was maintained throughout the research.

Given that this study attempted to represent the views of care home residents, of which a large percentage had dementia, it must be highlighted that there is a body of literature

that documents the fact that people living with dementia are largely excluded from research (Moore and Hollett 2003; Hellström *et al.* 2007; Sherratt *et al.* 2007; Dewing 2007). People living with dementia are already one of the most excluded groups within society (Dewing 2002; Wilkinson 2002), thus, it is argued that to exclude them from this study would have been unethical. Moreover, it is argued that a better understanding of the social networks of all residents would aid care homes to better support these residents. However, due to the time constraints and research design of this project, it was concluded that involving people who were not able to give fully informed consent was not possible in this project.

3.4.1.1. Establishing capacity to consent

To ensure that only people who could give informed consent were included, I attended Mental Capacity Assessment Training to ensure that it was fully understood how to assess whether a person had the capacity to understand, process and consider the information that was being given to them. The training provided was for practitioners as well as researchers, and therefore gave multiple examples of how capacity could be assessed in multiple scenarios. However, it also gave very clear guidelines of what evidence is needed to be given by the participant for the assessment of whether they had capacity or not. This training meant that I felt confident in assessing a person's capacity, and in ensuring that the people who were included in the study had the capacity to give informed consent.

3.4.1.2. Gaining informed consent

Information sheets and consent forms were produced for all participants involved in the study (examples in Appendix 2 and 8). Separate information sheets were made for residents, staff and visitors. These information sheets were disseminated at meetings with participants. Resident information sheets were designed to be accessible to those with diminished cognitive capacity and eyesight. Time was allowed (at least one day) for the resident to process the information and discuss it with others, if they wished to do so.

After gaining permission from the resident to contact people in their network, staff, family and friends were contacted and I discussed the main aims of the study with them. They were given an information sheet explaining the study and time to discuss their involvement with others if they wished to do so before gaining informed consent.

3.4.1.3. Maintaining informed consent

It is also important to highlight that capacity was revisited during the research process, if it was felt that the participant lacked capacity at that time. Consent is an ongoing process within research and, therefore, throughout the study the principles of process consent were used to ensure the respondents were at ease with their participation (Dewing 2007). I noted before entering the interviews that a person might show signs of discontent through frustration, unhappiness, passivity and discomfort (Slaughter *et al.* 2007) rather than communicating directly that they did not want to continue with the interviews. Capacity was revisited on a number of occasions during the research. On two occasions, the threshold for capacity was met in the initial interview with participants, however, at further meetings, it was clear that the residents concerned did not have the capacity to consent. Both participants had fallen ill for different reasons between the initial mental capacity assessment and the start of the interviews, which likely meant that their capacity had been affected. I met with both participants again to see whether they had regained capacity, however, after two attempts (first at the meeting where illness had been identified, and second at the meeting to see whether the illness had subsided) it was deemed that it would be unethical to proceed. In this case, the participants were told that they would no longer be part of the research. In both cases, I was surprised that this was not a difficult conversation. Both residents knew they were ill and were content not to proceed any further.

3.4.2. Anonymity

Given that the study involved multiple egos and alters, some of whom lived and worked in the same care home, it was important for this study to take measures that would preserve confidentiality.

As recommended by Robins (2015), after the network data were collected from each respondent, the ego, and nominated alters were given participant ID codes (for example, 39018). These ID codes were used in all recording of network connections and databases. However, a document was saved in a separate space, without the network data, with the record of which ID corresponded with which ego and their demographic data, and again

another file was kept for alters. Although data visualisations do not have names or identities labelled, they may be labelled with their role, gender or relationship to the resident, for example, with 'Staff Member', 'Child', or a pseudonym. The identity of the care homes was also protected with pseudonyms and any identifying information was withheld.

3.4.3. Gatekeepers

Gatekeepers are key personnel who hold the power to grant or withhold access to the setting (Hammersley and Atkinson 1983). This project negotiated with three types of gatekeepers; ENRICH, care home managers and families/next of kin.

Care homes were accessed through the ENRICH network (ENRICH is described in Section 3.2). ENRICH required the project to have University ethics approval before granting access to care home details, however, once approval was received, they were very supportive in helping me gain access to care homes.

Once I had contacted the care homes, care home managers had the power to deny me entry to the care home. Overall, five care home managers denied entry for multiple reasons (see Section 3.2.1). The care home managers were thanked for their time, and a note was kept, indicating that they were not able to participate. Seven managers granted access to their care homes, however, once access was granted to the care home, I then had to negotiate access to particular residents with the manager. Varying levels of access to residents was given via managers, as discussed in Section 3.2.2.

Lastly, families were considered gatekeepers, even though the residents were deemed to have full capacity. In advance of the study, the stance was taken that, if a family member did not want their relatives to participate in the study, but the resident did want to participate, the family member's perspective would be brought into consideration. However, this would not automatically exclude the resident from participating, and, as all participating residents gave informed consent, it is likely that the resident's wishes would be upheld. In practice, there was no instance where the resident wanted to be included, but the family did not wish them to participate. However, there were occasions where residents did not want to participate unless their families approved. On a number

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of occasions, the family agreed to their participation, and so the residents were happy to be included. However, on one occasion, the family did not agree and the resident therefore did not want to participate.

3.4.4. Data Security

All data collected were kept securely stored on password-encrypted computers to which only I had access. Any notes, and/or paper copies of transcripts were kept securely in a locked cabinet only accessible by me. All relational data had identifiable names removed and replaced with alter and ego IDs for further protection of the participant's identity. Any data files that had identifiable characteristics were individually password protected.

3.4.5. Reflexivity

Influence of the researcher

At the research design stage, I was aware that the researcher can, in many ways, influence their participants. As Finlay (2002) suggests "Research is […] regarded as a joint product of the participants, the researcher, and their relationship". Specific to this project, I took steps at the research design stage to minimise my influence, in particular at the data collection stage. For example choosing to use validated data collection tools, such as Vanhoute and Nazroo's (2014) wellbeing measure and Hogan *et al.*'s (2007) target method. This helped limit my influence because I was asking each participant the same questions. I believe my influence was reduced as I felt that resident felt they were able to speak freely and discuss which types of support they found most important (e.g. the value of emotional support from family and friends).

However, in this project specifically, my presence as a young, busy researcher who was not restricted by the rules imposed by the care home created a power dynamic between some residents and myself. This was particularly apparent with residents who had a terminal illness, or were very lonely and socially isolated. On reflection, I believe my presence partially influenced the data because some residents would try not to dwell on how they felt about not having regular contact with friend and family. With these residents I tried to negate this factor by spending more time building rapport with them

before the data collection started, in order to make sure they felt comfortable talking to me about their concerns during the interview. Despite this, I believe I took every precaution to try to minimise my influence without harming the trusting relationship I built with participants.

Safeguard for respondents

A number of safeguards were put in place to make sure that any risk to participants was reduced. In particular I restricted the length of interviews to reduce fatigue and made sure that the resident understood that they could stop or pause the interview at any point. I also gave all residents external support sheet which signposted places for support such as 'Alzheimer's Scotland Helpline', 'Action on Elder Abuse Helpline' and 'The Care Commission' on an information sheet. Further to this I planned that if I observed any bad or abusive care in the care home then I would first have to report this to the care home manager and then the local authority. The participants were told at the time of consent that if they report such harm then I might need to tell someone.

Safeguards for researcher

I made extensive plans at the research design stage to protect myself as a researcher. The majority of interviews were carried out in the care homes, however some relative interviews were carried out in their private homes. On these occasions I would send the address of the interview to another person who was told to follow up with me and my supervisors if I did not make contact with them after three hours.

However, perhaps the most likely risk to myself as a researcher was emotional, as I would be talking to older people who were perhaps unhappy and may pass away during the research. Before the data collection started I made a list of possible places I could receive support, including student support services. Although, on reflection, my biggest support was my family and friends. This became especially apparent when three of my own grandparents died (one of which was living in a care home) only six months before data collection was due to start. Keeping in contact with family and discussing my concerns was imperative to maintaining my own mental health and wellbeing throughout the project.

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3.5. Data analysis

This thesis uses a mixed-method design which yielded a range of data types. The analysis uses relational network data and qualitative interview data from multiple respondents. The following methods of analysis were used; egocentric network analysis (a type of social network analysis), descriptive statistics, and a critical realist approach to qualitative data analysis. As Crossley and Edwards (2016, p. 6) argue:

> *the quantitative techniques of SNA are crucial for identifying and measuring the properties of networks and for identifying associations between such properties and wider behaviours and factors that might be regarded either as causes or effects of them but we believe that qualitative work is often essential if we are to understand the how and why of such associations.*

Thus, using a mixed methodology in this study was imperative to understand the structures and composition of the networks, but to also understand how these relationships were formed and to identify the underlying mechanisms which may trigger the formation of relationships and communities.

As such, each of the empirical chapters uses different methods of analysis:

Chapter 4 uses egocentric network analysis to describe the attributes, composition and structure of older people's support networks.

Chapter 5 takes a critical realist approach to qualitative data analysis in order to analyse interview data from staff, residents and relatives. It first aims to describe the mechanisms identified by staff which may have an impact on the support given to residents. The second section analyses resident and relative interview data in order to highlight the mechanisms that they believe impact the support that residents receive. In order to do this, data from staff and then residents and relatives were analysed separately but under the same critical realist approach.

Chapter 6 describes the development of a typology of support networks. Thus, it uses both social network analysis and qualitative data in order to create and then exemplify each 'type' of support network.

Chapter 7 uses quantitative methods to correlate egocentric network measures and the wellbeing score of residents to explore whether any network characteristics may have an effect on wellbeing. A critical realist approach to qualitative data analysis was then used in order to further explore the relationship between a residents support network and subjective wellbeing.

The following sections will describe each type of analysis used in the thesis, including egocentric network analysis, a critical realist approach to qualitative analysis and descriptive statistics.

3.5.1. Egocentric analysis

Egocentric research is interested in individuals and their immediate social environment (Perry *et al.* 2018). In this thesis, egocentric analysis is used to give a thorough description of the composition and structure of the support networks of older people living in care homes. Egocentric analysis was undertaken by using packages in R, including, but not limited to, *egor* (Krenz *et al.* 2019), *igraph* (Csárdi *et al.* 2019), and *tidyverse* (Wickham *et al.* 2019). All visualisations and measures were created by linking an 'edge-list', which is a list of all alters which are connected and an 'alter attribute list', which is a list of attributes associated with the supportive people nominated, through R.

A central aim of this thesis was to establish how the support networks of older people living in care homes were structured, and who supported residents. Therefore, Chapter 4 uses egocentric analysis to address these aims and capture variances in the structure and composition of these networks. The steps taken to explore the support networks of residents through the egocentric analysis of relational network data are displayed in Table 3.6.

Table 3.6. Egocentric analysis work package

Level of analysis	Analytical techniques
Ego level	• Descriptive statistics
Alter level	• Descriptive statistics
Network level	• Visualisations (with and without ego, total support received, type of support, type of tie relationship, frequency of contact, gender) • Measures of support (network size, tie strength: frequency of contact, closeness) • Compositional measures (proportion of relation ties, gender, frequency of contact) • Alter-alter ties (density, number of components)

The study of egocentric networks is not only an adequate method to describe who the ego is connected to, but also acts as a starting point where the consequences of such connections can be explored (McCarty and Wutich, 2005, p. 83). As such, the analysis of network data presented in Chapter 4 not only established a greater understanding of these support networks, and the important attributes and features of these networks, but it also established recurring patterns of support (or lack of support).

Based on this analysis, a typology of support networks of older people living in care homes (Chapter 6) was created by examining the patterns of support through egocentric analysis and themes of support which emerged from qualitative interview data. The qualitative data from interviews with residents explained why their networks were structured as such and why different types of relations provided support in some areas and not in others.

A detailed description of how the typology was constructed is presented in Chapter 6, however, the main factors that contributed to the characterisation of each type of support

network are detailed here. The networks were first grouped by considering important structural features, which were highlighted as important through the egocentric analysis and through consultation with literature. Secondly, the qualitative themes that emerged from interviews with residents were considered. As Bellotti (2015) argues, although residents could have had similar structures of support networks, they may utilise them differently and rely on different types of ties.

In this thesis, the emergent theme of support from staff was important for residents, and, as such, is a defining feature of the typology created. This was not only compositionally important, but often illustrated whether the resident trusted the staff, or whether they felt included in the care home. Thus, it became an important distinction between support networks. Therefore, the study found that there were differences in support between networks, and the grouping of similar types of networks could be made by analysing the structural and qualitative elements of the data. This analysis led to four main types of support networks of older people living in care homes being identified. Thus, egocentric analysis was a key method of analysis in this thesis and was used to partly answer research questions 1 and 3.

3.5.2. Critical realist approach to qualitative data analysis

As outlined in Section 3.1.2, this thesis adopts a critical realist approach. To reiterate, critical realism has a view of reality that argues that mechanisms, which cannot be measured, can trigger events which can be observed at the empirical level (Bhaskar 1998). Thus, this approach aims to identify and describe these mechanisms. 'Mechanisms' are reoccurring and formal patterns that can be viewed in the social world which give a potential explanation as to why events occur in particular situations (Crossley and Edwards 2016). These are potentially important to identify as they can: 1. contribute to a wider discussion of why social pattern exists and what may affect said patterns; 2. be compared to other studies which may be interrogating similar social patterns; and 3. identify these broader 'mechanisms' which may be driving events. In order to identify these mechanisms, this thesis uses Danermark *et al.*'s (2005, p. 193) critical realist analytical framework and which is outlined below:

Describe

Describe the observable events.

↓

Analytical resolution

Define which components of the observable events are going to be explored.

↓

Abduction

Re-describe and contextualise the data with the appropriate literature and theory of the subject.

↓

Retroduction

Purpose what mechanisms may be at work to cause such events.

↓

Comparison between different theories and abstractions

As a result of abduction and retroduction, discuss how these mechanisms could be explained by other theories.

↓

Concretization and contextualization

Give clear examples of how the mechanisms unfold in particular contexts in order to record the processes at hand.

Thus, this study will use this framework to identify mechanisms which may explain the events and patterns seen in the data collected. To give an example from the present study, residents either discussed their relationships with staff, or not. The event observable at the empirical level is the relationship between staff and residents. This is partly described thorough descriptions of the composition of support networks of residents, and the description given by residents about their relationships with staff members (if they are present). These descriptions are then re-described and contextualised based on mid-level theory and empirical evidence highlighted in the literature review. Using abduction, literature and theory are used to interpret what mechanisms might be driving the observable (the relationship between staff and residents) and retroduction is used to infer the real mechanisms which drive the observed (Danermark *et al*. 2005), for example, mechanisms such as 'organisation level constraints'. Discussion of these observable events (relationship between staff and residents) and the possible mechanism which may

determine whether this event occurs or not (possible mechanism: organisational level constraints) looks at how these mechanisms might compare to other literature in the field and how this event may unfold in different contexts. These casual mechanisms can be refined through the lens of micro and macro mechanisms. For the purpose of this project we are defining the difference between micro and macro mechanisms as "the difference between small- and large-scale social phenomena" (Ylikoski, 2012). Where micro mechanisms are social forces at an individual level, and macro mechanisms are at a community/societal level (Ylikoski, 2012).

Thus, by using a critical realist approach to qualitative data analysis, this project was able to engage in a wider discussion about the mechanism that may drive how connections and relationships are formed in a care home.

Qualitative data were managed and organised in NVivo (QSR International 2019), which is a software program used for the storage, management and analysis of qualitative data.

3.5.3. Quantitative analysis: Descriptive statistics

Descriptive statistics were used to analyse the difference in wellbeing scores between residents and groups. However, to accomplish this, the wellbeing score needed to be constructed from the wellbeing questions asked.

A principle component analysis (PCA) was attempted to create the wellbeing scale. PCA is a method which can be used to reduce a set of variables to a smaller number of dimensions (principle components) which still captures the majority of the variance captured in the original variables (Hair *et al.* 2014). The first principle component accounts for as much of the variability in the data as possible, and the following components account for as much of the remaining variability as possible, without being correlated to the previous components. This would allow for the creation of multiple components of wellbeing. By interpreting these components, this would give an indication of what factors drive lower or higher wellbeing and thus what factors are having a negative or a positive impact on a person's wellbeing. However, the principle components produced did not account for an adequate proportion of the variance, where

60% is widely deemed acceptable (Hair *et al.* 2014), and, therefore, the components created were not easily interpretable, as seen in Appendix 9. This is likely due to the small sample size. Thus, due to the lack of variance captured and the inability to interpret the principle components created, a more simplistic method was chosen in order to capture the maximum amount of data in the wellbeing score.

Thus, a score was made by taking an average wellbeing score for each resident in the sample (e.g. (CASP1 score + CASP2 score…. + CASP10 SCORE) / number of CASP terms). Although this is not ideal, as it does not account for the greater influence of some variables over others, it does however capture all data collected for wellbeing. As emphasised before, this is not a generalisable study and therefore this score was not used in any inferential statistics. Instead, it was used to suggest difference between groups, and was triangulated with qualitative data which aimed to illustrate how these differences are realised. The minimum value of the score was -1.68 and the maximum was 2.47. The score was centred, and thus the mean was zero. Figure 3.3 shows a histogram of the wellbeing score.

Figure 3.3. Histogram of wellbeing score
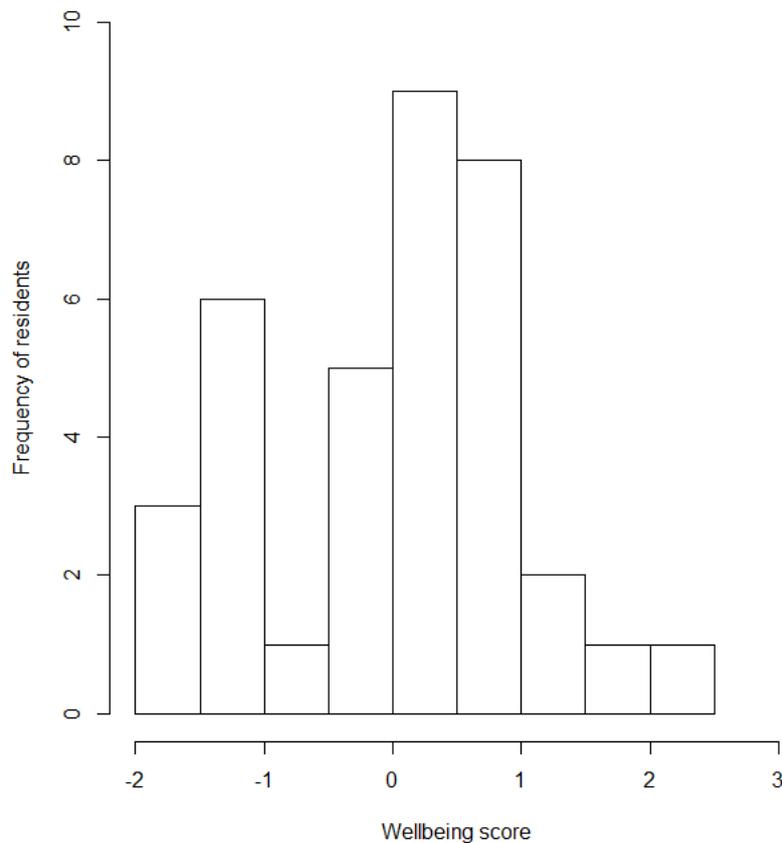
This wellbeing score was then correlated with network measures taken from the support networks of residents. Particular questions used to create the wellbeing scale were also used to interpret how particular facets of subjective wellbeing may be affected by the network characteristics of residents' wellbeing. Descriptive statistics such as boxplots were also used to compare the distribution and median score of groups.

3.6. Limitations of study

Although this study did not set out to be representative of the care home population, it also did not, at first, set out to exclude a proportion of the care home population. However, due to ethical considerations and time limitations, the resulting study has excluded some of the care home population as it does not include people without capacity to consent. All respondents of this study had the capacity to consent, and residents with the capacity to consent are in the minority of the care home population. Although this is a drawback of the study, it does not immediately follow that the sample selected does not give an

indication of the issues that others without capacity have. Also, it does not mean that some of the concerns that these residents have were not the concerns of the residents who do not have capacity in the past when they did have the capacity to consent. The support that residents of care homes receive is varied and complex, and this needs further understanding so that the support provided can be improved. Although this study is small in scale and does not represent the views of the whole care home population, this study is a starting point for further study into this topic and that it provides initial findings which will signpost future research to issues and concerns relevant for residents.

Further, by making comparisons to similar studies I could mitigate the limitations of the small sample by exploring whether my study was finding similar themes and pattern within the support networks of older people. For example comparing studies with similar typologies or had similarly analysed the networks of older people in different contexts, I could see if the network I was producing were radically different from other such studies. I confirmed that although my study did have new findings, there were patterns of similarities between my own and other studies such as Powers (1992) and Brown-Wilson (2008).

Further to this, people who were too ill to answer questions were also excluded from the study. However, this does not mean that the people included in the sample were not dealing with serious illness and ailment. Many of the sample were living with chronic illness, disability and ailments which were causing them a lot of pain and discomfort. They were given the choice to be part of the study, and they chose to do so.

As part of the interview, I assessed whether each respondent had memory problems. Although the use of a subjective memory problems assessment worked well to maintain the respondent–interviewer relationship without using medical records, the definition of 'memory problems' was limited. Using a better measure of cognitive impairment may have been more appropriate, such as the MMSE,[4] which is a well-established examination of cognitive function. However, if I had used the MMSE, this may have negatively affected the relationships with the residents and dissuaded potential participants. Further,

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[4] Mini Mental State Examination (MMSE) is an exam of cognitive function asking questions about time orientation, place orientation, attention, recall, language repetition and registration (Crum *et al.* 1993)

the people included in the study had mild memory problems at worst, and, as such, arguably, the potential social implications of having memory issues in this study would be limited. Thus, on balance, maintaining the respondent–interviewer relationship was deemed to be more important to the study.

The interviews with residents also attempted to gather information on the alters' occupations, in the hope that some measure of social stratification through occupation would be analysed. It became apparent very quickly that this data would not be easily collected and that much of the information would be missing. Therefore, in the very early stages of the interview process, this was dropped. Although this was definitely exacerbated by the fact that some of the participants had memory problems and could not remember what important alters did for a living, it is well established that gaining information on alters from egos is difficult from any sample.

At the start of the project, I had aimed to collect a sample of residents that were drawn from a number of different funding backgrounds, so as to gauge the differences between the experiences of support between people of different socio-economic backgrounds. This sample does have a range of people from self-, partial- and local authority-funded backgrounds, however, two-thirds of the sample is self-funded. This may be considered problematic, because there is less diversity in the sample than was hoped initially. However, due to the small sample size given to the study by each care home, the aim of gaining residents from each funding category from each care home quickly became impossible and this sampling requirement was dropped.

In order to make contact with care homes who would be willing to participate with research, the project used the ENabling Research In Care Homes (ENRICH) network. Although this was very helpful for gaining a great number of possible care homes, this also meant that the care homes were probably better than average in performance as they felt confident in being involved in research. This means that these care homes were confident enough to invite researchers into their facilities, which may indicate that these care homes may perform better than the average care home in Scotland and, thus, have the resources to support residents more effectively. Despite this, many of the care homes that were contacted had no idea what ENRICH was and explained that past managers had perhaps signed them up to the network some time ago.

Bonding social capital is theoretically characterised through 'trusting and co-operative relationships which are similar to each other in terms of social identity (Woolcock 2001)', I captured this through resident description of connections (closeness, type of support provided and density) and relationships with supportive actors (qualitative descriptions). Thus, I can suggest whether ties illustrate bonding social capital if they are trusting of these actors and if they have homogenous characteristics (come from similar backgrounds i.e. family, community). However during analysis this was difficult untangle given that ties that were traditionally 'bridging social capital' were was connected to 'bonding social capital'. Thus, although my operationalisation of bonding social capital was not ideal for defining firm distinction between bonding and bridging social capital, it perhaps reflects the lack of duality between these two concepts in reality.

During the analysis in Chapter 7, correlation statistics between wellbeing and network characteristics were created. Although the assumption is that the composition and structure of the network has an effect on wellbeing, I cannot account for directionality of this effect. For example, it could be that people who have more family members have higher wellbeing, however, it could be suggested that people who have higher wellbeing are more likely to have more family. However, a review of systematic reviews concerning the relationship between social support and mental health in older people suggests that social support has a direct buffering for stressful events (Bowling 1994) as well as an ability to alleviate the health effects of hardship (Schwarzer and Leppin 1989), which, overall, helps maintains wellbeing (Tajvar *et al.* 2016). Thus, although there is research to suggest that excessive support can create stress (Krause and Rook 2003), a larger number of studies indicate that social support positively and directly affects wellbeing (Tajvar *et al.* 2016).

On reflection, there are limitations to this study which inevitably shape who can be included and what can be analysed in the research. Future research could aim to have a more diverse sample or might consider including residents without capacity and a significant other in order to gather their views on support from a wider sample of people. Overall, although there are limitations to this study, steps have been taken to address each limitation in order to produce robust and valid research.

3.7. Summary

This chapter has outlined the key methodological choices of this thesis. It stated the research questions which were formed through gaps in the literature identified in Chapter 2. These research questions had particular ontological and epistemological underpinnings, which were relational sociology and critical realism. The chapter then discussed the validity of mixed methods in social network research, given this ontological and epistemological approach.

Given the research questions and the philosophical approach chosen, the chapter then discussed the practical issues of the research: sampling, data collection, ethical considerations, and data analysis.

By collecting relational network data, qualitative data and a wellbeing score from residents, the key research questions were answered and key concepts explored. In addition, the care home staff and significant others of the residents were interviewed in order to gain insight into their understanding of how residents are supported in care homes. These participants were sampled from care homes across the Central Belt of Scotland and with care homes linked to the ENRICH network.

Key ethical concerns were outlined, such as concerns about the residents' capacity to consent, their anonymity and working with gatekeepers. Additionally, the chapter included these concerns were addressed ethically and without harm to anyone involved in the research.

Modes of analysis were discussed in detail and outlined which types of analysis were used in each chapter. The ways in which this thesis used egocentric network analysis, a critical realist approach to qualitative analysis and descriptive statistics were all discussed in detail. Finally, this chapter outlined the main limitations of the research, however, it also outlined why these limitations did not significantly limit the rigour and validity of the study.

Chapter 4 Support Networks

Chapter 4 Outline

This chapter will address the first research question: *How are the personal networks (ego-nets) of older people living in care homes structured and composed?* Before describing how the networks are structured, this chapter will first describe the sample of residents, and their alters, to give a full and rich description of the attributes of who is included in the networks. This will illustrate who supports residents and whether alters with particular attributes are more likely to provide certain supports. Overall, this adds to a better understanding of residents' perceptions of support, what form of support is important for them and who they believe supports them the most.

The chapter has four main sections. Sections one and two describe the sample of residents and their alters, respectively. Section three explores the relationships between the ego and alters including; what type of support is provided, the label of their relationship, how close the ego feels towards the alter, and the frequency of contact between the two. This chapter will show what the residents' social support networks look like and how the structure of these networks may differ between residents.

4.1. The residents

As noted previously, 36 residents were sampled over seven care homes in the Central Belt of Scotland. Table 4.1 shows the demographic data collected about the residents. The majority of residents were female, self-funded and did not have memory problems. The average age of the residents was 87 years old, ranging between 72 and 100.

The sample age is older than the national average age of older people living in care homes, which is 81 years old (ISD Scotland 2018). In Scotland, 69% of older people living in care homes are local authority funded, making up the majority, while only 31% are self-funded (*ibid.*). As expected, the sample has less indication of memory problems than the estimated average number of older people living in care homes with memory problems, as the sampling strategy aimed to recruit people who had the capacity to

consent to the research, and, therefore, was not looking to sample those affected by advanced cognitive impairment. People affected by mild cognitive impairment may still have the capacity to give informed consent, therefore, if someone had the capacity to give informed consent, but had mild memory problems, they could still be included in the study if they wanted to participate.

Table 4.1. Demographics of residents

	Category	*n*	%
n		36	
Gender	Female	29	81
	Male	7	19
Funding Category	Self-funded	25	69
	Partially Funded	6	17
	Local Authority Funded	5	14
Memory Problems	Yes	17	47
	No	19	53
Care Home	1	6	17
	2	6	17
	3	5	14
	4	5	14
	5	8	22
	6	4	11
	7	2	5

There is quite an even spread of residents from each care home, with the largest number of residents coming from Care Home 5 and the least in Care Home 7. Most residents arrived in the care home in 2018 and, as shown in Figure 4.1, the number of residents who have been in the care home for many years are fewer. This is to be expected, as the

average length of time from arrival to death for older people living in care homes in 2018 was 18 months (Scottish Government 2018).

Figure 4.1. Arrival year in care home for residents
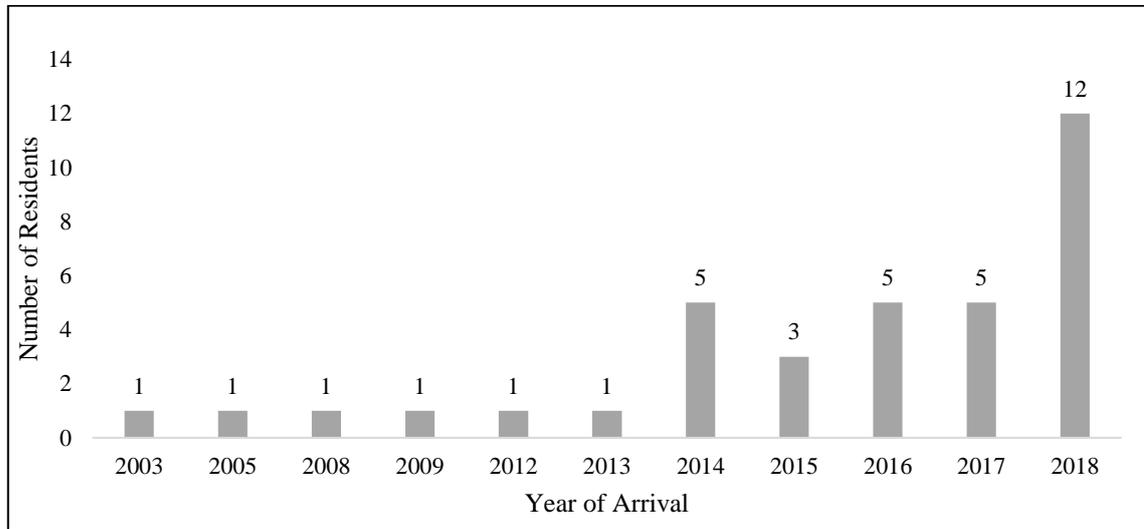
4.2. The alters

Alters are the actors in a network to which the ego is connected. In this study, the ego is the resident who was interviewed for this project. Residents were asked to nominate people who supported them in different capacities, and this created a list of people who made up the resident's support network. Hereafter, this list of people will be referred to as the alters when specifically discussing their position and role within the network. This is common terminology in network literature when discussing the actors within a person's network (Holstein 2018).

Below (Figure 4.2) is an example of Resident 42's support network. Resident 42's support network is used to illustrate particular aspects of the analysis throughout this chapter. In the first sociogram, which is picture of the relationships among members in a social network (Dominguez and Hollstein 2014), the ego is included, as well as the ego's connections to their alters. The alters have been allocated alter ID numbers so that each alter can be identified. The second sociogram shows Resident 42's support network without the ego, and their ties included. Removing the ego gives an impression of what the network would look like if the ego was not present, and therefore shows the importance, or sometimes unimportance, of the ego.

Figure 4.2. Resident 42's support network with and without the ego
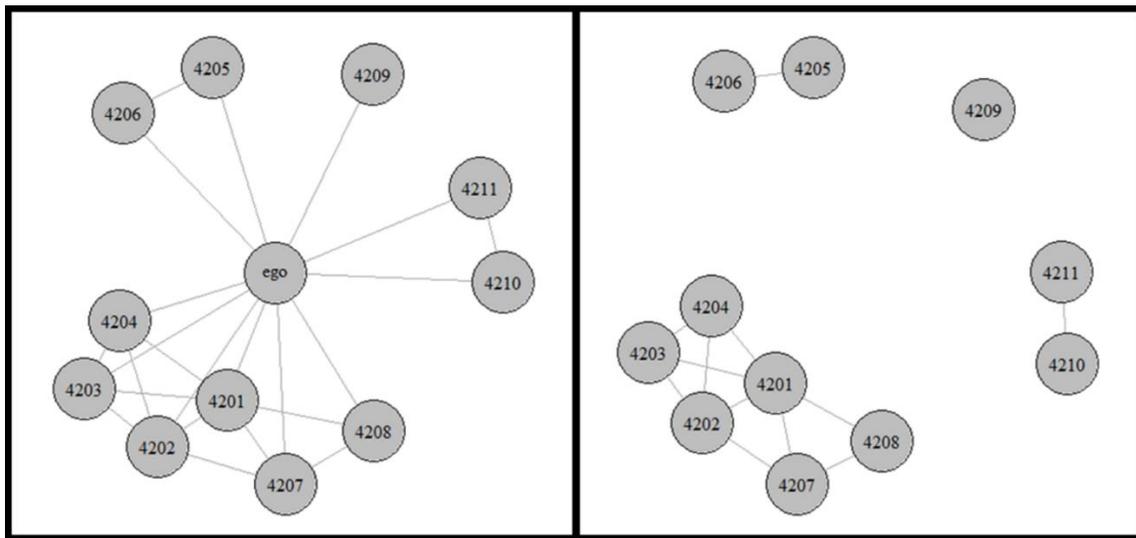
Below, Table 4.2 describes the alters' characteristics, including their relationship with the resident, their gender, closeness and frequency of contact with the resident. In total, 229 alters were nominated by the 36 residents.

The majority of alters were female and family members who are very close to the ego and have contact with the ego multiple times a week. The average age of alters is 60, with age ranging from 1 to 100 years old. Only three of the residents had a spouse who was alive, and all were men whose wives lived with them in the care home (*n*=2) or visited them every day (*n*=1).

Most of the information collected about the alters was about their relationship to the ego, and how they supported the ego. As well as discrete characterisations of the ego and alters' relationship, much of the detail around the relationship and support given by the alter is embedded in the qualitative data collected from the residents. The in-depth analysis of such data is located in Chapters 5, 6 and 7 of this thesis.

Table 4.2. Alter characteristics

	Category	*n*	%
n		229	
Relation to Resident	Family	122	53
	Friends	58	25
	Staff Member	39	17
	Other	10	5
Gender[5]	Female	155	69
	Male	69	31
Closeness to Resident	Very Close	114	50
	Less Close	92	40
	Not Close	23	10
Frequency of Contact	Multiple times a week	75	33
	Weekly	40	18
	Fortnightly	21	9
	Monthly	35	15
	Yearly	30	13
	Never	27	12

4.3. Relationship between the ego and alters

In order to explore the structure of the personal networks of older people living in care homes, it is important to explore the relationship between the egos and alters and the composition of the support network. This is because how the ego relates to the alter may determine why the ego looks to specific alters for support and therefore is an essential aspect of how the network is structured. This section will consider the distribution of

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[5] Five nodes could not be characterised by gender. This is because they were groups of people which the resident did not want to separate out into individuals, e.g. "Club Friends" or "Staff".

alters nominated for support by the ego, their relationship with the ego, closeness to the ego and frequency of contact with the ego.

4.3.1. Support

The five name-generator questions established who supported the residents and, as such, support was defined by the type of support suggested in the name-generator questions. Table 4.3 below provides an example of the personal support network of Resident 42 and which alters they nominated for each question. The graphs show the ego as a square, the alters who were nominated for the specific name-generator question as black circles and the alters who were not nominated in grey. The name-generator questions that indicate which alters have been nominated are positioned to the right of each sociogram in Table 4.3. These questions were used to establish what types of support alters provided to the ego and, broadly speaking, are labelled as 'Personal matters', 'Socialising', 'Advice', 'Help' and 'Other'. Some egos nominate the same alters for different name-generator questions. For example, the same alters have been nominated for personal matters and socialising by Resident 42.

Table 4.3. Resident 42's support network, with alters highlighted in black when nominated for respective name-generator question

Personal Matters 	1. From time to time, most people discuss important personal matters with other people. Who are the people with whom you discuss matters that are important to you?
Socialising 	2. From time to time people socialise with other people, for instance they visit each other, go out for an outing or for a meal. Who are the people you really enjoy socializing with?
Advice 	3. From time to time, people ask other people for advice when a major change occurs in their life, for instance, a change in location or a serious accident. Who are the people you usually ask for advice when such a major event occurs in your life?
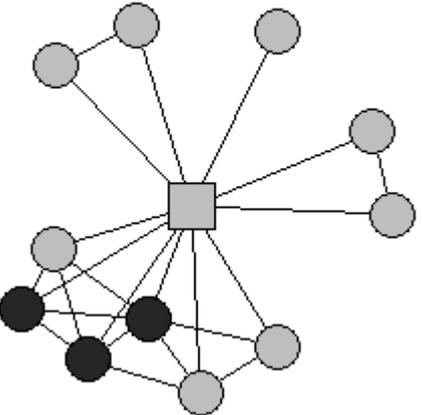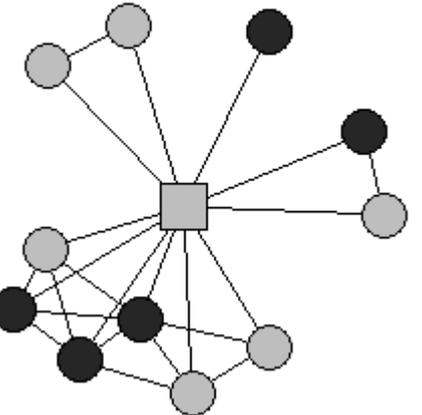
Help	4. Could you name anyone who has provided you with help recently?
Other	5. Please list anyone who is especially close to you who you have not listed in one of the previous questions.

For each of the name-generator questions, residents were allowed to name up to five people and could nominate a person multiple times across questions. Figure 4.3 describes how many nominations each name generator produced. If all residents were to nominate the maximum number of alters for each name-generator question, each question would have 180 nominations (5 nominations x 36 residents). As shown, the maximum number of nominations that a single question received was 77.

Figure 4.3. Number of nominations for each name-generator question
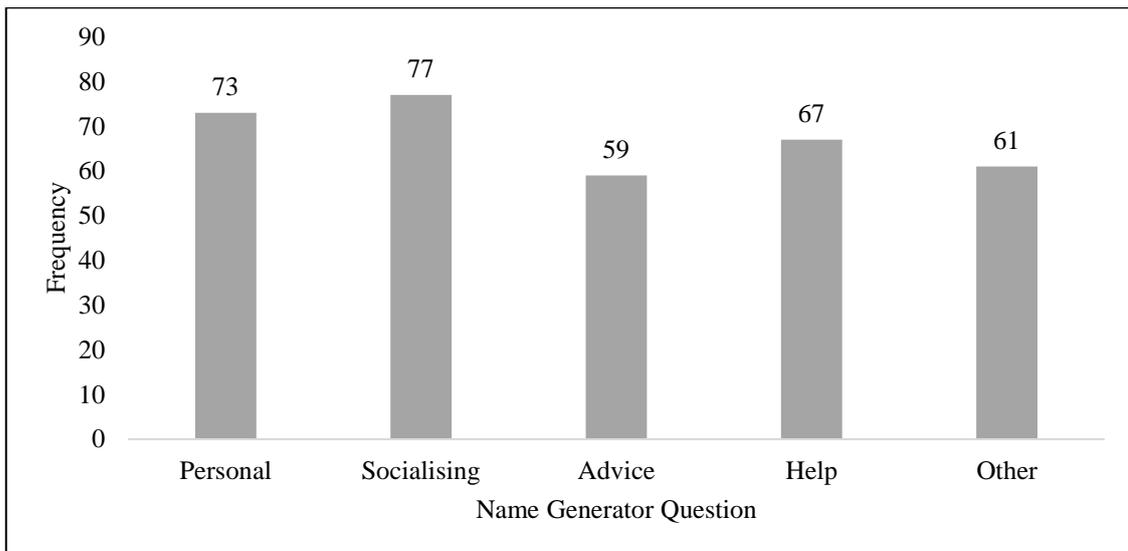
An unexpected result of these questions was the number of people who were nominated for the last question, which was designed to capture anyone who did not give support but was important to the resident. Arguably, this question captured just as many people as any other questions and perhaps this could be interpreted that the previous name-generator questions did not capture all types of support that a resident receives from other close alters in their networks or that not all close alters provide support for the resident.

4.3.1.1. Cumulative Support

Another interesting aspect of support is the number of times a single alter was nominated for supporting the resident. Given that the final question was designed to identify people important to the resident who had not been nominated previously, the maximum number of nominations a single person could have was four. Of those nominated, most were only nominated once. However, a small number of people were nominated three (23 people) and four (11 people) times, as shown in Figure 4.4 Evidently, these alters have importance for the ego who nominated them, and, therefore, looking at who these alters are and how they specifically support these egos will be of interest to the project, given it aims to understand how to better support residents. This will be explored more closely in the next section.

Figure 4.4. Number of nominations of support per alter[6]
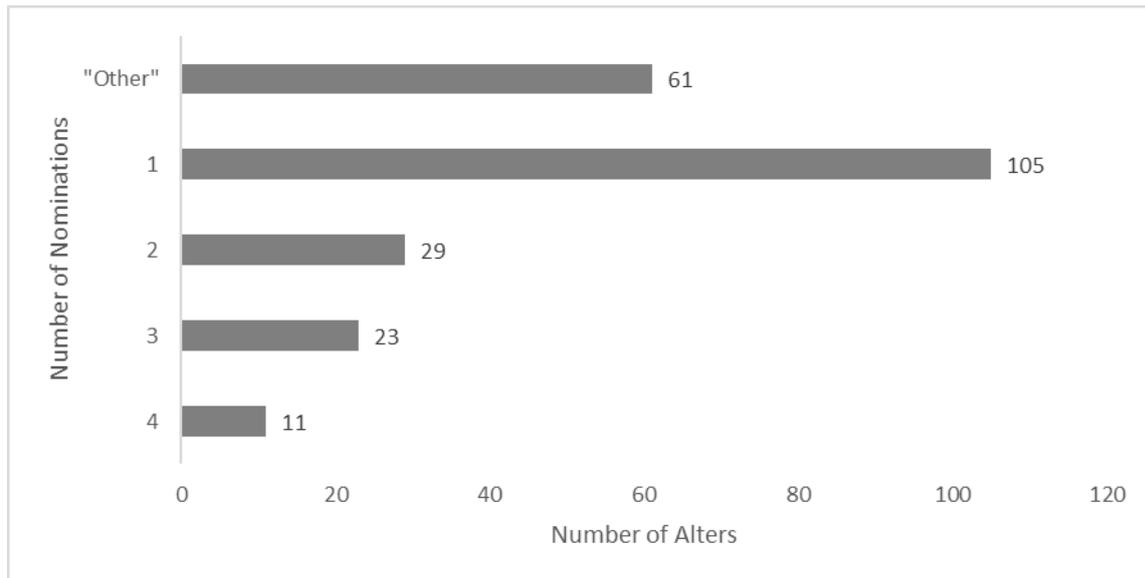
Further to this, establishing patterns of support may show us whether people who are nominated for one type of support are also more likely to be nominated for another. Figure 4.5 shows a Venn diagram of four types of support for which an alter could have been nominated. The fifth name-generator question, indicating any other close contacts that the resident had, is not included because none of the alters nominated for this name-generator question will have been mentioned for any other types of support. However, the 61 people nominated for 'Other' are indicated in the bottom corner of the Venn diagram. Figure 4.5 shows that people who are nominated for discussing personal matters are also often nominated for giving advice and socialising, with 33 people nominated for a combination of the three types of support (one for socialising and advice, five for personal matters and socialising, 14 for personal matters and advice, and 13 for all three). Most people were nominated for one of the types of support. However, there were a few (*n*=11) who were nominated for all four types of support that were discussed in the interview, and this will be discussed further on in the chapter.

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[6]Alters nominated for name-generator Question 5 (other close people) are included as 'Other' in this graph as they were not nominated for any one particular type of support.

Figure 4.5. Venn diagram of how many alters were nominated for each type of support.

A key part of the data collection process was establishing the relationship between egos and alters by establishing how emotionally close the egos and alters were, how frequently the ego was in contact with the alter and what the label of the relationship was between them. The next section will discuss these three aspects of the relationship in detail.

4.3.2. Relationship

The composition of a resident's egocentric network is important because it may affect what type of support, resources and information the resident can easily access. One particularly important attribute in these egocentric networks is who the alter is to the ego; family, friend, staff member or other.

Figure 4.6 (below) shows the support network of Resident 42. This sociogram has highlighted the relationships held between the ego and the alter by having the alters coloured by their relationship. In some ways, the sociogram for Resident 42 differs from the others because it has a spread of alters from all types of relationship, whereas most egocentric networks in this sample do not have alters from all four types of relationships.

Figure 4.6. Resident 42's support network with relationship to the ego highlighted
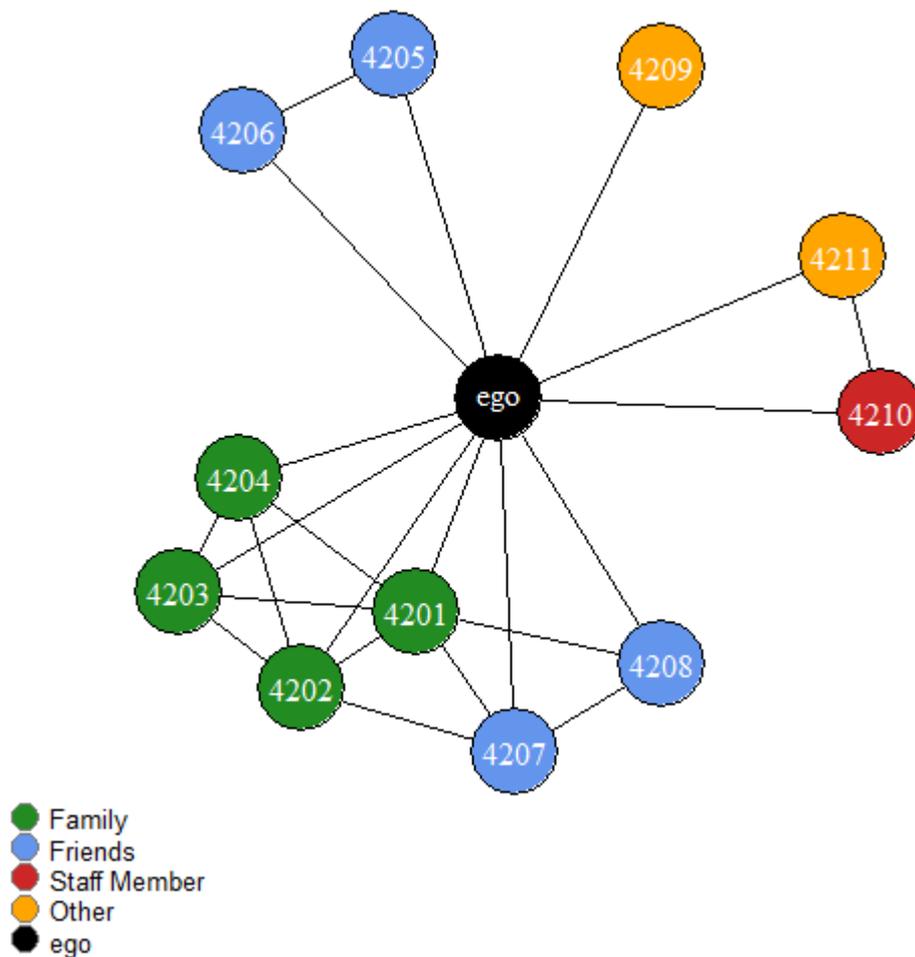
The majority of the sample of alters consisted of family members (53%), while friends and staff members made up 25% and 17%, respectively. Figure 4.7 shows the proportion of types of ties by each egocentric network. Starkly, there is a large majority of residents who have only family ties. Graph 1 in Figure 4.7 shows that 12 egocentric networks have only family ties present. Perhaps this is to be expected, as this is reflected in the literature that suggests that, as people get older, closer ties become even more important (Forsman *et al.* 2011; Cook 2006). However, the number of support networks that have no friendship (17), staff (24) or other ties (29) is apparent.

Figure 4.7. The proportion of relationships to ego by egocentric network
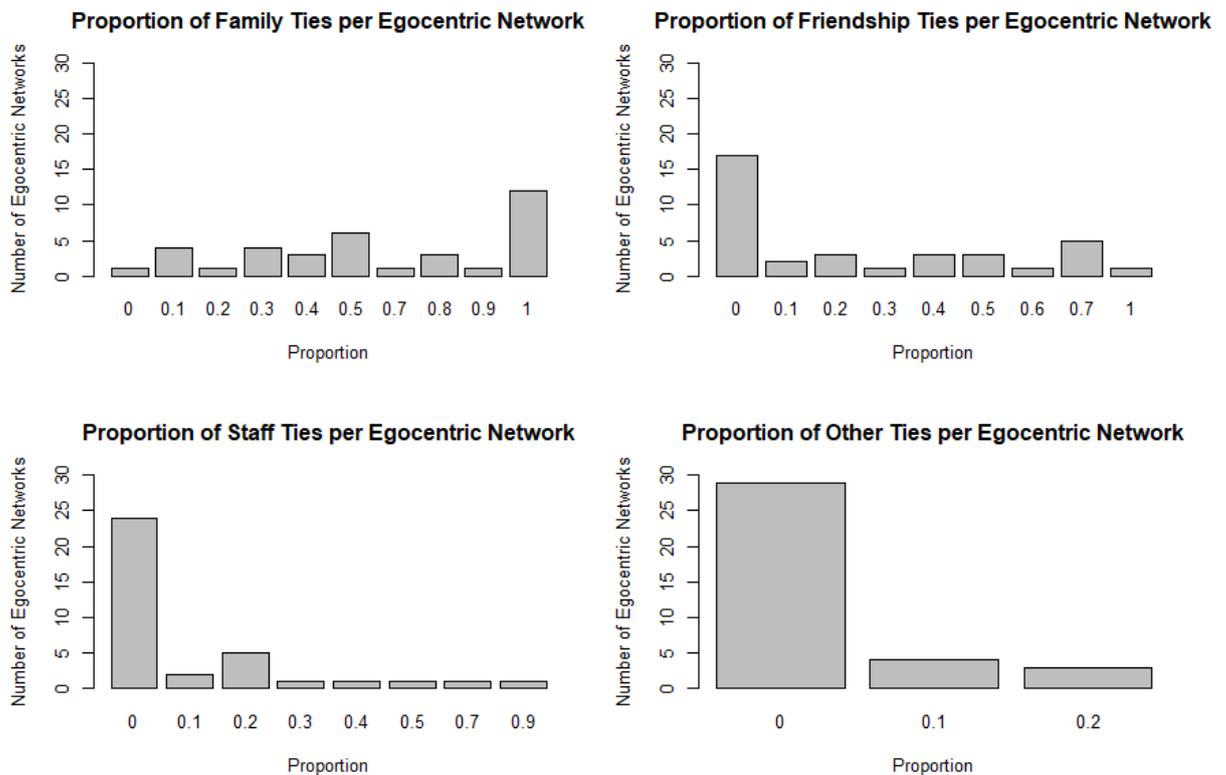
The small proportion of staff members is especially interesting as the residents live in a care home and therefore are engaging with staff members every day. In addition, many of the residents interviewed were ill, had difficulty with mobility or had a disability and therefore needed a lot of aid from staff on a day-to-day, or even hourly, basis. For residents to only nominate 39 staff members in total, and for this to be concentrated among only 12 ego-nets, perhaps shows a number of scenarios:

1. These 12 residents have a different relationship with staff, which means they have nominated staff as giving support, unlike residents who do not have this relationship with staff.
2. Most residents did not want to disclose their relationship with staff.
3. The name generator questions were not phrased correctly to capture relationships with staff adequately.
4. The majority of residents do not feel connected to the staff.
5. The majority of residents do not regard staff as supportive ties.

6. As the name generators were restricted to 5 people per question, the residents only nominated those alters to whom they would immediately turn, which are not staff ties.

In any case, this finding will be explored further in Chapter 5, where the utilisation of organisational ties will be explored.

4.3.2.1. Relationship to the ego and support

An important aspect of this project is assessing what type of support is being provided, and who is providing such support, as establishing which ties residents were relying on for particular types of support could show which relations were most important to the egos.

Table 4.4 describes what proportion of the different types of support were given by what types of relationships. For example, for name-generator question 1, summarised as 'Personal Matters', 79% of the alters who made up those who would discuss personal matters with the ego were family.

Table 4.4. The proportion of types of support by relation to the ego

	What types of support are family, friends, staff and other types of ties providing? (% of type of support)				
	Personal Matters	Socialise	Advice	Help	Other
Family	79%	59%	78%	44.8%	49.2%
Friends	11%	36.4%	13.6%	19.4%	29.5%
Staff	6.8%	1.3%	1.7%	31.4%	19.7%
Others	2.7%	2.6%	6.8%	4.5%	1.6%
Total = n (%)	73 (100%)	77 (100%)	59 (100%)	67 (100%)	61 (100%)

Family ties make up a majority of the alters nominated for personal matters, socialising and advice. In addition, they are the largest group nominated for the 'Advice' and 'Other' name-generator questions. Therefore, it could be suggested that there is a great value placed on family members by the residents. Further, this might be detrimental to those who do not have family, if the norm is that a family member takes the lead on supporting

a resident living in a care home. It might be less likely that a resident gets the support that they need from other ties, or that they are more heavily reliant on other ties who may not necessarily have the time to dedicate to supporting the resident.

Visualisations of the support networks of the residents show how numerous the nominations of support are for family members, and therefore suggest how important family members are in individual support networks. For example, Resident 42's support network is shown in Figure 4.8 and shows what relationship the alters have to the ego (colour of node). However, the second graph does not have the ego displayed and the size of nodes reflects how many times they were nominated for different types of support. Although Resident 42 has nominated family members, friends, staff and other types of ties, it is clear that family members have been nominated for more types of support as their nodes are far bigger in the second graph.

Figure 4.8. Two sociograms of Resident 42's support network: Graph 1 with relationship to the ego in colour and Graph 2 without the ego, relationship to ego represented with colour and total number of nominations indicating size of node.
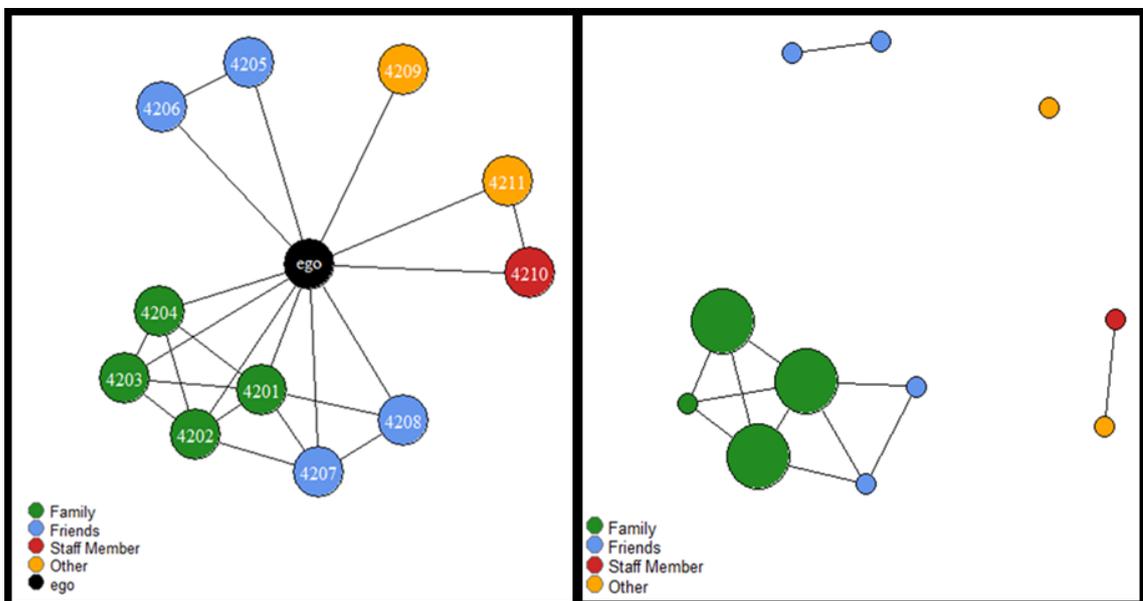
This suggests that family members play an important role in the support network of Resident 42. Figure 4.9 visualises the same format of Graph 2 for all 36 egocentric networks to determine whether this high nomination of family members is the same for the rest of the residents. As such, Figure 4.9 below displays all 36 egocentric networks,

without the ego, with the relation to the ego represented by the colour of node and the size of node indicating how many times an alter has been nominated. The bigger the node, the more nominations they have received from the ego.

There are a few friendship ties who were nominated several times for support, but no staff or other ties who stand out as providing three or four types of support. This is understandable, as it is to be expected that staff and other ties are weaker ties who are less likely to provide the emotional support that is illustrated by name-generator questions 1 and 2. As visualised, most of the larger nodes in the networks are green, which indicates that family ties are the ties which the residents find the most supportive, or at least provide the most varied types of support. The majority of egocentric networks have a family member who they are nominating multiple times.

Figure 4.9. 36 Egocentric networks with relation to the ego coloured and size of node representing the number of nominations
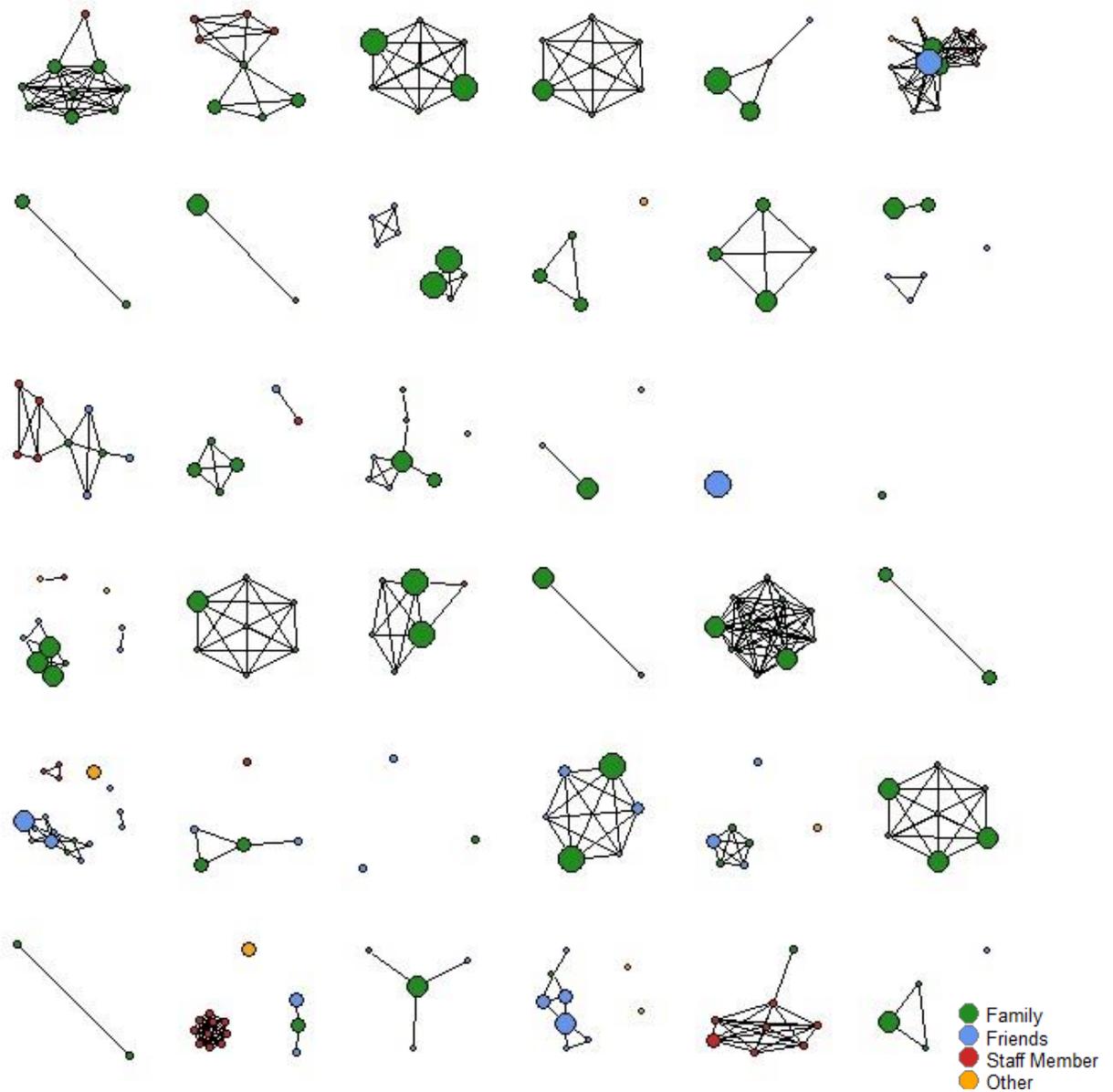
This relationship is broken down further into the types of relationships that provide different patterns of support. To do this, the previous Venn diagram has been used in Figure 4.10, but with the addition of the breakdown of what types of relationships are included in each pattern of support.

Figure 4.10. Venn diagram of types of support and relationship to the ego
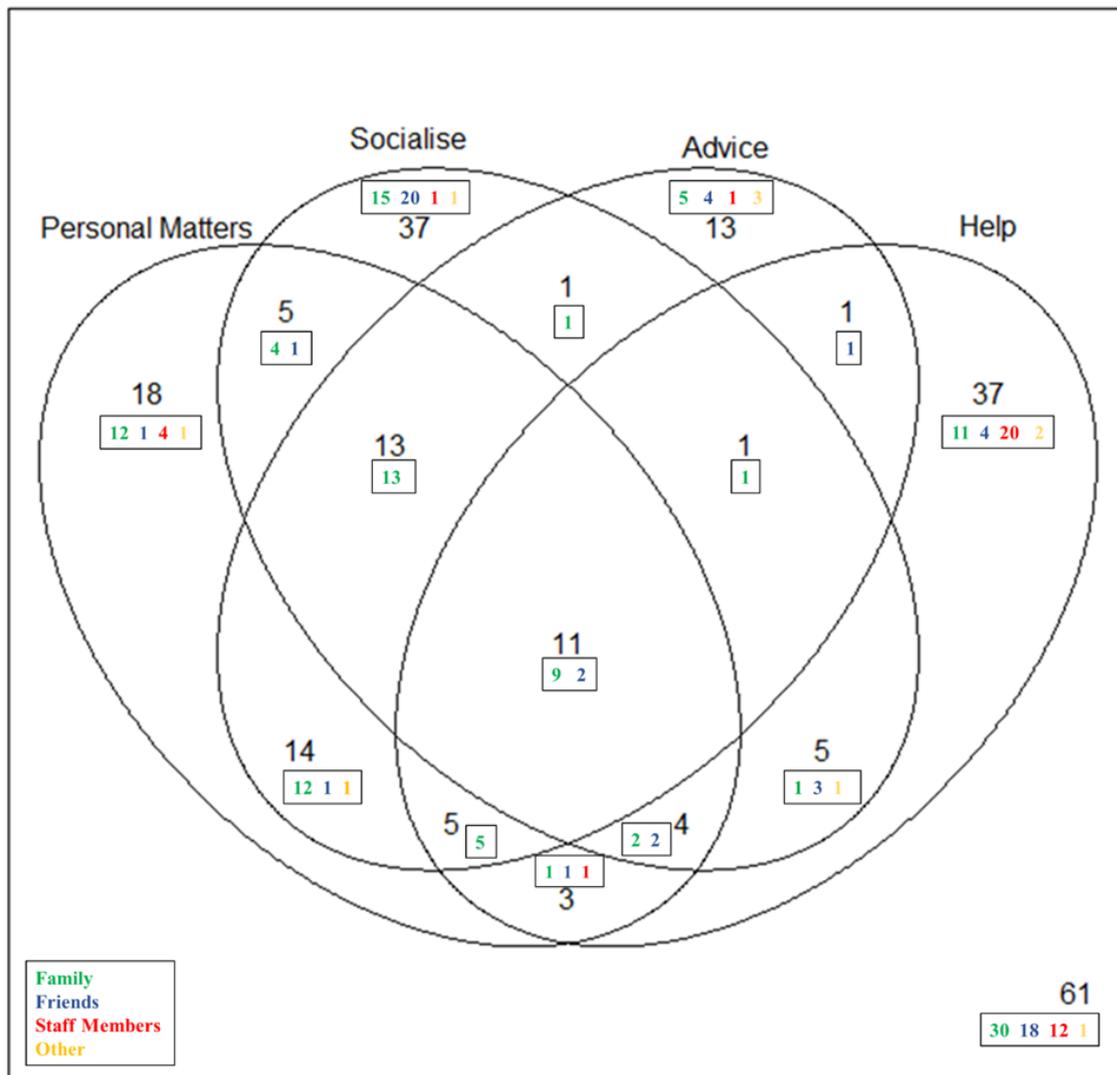
For example, if the crossover between personal matters and socialise is examined, it shows that, of the five people who provided both of those types of support, four were family members and one was a friend. Overall, the diagram shows that, for all five name-generator questions, there was at least one family, friend, staff member or other nominated. However, at the centre of the Venn diagram there are seldom staff members or others, with only one staff member being nominated for two types of support (Personal Matters & Help) and two other types of tie being nominated for two types of support (Personal Matters & Advice and Socialise & Help). No staff members or others were nominated for more than two types of support.

Additionally, the majority of networks only have one or two actors per network who are nominated a number of times, as seen in Figure 4.11. Even when networks consist of all family members, there are only one or two actors nominated multiple times. These highly supportive ties are nearly always children of the residents who play a large role in their lives, as highlighted below in Figure 4.11.

Figure 4.11. Support network of four residents with relationship to ego in colour and number of support nominations as size of node.
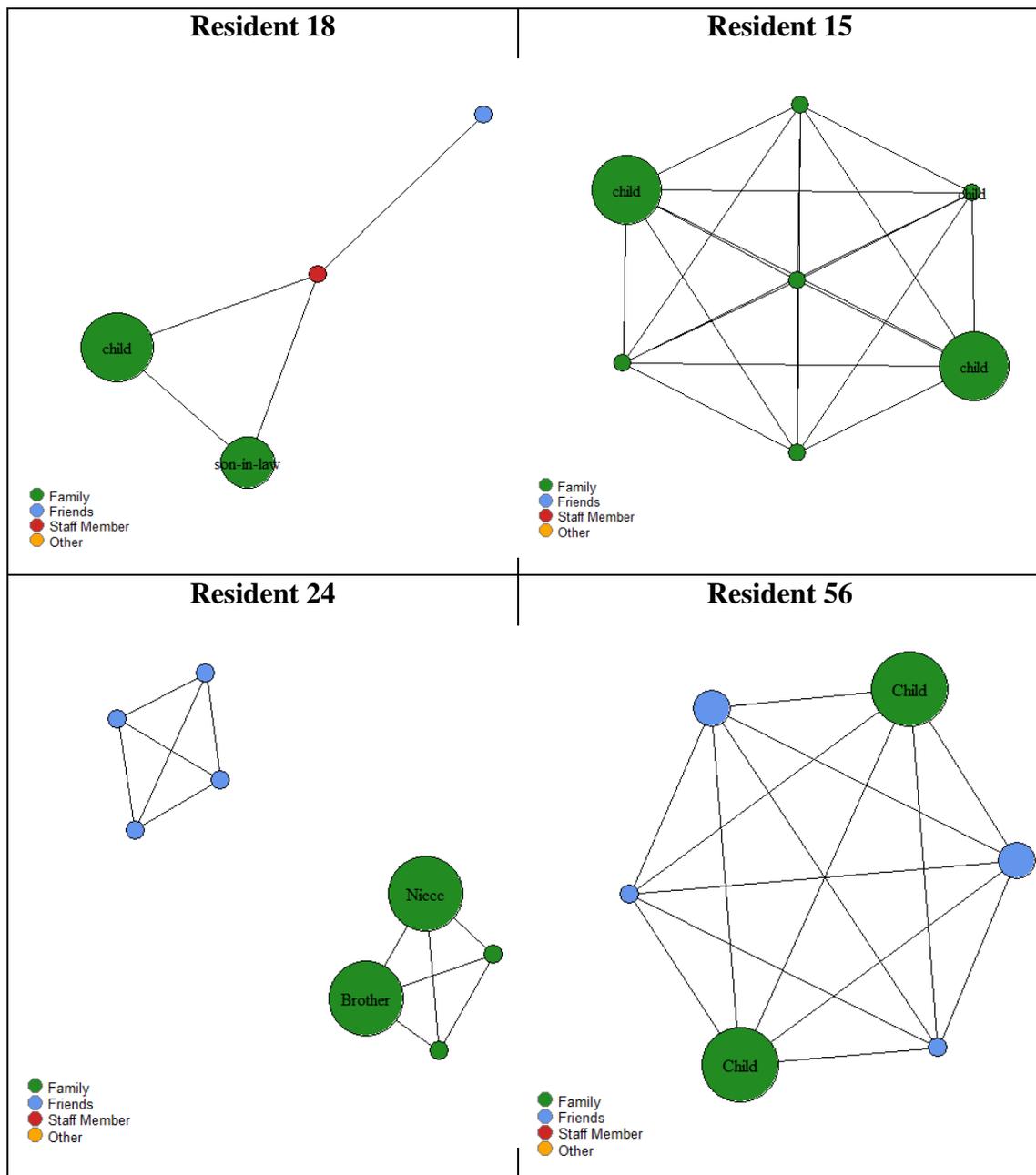
Figure 4.11 suggests that children of residents are hugely important to the support of older people living in care homes. Sociograms 1, 2 and 4 suggest that children are heavily relied on for multiple types of support and this was not uncommon for residents who had children. Children would often be the only visitor who would visit regularly, would have power of attorney, be in charge of all the resident's finances, legal matters, and health decisions, as well as being the main communicator between other family members and staff. There were a number of examples of this, such as Resident 18, who, on a number of occasions throughout the interview, expressed how important his daughter and her husband were:

> I: How often do you see (daughter) and (son-in-law)?
> Resident 18: Every night

> [...]

> I: Could you name anyone who has provided you with help recently?
> Resident 18: The daughter – See when I think the amount of runabout she's done for me. I tried to think of what to say ...

> [...]
> Resident 18: I really enjoy going out with the daughter and her husband

Those residents who did not have children were much more reliant on other members of the family, as displayed in the support network of Resident 24 in Figure 4.11. Resident 24 had a niece who was nominated multiple times for support and was mentioned many times for varying reasons:

> I: Diane (niece) probably deals with all your finances then?
> Resident 24: Oh ... I've handed everything to her. I said if she cheats me, she cheats herself because it's all going to her.
> I: So she must be your power of attorney and everything like this?
> Resident 24: Yes – She's got all that. I asked her if she would do that and she said of course. [...] I don't have any worries at all.

As Resident 24 did not have children, the responsibility and much of the decision making around Resident 24's care had fallen to her niece. In only one case, the resident did not have any family and in fact only nominated one friend in their support network. In this case this friend became incredibly important to the resident and supported the resident in almost everything.

Although there were exceptions to this finding, as stated above, it seems that the majority of residents who had children were reliant on them for all types of support. It is important to highlight that an alter's relation to the ego is almost certainly influencing the ego's decision on what type of support they provide, as well as 'Closeness' and 'Frequency of Contact'. Therefore, this will be discussed in the next sections which concern closeness and frequency of contact.

4.3.3. Closeness

Egos were asked to place their alters on a target to represent how close they felt to their nominated alter. Figure 4.12 below shows that the majority of ties were placed in the 'Very Close' concentric circle (50%) and the least amount of alters were placed in the 'Not Close' concentric circle (10%).

Figure 4.12. Emotional closeness of alters to ego in sample
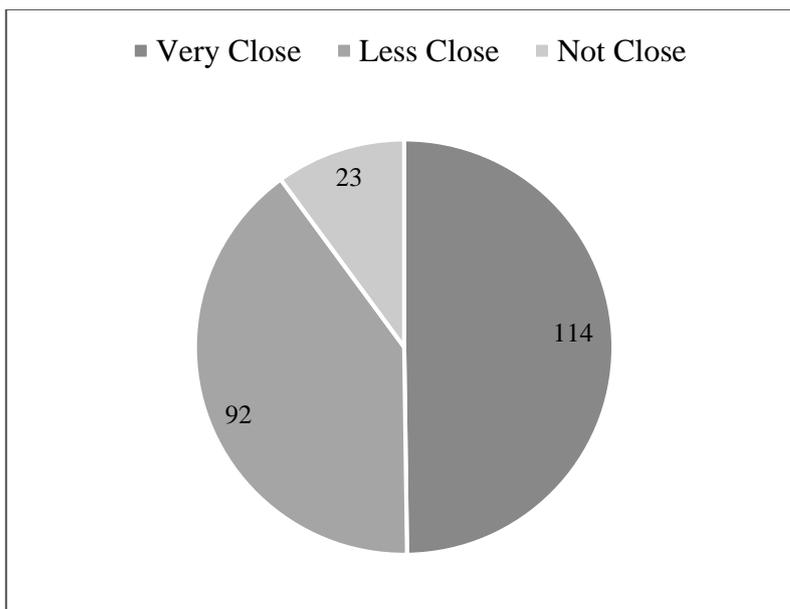
Below in Figure 4.13 is another example of Resident 42's support network in a different format. The resident is in the centre and their alters are placed in the corresponding concentric circle representing how close the ego feels to that alter.

Figure 4.13. Resident 42's support network with closeness of tie
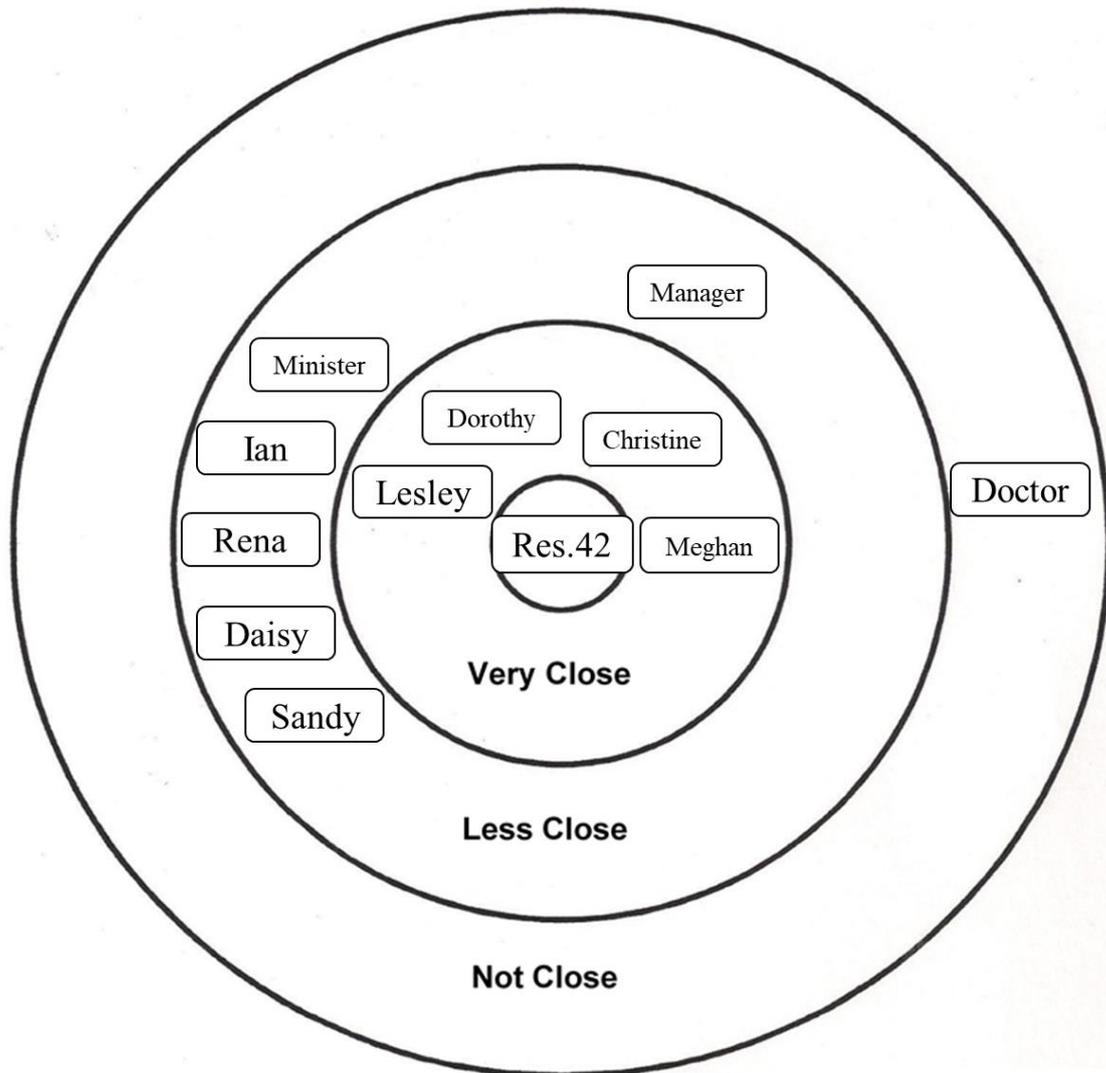
Resident 42 has four 'Very Close' ties, who are all immediate family members. They have a further six 'Less Close' ties, who are friends, a minister and the care home manager. Finally, Resident 42 has one 'Not Close' tie, a doctor who services the care home. Importantly, Resident 42's daughters were nominated first for discussing personal matters, advice and socialising, as well as being placed in the closest concentric circle. As well as this, Resident 42 added a comment about his grand-daughter, saying:

Resident 42: I feel close to her because she was the first granddaughter.

This was the case for many residents, who placed immediate family in the closest of circles, while emotionally supportive friends, staff and others would be placed in the 'Less Close' concentric circle. For example, Resident 42 discussed who they would turn to if they needed anything outside of the care home.

Resident 42: If I need anything I would ring ... I would get Susan and Gareth, or Peter and Nancy. They'd get something for me.

Additionally, if they had a problem in the care home, they could go to the manager to discuss it with her:

Resident 42: I would do it myself – I would go straight to Lou [care home manager]. Anything that happens in the care home, I will deal with it.

This illustrates that friends, and people with whom he had a personal connection, such as the manager, or his local minister, were deemed less close than immediate family, but closer than people who did not give emotional support, such as the doctor, whereas people like the minister and the care home manager would take time to listen to his concerns.

Figure 4.14. Resident 51's target
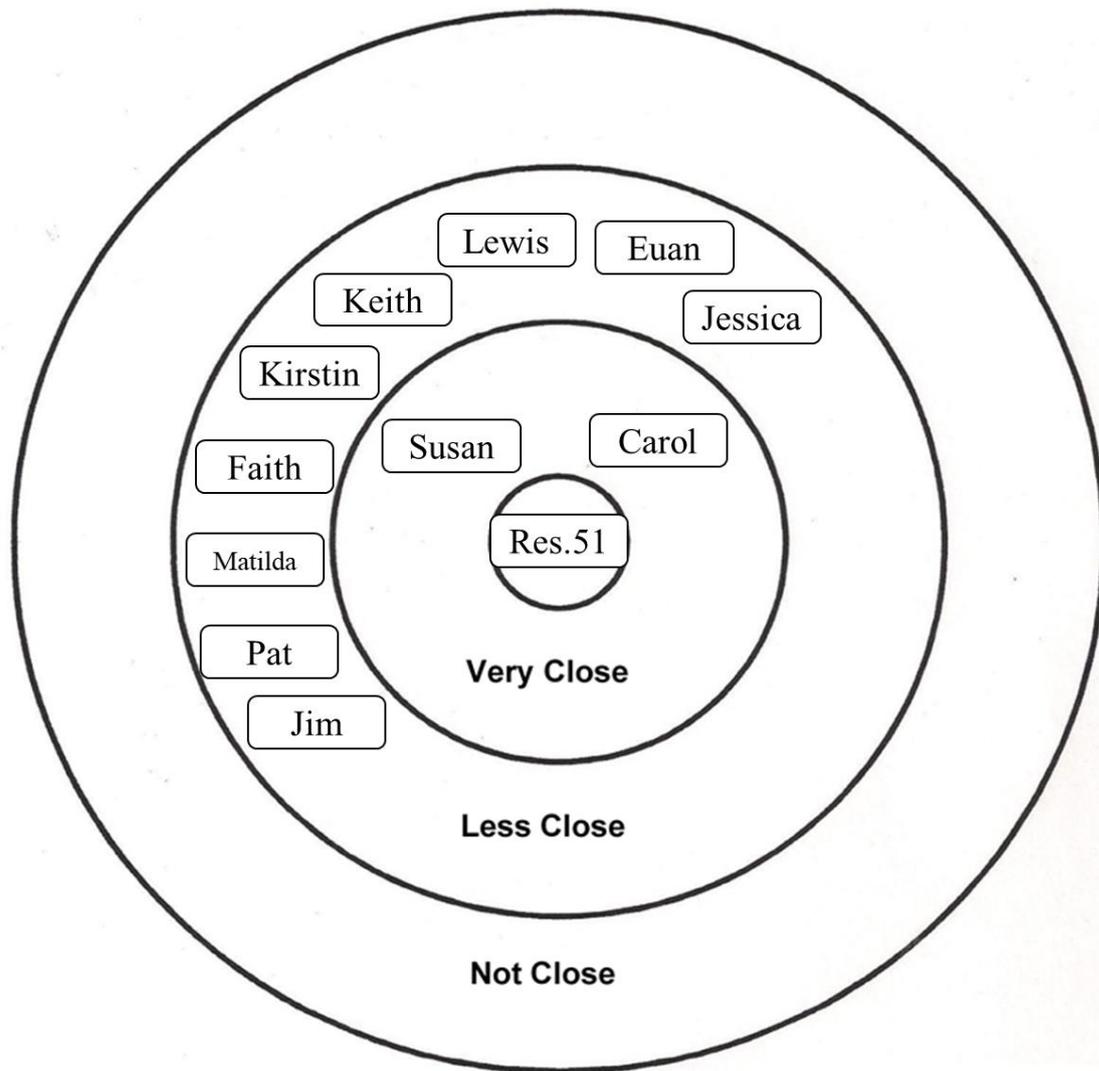
Overall, residents placed the most supportive family and friends in the closest concentric circle, with some placing all family in the closest concentric circle. This is illustrated in Figure 4.14, where two daughters have been placed in the closest concentric circle, while other family have been placed further away. This shows that there is a hierarchy of closeness when some residents are thinking about how close they feel to family and how much support they get from these alters.

Residents placed family who they felt they *should* be close to, but weren't close because of fallout or tension caused, in the 'Less Close' concentric circle. This was often followed by a reason as to why they were less close to this person and a justification of why they felt this person wasn't as close to them, and sometimes, to the rest of the family. This was

certainly the case for Resident 15 (as in Figure 4.15), where one of the sons' wives had become less communicative in the family because of a difference in priorities and thus had been deemed "*not a naturally friendly person*" by the resident. Other residents reflected on disagreements within the family in this manner as well, by 'demoting' the family member to a less close position.

Figure 4.15. Resident 15's target
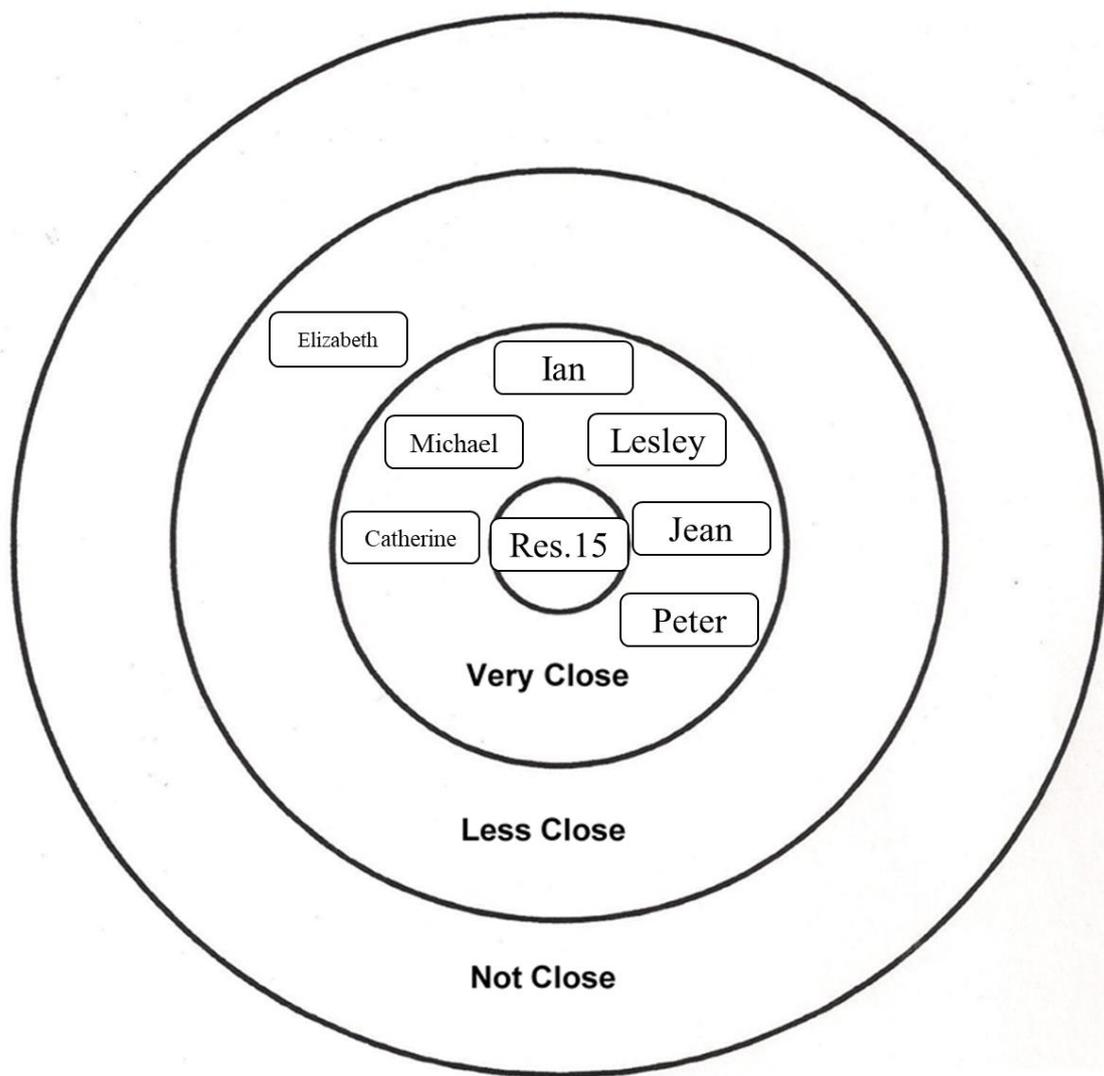
Residents were more likely to place friends in the 'Less Close' concentric circle because, for most people, family were deemed as closer and more valued. This was certainly the case in Resident 56's target (Figure 4.16).

Figure 4.16. Resident 56's target
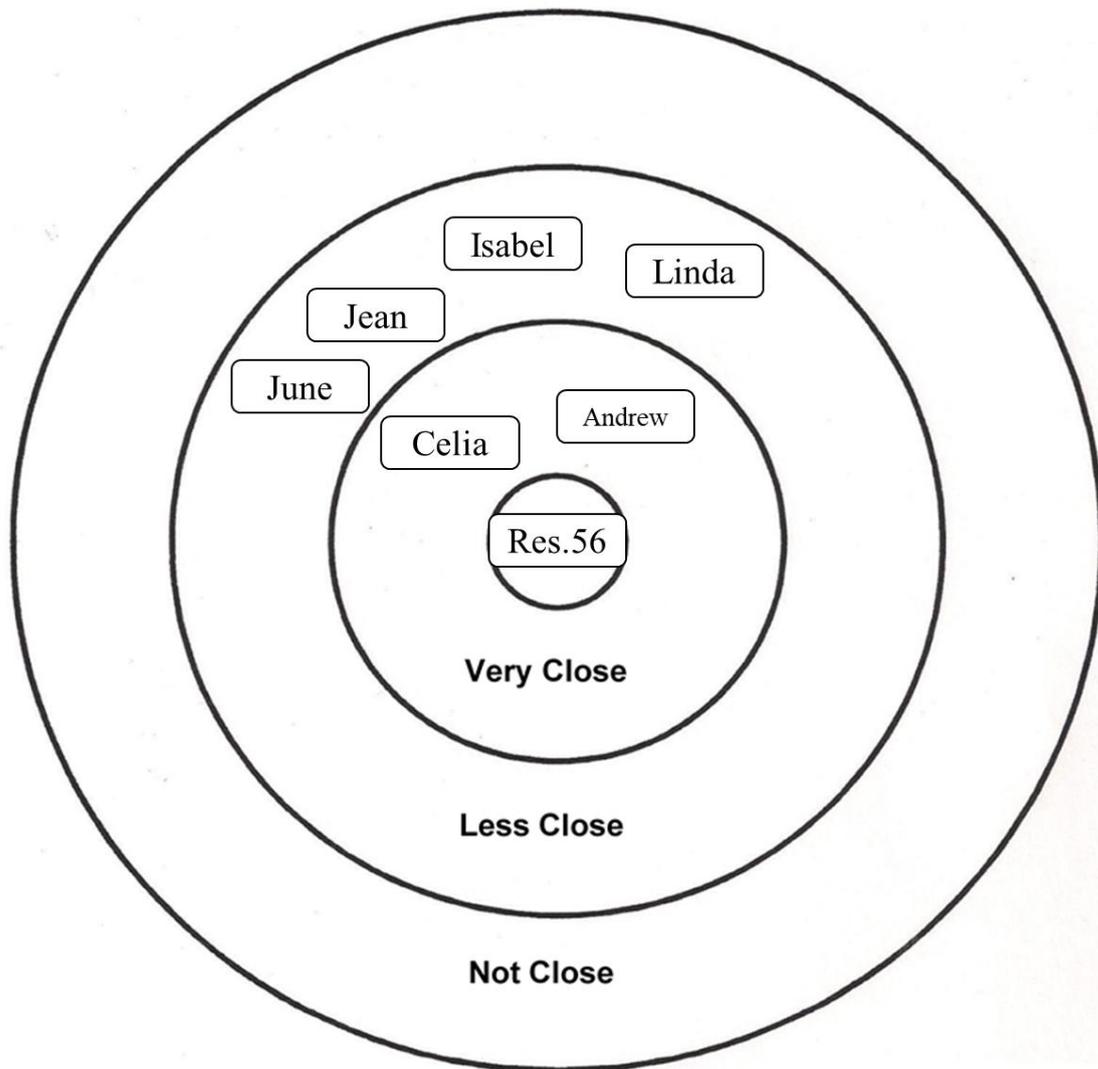
However, when family were not present, because they did not have family, their close family members had become ill, they only relied on distant family, or family lived far away, then friends became a lot more important to the resident, and thus, were placed in closer concentric circles. This was true for Resident 64, who found that friendships were very important to them because her brother was ill and she did not have any children to support her. Further, Resident 64's target (Figure 4.17) illustrates the finding that staff and 'Other' ties were more likely to be placed outside the 'Very Close' concentric circle. Residents tended to only place staff members and others who had built an emotional connection with the resident in the 'Less Close' concentric circle.

Figure 4.17. Resident 64's target
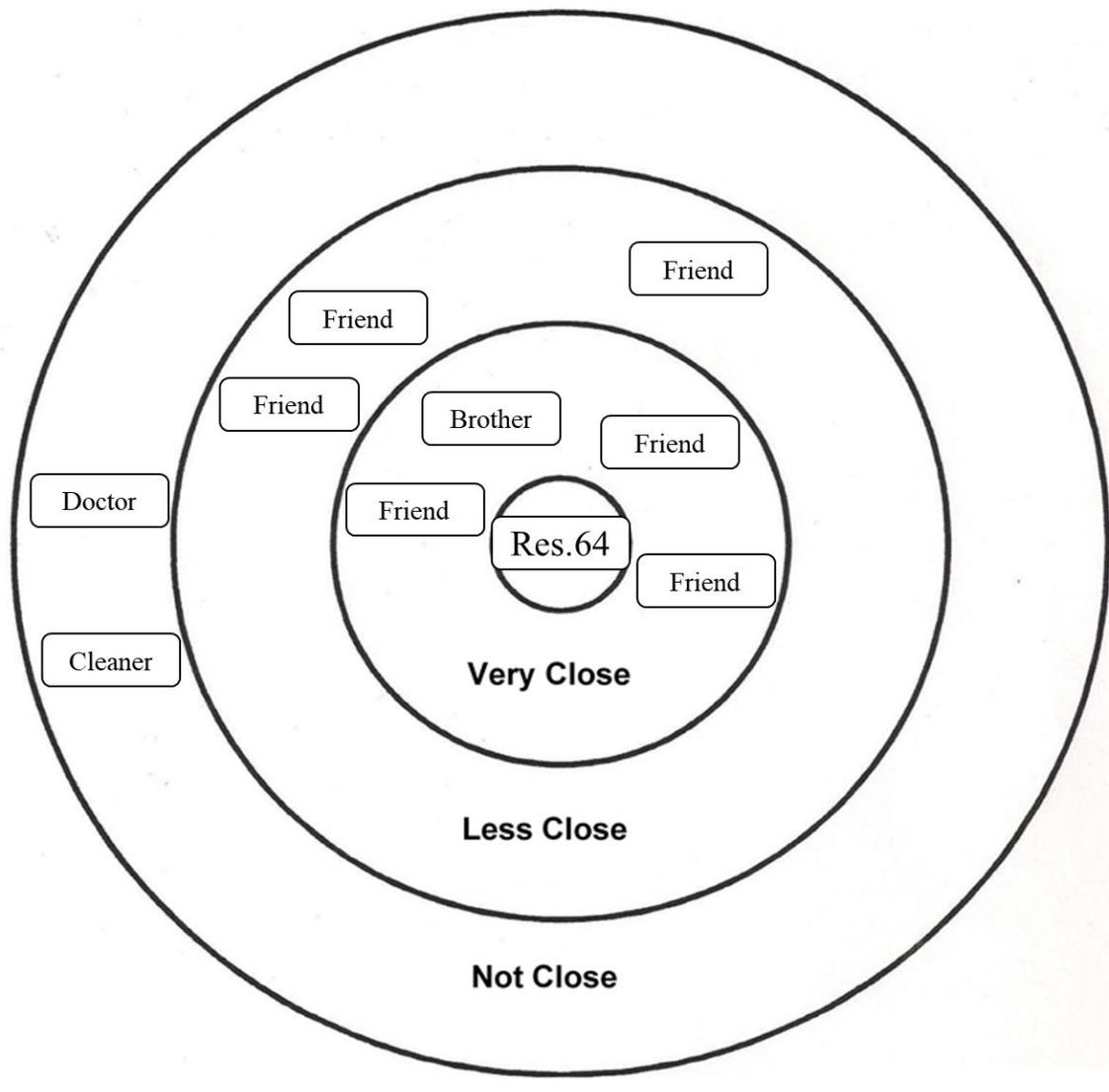
In sum, all egocentric networks have at least one 'Very Close' tie and few have 'Not Close' ties. Many of the 'Very Close' ties were clustered together, and most certainly represented clustered family and friendship ties, with staff and 'Other' ties more likely to fall in the 'Less Close' or 'Not Close' concentric circle. Resident 64's support networks are mostly comprised of 'Very Close' ties. However, half of the alters are characterised as 'Less Close' or 'Not Close' which suggests it is not just 'Very Close' ties that are providing support to the residents.

4.3.3.1. Closeness and support

Through Granovetter's theory of weak ties, it could be hypothesised that ties who are close to the ego are more likely to be nominated for emotional support, whereas less close ties are more likely to provide new resources, information and material goods (Granovetter 1973; 1983).

Table 4.5 shows the frequency and proportion of support nominations by the closeness of tie. All types of support are more likely to be provided by very close ties, with the exception of those alters nominated as 'Other' important ties. However, it could be suggested that 'Help' ties have a more even distribution across the three categories of closeness, and therefore help is more likely than the other three types of support to be given by a not 'Very Close' alter.

Table 4.5. Types of support by closeness of tie

	What type of support are very close, less close and not close alters providing? *N* (% of type of support)				
	Personal Matters	Socialise	Advice	Help	Other
Not Close	1 (1.4%)	3 (3.9%)	1 (1.7%)	10 (14.9%)	8 (13.1%)
Less Close	12 (16.4%)	28 (36.4%)	16 (27.1%)	19 (28.4%)	30 (49.2%)
Very Close	60 (82.2%)	46 (59.7%)	42 (71.2%)	38 (56.7%)	23 (37.7%)

4.3.4. Frequency of contact

Residents were asked how often they had contact with the alter who they had nominated. Figure 4.18 looks at the frequency of contact given for each alter in the sample and shows that the majority of alters are seen multiple times a week. However, caution needs to be applied when interpreting this result as nearly all staff members nominated were seen multiple times a week because they worked in the residents' home, and therefore most of the variation in frequency of contact is between family, friends and other ties of the resident.

Figure 4.18. Frequency of contact between alters and egos
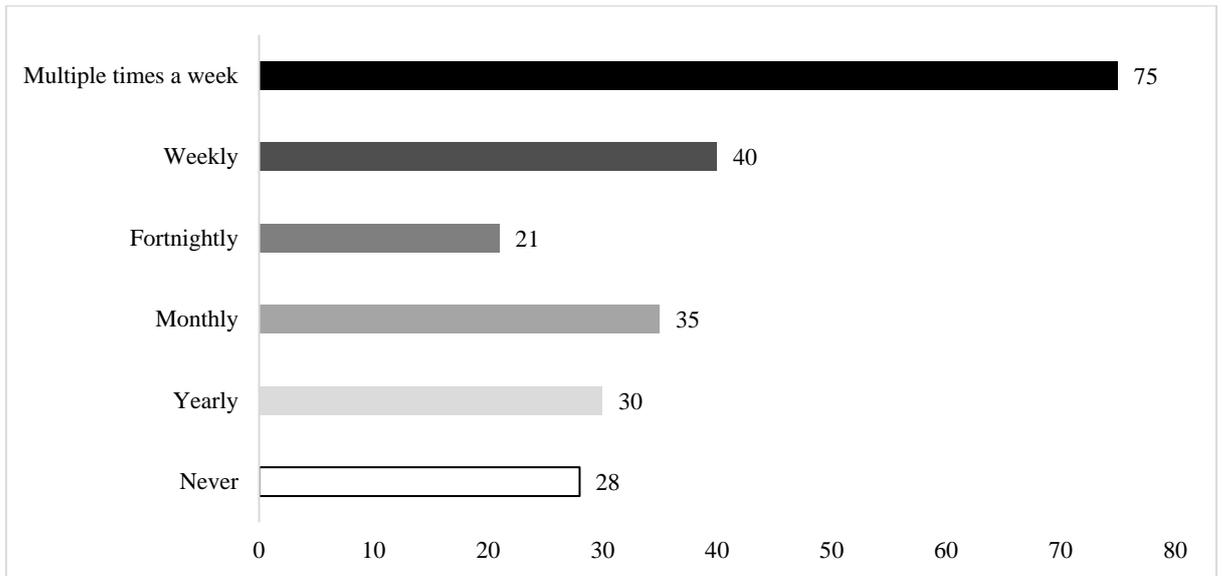
Figure 4.19 shows the frequency of contact by type of relation grouping. Most staff members were seen multiple times a week and supportive alters classed as 'Others' were spread evenly from 'Never' to 'Multiple time a week'. Most family members were seen multiple times a week, weekly or fortnightly. However, five family members were never seen, and 19 were seen yearly. Frequency of contact with friends was not as regular as other types of relations. Although five were seen multiple times a week and nine weekly, there were 20 friends who were never seen. This is quite a large number of friends who were considered supportive, but who were not in contact with residents. This may indicate that there are barriers to having contact with friends that need to be explored.

Figure 4.19. Frequency of contact by type of relation
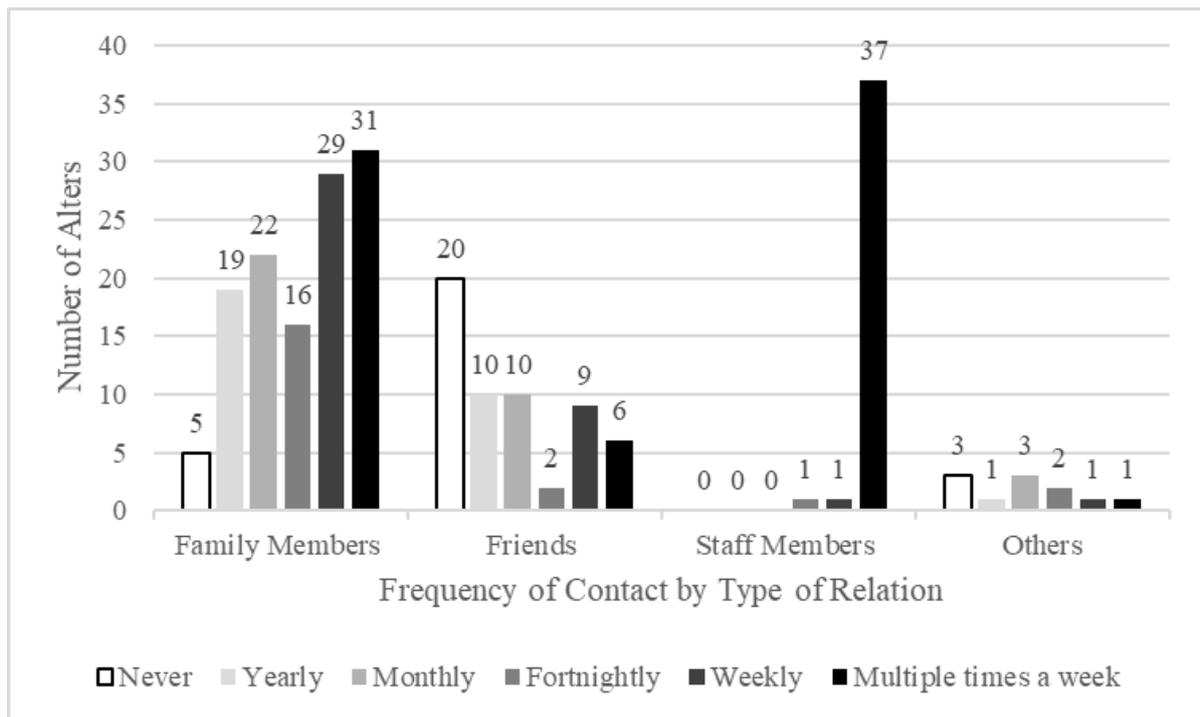
Resident 42's egocentric network in Figure 4.20 shows the frequency of contact of each alter in their support network. Again, the resident is shown in red, with the shading of the alter becoming darker the more they have contact with them.

Figure 4.20. Resident 42's support network with frequency of contact highlighted
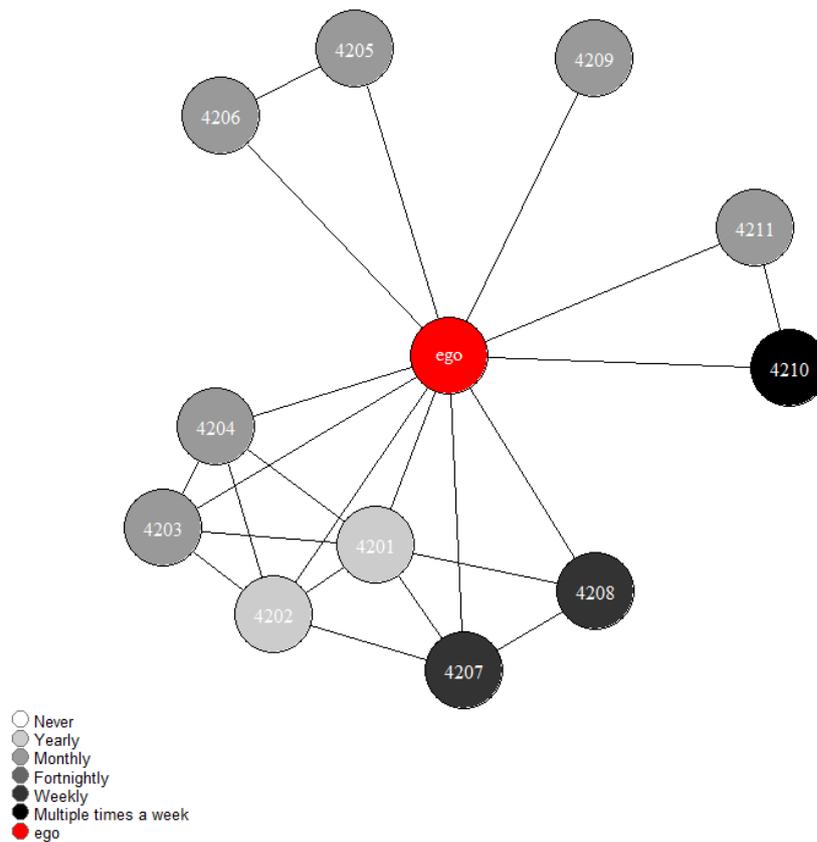
The resident explained that he is visited by two of his daughters (4201 & 4202) yearly because one lives in London and had a busy job, while one "*lives in Australia and she'll be here next week. But she only gets here once a year maybe*". 4203 is another daughter and 4204 is her daughter, who are seen monthly because they live in England and can only visit that often.

As such, the resident sees his friends (4205–8) more often because his family live in England or further away. Two of these friends he explained: "*They are [wife] and I's best friends for 30-odd years*", and, as such, he sees them weekly. However, his other friends did come to visit:

Resident 42: About once every couple of months because she's bad now. Most of the friends that we have, or had, are all like us. They're all old y'know in their 80s and 90s. Most of them don't drive anymore, or they shouldn't. Just one of these things. And I wouldn't want to be friends with anyone else.

As the care home manager (4210) works in the resident's home, he sees her more than weekly. On the other hand, he sees 4209 and 4211 monthly, because one is a minister who comes from his local church and the other is a doctor who regularly attends to people in the care home.

Figure 4.21 shows the sociograms for each egocentric network in the sample, with the same colouring applied as above. Again, it is shown that many alters are seen multiple times a week, however, some have many alters who they rarely or never see.

Figure 4.21. 36 Egocentric networks with ego and frequency of contact highlighted

Never
Yearly
Monthly
Fortnightly
Weekly
Multiple times a week
ego
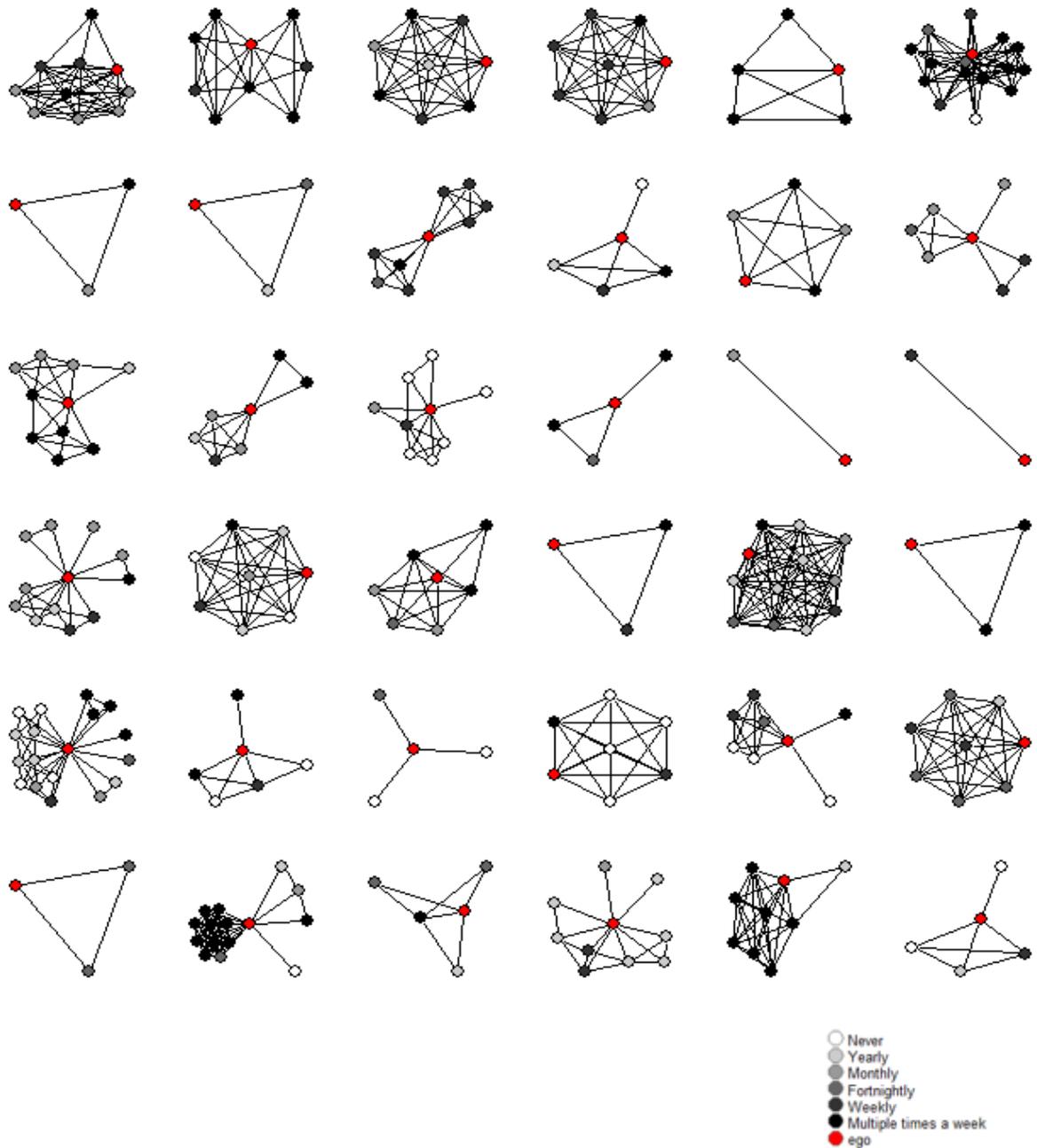
In particular, it is important to highlight that 28 of the alters nominated are never seen by residents, and a further 30 are only seen yearly. Fourteen of these alters who are never seen were concentrated in these four support networks (Figure 4.22). Figure 4.22 shows that some of the residents have regular contact with fewer alters than they name and, thus, might reflect the fact that some residents felt the need to mention people who were previously in their support network, rather than people who they regularly had contact with more recently.

Figure 4.22. Four egocentric networks with alters shaded by frequency of contact and ego in red
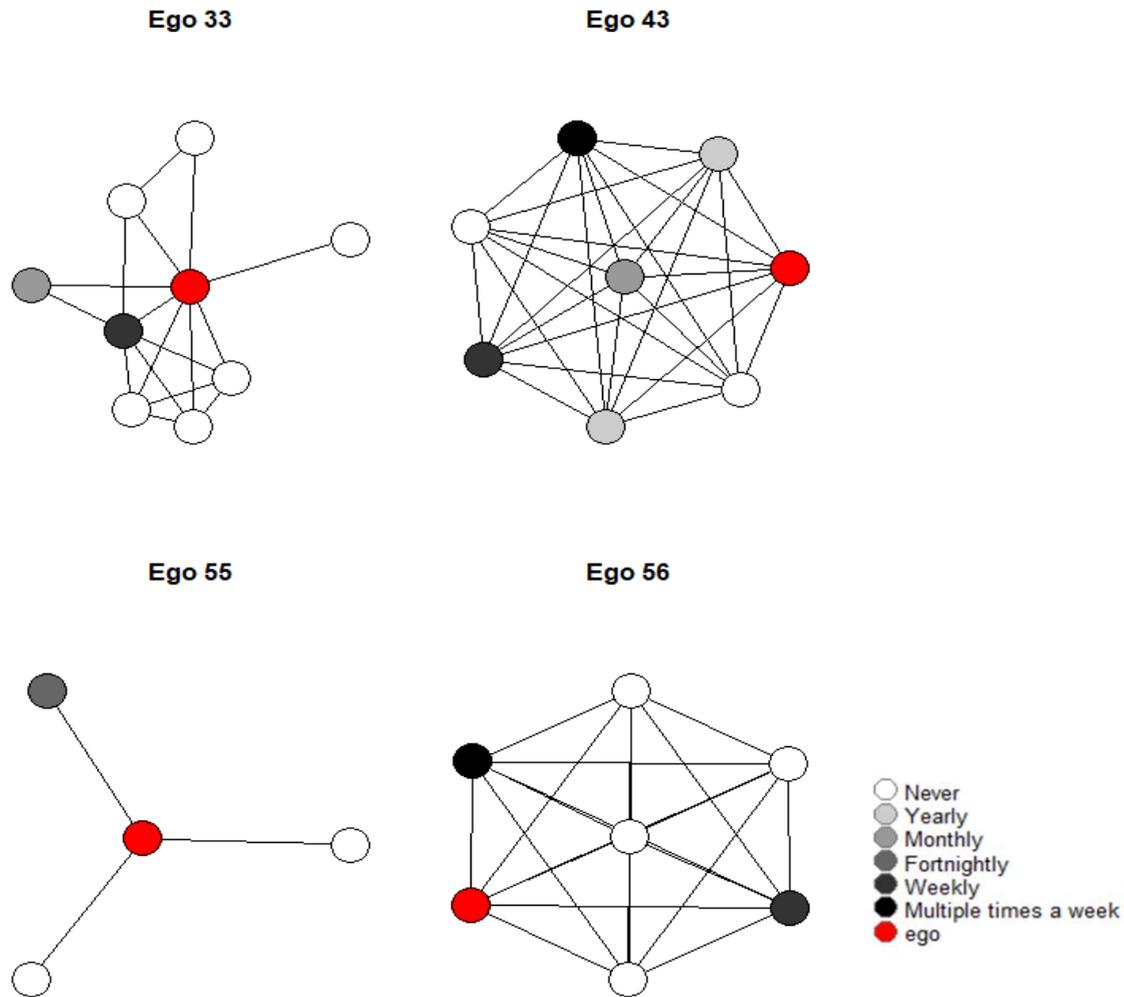
For many residents, this was due to their move into the care home; either the care home did not have good transport links, their alters could no longer come to the care home due to illness or inability to drive, or the ego had moved too far away to make it viable for the alter to visit any longer. When pressed to see whether these alters made contact in different ways (e.g., phone, skype, etc.), many mentioned that this was not an option, or not an option that they would pursue.

> *I: So I'm guessing you don't see Mary so much either?*
> *Resident 33: No, I don't see any of these people.*
> *I: Do you ever phone them?*
> *Resident 33: No, I write at Christmas time. I write them a Christmas card.*
> *[…] There's not much to phone about.*

Further, a few residents mentioned that this was not an option anymore, because their phone had been removed from their rooms because they had called 'too regularly' or that they got confused with the phone and did not like the loud noise it made. For some residents, phones were present in their room, but were rarely used to contact alters who they did not see any longer or who they saw less regularly. Residents seemed to be more likely to call family or friends who already called into the care home regularly, and they were usually calling them to ask them to bring something to the care home that the resident could not get themselves.

4.3.4.1. Frequency of contact and types of support

Frequency of contact with the resident is likely to affect what type of support an alter can give, and, indeed, whether an alter can provide support at all. Table 4.6 shows the proportion of type of support by how often the ego has contact with the alter. Over 50% of alters who discuss personal matters with the resident are seen weekly or multiple times a week. This will most likely capture people who visit the resident most often and therefore are more likely to discuss personal matters with these alters because they are spending more time with them. Those alters who are nominated for 'Help' have a similar distribution over frequency of contact, as over two-thirds of alters who are nominated for 'Help' are seen weekly or multiple times a week. However, some of these alters who provide help, and who are seen multiple times are week, are likely to be staff, as they work in the resident's home. Regardless, the large majority of people who provide 'Help' are in contact with residents at least weekly, suggesting that residents are more likely to have nominated people for 'Help' if they are regularly available to the residents.

Table 4.6. Frequency of contact by support (*n* (% type of support))

	Personal Matters	Socialise	Advice	Help	Other
Never	2 (2.7%)	9 (11.7%)	6 (10.2%)	6 (9%)	9 (14.8%)
Yearly	10 (13.7%)	17 (22.1%)	3 (5.1%)	2 (3%)	7 (11.5%)
Monthly	8 (11%)	10 (13%)	10 (16.9%)	2 (3%)	15 (24.6%)
Fortnightly	6 (8.2%)	6 (7.8%)	7 (11.9%)	8 (11.9%)	6 (9.8%)
Weekly	18 (24.7%)	15 (19.5%)	11 (18.6%)	13 (19.4%)	9 (14.8%)
Multiple times a week	29 (39.7%)	20 (26%)	22 (37.3%)	36 (53.7%)	15 (24.6%)
Total *n* (%)	73 (100%)	77 (100%)	59 (100%)	67 (100%)	61 (100%)

Further, of those alters who are nominated for socialising, a third are seen yearly or never by the resident, and 25% of alters who were nominated as 'Other' close people who were important in the network are also only seen yearly or never.

4.3.5. Social capital in personal networks

Within this thesis, social capital has been categorised into two types; bonding and bridging social capital. Relations to close family and friends are likely to produce bonding social capital due to their closeness and similarity with other family members (homogeneity). While staff members, are more likely to produce bridging social capital by having access to wider networks and bringing in new resources for residents to access. To explore this further, this chapter demonstrates in Tables 4.4, 4.5 and 4.6 that family ties are most likely to be very close and visit weekly; friendship ties are more likely to be less close and visit monthly and yearly; while staff are not close but speak daily. However exploring whether these concepts (type of relation, closeness and frequency of contact)

are correlated with different type of support can show whether different strengths/type of tie are more likely to produce different types of support. Table 4.7 shows the correlations between these variables and shows that type of relation and strength of tie are not always highly correlated with type of support. The highest correlation was between closeness and personal matters, which indicates that the closer an older person feel to their nominated alter, the more likely an older person feels that they can talk to them about personal matters. However, the only significant correlations are between staff members and personal matters, socialising and help. Indicating residents are more likely to feel that staff will provide them with help, but less likely to socialise or discuss personal matters with them. This findings would suggest that staff are more likely to provide bridging social capital as they are not providing emotional support, but are providing practical support that residents cannot receive from others in their network. Further, despite lack of significance, family and friends are more likely to give advice and discuss personal matter which is perhaps more indicative of bonding social capital.

Table 4.7 Correlation table: Closeness, Frequency of Contact, Relation and Type of support

	Closeness	Frequency of Visit	Family	Friend	Staff	Other
Personal	0.42	0.20	0.35	-0.22	-0.18**	-0.05
Social	0.17	-0.10	0.09	-0.15	-0.24**	0.07
Advice	0.26	0.10	0.29	0.18	-0.30	-0.06
Help	0.02	0.31	-0.11	-0.09	0.24**	0.00
Other	-0.14	-0.11	-0.05	0.06	0.04	0.08

4.4. Conclusion

One of the core aims of this thesis was to better understand the support networks of older people living in care homes. This chapter has explored the characteristics of the support networks of older people living in care homes. Specifically, this gives a better understanding of who supports residents, what type of support they provide, how close residents feel to these supportive alters and how often they have contact with them.

The chapter started by describing the characteristics of residents before moving onto the composition of the networks themselves. Supportive alters were mostly female, and family members, who were deemed to be very close to the resident and visited multiple times a week. This showed that residents valued the support of family members more than any other type of tie and were more likely to feel supported by people they saw in person and felt very close to.

When examining who residents nominated for support, the results showed that 24 residents did not nominate any staff members and 17 did not nominate any friends. The fact that the majority of residents did not feel that they were supported by staff members is interesting and will be explored in much more detail in future chapters.

A small group of people were nominated multiple times for support, and largely these were family members. Further analysis showed that the most supportive alters were nearly always children of the residents, while a couple of these alters were 'best' friends or very close family members who were very involved in the resident's lives. These findings show how important children are to residents and therefore highlights the importance of care homes engaging with these children in order to maximise support for the residents. However, it might also emphasise the lack of support felt by residents from staff, given that residents are heavily reliant on children, and other close family members, for support from outside of the care home. Consideration will be given in future chapters when looking at qualitative data to see whether residents do not feel supported by staff, or whether they prefer to rely on the support of their children and close family.

Analysis of the alters' closeness to the ego also showed that residents often rated their most supportive ties as their closest ties, whilst other ties were nearly always deemed less close or not close. Residents reported that the most supportive alters were seen 'multiple times' a week, yet nearly half of these alters were staff who worked in the residents' home and therefore frequency of contact was less indicative of residents' perceptions of support. Although, generally, those alters who were nominated for support were seen at least yearly, there were also some residents who had nominated people who they *did not* see any longer because they had moved away from their locality or because of mobility issues.

This chapter offers a description of the alters who support residents, while the following chapter aims to explore how the care home supports residents and how the support that is provided by the organisation is viewed from the perspective of residents and relatives, as well as from that of the staff. This will add to the current chapter by not only identifying mechanisms underlining support at the relationship level, but also at the level of the organisation.

Chapter 5 The Organisational Tie

Chapter 5 Outline

The previous chapter discussed the composition of the support networks of older people living in care homes. Arguably, staff members could be a large part of residents' support networks. Past research has discussed the importance of bridging social capital in order to gain new information and resources (Putnam 2000), while organisations could be a key source of informal support and resources for its users and members (Small 2009). However, as found in the previous chapter, some residents did not nominate staff for support. Thus, despite there being the potential for support between resident and staff, residents did not believe that support was present or did not want to capitalise on this support.

This chapter delves into the support provided by staff and by the care home in general. In particular, it will look at what mechanisms underline support in care homes, and how this is viewed differently by staff, residents and relatives. Perhaps more importantly, given the findings in Chapter 4, it will also explore what staff, residents and relatives believe are the biggest barriers to support. Thus, exploring what care homes, as a potentially resource-rich organisational tie, can provide for their residents. The research questions addressed in this chapter are as follows:

> *2a. How do care home staff feel they support older people and what are the barriers to this support?*
> *2b. How do residents, and their relatives, feel they are supported in care homes and what are the barriers to receiving this support?*

This chapter answers these research questions by first exploring how staff feel they support residents and what they feel are the barriers to this support. The second section describes how residents feel they are supported by the staff, and the wider care home, and how they think this support could be improved or what is restricting the support they need in the care home. Thus, by considering the perspectives of residents, relatives and staff, factors which may hinder or encourage support of residents may be explored.

5.1. The staff's perspective

The sections below display the results of a critical realist approach to qualitative data analysis carried out on the interview data of staff, as described in Section 3.5.2. The results show the mechanisms which may have an impact on the occurrence of support in care homes from the staff's perspectives.

5.1.1. Care homes as resource and knowledge-rich hubs

Most residents of care homes are living there because they need care and support, and the resources of the care home are essential to their day-to-day living. Staff were asked about how they supported all residents, not just the residents in the sample. In interviews, staff often described all the daily tasks that they completed to support residents who were part of their formal duties as carers, nurses, or managers.

From the staff's descriptions, a typical day consisted of supporting residents to get up, carrying out personal care, helping residents at meal times, assisting with medication, taking residents to the shops, to activities, on bus trips or to appointments, bringing cups of tea, communicating with families, checking in on residents, updating care reports and helping residents to bed. Although carers could see a routine in their days (or nights), they always mentioned that these shifts could change slightly, particularly if something happened in the care home, such as an accident, or if someone became ill or died. One deputy manager, who was also the clinical nursing lead, would often help nurses and carers, and described a nursing/carers shift as a *"production line"*, suggesting that there were routine tasks and activities that had to be completed in a nurse's or carer's shift. One senior carer outlined part of her day:

> *Senior Carer CH1: [...] So it means their medications are then getting handed out, so that they're [residents] on time for the rest of the day. Then, once we [carers and nurses] finish that, it's basically get them in for their lunch, make sure they've had enough to eat, had enough to drink. Make sure they're interacting with other residents and the staff. This afternoon, there's a concert on, so the majority of them are all at the concert, or if they want, they can go into*

their rooms with their families, and things like that. Then it's back to dinnertime.
It's like one big continuous cycle.

Thus, despite carers suggesting that they spent the majority of their day with the residents, this time was quite scheduled and 'task-orientated'. Residents described how staff might help them on a day-to-day basis with essential personal and medical care:

Resident 32: They help me dress and go to bed and they help me bath or have a
shower. They are the responsible for that, so they really know me!

Resident 63: They're very good. The nurses are all, well some are better than
others. But most of them are good. Carers I've known them for so long and I know
them all. I've no complaints about that. The nurses do my injections, I could do
them myself, but the nurse does it.

Therefore, all staff, and some residents, did agree that staff supported residents in a number of ways. However, there was a large proportion of residents who did not agree that staff supported them in their day-to-day activities. This aspect will be explored in the second part of the chapter, which explores the opinions of residents and, specifically, discusses why residents do not see staff as supporting them.

Nevertheless, many managers and senior staff noted that administrative tasks took up at least 50% of their work time and they believed that this was one of the main barriers to providing support. One manager took the time to list some of the administrative tasks that she had to complete regularly:

Manager CH1: Inductions, induction training and things and then the other side
from the HR point of view like disciplinary meetings and things like that. [...] You
have all audits and everything to do. You have monthly audits, you have weekly
audits, you have medication audits, you have housekeeping audits, you have
kitchen audits, just millions of audits, training audits. Even you're responsible for

people registering with the Scottish Social Services Council.[7] Now all the carers need to be registered with that. So, you're making sure you're doing an audit on that every month, making sure that all your staff that should be registered are registered, checking up on your nurses and things like that. They are pin registered, that their pins are up-to-date and accurate and things like that as well, they're registered with the Nursing and Midwifery Council. It's huge.

In their view, this meant that the time taken on administrative tasks took away time that could be used directly with residents and families. Managers acknowledged that recording the changes were essential to documenting the status of residents, but felt that the requests of the Care Inspectorate and families had sometimes gone too far. As a number of staff discussed:

Manager CH2: Well, the record-keeping obviously is really important and it's kind of a proof of the things that we do but it's very difficult to keep up to date with it. Really, really difficult because there's so much within the day. So, for instance, just there I was taking a cup of tea to a lady and some biscuits, but I don't note that down anywhere but if we were trying to prove or show that we had really good practice, you would want people to know that you do those small things, you know.

Deputy Manager CH4: One five-minute conversation with doctor about two residents, that aren't particularly well, led to about 40 minutes of paperwork.

Thus, from the perspective of staff, the large number of administrative tasks and the time taken to complete these tasks was one of the biggest barriers to providing direct support for residents. A carer also described how the number of administrative tasks had also increased for 'on the floor' staff:

Senior Carer CH5: Before […]– and I'm going back fifteen years maybe – you all just got a report for your own individual floors; you didnae [didn't] have

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[7] SSSSC is the regulator for the social service workforce in Scotland. For more information visit: https://www.sssc.uk.com/

anything to do with care plans, you didnae [didn't] have folders to fill out, the nurses done all that. [...] Whereas now... we have like charts and that to fill in, back then it was the nurse that done it all. [...] Whereas now you're coming in and you've got to remember to document bowel movements and if they've had visitors and things like that.

Staff voiced that it was important to record these events as regulators and family wanted to be informed, however, they also indicated that this record keeping was getting in the way of attending to and getting to know residents.

In addition to this, a common complaint by staff was that there were not enough carers. Therefore, although they could provide the basic care needed for residents, they suggested they were not able to spend the quality time needed to nurture relationships with all residents and thus provide the best person-centred care. When asked what the staff would want to improve, the most common response was more staff:

Senior Carer CH5: That extra person in the morning. I know that sounds stupid but it's an extra pair of hands. Even if it is just to assist people with their breakfast or to make breakfast; it would be great to have somebody in the pantry and just to say that's so and so ready for their breakfast – right, no bother, and away they would go and make the breakfast. That ten minutes is giving you a chance to spend another ten minutes longer with another resident.

Residents agreed with the staff members' arguments that the lack of staff members at hand resulted in staff rushing or delaying care duties, which resulted in worse support for residents.

Resident 53: Either there is not enough staff or there is not enough time, or their time is not being used effectively.

However, although staff and residents suggested that there were not enough staff, or staff were too busy, in all care homes, the use of agency staff[8] was more apparent in care homes located in less affluent areas. Care homes in more affluent areas either rarely, or never used agency staff, whereas it was quite common in less affluent care homes, such as Care Homes 4 and 7.

Staff considered the care home as a place that could potentially provide a wealth of support, care and resources to an older person. However, they believed administrative tasks and a lack of staff could take time away from getting to know the resident or providing more emotional support.

5.1.2. Care home staff making meaningful relationships

Many staff mentioned that it is not the tasks that they do, but *how* they carry out those tasks that allow them to establish meaningful relationships. In particular, staff believed that building a relationship along the way helped to support residents because they learned how to care for residents, as they wanted to be cared for. They felt that it was the everyday conversations and interactions they had when carrying out tasks and activities that made the difference, and, thereby, the support given to residents was more valuable.

> *CH1 Manager: Look, when you're getting somebody up in the morning it's not just a case of that routine thing of getting somebody washed and dressed and things like that. What do you talk to them about when you're getting them up? Because it's the most personal time you can spend with somebody when they're stripped and they're naked and they're vulnerable and you're washing them and you're just talking, you're doing things to make them feel at ease and even yourself to feel at ease sometimes. And the things that come out of that.*

Staff members acknowledged that spending quality time with residents and getting to know them was important to their care, especially when the staff members were trying to

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[8] Agency staff are staff members who are supplied by, and are responsible to, an employment agency and are not permanent members of staff (Manthorpe *et al*. 2012).

build trust with the residents and when they were trying to establish how the residents might prefer that certain tasks were completed.

> *Senior Carer CH5: You, like, [get] to know who likes to get their face washed and who doesnae [doesn't].*

However, staff suggested that building a relationship with residents was difficult when the older person did not understand why they were living in the care home, or when they did not want to live in the care home. Some staff also voiced that if a resident's health worsened, then the relationship between staff and resident would also deteriorate as sometimes the residents blamed the staff or became frustrated:

> *Carer CH1: She had, well we think, she had had a TIA[9] when she was asleep. And she didn't trust the staff after that. She thought the staff had done it to her. So, for a good year, she wouldn't speak to us.*

> *Carer CH5: 'I want to go home to my own house.' And you try to explain to them that this is your house now. No, this will never be my house – but it is, and it's hard.*

Thus, care home staff felt that the negative perceptions that residents held, towards the staff and the care home in general, were a barrier to creating meaningful relationships. This meant that staff were often trying to overcome negative attitudes before they had spent time with each other.

Care home staff mentioned that it was not only during care tasks that they tried to get to know the residents, but also through activities which were held throughout the day. Activities were used by staff to engage residents and families, encourage socialisation and give purpose to a resident's day. However, some care staff revealed patronising views about resident activities which may hinder resident and staff relations:

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[9] A Transient Ischaemic Attack (TIA) or "mini stroke" is caused by a temporary disruption in the blood supply to part of the brain. For more information consult: https://www.nhs.uk/conditions/transient-ischaemic-attack-tia/

> *Senior Carer CH1: We'll [care staff] make sure the residents are actively doing something. Whether it be, like painting, if they want to kid on they're DaVinci, and all that, they'll get their wee paintings out and they'll do it.*

Thus, it seemed that while some residents held negative views of staff, some staff also held patronising views of resident's activities. Arguably, these views would not encourage meaningful relationships between staff and residents if they had been revealed to one another.

Care staff voiced how they tried to build relationships with residents through activities by getting to know them while participating in what they were doing. All care homes employed activities co-ordinator(s) who scheduled an array of activities for residents of all abilities. Activities ranged from large group gatherings for entertainment or music, smaller group activities such as games, craft, readings, physical activity and outings, or one-to-one sessions of nails bars with hand massages, therapy pets, watching television or just sitting in company for people who do not adjust well to large groups or who had less ability to communicate and interact.

Activities co-ordinators in particular found it difficult to arrange meaningful activities, especially when they admitted that they had a limited understanding of what activities would really help and engage residents with cognitive impairment and more serious physical disabilities.

> *Activities CH3: I mean, the one thing that surprised me when I came here was the lack of people that were able to walk. And that immediately, sort of, scaled-down my plans.*

> *Activities CH5: We've got people ... some of the carers will just bring certain residents along who can't actually participate or do anything. That is quite a tricky one and ... especially when you've not got any, sort of, communication skills or ... you know, you can't have a proper conversation with them. That is quite difficult. And I, kind of, just think, well I know that music makes a big difference. That is a bit of a grey area for me, I will admit.*

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Often activities co-ordinators would voice that the activities that they were doing with people who had more advanced dementia or physical difficulties were limited and often tokenistic. This is perhaps concerning given that a large proportion of residents live with dementia and, therefore, if their dementia advances, the activities in which they can participate are also limited.

> *Activities CH3: If they're lying in bed, I often feel the best activity they're getting is from their carers that are sitting with them for lengthy periods giving them their lunch. I don't think there's much more I can add to that, to be honest.*

> *Activities CH5: And if they can't physically do an activity, then even just spending one-to-one time. I do that quite often. I just go into the room and have a chat or put some music on, or have a coffee and … you know, 'cause some of the people don't … there's some residents don't come out of their rooms, but they might just like a little hand massage, have a little chat. You know, just to, sort of, be there and to comfort them.*

Staff made it clear that it was their aim to have meaningful interactions with residents throughout their personal care and that this helped support residents because they were able to better understand the wants and needs of residents. However, staff suggested that this was perhaps easier in theory than in practice, as residents did not always trust staff and it took time to build relationships with residents. Although staff voiced the opinion that they interacted with residents through activities, it seemed that this was limited by who attended scheduled activities, which was most certainly skewed towards people who had less cognitive impairment and physical disabilities. Overall, staff did discuss person-centred care ideals, however, there were barriers to providing more emotional support as staff felt they were unable to make meaningful connections with people whose health was worsening.

5.1.3. Care homes as brokers and advocates

Employed staff of the care home were not the only people who were supporting the residents within the care home. Staff also acted as brokers in order to gain resources

outside of the care home and for other organisations and experts to aid residents through the care home. As well as the day-to-day care and nursing that in-house staff provided, the care home staff liaised with external support, such as specialist consultants, daily. Staff gave examples of multiple teams that residents had engaged with:

> *Manager 6: Speech and language, behavioural support, CPNs [community psychiatric nurses], dentists, because people can't go out as much to the dentist as previous. Opticians come in. Physios will come in.*

> *Senior Carer CH1: On a daily basis, in [NAME] Unit especially, we have, we'll have the GPs, we'll have the CPNs, for the mental health side. We've got the physios, we've got the SaLT [Speech and Language Therapy] team, the podiatry, the chiropodist. They're usually the main ones that will come in. Anybody else outwith, is usually because the doctor has asked them to come out, or the families have brought them in themselves.*

Thus, by living in the care home, residents had access to a wealth of knowledge and resources which not only came from experienced staff, but also from external experts, and which were co-ordinated by care home staff. One resident in particular was very grateful for the expert knowledge of one external doctor who was brought in when the resident was experiencing abnormal symptoms:

> *Resident 43: [Described unexplained symptoms which were discussed with doctor] Last week he [external doctor] said let's take some blood off you and send it to the lab. So [after the results came back] I was sent to local hospital and that's when they picked it up. And if he hadn't picked it up, then I wouldn't be here now.*

Therefore, through the care home organising regular visits from the doctor, the resident's symptoms were highlighted as problematic and, thus, an underlying, more serious condition was detected.

As well as this, staff were often advocates for residents when they tried to arrange for specialists to come to the care home, rather than the resident going to a hospital, which might disorientate or exhaust a resident who might have cognitive impairment or physical

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disabilities. Nearly all care homes had a staff member mention that the time taken for referrals to come through was much longer due to a perception that NHS staff did not think that care home residents were a priority.

> *Manager CH1: I just feel as if, because they're an old person or in a care home, they don't seem to be a priority, but they are a priority. They're somebody's mum and somebody's dad. [...] that can be a wee bit frustrating but definitely it's harder now to get the services and it's a longer process and everything's got to be a referral form now.*

Therefore, staff felt that they were having to advocate for residents in order to get the resources they needed from the NHS. Thus, this could be an example of organisational ties working against residents, where the label of being a care home resident means that it is harder to get the resources needed in daily life, as there is a perception that NHS staff believed that resources should be a priority elsewhere.

5.1.3.1   Care homes and cuts

In addition to being given less priority by NHS staff, many care home staff members believed that one of the biggest barriers to residents receiving support externally was a cut in funding.

Care homes are particularly affected by cuts in funding through government austerity policies which have given local authorities less budget and in turn, have left local authorities less money to invest in care homes, as well as other health and social care services. Age UK estimated that there has been a £160 million cut from adult social care in the past five years. (Age UK 2019b). This reduction of funding has resulted in two large care home providers (Four Seasons and Southern Cross) to collapse in recent years as the biggest funder of care homes are local authorities. Care homes that home a higher number of local authority funded residents are under a greater risk of collapse as these residents pay a lower residency fee and thus the care home receives less funding for these residents (Age UK 2019b). These care homes are also more likely to be located in less affluent areas.

This research shows that because the social care industry has less funding, and increasing demand from older populations, staff believe that funding is being prioritised to other areas because care homes are perceived as not as important. Further to this, there is evidence of the government prioritising other health care areas. Age UK (2019b) report that funding for secondary care (e.g. hospitals) has increased year on year, whereas funding for other areas has only increased moderately or not at all.

In short, there is evidence of real cuts to funding for care homes and this was especially apparent for managers when trying to broker services and medical support from NHS services:

> *Manager CH4: The longest referrals to come through are probably from the community mental health team. I think they're probably quite a stretched resource.*

> *Manager CH1: We have to do referrals to physio. I think with all the cutbacks and things like that now it's quite difficult and, do you know, it can be quite upsetting sometimes.*

However, care homes which had more residents who could refer themselves to private services, such as Care Homes 2, 5 and 6, were arguably less strained for these services. Although these care homes were indeed in areas which were more affluent. Additionally, those care homes in more affluent areas had better access to community services, such as social groups and lunch clubs, whereas care homes in less affluent areas were more affected by local authority budget cuts because they were more reliant on local authority-run services. One care home in particular had become aware of large funding cutbacks and had lost access to other resources that they used to rely on:

> *Manager 7: We did have links with the local community centre, there, but it's fallen away. The actual things they had in it have fallen away, resources, just money, basically.*
> *I: Yeah. What things did they used to have?*
> *Manager 7: They used to have a lunch club, and things, the residents used to go over to, but that fell away. It's all to do with resources from the City Council.*

In contrast, one care home in a more affluent area was able to boast of many different community links:

Manager 6: The theatre company comes in and entertainment […] but predominantly it's the children, it's the schools. Now whether that's the primary schools, the nursery schools or a dancing school, you know, like Highland dancers. […] We've got a harvest festival and they'll come in and they'll bring fruit or they'll bring flowers and things from the schools and they'll go round the residents and give them all flowers and chat to them. Church groups come in as well and [there is] an intergenerational project just now as well.

Further to this, these care homes were much more restricted in terms of budget for activities. Conversely, in more affluent areas, care home managers were not restricted by budgets, as two care home managers suggested:

Manager 6: Money's not a problem. If that's what we need, that's what we get.

Manager 1: We really don't work on a budget and that's the nice thing about the [company name] care homes, I think. […] We don't run on budgets. If I want something, I get it. […] If I needed dinners in bed or something for somebody. I mean today I needed another kind of commode chair for someone. We don't use commodes, but this lady prefers it, it's her choice to be on that for a shower. It's a shower kind of type, but it's a chair with the commode part in it and that's what she prefers because she's very at herself and can say that's what she wants.

Thus, having a more flexible, less restrictive budget allowed managers to cater more for the preferences of residents. In contrast, other care home managers had to fund-raise to increase the budget or made it clear that their job was about running a business:

Manager 7: We've done sponsored walks to Donaldson Park where we've took a couple of the buses and things like that for the Residents' Fund and we all went Donaldson Park.

Manager 4: My job is to sell the bed, I'm a care home manager, that is my job, sell the beds, keep the beds full, you know, it's a business. Ultimately, it's a business.

To be clear, managers at all care home were doing their best to care for and facilitate resources for all residents. However, it was also clear that the more affluent care homes were less restricted by budget and local authority resources, while others had to find other means to fully support residents.

Thus, care home staff assumed a number of roles in order to facilitate a great deal of care, medical support and specialist expertise from outside of the care home. Not only did they assume a broker role between NHS staff and residents, they were also advocates for the older people when there was resistance in getting support for older people. Arguably, this resistance comes from people's negative perceptions of older people living in care homes, and thus being linked to the care home could have a negative impact on getting resources for residents. However, this is also compounded by cuts to the NHS and local authorities, which have reduced the number of services that can be provided. Furthermore, gaining support from outside the care home was made more difficult in less affluent areas as cuts to local authority funding were felt more keenly in these areas as more people relied on local authority support. Overall, care home staff were seen to undertake the role of a broker and advocate for residents to gain support from elsewhere, however, these efforts were being hindered by perceptions from external staff that care home residents were not a priority, cuts to community services and inequality in areas where cuts were felt more keenly.

5.1.4. Coordinating with and supporting visitors

There was a perspective in all care homes that building relationships with visitors was just as important as building a relationship with residents, because it meant that staff were co-ordinating with visitors to provide support and care. Co-ordination with visitors was perceived as being not only beneficial for the resident, but also for the visitors, too, as most of them were going through emotional experiences and sometimes had health issues

of their own. One carer summarised why supporting families of residents was important for them:

> *Senior Carer CH1: It's all about the residents, and the families. And we're not just here for the residents, we're here for the families as well. […] Because a lot of them will come and go, [they] were having a few problems in the house, and this is what it is. So we try our hardest to help them as well, as well as helping the resident. And in turn, it works out both ways.*

For the majority of staff, building a trusting relationship with families happened right from the start, where families would, at first, be hesitant about considering a care home and therefore needed reassurance from staff members that this was the right decision, or that the care home they were considering was the right option.

> *Manager CH3: That's another thing I like to do, is taking people around [the care home] is critical, because the conversations you have are huge, and that you tend to just be listening most of the time. So, you bring people around here and you say, how can I help you? That's all you need to say for about the next ten minutes. And you just need to listen […] That's part of building up the emotional connection, the caring connection, the understanding, the reaching out, the empathy. And I think it's important you establish that at the very beginning.*

For staff, alleviating this guilt and building up trust with families from the beginning was important for building a supportive and co-operative community around the resident. From the staff's perspective, this was beneficial for the resident because they could request items for the resident faster through the relative, conversations about care plans were easier and arranging outings went smoother. As relatives were often reliant on receiving updates from staff members, and staff members were often reliant on relatives to bring in items for residents, for many, this became a reciprocal relationship which would alleviate the strain on both parties.

This relationship between staff and relatives became even more important if a relative was not coping at home, or if the resident became unwell. It was important to staff to try and find ways in which they could help the families alleviate their stress, even though

this was not necessarily their job, but perhaps out of professional necessity. This went further than just helping with the care of their loved one, to finding material ways to support the family members under stress.

> *Manager CH5: Well, we've got a gentleman who comes in ... who used to come in every day to visit his wife, and he's now got terminal cancer, so he's coming in three days a week, because he was getting burnt out, but things like we've offered him ... if we can see that his diet's maybe not been very good, come and have your meals here, come and have your lunch here, or is there anything else we can help with, so he was struggling with his bedsheets, getting them washed, bring them over here, we'll do them for you, stuff like that.*

Staff also tried to build relationships with families through formal channels such as involving them in advanced care planning, relatives' meetings and events. However, relatives' meetings often had few numbers, some volunteering groups had more success than others and some families did not want to be involved in care review meetings:

> *Activities CH3: Newish people tend to come [to relatives meetings], just to, sort of, get the lay of the land. […] the regulars come. It's a fantastic opportunity for them to get to meet other relatives, 'cause they don't ... some people don't get to meet other relatives.*

> *Manager CH3: Well, Ruth [Activities Co-ordinator] and I tried to generate some interest in a support group for families. But the families weren't that keen. They said that, the way things were, they created their own little support group by just getting to know each other. You know, we were trying to kind of, like, do we formalise that.*

Thus, although formal actions are often taken in care homes to encourage staff, visitors and residents to work together, often these formal settings such as volunteer groups or relative meetings are less successful. However, more informal gatherings, such as fundraising and social events, seemed to encourage more participation from and between families.

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> *Deputy Manager CH7: And it was a great day on Friday [at the social event], because there were lots and lots of people there, a lot of the relatives came, everybody was involved in it. There was a buffet put on, cakes made, et cetera, and it was just a good day.*

Furthermore, communal spaces seemed to be key in facilitating informal support between visitors:

> *Manager CH7: Especially when the weather's been so good, the garden's been open, so the relatives have been out in the garden, and speaking to each other.*

> *Manager CH1: We've got the café ... that's the wee hub of the place where people like to meet everybody and all talk amongst themselves and things like that.*

Most notably were cafés (situated in two of the seven care homes), which were designed to be inviting and 'shop-like', as cakes were displayed and visitors could buy a 'posh coffee'. These areas were used for formal meetings as well, but were most often used by the families and residents informally. Communal spaces encouraged fellow family members to meet, discuss the experiences they were going through, bump into staff and other residents, find out about the goings-on of the care homes, be updated by formal advertisements (normally posters and notice boards), but were also places where residents could bump into each other, or where residents could go if they did not want to stay in their rooms.

5.1.5. Summary of staff perspective

Staff accounts of the support they provided to residents portray care homes as hubs which are resource-rich in information, material goods, care and nursing support, as well as emotional support. They not only provided essential day-to-day care and medical attention for residents, but they also felt that they supported residents emotionally by getting to know them, encouraging trust and working with residents for their own care. This chapter found that care homes provide support through acting as a source of knowledge and resources, but also by staff brokering expertise and resources from the NHS and the community. Care home staff co-ordinate with visitors in order to combine

their efforts, provide the best support for residents and relieve stress from relatives and staff alike. More informal support was facilitated through the use of communal areas which were used by visitors, residents and staff alike. However, staff felt that the biggest benefit was to visitors, who then met each other naturally in these areas and gave visitors an opportunity to discuss their concerns with others informally.

Although an older person living in a care home has the potential to tap into this resource-rich hub, there were barriers to this support outlined by all parties, some of which, are becoming more difficult to overcome unless care homes are willing to adapt. Staff felt that the amount of administrative work that senior staff had to complete was increasing, and that it reduces the time staff are spending with residents. Further, they felt that, with increasing pressures to spend quality time with residents, as well as carry out their day to day tasks, there were not enough staff members at hand. Staff also found it difficult to make meaningful connections with residents who had declining health and increased cognitive function. This was especially difficult when the residents voiced that they did not want to be in the care home or had an overall mistrust of the staff. Furthermore, although activities were used as a means to provide emotional support and create meaningful interactions between staff and residents, these were often limited to older people who had less cognitive impairment and physical disabilities. Although all care homes enabled visits from NHS staff and an array of experts to provide specialist care to residents, staff did feel that there was resistance or delay to the care for two main reasons. Firstly, there was a perception that residents were sometimes given up on by external supports, and, secondly, they felt that the reduced budgets of the NHS and local authorities reduced the resources available to these services.

Chapter 2 discussed how Small's (2009) study showed that organisations could provide formal support and resources, and incidentally, the practices of the organisation also allowed users to access more informal supports. This section of the thesis partially mirrored these findings with analysis identifying that care homes were hubs of knowledge and resources, while also brokering resources from elsewhere.

However, informal supports were not as evident, and usually stemmed from cafés, were families and residents could exchange informal support, which the majority of care homes did not have. It is worth discussing that the formal and informal role of care home staff

members may also vary depending on their role. For example although the formal tasks of a carer's role is concerned with personal care, daily routines and liaising with residents and families, a care home nurse also has these responsibilities to a lesser extent while also leading on tasks such as medication and liaising with external doctors/specialist. Person centred care frameworks would dictate that activities such as liaising with family and developing meaningful relationships with residents are a formal element of any role in a care home. However it is clear that different roles have varying capacities and time constraints to do this. Social care policies, such as person centred care or relationship centred care, state that creating meaning relationships and communities within care homes are a formal element of social care. However this thesis has shown that these key elements of person centred and relationship centred care are not evident in every care home, or for every staff member.

In reference to organisational ties, this means that care homes act differently to the theoretical framework that Small (2009) dictates. Although care homes, as organisational ties, do have formal and informal elements to the support they provide e.g. medication/personal care or liaising with community groups, care homes differ from this theoretical framework because they are trying to formalise this informal support through care practices such as relationship centred care. Care homes are doing this by making the creation of meaningful relationships between resident and staff, but also staff and relatives, a formal element of a staff member's role. By making the creation of meaningful relationships and the creation of community an essential element of staff roles, care homes are recognising the importance of this informal support in social care. However, although this informal support is a formal part of care frameworks, it is not evident across all care homes. This will becoming particularly evident in the upcoming resident section, where they will describe the support they receive in care homes.

Overall, staff felt they provided a wealth of support for residents and their families. However, this was sometimes hindered by time and administrative burdens, the declining health of residents or external limitations.

5.2. The residents' perspective

How do residents feel they are supported in their care homes and what are the barriers to receiving this support?

Chapter 4 showed that not all residents described a supportive relationship with staff. However, in the previous section, staff outlined how they supported residents through creating meaningful relationships with them, and by coordinating support with the families. They also discussed how the care home provided a wealth of resources and brokered external supports from specialists.

Thus, this section is particularly interested in how residents feel the care home supports them; this could be directly from staff, or it could include resources and information that the care home generally provides. This section will explore the mechanisms which emerged from the accounts of residents, and whether residents identify similar factors to staff.

5.2.1. Staff providing direct support

Residents who had better relationships with staff discussed how these relationships were cultivated. One resident discussed how one carer took her to her local church one day:

> *Resident 53: She [carer] was so good! The people who came to speak to me. I knew who they were. But she would engage. She didn't take over, neither was she just a dumb blonde. She engaged nicely and she was really very, very good.*
> *I: She was like a companion?*
> *Resident 53: Yes yes yes – and that sort of experience. It forges a stronger bond. Because you've done something different outside the place. Nothing to do with this place. We shared that you see? And that's always a good thing.*

Thus, by being able to spend quality time with her carer that was not based around the care home and her own personal care, the carer and the resident were able to share a pleasurable experience together. Thus, acknowledging the lived experience, wants and needs of the resident is important for everyday care. In this case, enabling the resident to go her community church while the staff member engaged with the resident and her

fellow church members, meant that the carer could get to know the resident better, and vice versa. Arguably, providing this additional support is completely aligned with a care home policy that adopts a person- or relationship-centred care framework. However, this is clearly limited if carers are not given time to have these experiences with residents, or when the care home does not have the resources to allow for this time and space.

However, as suggested by the term '*not just a dumb blonde*' used by the resident, some residents, including this one, did not always have the best opinion of carers. Some residents would comment on carers being foreign, not having a British accent, 'being silly' or referring to them with child-like terms. Thus, these perceptions created extra barriers for foreign, non-white or younger carers to establish relationships with residents. As such, it seemed that staff had to go above and beyond to create friendly relationships with some residents and the onus to create this relationship was largely placed on the carers, not the residents.

However, residents and relatives suggested that the staff they had the best relationships with were those staff who communicated well and told residents if they made a mistake. In contrast, when staff members did not do this, those residents who could argue their point would make themselves heard or relatives would become frustrated with staff:

> *Resident 35: Well I'm supposed to have the hairdresser's tomorrow. They'll tell you the day, but not the time. So that's a difficult one.*

> *Relative 19: One of the girls had given her the wrong tablets and Barbara told her and she wouldn't take them. She knew she hadn't to get them, but the girl denied it, which was a bit silly, because Barbara took them straight to the [manager's] office.*

Residents suggested that, in addition to staff not being honest, some staff would not speak or act kindly to them:

> *Resident 44: I'm really miserable. Maybe I'm watching something on the telly and I'm asking to go [to the toilet] and they say 'not now' or something like that. They don't take me. […] They don't have enough staff. I mean sometimes it's*

every day, or you ring the bell and they don't hear it, or they say they don't hear it. You've just got to wait. They say, 'You'll just have to do it in your seat'. I'm not doing that! This is an expensive seat! I'm not going to soil the floor.

Thus, residents suggested that carers who openly communicated with them, and were honest about what they were doing with their care, were the carers with whom they had a better relationship. This was in addition to carers who spoke to them in a dignified and respectful manner. This suggests that residents were looking for particular qualities in carers, rather than looking for specific types of support.

As well as this, some residents mentioned that the turnover of staff was quite high and, therefore, the staff were not employed in the care home long enough to get to know the resident or get to know how the resident liked things done.

> *Resident 42: Staff change quite regular in here.*

Additionally, many residents and relatives voiced that they did not want to create relationships with staff that were loud, used bad language or were demanding of the resident:

> *Relative 61: Amanda [carer] is very possessive of giving mum the shower, she doesn't like other ones [carers] doing it, and it's again the language thing ... Ugh! "I shower you on Wednesday!" and it's not the thing, it's the demanding way.*

> *Resident 44: R: I can't bear it. […] They just swear away and it's horrible. I don't like it.*

> *Relative 71: Basically that she [carer] was demanding. She was wanting him to do something [that] he didn't want to do or something to that effect, but […] I got the feeling […] he just didn't like her attitude.*

Although the behaviour of carers was, on many occasions, called into question, arguably, some of these complaints showed class divisions between some residents and staff. Many

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residents were from higher socioeconomic statuses than the carers who were taking care of them and were not accustomed to working-class culture. These comments may therefore give an indication of salient socio-economic differences between some staff and residents. Previous socio-linguistic literature has discussed patterns of swearing in different cultures and social backgrounds. Specifically, researchers have explored the unacceptability of using bad or blasphemous language in religious communities (Allan and Burridge 2006). Arguably, older generations in British society are more likely to be religious or socially conservative and therefore less tolerant of this language. However, McEnery and Xiao (2004) found that people of lower social class were more likely to frequently swear than those from higher social classes. Thus, perhaps there is a socio-economic barrier to establishing meaningful relationships with staff, especially if carers act and talk differently from residents.

Section 5.1.1 illustrated how residents felt that staff supported them with their personal and medical care and in this section residents voiced that some staff supported them by making meaningful connections with the residents. They did this by spending quality time with the residents and getting to know their likes and dislikes. Examples of going above and beyond were a key way that residents showed how staff supported them and got to know their personalities.

However, there were a number of barriers to creating these meaningful relationships, which were sometimes created by organisational pressures, but others seemed to stem from the prejudice of residents or tensions between staff and residents. Notably, a lack of time spent with residents, high turnover of staff and not having enough staff were voiced as reasons that staff were not able to get to know residents properly and therefore could not create friendly relations. These could partly be determined by the organisational pressures on staff, but could also be driven by the organisational culture of the care home. For example, if other staff paused to have longer conversations with residents, or if they took a bit more time to help a resident complete a task rather than rushing, then other carers would follow suit.

Residents also noted the characteristics and personality traits of staff with whom they were more likely to have good relationships and therefore they were more likely to turn to for support. Staff who were polite, communicated well and were honest about their

mistakes were mentioned as being favourable. Additionally, residents suggested that they did not appreciate staff who used bad language or were loud. These divides between staff and residents could perhaps be attributed to different social and cultural backgrounds. Thus, although forming meaningful relationships could lead to better support and care, as evidenced here and in other literature (Brown-Wilson 2009), creating these supportive relationships between staff and residents could not only be solved by 'spending more time together'. Residents had clear personality preferences, and this factored into whether residents enjoyed the company of certain staff.

5.2.2. Meaningful activities

Another way in which some residents felt they were supported was through care home led activities, as some residents valued the purpose and escape it gave them. This also reflected the views of staff, as discussed in Section 5.1.2, where they discussed activities as a part of the support that the care home offered residents. Activities were seen as a staple of care home life by staff, families and residents. Importantly, residents often viewed activities as *only* scheduled events, groups, outings or fun tasks that were organised by the activities co-ordinators. However, staff usually had a broader view of what activities could be, which included any day-to-day interaction. Many residents found joy in activities and some went as far as to say that some of the activities were the best part of their week:

> *Resident 53: I enjoy the craft group. Those girls [staff] are absolutely lovely and the best of every week. No contest there. So that is a pleasure to me and I've done a lot of work over the years in there.*

Craft activities in particular were highlighted as a way in which residents could bond with staff because the staff would often be helping residents by getting material for them and therefore the residents felt that staff were helping them do something for a purpose.

Activity co-ordinators made an effort to arrange activities that would engage more specific groups of residents, although, as discussed before (Section 5.1.2.) activities co-ordinators did find some difficulties in this. This also seemed to be reflected by residents,

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as some voiced that particular activities did not appeal to them. Some residents did not want to be in big groups and the abilities of residents varied widely. This meant that activities could be catered towards different groups of residents and staggered over the course of the day so that everyone could participate over the day. However, activities seemed to be mostly catered towards those who had the least cognitive impairment and physical disabilities. One resident commented that, because of the small number of people who had the ability to attend the activities, sometimes she felt she had to attend these co-ordinated outing and events:

> *Resident 31: For example, she had the children in the other day. So I feel obliged to do that because there's not many who can come down for that. And the children are lovely and pleasant.*

As well as this, those residents who did not want to participate in any activities would often characterise themselves as 'loners', which relieved them of the obligation of attending the activities. Thus, although group activities offered purpose to some and were offered to all residents, they often only engaged a small proportion of residents.

Activities co-ordinators would also arrange larger events where everyone would be invited. However, these events were often much more passive and often involved listening to music or watching a local theatre group perform a short production. This often resulted in activities where some people were uninterested, or, at its worst, they felt they were being patronised:

> *Resident 19: I just thought that there should be more up to date with music. I went in and she was singing the farmer's dog was on the ground and his name was B I N G O and that's old! What's that all about?*

Thus, some residents voiced that having activities that were inappropriate to their needs and wants could be frustrating and made them less likely to participate in future events. This mismatch of activities also meant that residents who may have gained a better relationship with staff were less likely to attend.

In addition, most activities were more appealing to female residents than to male. The majority of residents in care homes in Scotland are female, and this seems to have resulted in the majority of activities being stereotypically feminine. For example, a lot of the activities were based around crafts, singing, baking and flower arranging. Despite this, care homes did make an effort to engage male residents, but often these were small gestures or outings aimed at the men in a group:

> *I: So you're away for pie and a pint today? Do they do that every week?*
> *Resident 13: No only once in a while. Maybe once a fortnight.*

Further, male residents often felt 'outnumbered' and therefore they felt they could not use communal areas, which were mainly female-dominated.

> *Resident 42: And one time we were down there [lounge], me and the two other men, and we wanted to watch the football. But they [women] didn't want to, they all started [respondent makes moaning sounds].*

Therefore, not only did men have less opportunity to make meaningful relationships with staff and fellow residents because there were less activities that appealed to them, they sometimes felt excluded from communal areas, where they could potentially engage with different people. The male residents believed that this happened because these areas were often used for what the majority of people wanted to do, and the majority were female residents.

Staff often mentioned that mealtimes and activities were the main ways they encouraged residents to socialise together. However, many residents and their relatives voiced that, although they were in the company of other residents, they were not necessarily communicating or even wanting to communicate with each other:

> *Relative 52: He doesn't tend to interact with other residents at all not really.*

> *Relative 71: Unfortunately the man that sits near him in the dining room [...] he had a stroke and it's really hard to communicate. [...] I'm not aware really of him striking up friendships with anybody.*

Resident 53: There's no-one in here I really enjoy socialising with. […] No-one in here. Who else can I socialise with?

Thus, although residents may be with each other at these times, they may not be creating lasting relationships with each other, or feel as though they can go to one another outside mealtimes. Therefore, despite spending time with other residents in communal areas, and during activities and eating times, gaining informal support from fellow residents was not common.

Residents suggested that activities were good for getting to know staff and in creating a sense of having a purpose that staff and residents could work together on. Activities coordinators aimed to cater for a range of abilities which meant that the wishes and abilities of residents were taken into account when organising the activities for the week. Care homes organised residents' meetings to gather ideas of what they would like to do and where they would like to go on the trips, thus, giving residents some autonomy and choice as to what would be happening in the care home in the future. However, this sometimes meant that events that were organised for all residents were not appropriate for some, as they could be too loud for some, because of the crowds, and too patronising for others. This sometimes resulted in few people attending activities and therefore some residents felt obliged to attend activities, even if they did not really want to.

Activities could be especially frustrating for men as the majority of the care home population was female. Men were often disinterested in stereotypically feminine tasks, such as art and crafts, and felt 'out-numbered' in communal areas. Often activities coordinators tried to appease men with men-only outings and events, but these were irregular.

As staff had a broader view of activities, they mentioned that mealtimes were a good time to encourage residents to socialise together, and also for staff to spend time with residents. However, residents voiced that this was not always the case, and making relationships with residents was difficult when they had little in common or had varied cognitive and physical abilities.

5.2.3. Maintaining links to the community

A key concern of residents was that they were isolated from the 'outside world' in the care home. Residents felt keenly that they still wanted to be included in the communities they had resided in before moving into the care home. Some were previously part of community groups, sports clubs and churches, which was a big part of their identity. Indeed, for some residents, being able to keep in touch with these communities was very important to them. However, often these connections had slipped away because of distance, inability or lack of transport. One resident was still a member of her home-town heritage society, however, she was not able to visit her friends from the society because of the distance it would take to get there. Therefore, the only way she kept in touch with them was by sending cards at Christmas time and keeping up to date with the local paper, which sometimes discussed the society's work:

> *Resident 33: I used to be a member of a Heritage Society and I use to work in their shop. They send me local newspapers so I bought a book to keep the clippings in.*

Maintaining links to local communities, where they had previously lived, was very important for residents, but arguably this is more difficult for care homes to facilitate, especially if they have no knowledge of these previous ties. However, residents were often looking for small gestures to remain connected to their communities. For example, one resident, who had sight difficulties, could no longer read the local paper sent to her by her old neighbours, so her daughter arranged for a 'speaking' newspaper to be sent to her weekly so she could listen to the local news. Resident 33 was still able to read her local newspaper, and so, her daughter had arranged the paper to be delivered to the care home for her. There were a number of examples such as this, where residents required a small amount of help to maintain links to their community, however, these needs were mostly being met by family members, and not the care home. This is perhaps worrying for residents who do not have family, or for those who do not have contact with people from their previous community.

In particular, it was important for many residents to keep in touch with their local church. Although the care homes did facilitate this on rare special occasions, this was often not

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the case because of the time taken to get to the church or a lack of resources/staff need to go every week. Residents often had to rely on friends, fellow church members or taxis (if they were able to use a taxi) for transport to the church.

Resident 24: I go [to church] every week. One of my friends [from her church] takes me to church every week, and she's very good.

Resident 31: I used to go to guilds and the badminton club at the church. I really miss the church because I was part of the guild and now they have a new minister and I think everything is going very well [at the church] but ... At least I get [there] when this girl can come for me.

However, for many residents, this was not an option as they did not have the social connections or transport to facilitate this. Thus, many were reliant on church members coming to visit them, or a general minister/priest visiting the care home. As many residents could not leave the care home without assistance, finding the time and resources to facilitate visits to their local church was difficult. Although care homes often facilitated local ministers coming into the care home, having personal visits and organising mass/communion, the majority of these were from a local priest/minister who was attached to many local care homes, rather than the personal churches of the residents. Further to this, these general visits were often not as regular as residents would like:

Resident 42: Well he [minster] comes up here, every couple of months

Religious residents often commented on how important these visits were, or that they would like them to be more frequent. However, for many residents, the importance of keeping in touch with their local church was social, rather than being driven by faith, and therefore this did not meet the needs of these residents. In either case, it is clear from the residents that maintaining links to previously strong ties in their community was important to them and care homes were not supporting this to preserve these connections as residents would have liked.

Some care homes tried to retain links to the communities in innovative ways. Some care homes liaised with community groups from outside the care home to provide

entertainment and social groups outside of the care home. While some co-ordinated with local churches, nurseries and schools, others had links with community groups which had weekly game afternoons or lunches. One care home co-ordinated a minibus to and from a local community group which also picked up one of the resident's friends along the way so they could attend the group together every week:

> *Resident 19: We meet every Monday at the club and she plays dominoes with me. She used to walk up but it's too much now so she gets picked up on the bus!*

Although this community group was not a group that the resident had previously been connected to, it allowed her to stay in touch with a long-term friend, while going back to the area in which she lived for most of her life. This is one example of how the care home found a happy medium to accommodate the resident maintaining her connections to friends, while making it cost- and time-effective for the care home to use the minibus because there were three or four residents who attended the group every week.

5.2.4. Interlink with staff and families

For many residents, their families were a big part of their identity. This meant that, for some residents, staff getting to know their families was just as important as getting to know them. Therefore, a key way to support residents was to include their relatives and, in some cases, facilitate residents and relatives coming together within and outside of the care home as this was very important for residents.

However, residents voiced that staff getting to know their families was not the norm and it was only particular staff who took time to get to know their relatives. From the residents' perspective, it was often a particularly sociable carer, the manager or the activities co-ordinator who took the time to get to know relatives. This often resulted in the residents nominating said staff member for support, as explained in Chapter 4, and this will be discussed further in Chapter 6.

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If the staff took time to get to know the resident's families, then the resident not only benefitted from a better relationship with staff, but they also felt that they could rely on staff and family to co-ordinate together:

> *Resident 63: Well there was one at our table who was just a bit strange always, picking on things. And I wasn't very happy. But I went to Fiona [daughter]. And she and the staff sorted it. So I was moved tables to another table. And that was fine.*

This was especially true for couples who lived in the care home together. For example, Resident 13 lived with his wife, who lived with advanced dementia, in the care home. He described one event that they had attended with the staff:

> *Resident 13: It was great. The whole place was packed. There wasn't a seat free and who was at the front but Mary, my wife. The nurses were all around her getting her to cheer [for me] but she didn't. [respondent laughs]*

Despite his wife not responding to him at the event, Resident 13 was grateful for the staff encouraging his wife to be involved. Resident 13's relationship with the carers was strong because they took the time to care for him and his wife while getting to know them and their family members. This meant that the resident had a great deal of gratitude for the carers involved and they worked as a team with his family through his wife's care and his own. This meant that when something did happen in the care home, the resident had confidence and trusted the staff to keep their daughter informed and to work with his family members:

> *Resident 13: If something was to happen with Mary [wife] and we needed one of the nurses then we would just say – make sure to say to Ann [daughter]. Anything that's needed she'll attend to it.*

Residents who felt that the staff knew their relatives seemed to have more trust in the staff and have a friendlier relationship. Thus, cultivating this relationship between staff and relatives could be very important for improving relations between residents and staff, as well as encouraging a supportive environment in the care home in general.

However, some residents had experienced negative situations with staff, and thus, although their family was very important to them, they did not want staff and their families to integrate as they did not trust staff, which hindered the co-ordination of staff and relatives. This not only meant that the relationship between staff and residents was not as good as it could be, but it also meant that relatives took a different approach to interacting with staff members:

> *Relative 71: I really approach the staff ... really by myself. If I want information or something like that or the staff will come and speak to me themselves. It's not something I do with my father. It's something I do independent of him.*

Therefore, relatives felt the need to detach themselves from staff in front of the resident, because the resident did not want to be associated with the staff. Additionally, staff also suggested (in Section 5.1.4) that residents could be very reliant on family members, and this may not be helpful if the family member was already 'burnt out' or if the resident did not trust staff. Staff members suggested that sometimes family members needed to stop coming in as regularly, at least initially, in order to prevent them burning out further, or, alternatively, taking a break could encourage residents to start trusting staff more:

> *Senior Carer 1: The daughter had went on holiday, she went away for four weeks, and she [resident] obviously didn't have anybody but the staff. And then, that's when she started coming back round again as if, no, I can trust you.*

Thus, cultivating a relationship between staff and relatives was important for a number of reasons. Firstly, those residents who felt that their relatives had good relations with staff, felt that they could go to staff or family if they had a problem in the care home and they knew that family and staff would work together to resolve it.

Secondly, residents who felt staff had a good relationship with their relatives were more trusting of staff, and, further, this cultivated a better relationship between residents and staff. For the majority of residents, their families were a big part of their lives, and therefore, of their identity. Thus, if staff built a good working relationship with the relatives of residents, then the residents tended to show greater appreciation towards staff.

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From the perspective of residents who had a good relationship with staff, there was a great benefit for staff cultivating a relationship with relatives. In Section 5.1 of this chapter, staff voiced that having a good relationship with relatives would make their jobs easier, for example, getting items for residents faster and make co-ordination/communication more efficient, which in turn would benefit the resident. However, residents suggested that cultivating this relationship would not only do the above, but allow them to trust staff more and create a supportive community around the resident.

However, this relationship was sometimes not easy to cultivate. Negative experiences with staff could result in some residents not wanting their families to integrate with staff and this could hinder the coordination of staff, relatives and residents. Staff suggested that sometimes families could help cultivate this relationship by stepping away from the care home more regularly, and thus, helping residents to trust the staff, which might in turn allow a more coordinated approach between staff, residents and relatives to emerge. However, it seems this would not be the case if residents felt that the staff treated them badly, rather than the residents needing time to get to know the staff. In any case, there was a general consensus that an interlinking relationship between staff and families was beneficial to all parties. However, the barriers to this co-ordination were complex, and not easily resolved if the resident did not want to trust staff.

5.2.5. Summary of residents' perspective

Through the resident interviews, four main themes emerged when considering how staff and the wider care home supported them: staff provided direct support, activities, maintaining links to community, and interlinks between staff and family.

Although residents gave varying accounts of staff who supported them, and others, who were less supportive, staff who had more personal connections, regardless of the practical help they gave, were the staff for whom residents cared the most. Residents suggested that staff who connected with their families were those who were most valued and more likely to be suggested as supportive. Staff who got to know family members were trusted

more, and residents felt they could rely on them. Therefore, as relatives and staff built a relationship, and because family was a big part of a resident's identity, residents and staff built a stronger connection. However, from the residents' perspective, it was not the norm for staff members to really get to know families and some residents voiced a reluctance for staff and relatives to mix. Families voiced that, even if they did not interact with staff in front of the resident, they felt they could obtain the relevant information from staff members, although this may reinforce a distance between residents and staff.

Some residents had formed friendships with staff, where they would spend a considerable amount of time with these staff members. Where these relationships had formed, residents indicated that these staff members had the qualities required of a carer, by often commenting that they were polite, kind, communicative and honest. Alternatively, they described how staff with whom they did not get on were rude, used bad language and were often demanding of the residents.

Residents suggested that there were many opportunities to fill their day with activities. For some residents, this was a big part of their day-to-day life in the care home, whereas others did not participate in activities. Activities facilitated better relationships with staff, however, there was little evidence of residents making friends with other residents through these activities. In particular, residents were reluctant to participate in activities if they were not appropriate activities, or if they felt they could not leave during the activity and thus felt trapped. Men in particular felt they were not welcome in more gendered activities or in communal spaces because they were female-dominated spaces. For residents, maintaining links to their local community was very important and was often mentioned as a 'sore point' for those residents who were not able to maintain those connections. For some residents this did not mean that they needed to visit that community, but they still wanted to feel involved, such as receiving local news or keeping in touch with old friends from that community. Many residents were able to maintain these links through the help of family, and there were only a couple of examples of care homes maintaining these links. In particular, care home staff could be doing more to help residents to do this by finding ways to link to communities. More solutions to maintain these connections need to be found, especially for people who want to keep in touch socially and religiously.

5.3. Discussion of Mechanisms

A core aim of this thesis was to better understand how care homes (the organisational tie) support older people and to identify the mechanism which underline this support. To do this, a critical realist approach to qualitative data analysis was used in order to identify mechanisms which may encourage or hinder the provision of support to residents. Data from staff, residents and relatives were consulted and resulted in a number of mechanisms being identified using both the staff perspective and the resident/relative perspective. To illustrate this, visualisations of the mechanisms identified from analysis are displayed below:

1.   Micro-level mechanisms

    1.1.   Staff providing direct support (care home resource/knowledge-rich hub)

        a.   Care home budget restrictions (no. of staff, resources, activities)

    1.2.   Meaningful relationships between staff and residents

        a.   Meaningful activities

        b.   Resident's complex care needs

        c.   Attitudes of staff and residents towards each other

        d.   Understanding/training of staff

    1.3.   Coordinating with and supporting visitors

2.   Meso/Macro-level mechanisms

    2.1.   Care homes as brokers and advocates

        a.   Priorities and funding of local authority and NHS

    2.2.   Requirements of the regulator (admin tasks)

    2.3.   Maintaining links to the community

Residents, staff and relatives highlighted a number of events which contributed to similar emerging mechanisms, however, in some cases, it was only staff or only residents and relatives who highlighted events which contributed to a mechanism (e.g., only staff highlighted alternative priorities for NHS staff). All mechanisms are discussed below:

1.1.   Staff providing direct support (care home resource/knowledge-rich hub)

Staff members felt they supported older people in a number of ways, including through care, nursing and emotional support. Some residents agreed that staff were supportive, however, residents voiced concern that sometimes support from staff, and the care home in general, was hindered by more than just lack of resources, budget and time. Residents voiced that relations with staff were often not as good as they could be because some staff were rude, rushed, were not polite or used bad language. Staff agreed that they were often rushed between residents, especially at busy times and both staff, and residents, attributed this to a lack of staff, and there being a lack of time to spend more time with residents.

1.2. Meaningful relationships between staff and residents

Both staff and residents believed that more support and effective care would be provided if staff and residents had better relationships. While both staff and residents believed that a key way to cultivate meaningful relationships was through spending extended periods of time together, residents believed that spending time with staff outside of caring tasks was important. Staff were much more likely to suggest that spending longer with residents on care tasks, so that they could get to know the resident, was much a more likely and obtainable possibility, whereas residents indicated that the strongest relationships between them and the staff had been made outwith care tasks, and even better, outside of the care home itself. Indeed, this is something that care homes are perhaps aiming for but not necessarily achieving due to time and budget pressures.

However, staff believed that a bigger barrier to building relationships with residents was due to residents having more complex care needs and having a higher likelihood of cognitive impairment when they moved into the care home. Thus, staff felt they were no longer able to make as many meaningful connections with residents as they once were.

This is perhaps compounded by some staff's own admittance that they did not have the proper training and therefore understanding of dementia, and were unsure of what activities would be most appropriate for people living with dementia. Furthermore, the negative and patronising attitudes of staff emerged during the interviews, which may also impair the making of meaningful connections between staff and residents.

1.3. Coordinating with and supporting visitors

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Perhaps most importantly, residents felt that those staff who cultivated a good relationship with their family members and communicated effectively with these family members were the staff who were able to support them best. Residents suggests that this is not the norm and, therefore, this perhaps provides a reason as to why many residents do not feel supported by staff.

Staff members described a number of ways in which they felt they coordinated with visitors to support residents, and, further, a number of ways in which they supported visitors who may need support themselves. They described setting up relatives' meetings and trying to engage with families. However, it was much more likely for staff to discuss coordinating with family members to support residents, rather than describing getting to know the families and spending time with families and residents together.

2.1. Care homes as brokers and advocates

Staff were also supportive in indirect ways, such as brokering support from external sources and advocating for residents. This seemed to be a key role for care home management and, indeed, for 'on the floor' staff who communicate with external specialists day-to-day. However, this support was sometimes hindered by the preconceptions of NHS staff who believed that older people living in care homes should not be considered a priority, and thus care home staff needed to argue for resources and timely visits. Staff also viewed this as a result of cuts to NHS funding, where NHS services were having to run on reduced staff and budgets and therefore needed to prioritise their resources.

This was also apparent for care homes that were situated in less affluent local authorities where funding had been cut from community services that the care home previously relied upon (especially with regards to entertainment and community services). Thus, care home staff who worked in less affluent areas had to fund-raise for resources, rather than having a budget at hand to assist residents.

2.2. Requirements of the regulator

Further to this, staff members noted that the requirements of the regulator had become a large burden, and that the administrative tasks that were required to meet regulatory standards were, in the long term, taking time away from residents and their families.

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2.3. Maintaining links to the community

Additionally, residents made it clear that maintaining links to their local communities was important for them. However, this was not talked about among staff. Staff did mention keeping a link to the care home's local community, which, indeed, could be the resident's local community, but many residents had come from other localities and had moved to be closer to family. Residents often only needed small gestures to maintain this link, which could be easily met by staff and care home budgets.

Chapter 4 established that only 11 residents out of 36 nominated a staff member for support. Despite this finding, this chapter identified a number of ways in which residents described support from staff and the care home overall. Thus, there is a dissonance between residents acknowledging that care home staff are supporting them (by nominating them for discussing personal matters, help advice and socialising) and the support that residents describe is happening within the care home.

Perhaps the reason for this disconnect is eluded to in this chapter, as, although residents established many ways that staff supported them, they also identified a number of ways in which support was hindered. Thus, although they recognise that staff sometimes support them through activities, coordinating with family and providing care, they may not have nominated staff for support because of factors such as: rudeness, using bad language, negative experiences, or feeling that the care home is not where they want to live. Thus, although staff did support them in many ways, multiple negative interactions with staff, and residents' discontent within the care home, resulted in them feeling that they were not able to nominate staff.

Alternatively, the lack of nomination could be due to a lack of personal connection with staff. Past literature has discussed the importance of bonding social capital for older people (Forsman *et al.* 2011) and, thus, support from bridging social capital, such as staff, might not have the same meaning or value for older people. Thus, although staff did provide essential material support, such as medical and personal care, as well as providing means for family and friends to visit, activities and external support, these were not actually the personal connections that residents nominated. This perhaps, gives more weight to approaches to care such as person-centred or relationship-centred care, where

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there is more of an emphasis on creating a meaningful and emotional relationship with residents. However, this might also suggest that these approaches to care are not being fully carried out in these care home settings, due to the lack of nominations.

5.4. Conclusion

In this chapter, the views of residents, visitors and staff were consulted to answer the following research questions:

> *2a. How do care home staff feel they support older people and what are the barriers to this support?*
> *2b. How do residents, and their visitors, feel they are supported in care homes and what are the barriers to receiving this support?*

This chapter has described some possible reasons for residents feeling supported by the care home and its staff. It has also described how staff felt they supported residents and why they felt they were not able to create meaningful friendly relationships with residents. This chapter therefore built on the findings of Chapter 4, which showed that the majority of residents did not feel supported by staff, and, thus, Chapter 5 has given some insight into why these relationships may or may not exist.

Adding to this, Chapter 6 aims to find patterns of support in the support networks of older people living in care homes. Through the analysis of relational network data and qualitative data, this chapter will create a typology of support networks. Not only will this give an insight into where support is lacking or greatest for residents, but, through qualitative analysis, it will also explore the residents' perceptions of the types of support that shape their support networks.

Chapter 6 Typology of Support Networks

Chapter 6 Outline

Having established how the support networks of residents are composed and what mechanisms may have an impact on the provision of support for residents from the care home and its staff, this chapter now examines how these patterns of support can help produce a typology of support networks. The research question addressed in this chapter are as follows:

3a. Are there types of support networks of older people living in care homes, and if so, how can they be characterised?

Residents are seen to rely on a number of different ties for support, but family ties seem to dominate in importance for the majority of residents. Given that these people are living in a care home because they need care and support, the relationship between them and staff is particularly important. Further, how staff interact with other supportive relations seems to influence the experience of residents through creating a supportive, coordinating community around the resident. Thus, the past two chapters have shown what the support networks of older people living in care homes look like, and how support, through the care home, is influenced. This leads to the current chapter, which will develop these ideas, by creating a typology of support networks informed by key findings from the past two chapters and considering it alongside key networks literature, which is discussed in detail within the chapter.

Creating a typology of support networks in care homes allows the exploration of reoccurring patterns of supportive relationships. Moreover, a typology can expose 'underlying rules or forces', such as social expectations or norms, which may influence the structure of networks (Giannelle and Fischer 2016). This could give insight into how to improve the support provided to residents, while considering other supportive ties and their network's structure. Thus, this typology adds to the discussion around the social inclusion of older people in care homes and as well as to the methodological literature by exploring distinctions between types of egocentric networks.

Chapter 2 outlined past research that had created typologies of support networks for older people and drew on the learning presented in these papers to establish a clear set of criteria which will inform this study's typology of support networks for older people living in care homes. This chapter will outline a short methodology which will describe the data, criteria and process used to create the typology. It will also introduce four main types of support networks for older people living in care homes by producing an in-depth discussion of the characteristics of the types, examples of each type of support network and rich descriptions gathered from participants describing their networks. The four types of support networks are named; the units, the social managers, the integrators, and the compartmentalisers. Each type has its own distinct structural features, but also differs qualitatively in the composition of the network and the sources of support within it. The chapter describes each type before moving on to presenting a short description of whether there are patterns of these types of support networks by care home, funding status or memory problems. This typology of support networks will then lead on to analysis in further chapters concerning organisational ties and wellbeing.

6.1. Construction of typology

The following sections will outline the method used to create a typology of support network for older people living in care homes. It will outline the factors that were considered when developing the typology and will describe how both the structure of the networks and the qualitative descriptions of relationships were included.

6.1.1. Mixed-method approach

Network structure will play an important role in dictating how to group the support networks of residents because the structure of a network can give an indication of how much support a resident could receive and how they are getting such support.

Previous typology researchers have considered many characteristics of networks in order to determine their criteria for differentiating between types, as discussed in Chapter 2, Section 2.5. This study had the benefit of collecting relational network data and qualitative interview data, and thus could draw on two rich sources of data to further

develop an understanding of how residents are supported in care homes. As such, a mixed-method approach to creating the typology was taken.

Taking into account the qualitative meaning behind network structures can lead to different types of networks emerging through understanding the intent and reasoning behind different connections forming. By using a mixed-method approach in creating typologies of networks, structure and connections can be explored while qualitative data can explain why similar structures may have different meanings and functions (Bellotti 2008). Therefore, the network and qualitative data serve two roles:

> *Qualitative accounts explore the subjective perceptions of personal dynamics and the mechanisms that regulate reciprocity and balance, and social networks analysis provides the overall structural configuration that regulates individual opportunities and constraints*. (Bellotti 2015, p. 106)

Thus, by allowing qualitative data to partly inform the typology, a richer understanding of how support networks are created and maintained can be explored. Bellotti (2008) discusses how she considered measures of size, density, components and the qualitative data collected from respondents to create four main types of friendship networks for 23 single people living in Milan. The rich descriptions of friendship networks that the participants provided meant that Bellotti could disentangle networks that had similar structures and realise the function that each friend had in the network. The function and meaning behind relationships and the way residents utilise their support networks, can inform whether there are patterns in network utilisation which are systematic. Thus, by taking into account the descriptive data provided by the residents in this thesis, the structural data can be built on to provide a more informed typology of support networks for older people living in care homes. This in turn will allow a better understanding of the patterns of support that exist in care homes and where support is being provided or lacking.

6.1.2. Creating a typology of support networks

After becoming familiar with both the network and qualitative data, a typology of support networks emerged whereby groups of networks with similar structures and qualitative

descriptions of relationships were revealed. Several key aspects emerged as being important for defining different types:

Firstly, it was clear that there was a difference between residents who had nominated staff for support or not, because this indicated that the resident might be lacking or resisting an important source of support. Chapter 5 has explored the relationship between staff and residents explicitly, however, this chapter will take this further, and will use the residents' relationship with staff as a defining feature of the typology. Thus, whether a resident had nominated a staff member was considered a key factor in the typology.

Secondly, the number of components within the network was important because, as informed by previous research, the density of a network may influence the flow of information in a network and communication between supporting alters (Crossley *et al.* 2015). After exploring the structural network data and the qualitative data, it was clear that some residents did prefer to keep supporting alters separate from each other and thus they had multiple components in their support network. Alternatively, other networks showed how supporting alters were connected for different reasons, either through relation, the resident had encouraged such connection or a connection of necessity. Therefore, whether a resident's supportive alters were connected, and especially whether all supporting alters were connected to each other, became another key factor in the creation of the typology.

A detailed description of each typology is now included in the following sections. This typology is not generalizable and does not represent the Scottish care home population. As reiterated by Bellotti (2015), typologies created through these small samples are reflective of the sample at hand, and, as such, the addition of further networks could reveal other types of support networks or, indeed, could indicate other more pressing factors that may change how the support networks of older people can be characterised. However, it does give insight into the relationships and supportive ties of residents within the Scottish care home system, which may inform further research into how to support older people living in care homes. Thus, by comparing the typology created in this study to other typologies of similar populations, overarching themes can be explored, especially when discussing reoccurring mechanisms which impact the support of older people.

Therefore, it is useful to create typologies of support networks in order to better our understanding of the patterns of support, or perhaps the lack of support, in care homes.

6.2. The typology

Four main types of support networks were identified: the units, the social managers, the integrators, and the compartmentalisers. Thus, Table 6.1 describes a simple way in which the networks can be grouped into the identified types.

Table 6.1. Mechanism for creating typology of support networks

		Does the support network contain a staff member?	
		Yes	*No*
How many components does the network have without ego?	*1*	The Integrators	The Units
	2+	The Compartmentalisers	The Social Managers

Table 6.1 shows a simple way in which to characterise each type of support network, while Table 6.2 lists the network measures (size, density and number of components) for each resident's support network with their ego ID. These measures are taken excluding the ego. Table 6.2 also presents the type of support network each resident was assigned in the final column and shows the structural differences between each network, and their assigned types. This table also includes density, which is 'the number of ties in a network expressed as a proportion of the total number that are possible' (Crossley *et al.* 2015, p. 15) and the number of components. Components are a subset of nodes which are connected directly, or indirectly through a chain of ties and/or intermediaries (Crossley *et al.* 2015).

Table 6.2. Summary of network structures and network type

Ego ID	Size	Density	Number of Components	Type of Network
Res. 15	7	1	1	The Units
Res. 16	7	1	1	The Units
Res. 22	2	1	1	The Units
Res. 23	2	1	1	The Units
Res. 26	4	1	1	The Units
Res. 35	1	1	1	The Units
Res. 41	1	1	1	The Units
Res. 43	7	1	1	The Units
Res. 48	2	1	1	The Units
Res. 52	2	1	1	The Units
Res. 56	6	1	1	The Units
Res. 58	7	1	1	The Units
Res. 61	2	1	1	The Units
Res. 51	11	1	1	The Units
Res. 63	4	0.5	1	The Units
Res. 25	4	0.5	2	The Social Managers
Res. 72	4	0.5	2	The Social Managers
Res. 34	3	0.33	2	The Social Managers
Res. 57	7	0.48	3	The Social Managers
Res. 24	8	0.43	2	The Social Managers
Res. 55	3	0	3	The Social Managers
Res. 27	6	0.27	3	The Social Managers
Res. 33	8	0.32	2	The Social Managers
Res. 64	9	0.25	3	The Social Managers
Res. 11	9	0.83	1	The Integrators
Res. 44	6	0.8	1	The Integrators
Res. 71	8	0.79	1	The Integrators
Res. 18	4	0.67	1	The Integrators
Res. 13	8	0.57	1	The Integrators

Res. 19	15	0.52	1	The Integrators
Res. 31	9	0.42	1	The Integrators
Res. 32	6	0.47	2	The Compartmentalisers
Res. 54	5	0.40	2	The Compartmentalisers
Res. 62	14	0.52	3	The Compartmentalisers
Res. 42	11	0.22	4	The Compartmentalisers
Res. 53	17	0.16	5	The Compartmentalisers

The Units are a type of support network with no staff members nominated for support, and are very dense with only one component. As residents in this type receive support from alters who are all connected, this type of support network has been named the 'Units'.

The social managers also have no staff members nominated for support, but, unlike the 'Units', they have multiple components, and therefore are gaining support from different groups of people who do not know one another. Of course, this results in these networks on average being less dense than the units.

Similarly, the 'Integrators' are a type of network which, like the 'Units', comprise only one component. However, the 'Integrators' differ because they include staff members in their support network. Additionally, the 'Integrators' are named as such, because the staff members are integrated into the support network and therefore family and friends know the staff members who are also supporting the resident.

The 'Compartmentalisers' are different from the 'Integrators' because, although they include staff as supportive alters, these staff are typically not connected to family members and, as such, the networks are less dense and have multiple components. They have therefore compartmentalised different sources of support.

Figure 6.1 shows every network included in their type of support network. From this visualisation, the structural similarity displayed in Figure 6.1 can be viewed through the networks.

Figure 6.1. Visualisation of each support network by type

The Integrators	
The Compartmentalisers	
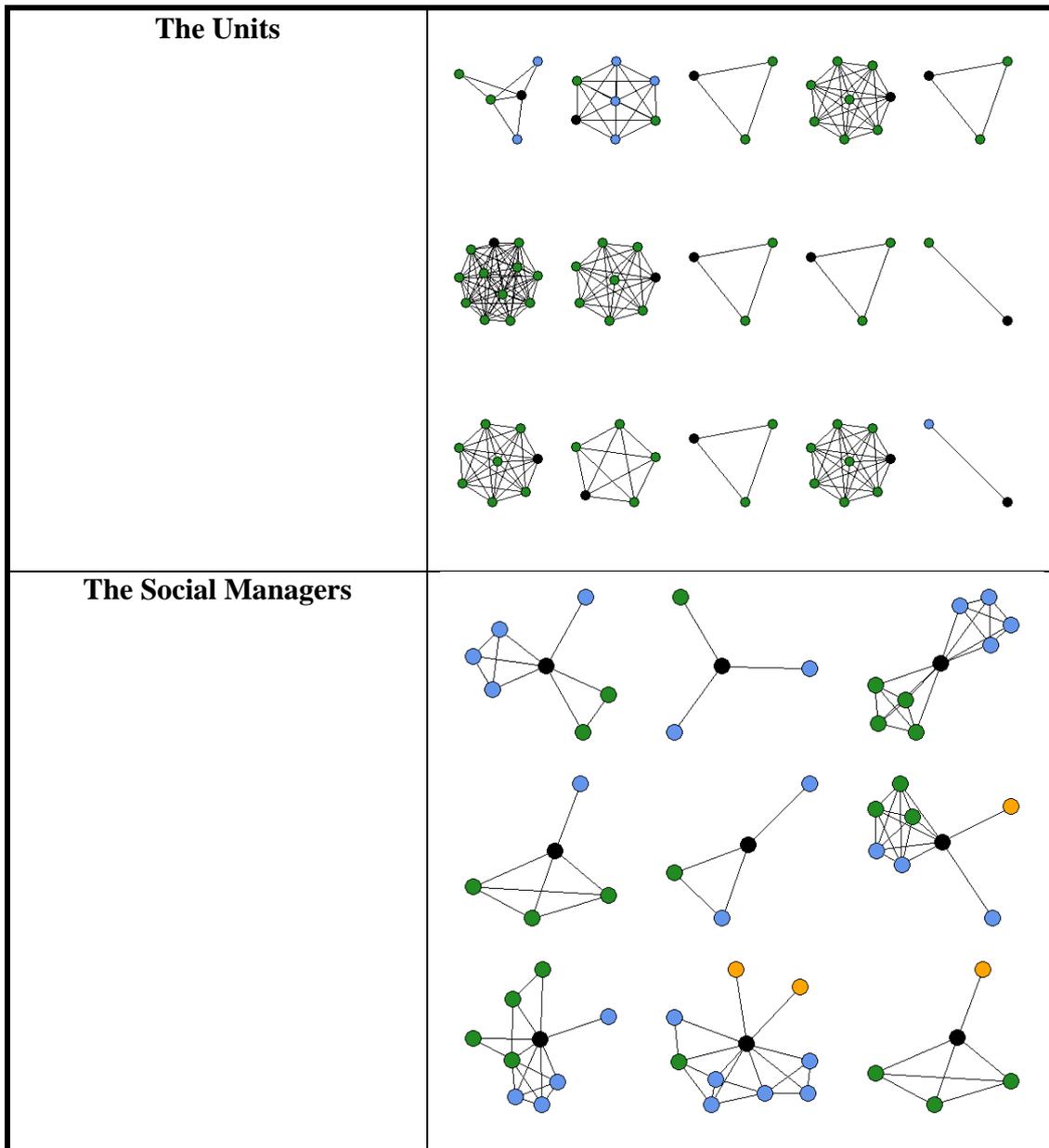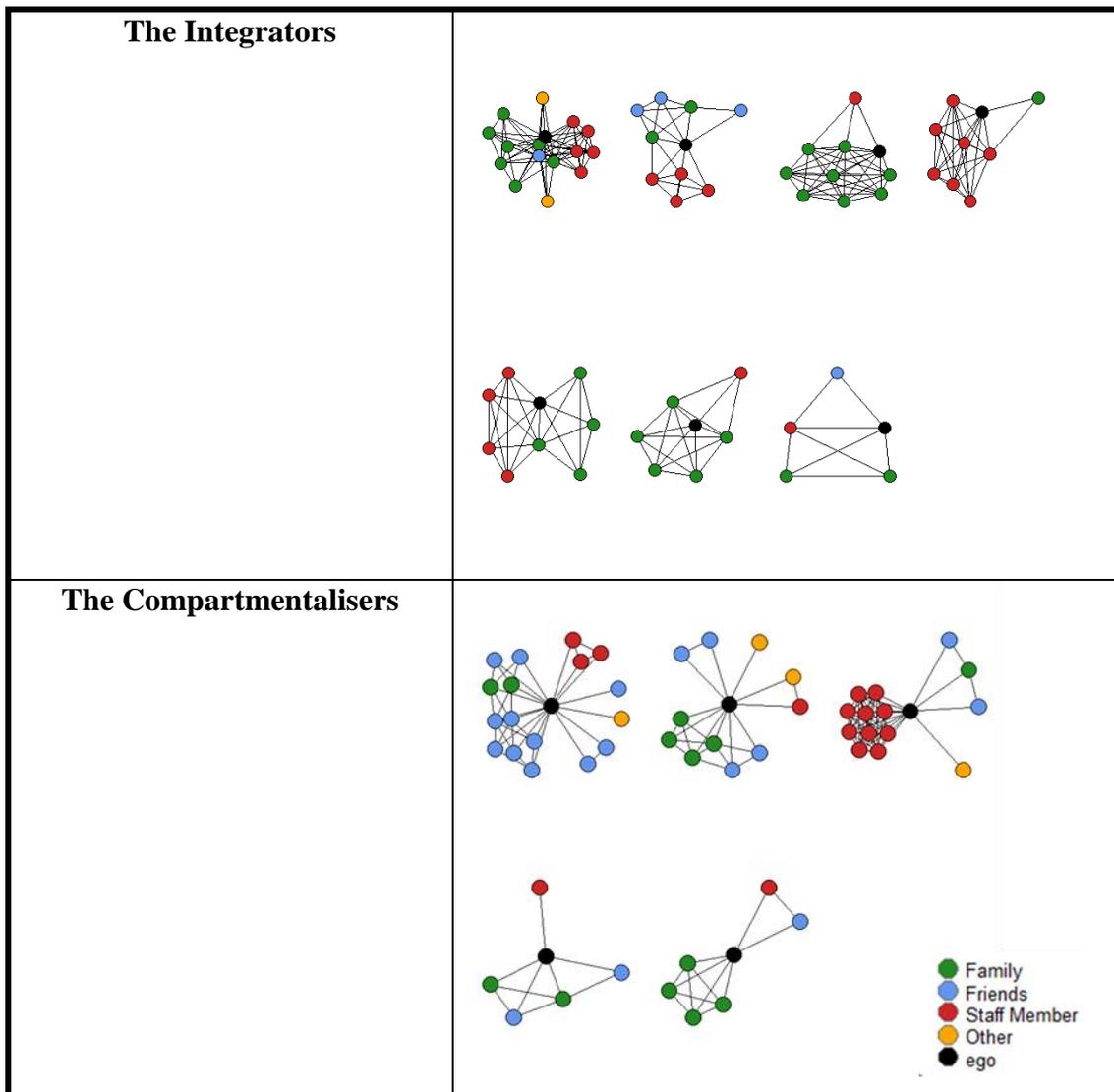
The following sections describe, in detail, each type and also outline how each type of network is qualitatively different from the others, thereby showing how the structure of the networks and the residents' utilisation of support can be grouped.

6.2.1. The Units

The first type of resident's support networks is the 'Units' and there are 15 'Units' in this study. These networks consist of only family and/or friendship ties in which there is only one component. This was the most common of all the types, where family and friends were the sole sources of support and great value was given to the support received by these close alters. The size of the support networks ranged from one to 11 and all but one network (Resident 63 had a density of 0.5) had a density of one, as seen in

Table 6.2 and Table 6.3. The support networks of these residents were characterised as the 'Units' because they all consisted of one component which the resident relied on and was close to all alters. These residents also never nominated staff and typically were reluctant to acknowledge staff in general, had a negative relationship with staff, or stated outright that they received no support from staff.

Table 6.3. Summary characteristics of the Units

	Size	Density	Number of Components
Min	1	0.5	1
Max	11	1	1
Average	4.33	0.97	1

Residents whose networks affiliate with this typology, ranged from 85–98 years of age, their residencies started between 2014 and 2018, and 12 out of the 15 were females. Three residents were local authority funded, one was partially funded, and eleven were self-funded.

A typical example of these networks is Resident 16, who is local to the area and had moved into the care home four years previous to the interview. Resident 16 was the oldest of 10 children (some of whom had passed away and others were not nominated for support) and was a widow. She was close to her family and this is illustrated in her support network (Figure 6.2) and in her interview, in which she only mentioned family ties that supported her in multiple different ways. In particular, she discussed her closeness to her siblings and her children:

> *Ego 16: My sister, June. We are very close. We shared our life together. She was my bridesmaid and I was hers.*

Figure 6.2. Resident 16's support network
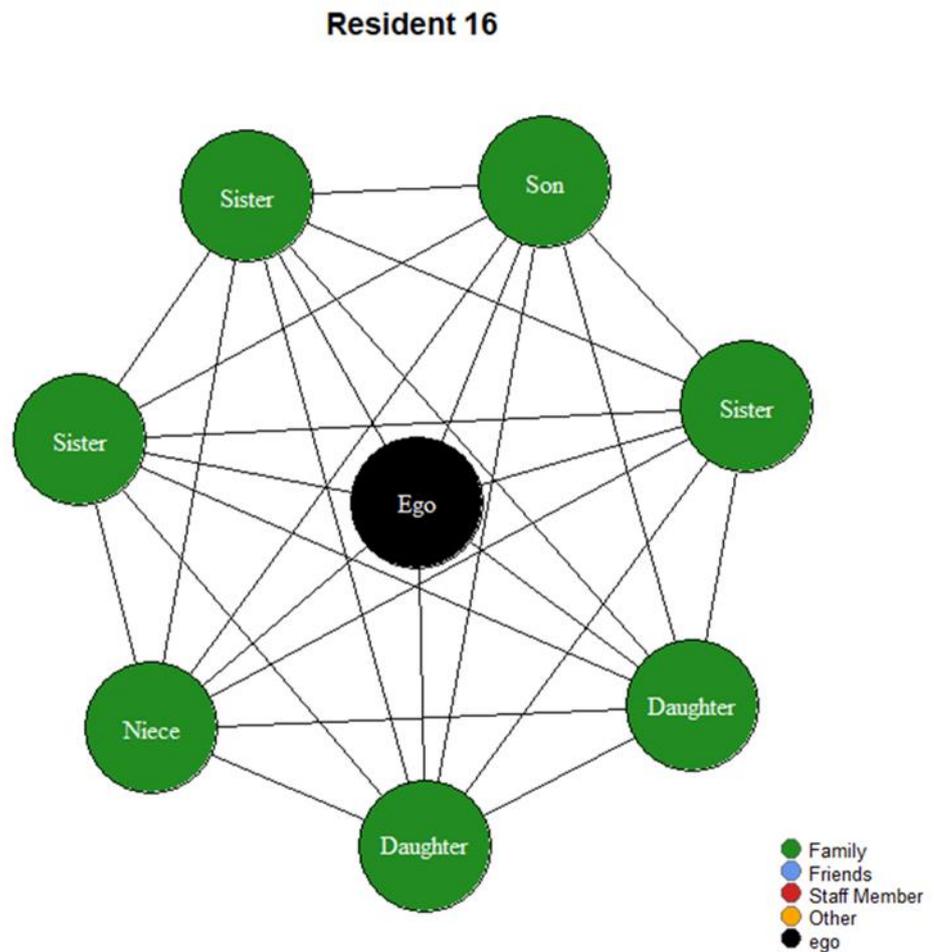
Resident 16

This resident would often mention how much time she spent with family, both inside and outside of the care home, and was quick to give examples of how much her family would fuss over her by buying her clothes that she did not need:

> *Resident 16: I'm going to spend the weekend at her [daughter's] house – her son's house – and the rest of the family will come there to see me.*

> *[...]*

> *Resident 16: We go to the cafe [in the care home] and get a coffee. My family and sister are always buying me tops. Wee busy-Beth, that's my daughter, she cleaned everything out but there are still tops in there with the wrappers still on – that have never been used.*

Other residents would often mention the continuous support of family members and how they would go out of their way to help them. Resident 43 described how his daughter would do his washing despite there being a full washing service in the care home:

I: Does Gillian come to visit?

Resident 43: Yes, twice a day. She comes straight after her work, travels from Glasgow, goes home has dinner and then comes back in at about 8pm every day.

[...]

Resident 43: She does all my washing and everything.

Again, you can see how family-orientated Resident 43 is in their support network (Figure 6.3), with only family members nominated throughout the interview. However, there is also a gendered distribution of care, where much of the 'caring', including his washing, was left to his daughter. This was a common occurrence within the care homes, where daughters were expected to do 'the extra' caring, such as picking up items from the shops, doing much of the coordinating with staff, communicating important information back to the rest of the family, and doing washing. Resident 16 and Resident 43 were similar in that regard, in that, although they had both sons and daughters, it was indeed the daughters who were the main supports. This is interesting, given that the large majority of carers in the care home were also females, however, many residents would look to female family members, and particularly daughters, for extra care. This illustrates that there was not only a gendered distribution of care, but also a familial distribution, where daughters and nieces were expected to co-ordinate and organise before other family members.

Figure 6.3. Resident 43's support network
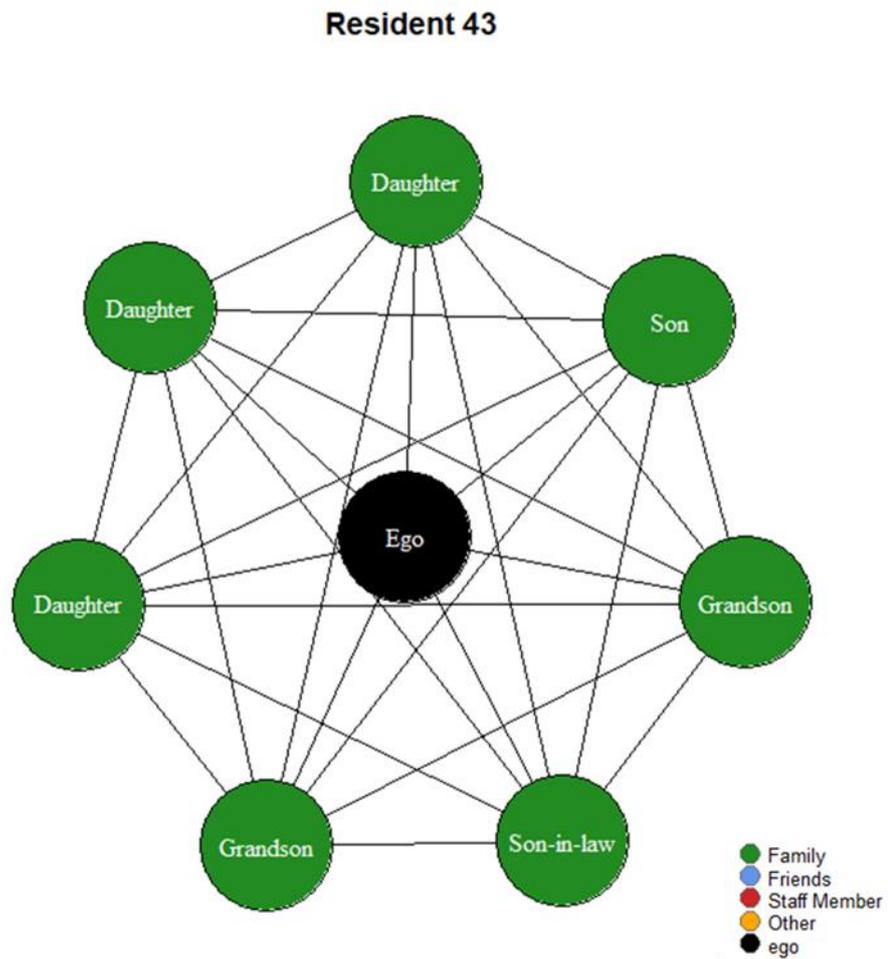
Resident 43

Resident 16 and Resident 43 described how their family were their main link to outside of the care home and that they would often bring in treats from outside the care home, find ways to help them with non-essential tasks and visit them multiple times a week. Although it was clear that both residents needed a lot of physical and medical support, as both were wheelchair users, the residents did not name any staff members who supported them. Instead, the residents were solely focused on the support of their family, and would often mention the hands-on approach that family members took in times of need, which was very typical of the type. For example, in one instance, Resident 16 described how her daughter had offered to extend her house so that she could live with her and her family. This was much like Resident 22, where her daughter and son-in-law had offered to have her live with them.

Figure 6.4. Resident 22's support network
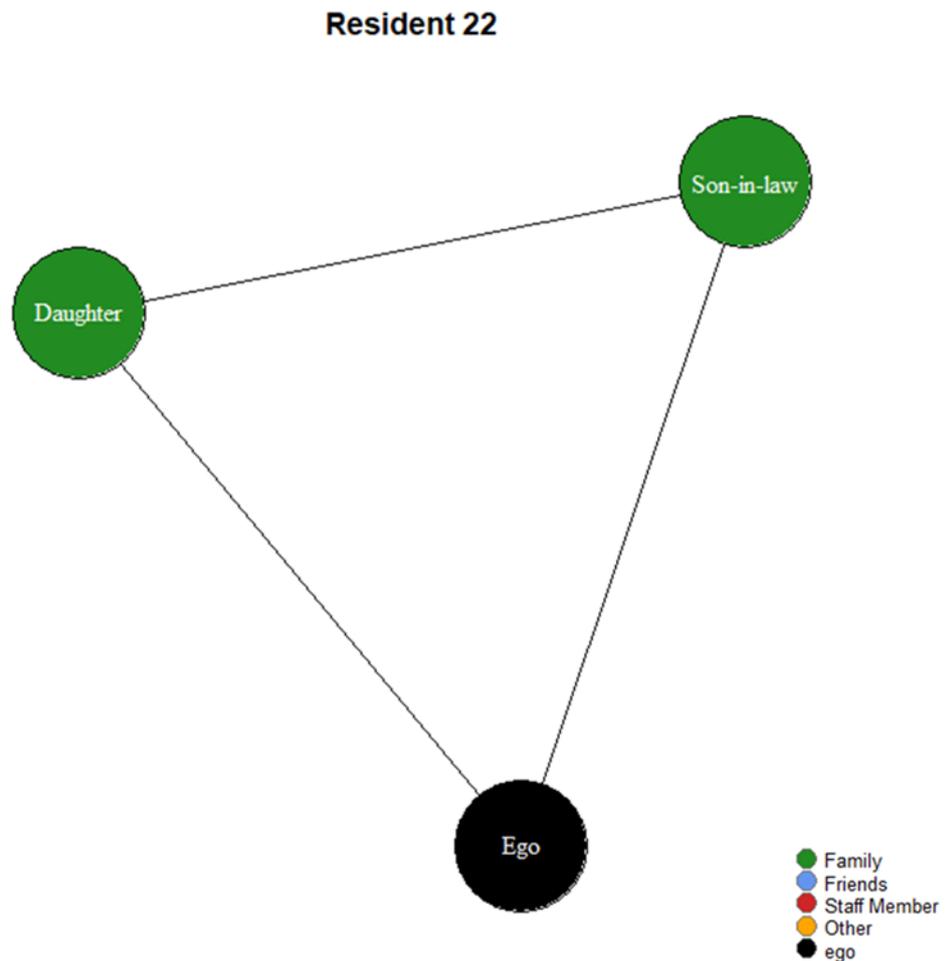
Resident 22

Resident 22: He's very kind. He said to me, once my husband had died, would I consider selling my house and I could either come and stay with them, or if I wanted a flat of my own they would help me find one. […] I will always remember that.

Thus, the Units were very reliant on family and friends for support, which meant, for many residents, that these supporting alters were their only contact from outside the care home. Thus, although the size of network within this type varied from 1–11, this did not change the perception of the resident that all of their support came from family or friends from outside of the care home, and not within the care home.

Another key characteristic of the 'Units' was their attitude towards staff. Many of the residents who had support networks of this type were nonchalant about the presence of

staff and the care home in general, or had had a bad experience with staff members that meant they did not consider the staff as 'supportive'. Residents who had 'Unit' support networks acknowledged that they needed to live in the care home, but did not particularly want to live in the care home. Many would describe how they would not want to place the burden of their care on their families:

> *Resident 16: It's alright, Hen, but it's not home but I won't ask my family to take me because, as I told you, I looked after my mother-in-law [and she remembers how taxing it was].*

Other residents described how it was not only because family could not care for them, but also, because living further away, whilst having complex care needs, put a lot of pressure on family members to travel long distances to see them. Therefore, moving into a care home closer to their family was preferable, despite the higher care costs. This was certainly the case for Resident 43, who moved from a cancer care hospital into the care home:

> *I: So it was really a financial decision as to whether you could afford to live here?*
> *Resident 43: Yes, 'cause Lou [daughter] had to travel over to Fife and she still did that twice a day. Twice in the night.*
> *I: So in a way you were happy to come here to alleviate her travel?*
> *Resident 43: Yeah, that's mainly why I came here.*

As well as a great dependence on family and friends for support, this support network type was characterised by not nominating staff for support. In addition to this, the qualitative data detailed further reasoning for not nominating staff members for support. Many 'Units' did not like the environment that they were living in or had an indifferent relationship with staff. Resident 41 is a widowed 75-year-old female. She describes how she would rather live elsewhere, but she feels as though she does not have any other choice, as her daughter cannot care for her, and she feels as though she does not have a close relationship with any staff member:

Resident 41: I don't like it [here] at all. I'd rather have a place of my own. But I can't really afford that now. Well I can afford it, but it's not my money anymore. It's the people looking after me, when I'd rather be looking after myself.

I: Of course. Are the staff polite?

Resident 41: Some are, some aren't. They think they're doing me a favour.

I: Oh right. [...] But some are quite nice?

Resident 41: Yeah.

I: Are there some in particular that are very good?

Resident 41: Not particularly, I wouldn't want to name anybody.

While Resident 43 describes how there are not enough staff to help him, and because of the number of staff it takes to get him out of bed and into a wheelchair, this means that he hardly ever gets out of his bed apart from essentials (bathroom, washing etc.):

I: Do you think if you wanted to spend the morning in the wheelchair do you think they [staff] would be able to do that?

*Resident 43: No *sigh*.*

This discontentment with staff, or lack of staff, seemed to fuel residents' reluctance to rely on them for support. This thereby characterised the support network of the residents as networks which were more focused on the support of family and friends, rather than on professional staff.

6.2.2. The Social Managers

The second type of support network is named the 'Social Managers', and there are 9 'Social Managers' in the sample. This second type of support network is characterised by, again, not nominating staff members for any type of support but comprising at least two components. This meant that the 'Social Managers' were, on average, less dense than the 'Units' with a density score between 0 and 0.5, as seen in Table 6.4, thus suggesting that the residents can go to multiple groups of people for support, each of which may have different points of view or areas of knowledge. Although having separate groups for support could be considered advantageous with regards to accessing different

supports, the perceived lack of support from staff members in both the support network data and the qualitative evidence suggests that these types of support networks are shaped by their reluctance or indifference to integrate with formal care staff.

Table 6.4. Summary characteristics of the Social Managers

	Size	Density	Number of components
Min	3	0	2
Max	9	0.5	3
Average	5.78	0.34	2

Residents in this grouping were mostly females (eight of nine) and consisted of four partially funded and five self-funded residents. They were aged from 75–100 years, and their length of residencies started between 2003 and 2018 at the time of interview.

This type of support network had two or three components each, and thus the group was named the 'Social Managers' as many of these alters would socialise and gain emotional support with separate people, or groups of people, within their support network.

A typical support network of the 'Social Managers' was Resident 25, who was divorced. Resident 25 made it clear that she did not like to participate in anything in the care home, and she did not really intimately engage with anyone in the care home. However, she would take any opportunity to go out of the care home, for example, on trips organised by the care home, or, when her family visited, she would always go out with them and never stay in the care home.

> I: When, for example, Jan visits you what do you normally get up to?
> Resident 25: We certainly go out for a meal, we don't stay here in the home.
> [...]
> I: The care home puts on events and things like that, do you go to any of them?
> Resident 25: Not really – I like to go to trips. We occasionally go to Greenfoots [garden centre] and have a coffee or something.

Figure 6.5. Resident 25's support network
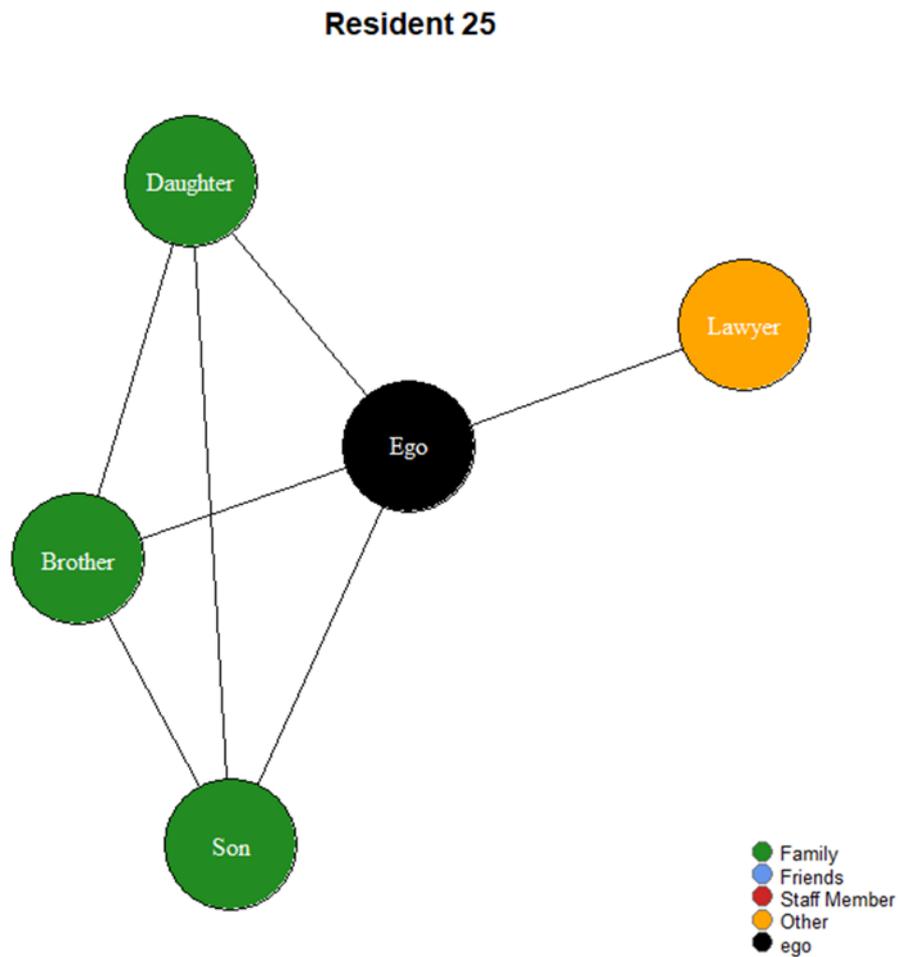
Resident 25

The social managers have separate groups of people in the network who were not connected to each other. Often it would be family members kept from a friend, or a group of friends that the resident knew separately. An example of this commonality would be Resident 24, who was a 91-year-old female who had lived in the care home for 9 years. She moved into a care home which was close to her old home and her family, and she was particularly close with a niece of hers who helped her a lot as she had no children of her own. However, she maintained links to her local church, which she had attended for years before she came into the care home:

I: Do you go [to church] often?

*Resident 24: I go every week. One of my friends takes me to church every week,
and she's very good. But I can't remember her name. That's one of the people
who is not a relation. But she's a friend who would take me anywhere and do
anything for me. She's very good. […] And if she can't manage she get somebody
else. Usually someone in the choir, and her husband will come at times too, when
she can't come.*

Figure 6.6. Resident 24's support network
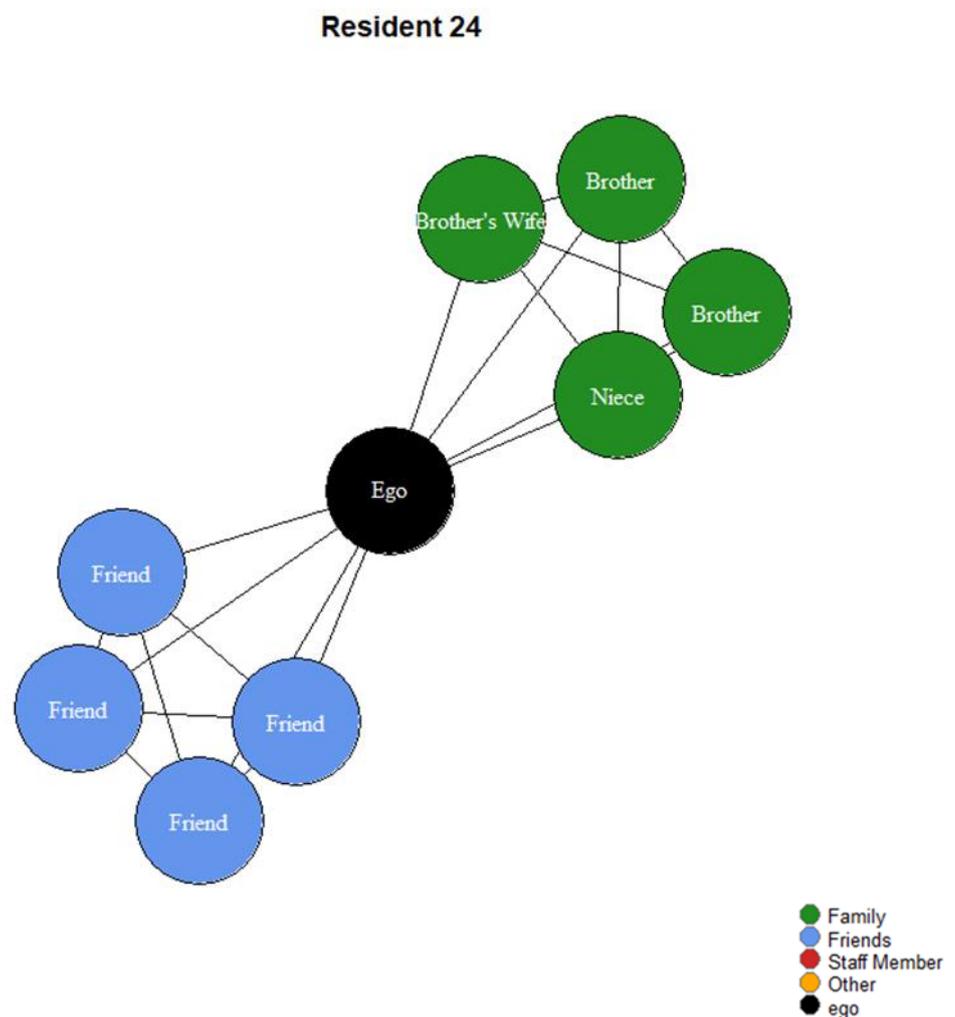
However, because none of her family attended her church, she found that she had two
separate groups of support in her network, as illustrated by her socio-gram and the
following statement:

Resident 24: Andrew and Amanda are in the same church as David and Louise. But David and Louise won't know Sheila. But they've seen me with her before, but I don't think she would know who they were. Because if you meet someone in a different environment … y'know. […] Yes, my family and my church friends probably don't know each other.

In some ways, Resident 24 and Resident 34 are similar because of their maintained connection to their local church to which they both attended. Resident 34 kept connected, but through a congregation member who originally visited her when she was admitted to hospital to bring flowers from the church. However, she maintained contact because Resident 34 was no longer able to get to church and, as such, started to visit when she came into the care home:

Resident 34: She comes to me every other Friday. […] She's a super person. She comes with communion.

This church friend was a key person of support for Resident 34 because she was still able to hear about the new events happening in her old church, even though she was no longer able to attend. As Resident 34's church friend visited her in the care home, she and Resident 34's daughter became acquainted in the care home. Resident 34 remarks:

Resident 34: Yes [they know each other], Sarah [church member] has a little dog, so they [church friend and daughter] have something in common.

However, as shown in Figure 6.7, neither her daughter, nor the church congregation member, knew her friend in the care home. This is because the church congregation member, and her daughter, prearranged with Resident 34 when they would visit, and she only spoke to her friend in the care home during pre-organised activities or during meals:

I: And so what sort of things would you do with Lily [CH Friend]?
Resident 34: With Lily? I might take her arm and take her downstairs, in the lift, and we will go to the main lounge where there might be a music concert or that sort of thing.

Figure 6.7. Resident 34's support network
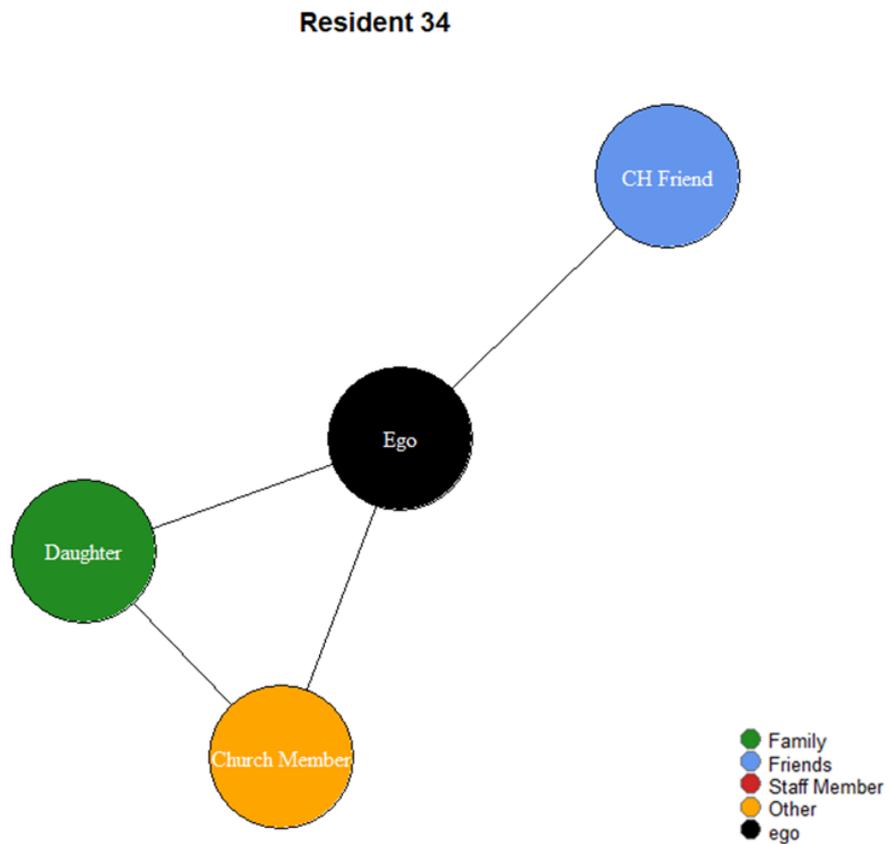
Resident 34

Although Resident 34 mentioned that she can go to staff, she did not want to include them on her list of people who supported her; instead, she talked about how she appreciated the staff '*giving me my own space*' and how she thought '*It's important that you've always got someone in the background.*' Resident 25 reinforced this message by mentioning that the staff just left her alone in her bedroom but '*They're always around to see that you're alright.*'

Staff were often viewed as a safety net that they never needed to use, or background workers, by many residents in this typology and, when probed about the role of staff in their lives, they often talked about how they did not know the staff or, as with Resident 34, they were just in the background. Resident 33 talked about how the staff were too busy for them to make a connection:

Resident 33: I don't really know many people – only my own family. The people who work here they are busy all day long. And with their own families and their own concerns – they work around the clock from 8am until 9pm - so they're tired.

This line of thinking may have also been reinforced by their feelings of not wanting to live in the care home. Resident 33 goes on to say:

Well I'm living in a care home so I can't be satisfied with that because I should be living in my own home.

Figure 6.8. Resident 33's support network
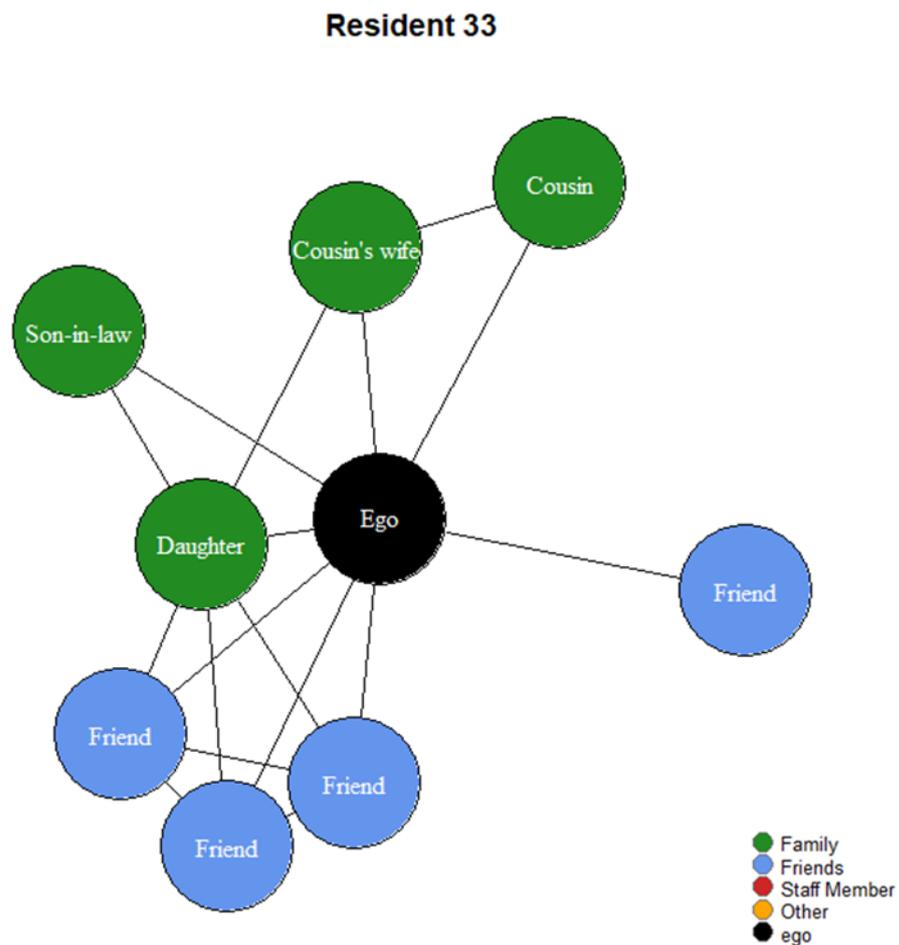
Distancing oneself from staff was a common trait of these residents and, indeed, sometimes residents would also distance their families. For Resident 25, distancing her family from the care staff gave her an element of control as she explained that she would be the one to talk to staff if she needed anything done:

> *I: Have they [daughter and son-in-law] talked to any of the staff?*
> *Resident 25: No, I'm pretty lucid.*

Overall, inclusion in the 'Social Managers' was determined by gaining support from alters who were not all connected to one another, and, further, these alters did not consist of any staff members. Qualitatively, we can interpret that these support networks were close to the family and friends who support them, and some maintained links to other areas of support. Most distinctly, these residents did not feel supported by staff members. This is where the next two types of support networks differ from the 'Units' and the 'Social Managers', because the next two types of support networks *did* nominate staff for support, but, as shown below, they had varying levels of trust in the support that they received from staff.

6.2.3. The Integrators

The third type of support networks is categorised by not only having a staff member nominated in their support network, but also by having only 1 component. As such, this means that staff and, in all these cases, some family, knew each other as far as the resident was aware. In this context, this means that some family members had contact with staff who cared for the resident, whilst the resident also felt supported by staff. This communication with staff and family members was important for not only creating a supportive community around people who have complex care needs, but also for allowing information to flow freely between the people who care for the resident inside and outside the care home.

The seven residents who had the 'Integrator' type of support network were aged between 72 and 87 and consisted of 2 males and 5 females. The start of their residencies ranged from 2005–2018 and, of the seven people in this type, one was local authority funded and one was partially funded, whereas the rest were self-funded.

As seen in Table 6.5, their support networks consist of 4 to 15 alters with a density range of 0.42–0.83, which, on average, is a higher density than that of the 'Social Managers'.

Similarly to the 'Units', the 'Integrators' only had one component and therefore were more likely to have a higher density. Although there is a wide range of alters in these networks, they are characterised by their alters being able to connect to each other directly or indirectly through another alter- and thus, were composed of one component.

Table 6.5. The summary characteristics of the Integrators

	Size	Density	Number of Components
Min	4	0.42	1
Max	15	0.83	1
Average	8.43	0.66	1

Resident 18 was an 83-year-old widowed gentleman. He had only lived in the care home for 6 months but had already integrated into the care home and was widely known by the staff as a bit of a joker. He was a wheelchair user but chose to spend most of his time in his bed as it was more comfortable than his chair. His daughter came to visit him on most days and, as such, was his biggest support. Resident 18's support network is a classic example of an 'Integrator' (Figure 6.9) because his support network comprised family members and a staff member who were connected, as well as a fellow care home friend. However, importantly, he felt a closeness to the carer who took care of him in the care home, which is a common trait of the 'Integrators':

> *Resident 18: There's a carer in here and I've never met her in my life until I come in here. [pretending to be the carer] '[Resident 18] do you need this, do need that?' She's so helpful, so she is. She's away to London this week. I'm glad it's Wednesday – she should be back Saturday. I miss her.*

Figure 6.9. Resident 18's support network
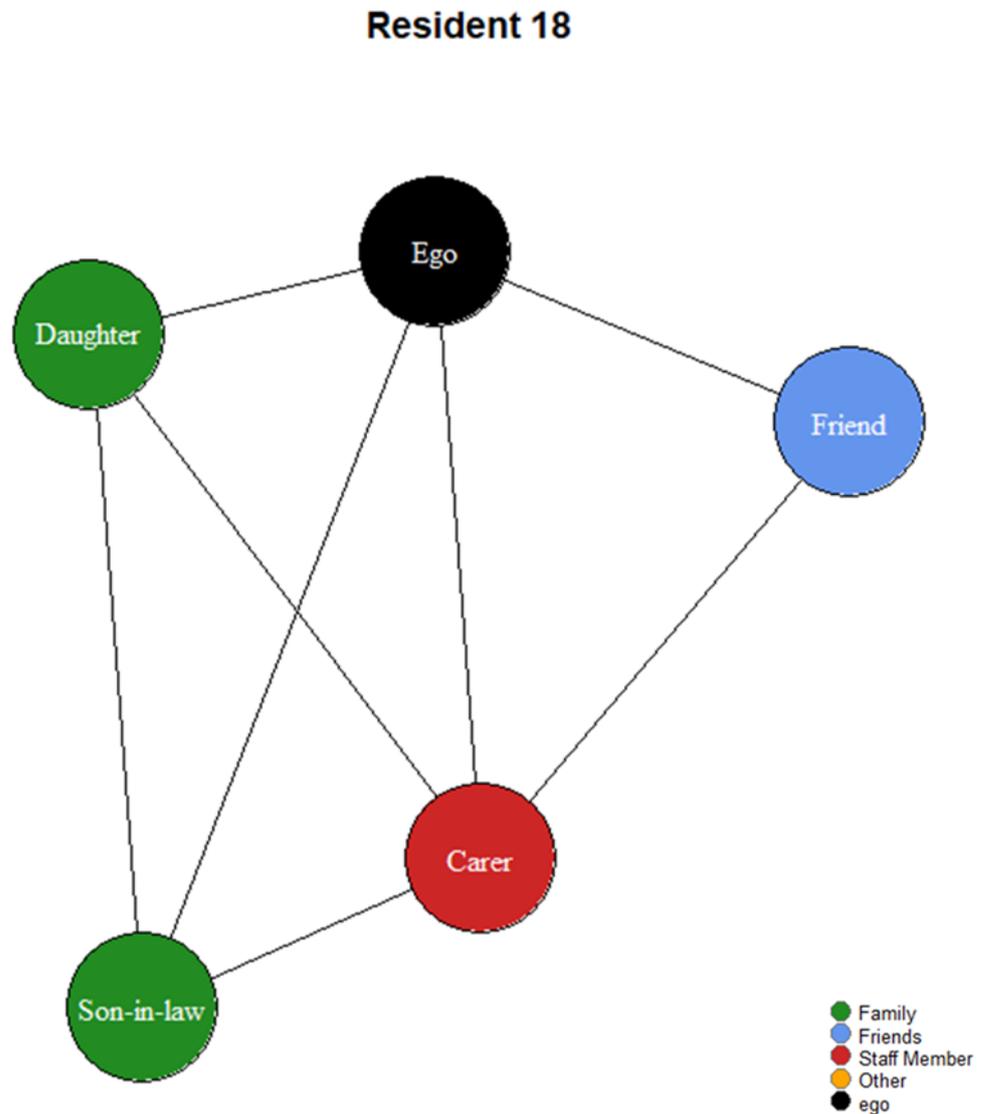
Resident 18

Residents who perceived staff to know their family members often spoke of the close connections they had with one or two staff members. Not only did they acknowledge the day-to-day help that the staff provided, but they also talked of a closer connection. Resident 44 talked about one carer in particular:

> *Resident 44: Well one night he came in [to my bedroom] and I wasn't feeling alright. He says, 'I'll fetch you pillows and you'll be alright.' So kind. 'I have to leave you, but I'll come back as soon as you let me know. All you need to do is buzz that.' [the buzzer] […] That's what a nurse should be like. He's just so kind.*

Whilst other integrators talked about not only having a close connection with some staff members, but also spending quite a lot of time with these staff member, as Resident 31 did:

> *Resident 31: And I help call round with Sasha [activities co-ordinator] quite a lot she's great. She's a lovely person and she works so hard. She was painting one of the chairs last night and we'd been out at [place] in the early afternoon.*

Even when describing more than one staff member, some residents would almost describe being part of a surrogate family:

> *Resident 13: And the staff here- the girls are great. They'll treat me like their uncle. I know everyone and I know all their names. They talk to me the same way you know. They say 'Our Phil [Resident 13],' they say.*

Thus, having a meaningful connection with staff was important to the 'Integrators'. However, in addition to having a close relationship with at least one staff member, this type of support network also had connections with family, friends or others who they felt supported by. Resident 13, who is quoted above, is an 84-year-old man who has lived in the care home for over two years. He moved in just after his wife, who has advanced dementia, was moved into the care home. They do not share a room, but:

> *Resident 13: I call on her. And Donna [daughter], she calls on her, she doesn't have much time, but they call in on her and take her to the cafe and have a coffee with her go out with a wheelchair just get a bit of fresh air.*

Resident 13 has built relationships with the staff whilst also relying on the support of his family to help care for his wife who has more complex care need than himself:

> *Resident 13: Yeah she [wife] needs a lot more support. She sleeps an awful lot, so I think that's a bit of a problem she just sleeps all the time. And she sleeps for too long and too deeply then the nurses just put her into bed. Sometimes we'll get her ready and we can get her up for one of the lunch breaks or something like that. They're great looking after her.*

Resident 13: She [daughter] takes to do with everything and finance to discuss that. And everything that's attached to being full time in a care home. Everything single thing that happens. If something was to happen with Wilma [wife] and we needed one of the nurses then we would just say – make sure to say to Donna [daughter]. Anything that's needed she'll attend to it.

Thus, his family and the staff are co-ordinating to support him and his wife. In particular, his daughter from his current marriage coordinated with staff and she had a lot of communication with staff, as illustrated in Figure 6.10.

Figure 6.10. Resident 13's support network
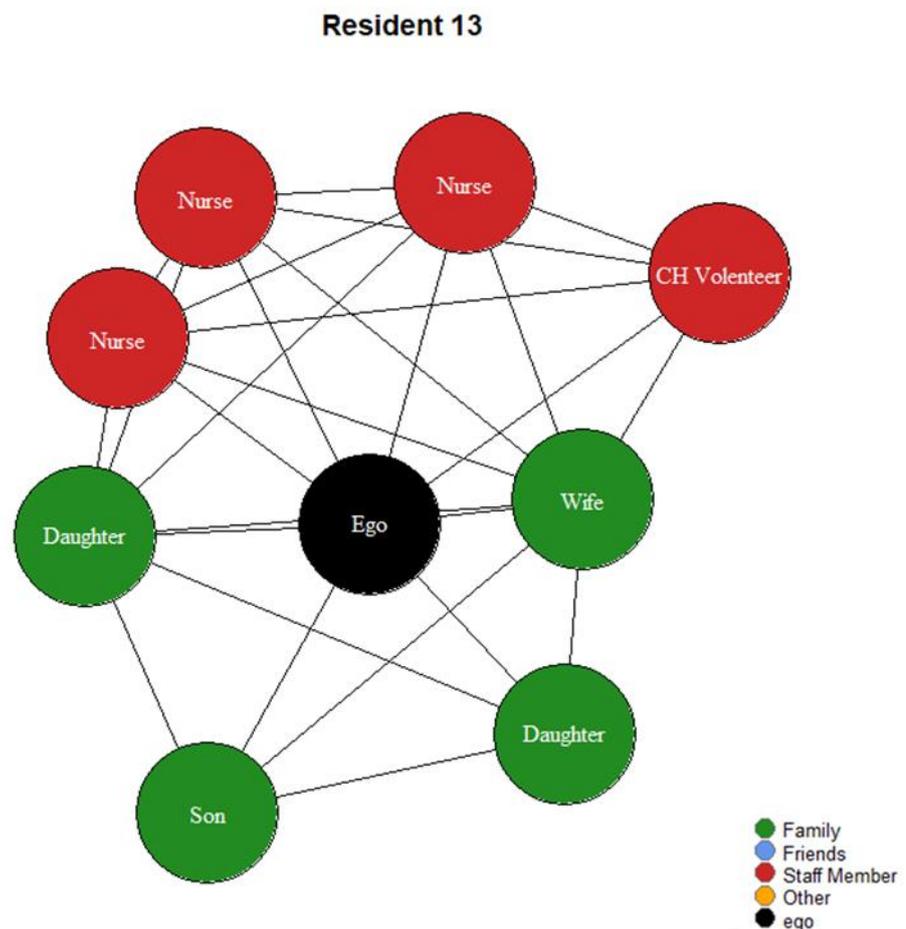
Other residents also discussed how important family were to them, whilst still being reliant on staff. As shown in Figure 6.10, Resident 44's support network is mostly composed of family members with the addition of one nurse. When Resident 44 was

asked about her children, she was quick to mention how much they supported her and her close connection with them:

> *Resident 44: My children. I am very important to them, at least I think I am. They're really good. Everyone talks about how good they are to me. They spent £100 on bedding and lights. Three sets of bedding – no one has the same bedding as me in here. They did that for mother's day. Really good for me.*

However, interestingly, Resident 44 also mentioned that, despite being very reliant on her daughters, sometimes their relationship was not always trusting. She explained that this was one of the ways in which staff and her daughter communicated:

> *I: Would your daughters talk to management?*
> *Resident 44: Oh yes, if there's something wrong then they would go straight to …*
> *They [daughters] don't believe everything I tell them, they like to get it from …*
> *I: Both sides?*
> *Resident 44: Yes, both sides. In saying that, Kath is fiery, more fiery than me. Yvonne is very quiet and peaceful. Kath is really good and thoughtful, but quite quick and if anyone said stuff about me, oh, she would just fly off the handle.*

This illustrates how some relationships between residents and families could be complex, despite being very fruitful in providing support. This was mentioned by a number of residents who were very close to family but had some disagreements.

Figure 6.11. Resident 44's support network
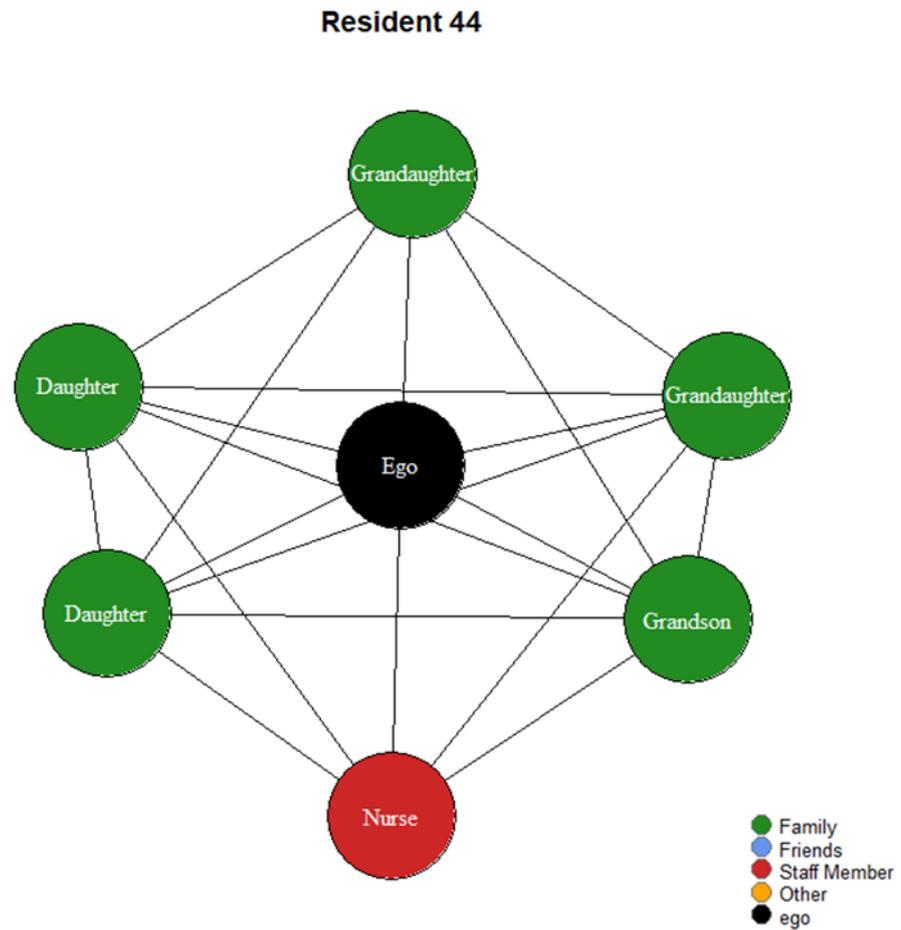
Resident 44

Equally, staff and family seemed to have very positive relationships, which added to this resident's positive relationship with staff members. A typical example of this was when staff made an effort to interact with other family members who visited the resident:

I: So obviously all your family knows each other, but maybe it is only [daughter] that know [Nurse]?

Resident 44: Well [Other daughter] knows her too

I: Okay. But maybe not your grandchildren? They would come into visit, but they wouldn't know [nurse] so well?

Resident 44: Well there was one day that they came in and [nurse] was bandaging me and of course he [grandson who is 4 years old] came in and of course he started washing and everything. She [nurse] said 'I think you're going to be a doctor.' He's very clever. And she said, 'Are you going to help me Dr…?' And he

said, 'Oh yes.' So he was bandaging me and bandaging me. Counting them up. Lovely boy. So he knows [nurse]. And they know her when he come to visit me.

The 'Integrators' would highlight that having a close connection between staff, family and themselves was not always about the care and physical support that they were receiving, but about having a genuine connection with staff, and most of all, being able to joke with them, as Resident 18 illustrates:

> *I: She [carer] must help you out plenty then?*
> *Resident 18: Yeah, Alright. I'll joke with her. She puts me in my bed and her badge broke, fell down the side. And she came back in and the daughter had seen it. She [daughter] said, 'Izzy [Carer], I'm going to ask you for something – where is your identity card [to show] that you're a nurse?' [respondent pretends to be the nurse looking for her badge]. She [daughter] said 'I'm going to need to ask you to leave. See you – you're up to your eyes in trouble if you've lost your badge.' Well – she [Carer] gets a wee bit excited. I said, 'Izzy [Carer] – stop your carry on. The little devil's [daughter] having you on. Go and look in her top pocket.' [Resident pretending to be nurse] 'Where was that?' [Respondent] 'Fell down the side.' *laughs**
> *I: Oh that's great.*
> *Resident 18: And she enjoyed that.*

Evidently, the resident and his family had a friendly relationship with the carer; relationships such as this one emulated the relationships that residents in the 'Integrators' had with staff. Thus, the connection went beyond 'just a working relationship' and meant that the resident felt as if they had a meaningful relationship with at least one staff member. The 'Integrators' were therefore not only characterised by nominating a staff member and having a network structure which was high in density and composed of only one component, but they also had a close and familiar relationship with some staff, which meant they felt more comfortable being in the care home. This familiar relationship between staff and resident is one that lacked in the following type of support networks – the 'Compartmentalisers'.

6.2.4. The Compartmentalisers

The networks that are described as the 'Compartmentalisers' are those networks who nominated a staff member in their personal support network, and who had two or more components in their support network. As such, they gained support from different groups, and the alters who supported them did not always know each other, and therefore were compartmentalised. The summary network characteristics seen in Table 6.6 for the 'Compartmentalisers' show that the network size ranges from 5–17 alters with lower density (0.16–0.52), on average, than the 'Integrators' (0.42–0.83), who had also nominated staff members. This is understandable, as this type seemed to prefer keeping supporting alters separate from one another to an extent, whereas the 'Integrators' had a path between all alters. Thus, this categorisation of support network has two or more components.

Table 6.6. The summary characteristics of the Compartmentalisers

	Size	Density	Number of Components
Min	5	0.16	2
Max	17	0.52	3
Average	10.6	0.35	3

The five residents with this type of support network were between 67 and 100 years of age, there is only one male in this grouping and only one person with local authority funding, while the rest are self-funded and female. Resident start dates in the type ranged from 2008 to 2018.

One reason many of the staff members are compartmentalised in these support networks was the lack of connection and affinity that the residents had with the care home and its staff. Thus, although the residents felt that they gained support from these staff members, they did not feel an emotional connection and therefore did not link them with their family.

Resident 32 is a typical example of the 'Compartmentalisers' (see Figure 6.12) as she had a supportive staff tie, but this tie was separate from her family support. She is 100 years

old and is a widow. Since she moved into the care home, she was told that she should not try to walk without assistance from a staff member – a piece of advice that she occasionally ignores. She has lived locally most of her life and therefore made the decision to stay in the locality for her care. Her only member of the family that lives locally is her grandson, who visited once a week, but her two children did try to visit her once a month. She did not receive any other visitors other than her family, but had one table companion in the care home who she talked to at dinner times. She, like other residents in this category, felt little connection to the staff and, therefore, had only nominated 'the staff' in general. Resident 32 was asked who they who went to if they needed help:

> *Resident 32: Just the staff in here. The only person that I would definitely go to would be my son and my daughter. But if I fell, or something like that in here then I would need help then. And it would just be whoever was on duty because they're all very well-trained people.*

Figure 6.12. Resident 32's support network
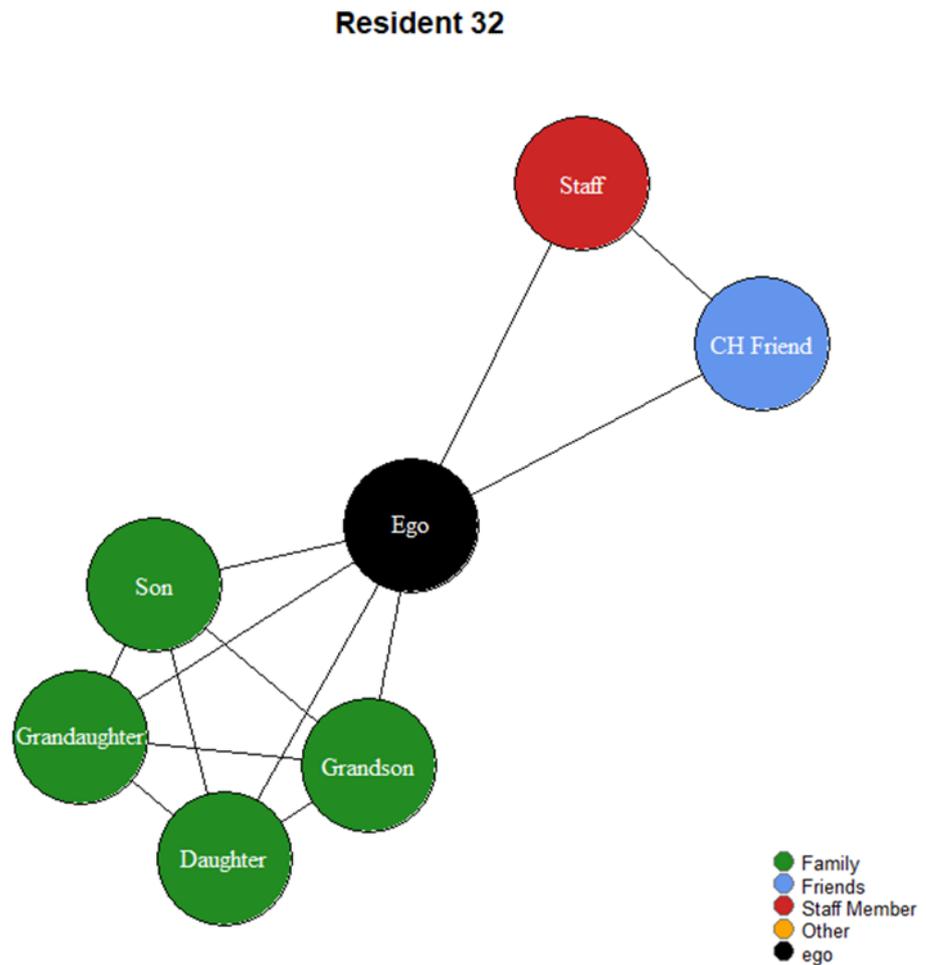
Resident 32

Although Resident 32 was indifferent about her feeling towards the staff, she had no ill-feelings towards them and seemed to treat them as passing people around her. Now, although Resident 42 reinforced this by explaining that the staff would help him if he needed it around the care home, he also emphasised that the care home was not able to retain a lot of staff. Therefore, for him, there was no point in trying to develop a close relationship with the staff. He explained:

> *Resident 42: People are just a number and they don't think you're a person.*
> *I: And that's quite common in here?*
> *Resident 42: Staff change quite regular in here. There are always 6 or 7 coming*
> *for a preview, for working here, to try it out, and out of that there are only 2 or 3*
> *of them, but they never appear.*

I: So they're not able to retain staff?

Resident 42: No, they never stay for long.

Although it could be argued that both Resident 32 and Resident 42 have indifferent attitudes towards staff, and thus are lacking in an emotional connection to them, Resident 53 would go further. Resident 53 was 77 years old and was a wheelchair user. She was helped by the staff to move from her bed to a wheelchair by a hoist, and had had many negative experiences with staff who put her in uncomfortable positions to move her and occasionally lost their temper with her. She described a few of her experiences:

Resident 53: I have to have the full body hoist and of course that means the sling is on me and the straps go on the sling and sometimes they've had the hoist too far away and they're pulling me to the hoist and I say make the equipment work for the patient, not the other way around. Bring it into me, so I am not being dragged to it.

Resident 53: I find it so hard at times when I am up against rough behaviour. Now that can be both rough handling, I've had quite a lot of that, and now I'm in such a position that it hurts. And, the people doing it, I know the carer I'm thinking of but I'm not saying the name.

Resident 53's family did not live locally and therefore she did 'not want to bother them' with her negative experiences of staff. In addition to this, Resident 53 only saw her family once a year and she was often in communication with the manager about her experiences. This meant that her family did not have extended contact with the staff when they visited because they were not around often enough to advocate for her. Both Resident 42 and Resident 32 also had family who lived far away and, therefore, they would discuss how they were maintaining their independence, without family, and with only a small amount of support from staff, if it was necessary. Resident 42 was a prime example of this:

I: Because your family live away, do you find that you're a bit more reliant on the staff in here on the day-to-day?

Resident 42: Well no, because I'm a loner. So I depend on myself. I'm only in here because my wife was here.

[...]

I: If you were to have an issue in the care home who would you contact?

Resident 42: I would do it myself – I would go straight to Susan [manager].
Anything that happens in the care home, I will deal with it.

Thus, although family living away was a big factor in family support and staff support not knowing each other in the compartmentalisers, the indifferent feelings towards staff fuelling a lack of connection between staff and family was illustrated by Resident 54. Resident 54's family lived locally, in her own words, they live 'just around the corner' and she nominated the staff as supporting her in the care home (Figure 6.13). Despite her family visiting multiple times a week, she was certain that her family did not know the carers who support her:

I: And what about the carers? Do Karen [daughter] and Michael [son] know the
carers?

Resident 54: No, they don't know each other.

Figure 6.13. Resident 54's support network
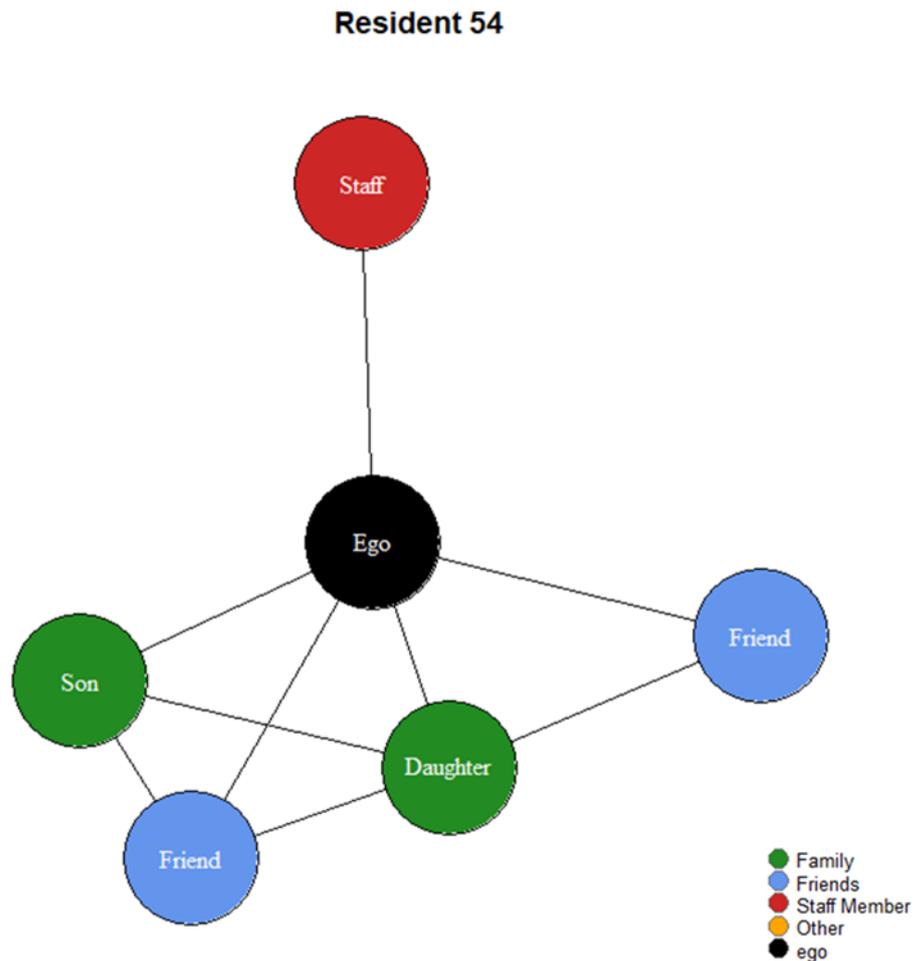
Resident 54

Resident 54 liked to stay in her room as she found it difficult to walk for more than a short distance and therefore her family would always come to her room to visit her. She reasoned that her family would only come to see *her* and did not stop to get to know the staff:

> *I: So Michael [son] and Karen [daughter], do they come in and help you a little bit around the care home?*
> *Resident 54: They just come to visit. [...] They know that I'm in room 3. And there's a bathroom through there, where I get washed and have a shower.*
> *I: So everything is in here that they would ever need?*
> **resident nods**
> *[...]*

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I: So you sort most of the things out with the staff and you would just go directly to the staff with anything that you needed?

Resident 54: *resident nods* I just press the buzzer.

The two other friends in Resident 54's support network were not very present, as one had never visited the care home and the other had only visited once in the two years that she had lived in the care home. Therefore, her main support came from her son, daughter and staff. Again, staff were considered helpful in the background but did not associate with the resident's family or friends, despite them living nearby and being a regular visitor to the care home.

Overall, although 'Compartmentalisers' acknowledged that the staff were sometimes helpful in a practical way, they would not spend any social time with the staff, other than in a facilitating or caring role, and there is no close connection between residents and the staff, unlike with the integrators.

6.3. Patterns of typologies

The different type of support networks presented here have advantages and disadvantages for the residents; however, having a certain type of network could be influenced by external factors. A factor to consider is whether different care homes were more or less likely to "nurture" different types of support networks. As the sample for this project only contained 36 networks, it is difficult to draw firm conclusions, however, from the observations shown, there is a larger number of 'Integrators' in Care Home 1, which may indicate better staff-resident relations in this care home.

Shown in Table 6.7 are the types of support network characterised in the chapter by the care homes sampled. Half of Care Home 5's residents in the sample (*n*=4) were 'Units', and no resident's support networks were 'Integrators', which may indicate that residents felt as though they were less likely to feel emotionally close to staff in this care home. Similar conclusions could be made for Care Home 2, where no residents nominated staff, and in Care Home 6, where only one resident was a 'Compartmentaliser' whilst the other three residents did not nominate any staff.

Table 6.7. Types of support networks by care homes

| Care Home | Did not nominate staff | | Nominated staff | | Row Totals |
	The Units	The Social Managers	The Integrators	The Compartmentalisers	
1	2	0	4	0	6
2	3	3	0	0	6
3	1	2	1	1	7
4	3	0	1	1	5
5	4	2	0	2	8
6	2	1	0	1	4
7	0	1	1	0	2
Column Totals	15	9	7	5	

Given the same caveats, it seems that a larger number of people with memory problems had support networks aligned with the characteristics of the 'Units', when compared to other types of support network in Table 6.8. Conversely, people with no memory problems seem to be more evenly spread across the four network types.

Table 6.8. Types of support networks by memory problems

	The Units	The Social Managers	The Integrators	The Compartmentalisers
Memory Problems	9	3	3	2
No Memory Problems	6	6	4	3

Further, Table 6.9 shows that, of the types of networks that did not nominate staff, the 'Units' and the 'Social Managers', three out of five local authority funded and five out of six partially funded residents are in these groupings. In contrast, self-funded residents were much more evenly spread across all types of networks.

Table 6.9. Types of social networks by funding type

	The Units	The Social Managers	The Integrators	The Compartmentalisers
Self-Funded	11	5	5	4
Partially Funded	1	4	1	0
Local Authority Funded	3	0	1	1

Making firm conclusions around the relationship between funding status, memory problems, care home of residency and type of support networks that older people living in care homes have is difficult, given the small sample in the study. However, small differences in these categories may hint towards disparities within the care home population. In particular, whether a particular care home encourages meaningful supportive relationships between staff and residents or if a resident's cognitive impairment might mean they are more or less likely to gain support from multiple sources and types of people. These are questions which cannot be fully answered by this study, but will perhaps start a conversation about how care homes can ensure that residents feel supported by staff, and what factors may prevent or encourage that relationship.

Typologies and social capital

Although the typologies were not explicitly linked with concepts of social capital and organisational ties, the resulting typologies do show how these concepts may result in better support for residents through their support networks. In many ways, the units and social managers had high levels of bonding social capital and lacked bridging social capital in their support networks. As discussed in chapter 2, bonding social capital refers to trusting and co-operative relationships which are similar to each other in terms of social identity (Woolcock 2001). By relying on these types of connections for support these type of networks were restricting their access to novel resources they could gain from staff and other ties which belong to differing social groups from themselves. However, with the use of the qualitative data, the typology has established that this lack of nomination of staff may actually be an illustration of the lack of trust, or lack of emotional connection between staff and residents who have these types of networks. Thus, although older people who had these networks were supported formally through staff members,

they did not feel that they had the emotional support from staff and thus did not nominate them.

Further, the compartmentalisers and integrators were characterised by having, at least one connection to a staff member, which could be described as having more bridging social capital, when compared to other types of networks. Bridging social capital refers to the connections between people who are unlike each other, and Putnam (2000) suggests that this type of social capital can provide access to other forms of capital. However, as discussed previously, the integrators were more likely to connect nominated staff members with family members and have a better relationships with these staff members, which may be more indicative of bonding social capital. Whereas compartmentalisers did not have this type of relationship with staff as they did not connect these staff members with family, nor suggest that they had a meaningful relationship with these staff members. This cultivation of bonding or bridging social capital with staff members may be important for wellbeing if, as suggested by this chapter, the integrators had a better experience in the care home, and thus, are more likely to have higher wellbeing. This suggestion will be explored further in chapter 7.

6.4. Conclusion

3a. Are there types of support networks of older people living in care homes, and if so, how can they be characterised?

By developing a typology of support networks for older people living in care homes, the study not only explores recurring patterns of support for older people, but also identifies systematic factors that affect a person's support network (Li and Zhang 2015; Giannelle and Fischer 2016) and thus identifies factors which would influence the social inclusion of older people living in care homes. Further, by using a mixed method approach, the typology created here was informed and meaningfully interpreted by the qualitative accounts given by residents. This would allow a better understanding of how residents made and maintained connections while living in a care home and how this affected their day-to-day living.

Chapter 4 described the composition and structure of all the residents' networks, and Chapter 5 described the underlying mechanisms that influenced the provision of support in care homes. This current chapter has built on these findings by considering the support network of each resident and their qualitative descriptions to explore the key differences in residents' perceptions of support. By creating this typology with standardised name generators and in-depth interviews, a better understanding of why different residents believed some relationships were more supportive than others has emerged and each type is summarised below.

Firstly, the typology identified 'Units', which are a type of support network which is totally reliant on family and friends. The network is very dense and has only one component without the ego included. The residents who have this type of network voiced a discontentment with staff and largely voiced that they did not want to be living in the care home, did not want to integrate in the care home, or would rather keep to themselves.

Similarly, the 'Social Managers' were also solely supported by family and friends, and equally would distance themselves from the care home and other residents in the care home. However, these support networks were composed of supporting alters who did not know each other and therefore the resident was supported by people from different avenues of their life, but not by the care home.

In comparison to previous typologies of the social/support network of older people, the Units and Social Managers are most comparable to more family-based or kin-based networks found (Wenger 1984; Powers 1992). This is interesting because family, in particular, were emphasised as of high importance to the support of older people. This thesis has added to previous typologies by adding a structural component (number of components) to the typology, as other studies have not included whether the people that support if received from are also connected themselves in their typology criteria.

The 'Integrators' and the 'Compartmentalisers' differed from the first two types of networks by nominating staff, thus showing that they felt supported by at least one member of staff. However, they differed structurally, as the 'Integrators' were denser on average and were composed of one component, whilst the 'Compartmentalisers' were less dense, had two or more components and none of the staff nominated were connected

to any family members. They were also qualitatively different, as the 'Integrators' were more likely to have an emotional connection to at least one member of staff, although this did not mean that all interactions with staff were positive. However, 'Compartmentalisers' were more likely to have a negative or indifferent relationship with all staff, and were more likely to name 'staff' in general, rather than a particular staff member.

Previous research of typologies of networks in care facilities have not defined their typology criteria around the presence of supportive staff. However Powers (1992) described two types of social network which have similarities to the Integrators and Compartmentalisers. One such network was labelled a 'balanced network' which were large personal networks with multiple different type of people, including staff. Often with this type of network, the resident would not only have a relationship with staff but have a friendship with a staff member. This type of network could be compared to the integrators who have good relations with staff, while having other family or friends to rely on for support too. Powers (1992) also found older people who had institution-centred networks, however these people would self-label themselves loners and would only want to limit their contact with others to the 'bare minimum'. Although the network types found by Powers (1992) do have similarities to the types found in this thesis, there are clear differences as Powers seems to only find networks in which older people are friendly with staff, or want limited relationships with everyone in their network. The use of qualitative data, as well as structural data, has allowed the current study to examine how residents perceive these relationships with staff, and what prevents them from creating more personal relations with them.

Overall, it can be concluded from this method that the support networks of older people living in care homes can be divided into four main types. This chapter has added to a small, but growing body of literature on how to create and define typologies for social networks. This is the first ever development of a typology of support network for older people living in care homes in Scotland. While it is specific to this sample, this typology could also inform how support is provided in other care home settings and enhances our understanding of patterns of support in care homes for older people.

This chapter has outlined four different types of support networks for older people living in care homes which have different structures and qualitative meaning. The next chapter

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will use this typology to analyse how different patterns of support may affect wellbeing. However, firstly it will analyse how key network characteristics might affect wellbeing through correlation statistics, and will then turn to how this may differ between types of support networks, before going on to describe qualitative themes that emerged from the interviews.

Chapter 7 Wellbeing

Chapter 7 Outline

This chapter will explore how the characteristics of an older person's support network may have an impact on their wellbeing. Further, it will examine whether having a different type of support network, as described in Chapter 6, may have an effect on an older person's wellbeing. Lastly, it will discuss the mechanisms which emerged from the wellbeing interview with residents. Therefore this chapter will be addressing three distinct research questions:

4a. What is the relationship between the personal networks of older people living in care homes and their wellbeing?
4b. Do different types of personal networks affect wellbeing more than others?
4c. What mechanisms underline the wellbeing of older people living in care homes?

This chapter enables a better understanding of how the support network of an older person can affect their wellbeing, and what aspects of their support network are most important for this outcome, from the resident's perspective. Previous research has made a link between increased social inclusion, social networks and social capital with better wellbeing in older people (Forsman *et al*. 2011, 2013; Forte 2009; Pinquart and Schiller 2000). Further, as the health of older people living in care homes is unlikely to improve, many care homes focus on improving and maintaining the wellbeing of their residents. However, an egocentric network approach, to the best of my knowledge, has previously not been taken to explore the link between the support networks of older people living in care homes and their wellbeing.

Thus, the first section of this chapter looks at characteristics of residents' support networks and establishes whether there is a relationship between these characteristics and their wellbeing. This section uses data from the wellbeing questions asked in the interview carried out with older people living in care homes. Residents were asked 25 questions about their wellbeing, which are documented in Appendix 1. From these questions, a wellbeing score was created for each resident, as noted in Chapter 3. This

section uses the wellbeing score and networks characteristic measures taken from the support networks.

The second section looks at the differences in wellbeing between the different types of support networks. It uses descriptive statistics to establish whether there is a difference in wellbeing score between the four types and draws on the qualitative themes that were discussed previously in Chapter 6 to try to understand why these differences emerge.

The third section looks at what factors residents identified as having an effect on their wellbeing and the mechanisms that may underpin these factors. This section uses data from the wellbeing interviews carried out with older people living in care homes. A product of these interviews was residents' descriptions of why they had responded as they had to questions about their wellbeing. Residents were asked to discuss their thought process and to reveal why they responded in such a way to each question. Thus, this chapter outlines the key mechanisms that emerged, and identifies the factors that residents believed influenced their wellbeing.

7.1. Subjective wellbeing

This section will reiterate how wellbeing is defined and measured in this thesis.

As discussed in Chapter 2, subjective wellbeing can be split into three distinct facets; eudaimonic wellbeing, affective hedonic wellbeing, and evaluative hedonic wellbeing.

The affective aspect of hedonic wellbeing can be represented through the emotions a person feels (Tinkler and Hicks 2011) and includes both positive and negative emotions (Vanhoutte and Nazroo 2014). The evaluative aspect of hedonic wellbeing can be defined as the appraisal of a person's life (Jivraj *et al.* 2014), and is often evaluated through life satisfaction (Pavot and Diener 1993). The eudaimonic wellbeing refers to the self-fulfilment and personal development that a person needs in order to maintain high wellbeing (Ryff and Keyes 1995).

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Due to these definitions, the three facets of subjective wellbeing are measured through the following measures, respectively; Positive and Negative Affect Schedule (PANAS) (Kercher 1992), Diener *et al.*'s (1985) Satisfaction with Life Scale (SWLS), and the Control, Autonomy, Self-realization and Pleasure (CASP) scale (Hyde *et al.* 2003). These three scales and their associated concepts are shown in Figure 7.1 below, which is a replication of Table 3.1.

Figure 7.1. Subjective wellbeing model with measures
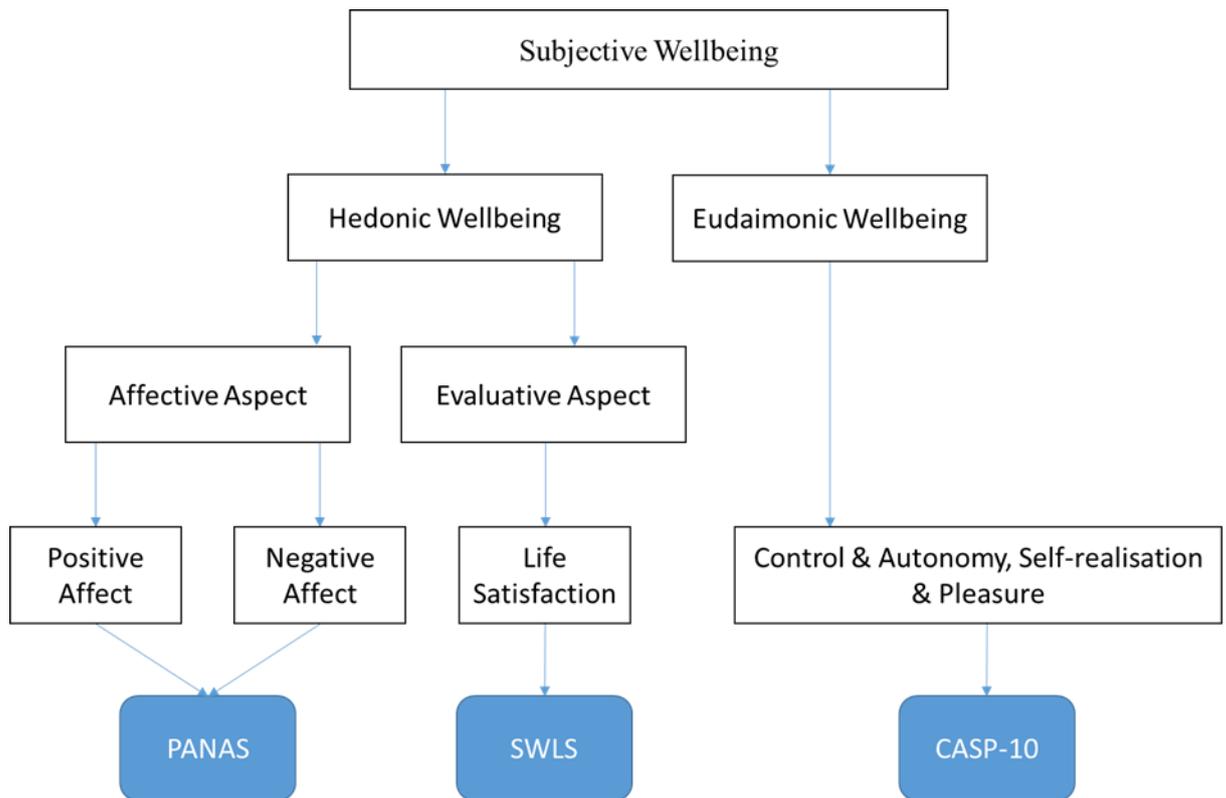
7.2. Network characteristics and wellbeing

4a. What is the relationship between the support networks of older people living in care homes and their wellbeing?

This section explores the relationship between the wellbeing and support network characteristics of older people living in care homes. A full table of each resident's network characteristics and their wellbeing score is in Appendix 11. This was completed

by exploring the correlation between the wellbeing score and support network characteristics of residents.

The hypotheses explored in this section are outlined in

Table 7.1, with each hypothesis always considering whether the network's characteristic would have a positive effect on subjective wellbeing. These hypotheses look at how the composition and structure of support networks affect wellbeing and were chosen through consultation with the literature and emergent themes in the data. Structural network characteristics, such as size, density and number of components, have been shown to have an effect on wellbeing (Wellman 1991, Antonucci and Akiyama 1987), while compositional characteristics, such as the presence of family and friends, have also been shown to have an effect on wellbeing in previous research on ageing and wellbeing (Forsman *et al.* 2011; Cook 2006; Brooker 2003; Brown-Wilson and Davies 2009; Kelly 2010). Therefore, the nine hypotheses were chosen due to their relationships with wellbeing shown in previous research. In particular, the analysis considered whether having a bigger or denser support network affects wellbeing positively (H1 & H2) and, also, whether having one component (path to everyone), compared to have multiple components (separate groups for support) would have a positive effect on wellbeing (H3). With regards to composition, the analysis asked; does having a friend or a staff member present in an older person's support network have an impact on their wellbeing (H4 & H5)? Only one resident did not have a family member in their support network, so this correlation was not included. As well as this, the analysis asked; does the number of family members, friends or staff members in a person's support network have an effect on an older person's wellbeing (H6, H7 & H8)?

Table 7.1. Table of hypotheses: the relationship between network characteristics and wellbeing.

	(a)	(b)
H1	A larger support network …	… would have a positive effect on the wellbeing of older people living in care homes.
H2	A completely dense support network …	
H3	Having one component, compared to multiple components …	
H4	Having a friend nominated for support …	
H5	Having a staff member nominated for support …	
H6	Having a greater number of family members nominated for support …	
H7	Having a greater number of friends nominated for support …	
H8	Having a greater number of family and friends nominated for support …	
H9	Having a greater number of staff members nominated for support …	

Table 7.2 is a table of correlations. Correlation analysis is a helpful statistical technique for showing how strong a relationship is between two variables and is expressed through a correlation coefficient (Hair *et al.* 2014). The correlation coefficient lies between -1 and 1, with -1 showing a perfect negative association and 1 showing a perfect positive association. Correlations involving a binary variable (e.g., presence of a friend in the support network) and the wellbeing score were calculated using point-biserial correlation. Correlations involving a metric variable (e.g., count of friends) and the wellbeing score were calculated using Pearson's correlation.

Table 7.2 suggests that having a larger support network has a positive, but weak, correlation with the wellbeing of residents. This may suggest that having more people supporting a resident is, overall, positive, however, also that there is a limit to this effect. Density has a negligible correlation (tending towards zero), which suggests that having everyone connected in the support network makes little difference for the wellbeing of residents.

Table 7.2. Correlation table of network characteristics by wellbeing score.

	Network characteristics	Correlation[10]
H1	Size	0.22
H2	Density	0.09
H3	Having one component (compared to multiple)	0.21
H4	Having a friend present in support network	-0.11
H5	Having a staff member present in support network	0.27
H6	Count of family nominated for support	0.30
H7	Count of friends nominated for support	-0.32
H8	Count of family & friends nominated for support	0.01
H9	Count of staff members nominated for support	0.32

However, having one component compared to multiple components has a weak positive effect on wellbeing, which perhaps suggests that it is better for alters in a person's support network to be able to connect, rather than a resident trying to maintain multiple groups for support. In reference to the results on density, this may indicate that it is less important that everyone knows each other, but rather, that the 'important' people in the support network are connected and communicating with each other. This relieves the resident of having to communicate important information between all alters, which in turn relieves stress and improves wellbeing.

Table 7.2 also suggests that having a friend present in an older person's support network has a weak negative correlation with wellbeing, and additionally, having a greater number of friends in their support network has a slightly stronger negative correlation. This could be potentially interpreted in a number of ways. Firstly, that relying on friends for support has a negative effect because they feel they are less able to rely on more traditional carers such as family and staff members. As well as this, if a person is relying on friends for support, rather than family or staff, then they may have to work hard to maintain these friendships and thus it may be stressful and taxing on their wellbeing. It could also be interpreted that relationships with family and staff are more strained, or complex, and thus a product of these strained relationships is turning to friends for support.

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[10]No correlations were significant. (***p< 0.001; ** p< 0.01; * p< 0.05)

Table 7.2 indicates that having a staff member in your support network has a weak positive correlation with wellbeing and, further, having a greater number of staff members in their support network has a slightly stronger positive correlation with wellbeing. This could suggest that having a staff member in an older person's support network could show that the older person trusts the staff and feels comfortable receiving care and support in the care home. Therefore, they are more likely to be happier in the environment in which they are living, because they feel supported by the people working around them.

Having more family members in an older person's support network seems to have a positive effect on wellbeing. This is perhaps not surprising, given the qualitative themes that emerged from the interviews with residents and points to the value that residents give to their family members and the time spent with family members. However, having more family and friends in an older person's support network has a negligible effect on wellbeing. This shows that, although both of these types of relationships are more likely to be considered to give emotional support, it seems that having more of these emotional ties does not affect wellbeing, thus giving more weight to the argument that family members are the most important type of support for older people.

7.2.1. Individual wellbeing questions

Subjective wellbeing can be viewed as three separate facets, and each facet was measured through multiple atoms in order to capture the full range of wellbeing. Thus, only looking at how the network characteristics of residents correlate with the overall wellbeing score does not explore how different wellbeing questions may drive the effect between network characteristics and wellbeing. Table 7.3 shows the correlations between the network characteristics of interest (as seen in Table 7.1) and the specific wellbeing questions that have a correlation of (+/-) 0.3 or over in order to exclude those results that have a weak correlation. The table also shows the wellbeing facet to which each question belongs. The sections below describe the results of the table.

Size (H1)

Previous research has discussed the potential benefits of having a larger support network on wellbeing, such as having access to more support or having more people to rely on in times of crisis (Wellman 1981). Table 7.3 shows that having a bigger support network, means you are less likely to feel left out of things and more likely to feel that you can do the things you want to do. There is also a positive correlation with feeling alert, distressed and afraid more often. Therefore, it could be interpreted that naming more people in their support networks could be an indication that the older people have more control and autonomy in their lives as they feel able to do the things they want and do not feel left out of things. However, it may also be interpreted that they are more aware of the changes around them, and therefore are more distressed and afraid about these changes.

Density and number of components (H2 & H3)

Having greater density has a positive correlation with agreeing with the statement 'If I could live my life again, I would change almost nothing' (0.31). This may be an indication that those networks that were denser were also more likely to consist of family members and, as discussed previously, this seems to be very important for residents, which could influence their life satisfaction.

Similarly, having a support network consisting of one component (compared to multiple) has a positive relationship with the statement 'If I could live my life again, I would change almost nothing' (0.34). However, it has a negative correlation with agreeing with the statement 'In most ways my life is close to ideal' (-0.31). This is interesting because this statement is also a question which contributes to the satisfaction with life/evaluative hedonic wellbeing facet. This may indicate that having a dense or connected support network is important for satisfaction with *overall* life circumstances, but not *present* life satisfaction. Thus, having a network consisting of one component is an indication of everyone knowing each other and in communication, which could be deemed good for the residents' support overall, but could also be an indication that everyone *needs* to be in communication because of the amount of support the resident needs.

Table 7.3. Correlation table: network characterises and individual wellbeing questions[11]

Network	Facet of WB	Individual wellbeing question (correlation of +/-0.3 or over only)	
H1 Size	CASP	I feel left out of things	(-0.37*)
		I can do the things I want to do	(0.31)
	PANAS	How often do you generally feel alert?	(0.35*)
		How often do you generally feel distressed?	(0.3)
		How often do you generally feel afraid?	(0.32)
H2 Density	SWLS	If I could live my life again, I would change almost nothing	(0.31)
H3 One component	SWLS	In most ways my life is close to ideal	(-0.31)
		If I could live my life again, I would change almost nothing	(0.34)
	PANAS	How often do you generally feel excited?	(0.33)
H4 friend present	CASP	I feel left out of things	(-0.37*)
	SWLS	In most ways my life is close to ideal	(-0.31)
H5 staff member present	CASP	I feel that the future looks good for me	(0.44**)
	PANAS	How often do you generally feel alert?	(0.32)
		How often do you generally feel distressed?	(0.4*)
		How often do you generally feel excited?	(0.3)
H6 No. of family	CASP	I feel left out of things	(-0.31)
		I can do the things I want to do	(0.3)
	SWLS	In most ways my life is close to ideal	(0.34*)
		So far, I have gotten the important things I want in life	(0.42*)
	PANAS	How often do you generally feel enthusiastic?	(-0.31)
H7 No. of friends	CASP	I feel that the future looks good for me	(-0.35*)
	SWLS	In most ways my life is close to ideal	(-0.37*)
H8 No. of family and friends	CASP	I feel left out of things	(-0.46**)
		I look forward to each day	(-0.35*)
		I feel full of energy these days	(-0.3)
	SWLS	I feel that life is full of opportunities	(-0.35)
		I feel that the future looks good for me	(-0.47**)
	PANAS	How often do you generally feel alert?	(0.3)
H9 No. of staff members	CASP	I feel that I can please myself in what I do	(0.33*)
		I enjoy the things that I do	(0.3)
		I feel full of energy these days	(0.3)
		I feel that the future looks good for me	(0.54***)
	SWLS	The conditions of my life are excellent	(0.41*)
	PANAS	How often do you generally feel scared?	(-0.32)
		How often do you generally feel excited?	(0.34*)

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[11] ***p< 0.001; ** p< 0.01; * p< 0.05

Family (H6)

Having more family in one's support network has an overall positive effect on the individual wellbeing questions. Residents who nominate more family members have a positive correlation with 'In most ways my life is close to ideal' (0.34) and 'So far, I have gotten the important things I want in life' (0.42). This indicates that having more family members to support a resident leads to them feeling satisfaction in their present and current life situation.

A higher count of family members also has a positive relationship with the statement 'I can do the things I want to do' (0.3), which may suggest that family members enable residents to do activities and complete tasks that they want done in their day-to-day activities. This is supported by the negative correlation between number of family members and the statement 'I feel left out of things' (-0.31), showing that family members might be particularly important alters who include and engage residents who live in care homes.

However, having more family members also has a negative correlation with residents feeling enthusiastic more often. This may indicate that, although family members engage and include residents, they are engaging them with more mundane tasks and, therefore, although residents are appreciative, they do not feel enthusiastic about these tasks.

Friends (H4 & H7)

Having a friend present in a resident's support network and having more friends present has an interesting relationship with individual questions of wellbeing.

Having a friend present in their support network had a negative relationship with the statement 'I feel left out of things' (-0.37), which, overall, suggests that having a friend to support a resident is a good thing for feelings of inclusion. However, having a friend, and having more friends, in a resident's support network also had a negative relationship with the statement 'In most ways my life is close to ideal' (-0.31 and -0.35 respectively). Additionally, having more friends in a resident's support networks also had a negative correlation with the statement 'I feel that the future looks good for me' (-0.35).

This may suggest that, although having a friend in a resident's support network is good for engagement and feelings of inclusion, it may also show that receiving support from friends in later life is an indication that they are not getting support from elsewhere. Thus, they do not believe their lives are 'ideal' and 'the future does not look good for them'.

Family and Friends (H8)

On four statements of evaluative hedonic wellbeing (measured through CASP), having a greater count of family and friends has an overall negative correlation. These include; 'I look forward to each day' (-0.31), 'I feel full of energy these days' (-0.3), 'I feel that life is full of opportunities' (-0.35), and 'I feel that the future looks good for me' (-0.47). This negative correlation suggests that having a greater number of family and friends may have a negative effect on how much optimism and enthusiasm one has for the future. These may also be indicative of how much control a resident feels that have on their future.

However, there was also a negative correlation between a greater count of family and friends in support networks and the statement 'I feel left out of things' (-0.46). Thus, despite residents who have a greater count of family and friends in their support networks having a negative correlation with statements which indicate optimism for the future, they also are less likely to feel left out of things. Thus, people who have a larger number of friends and family in their support networks are more likely to feel included, but are not positive about the future.

Staff members (H5 & H9)

Both having a staff member present in a resident's support network (0.42) and having more staff members nominated for support (0.54), has a positive correlation with feeling that the future looks good for a resident. Having more staff members nominated also has a positive correlation with agreeing that 'the conditions of my life are excellent' (0.41). This finding would indicate that staff having a relationship with residents has an overall positive effect on a resident's evaluative hedonic wellbeing. This suggests that those people who have relationships with staff may have a more positive outlook on their current and future situation.

Having more staff members present in their support networks also has a positive correlation with agreeing that they; feel full of energy these days, are able to enjoy the things they do, and can please themselves in what they do. This indicates that residents with more staff members present in their support network may have better eudaimonic wellbeing.

However, the relationship between residents and staff members and their affective eudaimonic wellbeing is more complicated. Having a staff member present in a resident's support network has a positive correlation with feeling alert, distressed and excited more often. This may indicate that those residents who have relationships with staff are more alert, than people who are less alert. Further, this may suggest that people who are distressed more have more reasons to have relationships with staff because they need help more often. However, people who have relationships with staff also have a positive correlation with being excited more often as well. This may suggest that having a relationship with staff could be an indication of engagement with the care home, and events around the care home in general, which could be exciting. Having more staff in a resident's support network gives a similar result, with having more staff members nominated having a positive correlation with feeling excited more often and a negative correlation with feeling scared more often. This may indicate that having more staff members in their support networks might make residents feel safer in the care home, and therefore less scared.

7.3. Types of support networks and wellbeing

4b. Do different types of support networks affect wellbeing more than others?

This section will look at whether there are differences in wellbeing between the different types of support networks. The previous section outlined that there is a weak positive correlation between having a staff member present, as well as having one component when compared to multiple components, on the wellbeing of older people living in care homes. When looking at the boxplots of these two characteristics in Figure 7.2, the first set of boxplots shows that the median wellbeing score of those with a staff members present is only slightly higher, however, the range of values is more condensed when

compared to those who do not have a staff member present in their support network. Similarly, in the second boxplot set, there is little difference in the median wellbeing scores of older people with one component when compared to those with multiple components in their support networks (the two factors used to create the typology). This perhaps shows that neither of these characteristics would drive a big difference in the wellbeing score. However, given that, in both boxplots, the confidence intervals are overlapping, this means there is no significant difference between the groups.

Figure 7.2. Boxplots: Wellbeing score by defining characteristics in typology of support networks

Staff present in support networks	One or multiple components in support networks
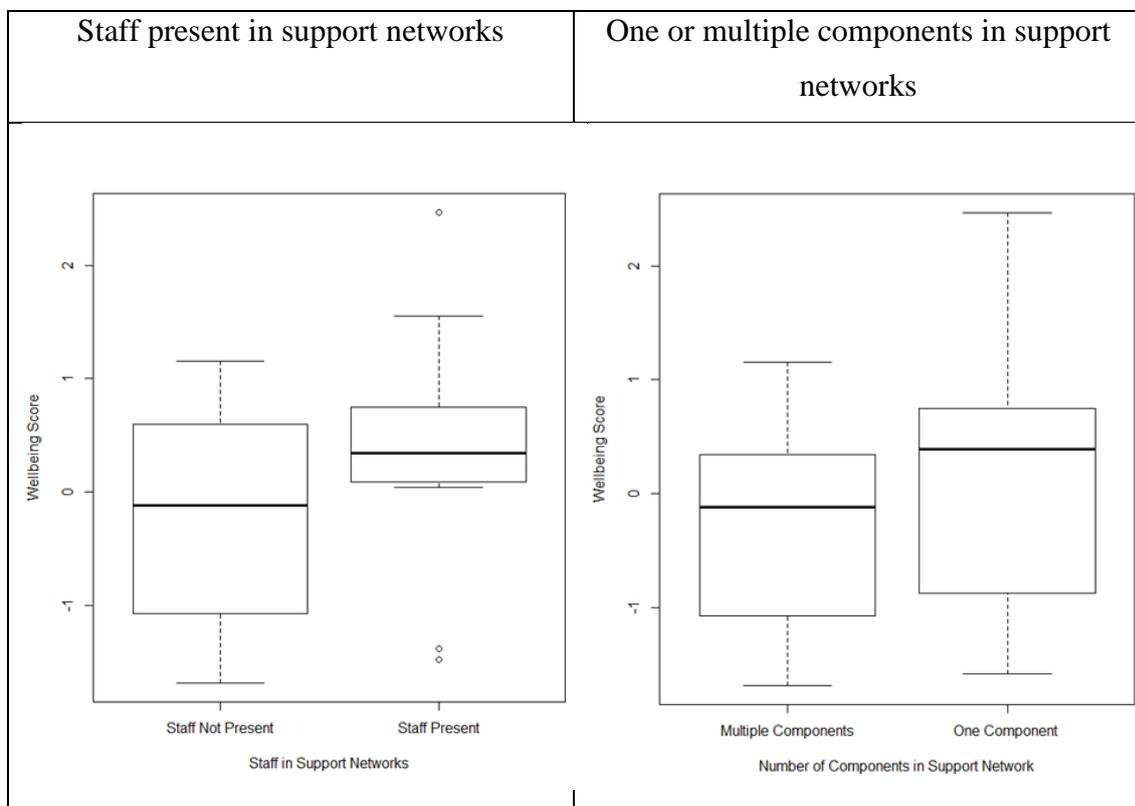
Further, when looking at Table 7.4, it suggests that the 'Integrators', as defined in Chapter 6, have a higher mean and median wellbeing score than other groups. The mean wellbeing score for the three other groups is between -0.35 and -0.17, where the 'Integrators' have a mean wellbeing score of 0.89. This may suggest that something about the support networks of the 'Integrators' is influencing the wellbeing of the residents.

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Table 7.4. Table of means: wellbeing score by type of support network

	Mean wellbeing score (*sd*)
The Compartmentalisers	-0.35 (1.02)
The Integrators	0.89 (0.83)
The Social Managers	-0.21 (0.86)
The Units	-0.17 (0.99)

Figure 7.3 shows four boxplots which represent the wellbeing score distribution for each type of support network for residents. The medians for each group show that the 'Integrators' have a higher median wellbeing score, when compared to the other groups, whereas they have a shorter range in their wellbeing score. This may be indicative of themes that emerged from the interviews with the residents, such as feeling comfortable and friendly with staff members as well as staff members and family communicating. The 'Integrator' results differ from those found in other types of support networks, where residents did not feel supported by staff, or they did not feel that staff and other supporting alters knew each other.

Figure 7.3. Boxplot of wellbeing score for each type of support network.

Boxplot of wellbeing scores
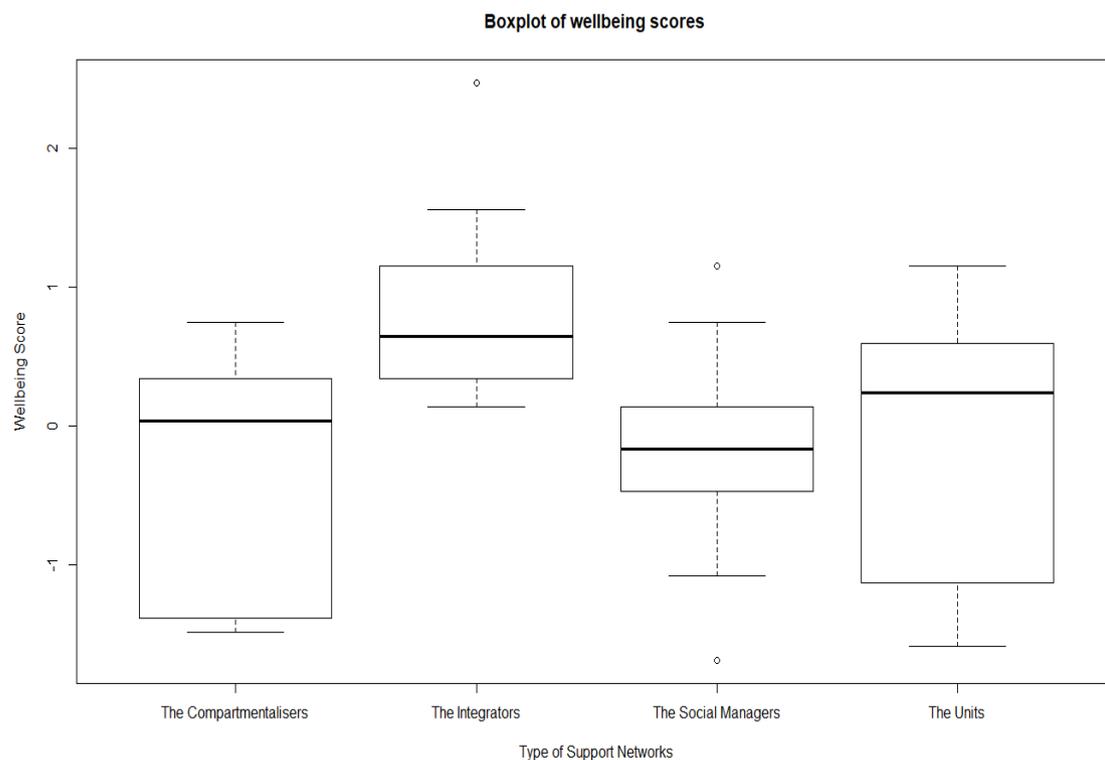
Overall, there is not a big difference in the median wellbeing scores of all four groups and the confidence intervals for all groups overlap, showing that there is no significant difference between types of support network. Further, the 'Units' and the 'Compartmentalisers' have a wider range of wellbeing scores, which shows that there is more variability in their wellbeing scores. Therefore, although the ranges of the scores for the 'Integrators' and the 'Social Managers' are smaller, and the average wellbeing score of the integrators is higher, strong conclusions cannot be drawn from these results due to the lack of difference and the small sample size. However, the following discussion section will draw together the qualitative themes and wellbeing score results to better understand the factors which may affect the wellbeing of older people living in care homes.

7.4. Mechanisms underlying wellbeing

> *4c. What mechanisms underline the wellbeing of older people living in care homes?*

This section explores the mechanisms identified through a critical realist approach to qualitative data analysis. Mechanisms were identified from the analysis of the wellbeing interviews which described what is important to residents with regards to their wellbeing. The wellbeing interviews identified six main mechanisms which affected residents' wellbeing both positively and negatively; stability bonding social capital, reduction of bonding social capital, difficulty in making new connections, affluence of care home, change in family relationship, and the adoption of organisational practices.

7.4.1. Stability in bonding social capital

Overall, residents felt that when their bonding social capital was maintained, their wellbeing was also being maintained. Sometimes this was maintained through strong family bonds being ever-present and continuing with some care duties, however, the care home did have policies in place to try to encourage close family and friends to participate in the care home and therefore encourage them to visit their loved one more often.

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As explained in previous chapters, residents believed that family members were their biggest supports, and therefore it is perhaps not a surprise that family members being present in the care home was deemed as being very important for most residents' wellbeing. Residents would describe how visits from family were what they looked forward to most and what gave their life meaning. Indeed, for many residents, family was a large part of their identity. They were fathers, mothers, brothers, aunties, grandfathers and great-grandmothers.

> *Resident 26: That's family. […]They're the important things for me.*

> *Resident 16: I get excited when my granddaughter comes to see me. I've only got one granddaughter and 8 big, tall, broad grandsons.*

> *Resident 32: Well I think my life has meaning to my family, and to my grandchildren. I'm not sort of ... isolated. My family are very interested to come and visit me, and they all do.*

As noted in the excerpts above, some residents felt that their families were the only people that mattered anymore, and indeed, without family, they felt they may be isolated.

However, one resident did not have any family, and, in other cases, residents did not have children or a partner, or their significant others did not live locally. In these cases, *friends* became much more important to a resident's wellbeing.

> *Resident 53: I have to think of friends who come in – the same faithful people. And I have been encouraged by. Obviously your friends are your family. […] The great value of them of course is that they've known me a long time. They knew you at home, what you were. Your home, your lifestyle, everything about you. What choice to wear, what your standards were. How you behaved, how you presented yourself.*

Thus, having long-term, emotional connections with family or friends were frequently mentioned by residents as being the most important part to their wellbeing as it not only

gave their life meaning, but it also gave them a connection to outside of the care home, and, perhaps most importantly, retained connections to people who understood their identity and history.

7.4.2. Care home affluence

However, care homes did have policies in order to help maintain this bonding social capital. Care homes had open-door policies so that significant others could visit the care home whenever they liked, with the exception of protected mealtimes and during sleeping hours, and care homes organised events which encouraged visitors into the care home on special occasions. However, the organisation of events was more regular in some care homes than in others. This usually depended on whether the care home had a set budget and whether the activities coordinator had the resources to organise such events.

> *Activities CH2: It's entertainment day on a Friday. We usually have our entertainment. It's like going out for a day. Well, I would say that. It's going out for a day and their family is there. See something that you'd maybe go to a show and you go with your family it's just a lovely connection that they've got.*

Whereas in other, less-resourced care homes, the families were left to meet in a more informal way through bumping into each other during visiting or through entertainment that happened on a less regular basis on special occasions.

> *Manager CH7: We find, up in the dementia unit, the relatives quite stick together. They're all going through the same experience, and I think that helps, especially with husbands and wives. We've had a lot of husbands that have been in, or wives that have been in. So it helps them, because the older generation, they know, they're all going through the same thing.*

However, the use of communal spaces also affected how relatives would visit. If the care home had the use of multiple rooms, then families had more spaces to use for private events and gatherings. Care homes that had more communal spaces, of different sizes, converted one space into a café where families and residents could meet in an area that did not look like the rest of the care home. If the care home did not have these varying

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spaces, residents and visitors were restricted to communal lounges that had other residents and families in them.

> *Activities CH2: They'll come in and they'll come into the café for a wee cup of tea and a bit of cake and each family member gets to know another family member by just chatting and, you know. It's a very friendly atmosphere.*

Thus, connections to close family and friends were important for residents and this displayed itself through the value that residents gave to time with these close ties. However, the following section will discuss the effect that losing this bonding social capital had on residents' wellbeing, and thus show why facilitating time with close friends and family should be a priority for care homes.

7.4.3. Reduction in bonding social capital

It was also apparent that when residents recognised that their bonding social capital was shrinking, this could be very upsetting for residents. This was a result of friends and family dying or friends and family who were once regular visitors not being able to visit any longer.

Perhaps it is not surprising that when family members and close friends passed away, this was especially detrimental to an older person's wellbeing. In particular, the death of a long-term partner lingered with residents.

> *Resident 31: And all this has happened since my husband died and I can't talk to him about it. It's very difficult.*

> *Resident 41: I was very ill when Denis died. That put brakes on me. My right arm was broken. I was completely lost – I still am in a lot of ways. I miss him terribly.*

> *Resident 42: My wife was next door [in the care home] and I could always chap and we could sit and chat between the two of us about what we were doing. But that's gone now. The important things in my life, as far as my wife goes, are gone.*

Many residents had been married for most of their lives. Therefore, losing the person with whom they shared everything and who they talked with most was difficult because their main support was no longer there. Further to this, due to the age of residents, and thus, their peer group, it was not uncommon for residents to discuss the loss of multiple friends and siblings as well.

> *Resident 35: [Over] the past month or two, several friends have died. I guess that could be described as distress. People get less and less the older you [get] ... you see.*

> *Resident 11: There was seven of us (siblings) Most of them have passed away,*
> *there's three of us now.*

Therefore, residents gave the impression that their personal network was becoming smaller, and more reliant on fewer people, when compared to earlier in their lives. It is important to emphasise that the death of a loved one for any person's wellbeing is detrimental. However, due to the resident's age, they were arguably hearing of the death of peers more often than a younger person. Thus, not only were they grieving for life partners, but they were also hearing of the deaths of multiple peers, siblings and people of their own age. All of which was described as taking a toll on residents' wellbeing. Ultimately, residents noted that these declines in health, in themselves and others, had contributed to them losing connection with friends.

> *Resident 42: I've lots of friends and friends that I used to have, they're all the*
> *same age as me or slightly younger, but they don't drive and if we ever went*
> *anywhere – it was the same people who would drive places. We would be*
> *singing here and singing there but it was the same people who would be driving,*
> *but now they can't drive. So they're worse than me – put it that way.*

This could give an indication of why having friends in an older person's support network might have a negative correlation with wellbeing, as some friends would still be living, but would be unable to visit, and this may frustrate residents.

7.4.4. Difficulty making new connections

Further to this, residents suggested that creating new friendship ties and therefore potentially having access to more bonding social capital was more difficult in the care home. Residents reported that establishing relationships in a care home was not easy. Not only did being in a care home restrict the possibility of making connections from outside the care home, but many residents noted that making friends with fellow residents, and even staff, had barriers. This added to residents feeling lonely and isolated. To reiterate, none of the residents reported that they had made new supportive friends, who were

residents, within the care home. When residents were asked 'who they liked to socialise with', no resident named another fellow resident that they met in the care home. The three residents who mentioned having a fellow resident with whom they socialised were previous neighbours or colleagues that they had known *before* coming into the care home. Therefore, none of the residents mentioned making *new* supportive connections with residents in the care home, despite being surrounded by people with whom they potentially had a lot in common. There were a number of reasons given to explain why residents did not want to make new friends; they did not want to be associated with other residents (especially those with advanced dementia), did not get on with/resented other residents, or they wanted to be left alone.

> *Resident 18: When you go in there for your dinner you hear strange things. There's a wee guy sitting at the table. I'm looking about and all of a sudden he starts 'Martha! Martha! Martha!' That's his daughter. And I said to him 'Oi Billy! She's not here! So shut it!' [Resident starts making noises and flapping hands to imitate what the gentleman sitting at the table did] And [he] starts banging on the table. 'Get him out of here!' [Respondent said to staff] See what I mean? The things you have to deal with?*

Residents would often not want to associate with people who had more advanced dementia. In interviews, they would sometimes mimic and make fun of other residents who had difficulty communicating or would repeat themselves. Other residents would mention that they pitied these residents, and they would sometimes make an effort to talk to them, but never had a meaningful interaction with them.

> *Resident 32: Most them are actually so disabled, mentally, I don't know what you call that, I don't want to decry them in anyway. But they're so mentally disturbed that you can't really have a conversation. They're so beyond anything. You talk to them just to give them an interest. They just sit and stare in front of them.*

For some residents this resulted in discomfort within the care home because they did not want to be associated with people living with dementia, or they did not know how to act

with them. Others would voice that they started to resent these residents because they would take up the majority of the staff's time, which in turn took time away from their own care.

> *Resident 53: For example my neighbour next door is a classic example – the amount of time he takes up, which others could perhaps benefit from, is unbelievable. And I know his family are amongst the most demanding. So this is where I'm very, very compromised and I resent it. I resent it very, very deeply.*

To reiterate, this study only included people who had the capacity to consent and some of the participants had a diagnosis of dementia. These residents were also the minority in the care homes. This is, perhaps, particularly interesting when thinking about the future of care homes. Residents and many staff members noted that residents were now arriving far later in their dementia journey when they moved into the care home. Thus, the likelihood of the residents forming meaningful connections is perhaps reduced because they have more advanced illnesses and disabilities, as well as the possibility of residents dying much sooner than in previous years and, therefore, they did not have time to make these connections.

> *Resident 42: Every time someone sees an ambulance come in here, unless you know it's for something simple. Like one of the men said the other day, 'They've taken three people to hospital in the past couple of months and they've never come back.'*

> *Resident 16: The men in my bit – there's only two or three of them – and they don't speak.*
> *I: So do you don't see any of the guys from the other side you just wait for your trips?*
> *Resident 16: I just wait for the trip – other than that I don't see other guys. Well there's one on this side called Simon, and he can talk a wee bit, but it's very limited.*

Therefore, some residents voiced that they could not make connections with fellow residents because of their disabilities or inability to communicate. Finally, many residents

wanted to keep to themselves and actively avoided contact with other residents and staff. For many residents, this stemmed from not wanting to live in the care home in the first place. Therefore, they tended to try and isolate themselves in the care home by not talking to others, not participating in activities and eating meals in their rooms as much as possible.

> *Resident 41: I could go down to the lounge if I wanted, but I don't fancy that. I'd rather be on my own. I'm a lonely person to be honest. […] And I'm just a loner in any case so I just step back a bit.*

Residents noted that relationships with fellow residents had a negative impact on their day-to-day living due to awkwardness, dislike of being in their company, or resentment for the staff time they took up. Some residents would actively isolate themselves from fellow residents and thus, they became lonely. Others would label themselves as 'lone wolves', claiming that they did not want company and were happy to not be associated with fellow residents.

Residents also noted that many people around them were passing away, or were very ill, and therefore it was difficult to make relationships with fellow residents. This added to residents' self-isolating behaviour, as this discouraged them from making friendships within the care home. Thus, residents who were interviewed felt that, rather than fellow residents forming a community around them, they actually could add to their isolation and thus, this had a negative impact on their wellbeing due to the loneliness this created.

Thus, despite the care home arranging many activities and events where residents could socialise, this did not necessarily mean that residents felt they were forming relationships with fellow residents. Therefore, it seemed as though the care comes focused more on inviting friends and family into the care home, rather than encouraging supportive relationships within the care home.

7.4.5. Change due to addition of organisational tie

Residents also identified a number of ways in which their support network had changed due to moving into the care home, which had affected the function of particular relationships and therefore their wellbeing. This included family members, who had previously been their main carer, taking less of a caring role as staff members were fulfilling this role. This led to relief for the relationship between residents and their families, however, for a small number of residents, this led to frustration that family members were less interested in their lives. The addition of staff members and the uptake of organisation practices meant that some residents could lead a more independent, less worrisome life in the care home. However, for some, the organisation practices of the care home had a negative effect on their wellbeing as it left residents feeling out of control. Further, being involved in the care home meant that resident sometimes felt forced to be in a community with which they did not wish to socialise.

7.4.5.1. Change in relationship with family

In particular, moving into the care home brought relief to some residents because they knew the burden of their care would not fall on their loved ones, who were often already stressed and burnt out.

> *Resident 26: It's not like being at home, but it's better [to be] taken care of here. Because I don't want my family to be harassed with it [her care].*

> *Resident 11: 'Cause, in the house I couldn't do anything. I would have to tend to my wounds all the time and that would take up my full day. […] I don't have the responsibility of running a house. You think you've got nothing to do. But you have. It takes a lot to run a house, you've got a lot of responsibilities.*

The release of care duties for family members was a good thing for the family, as it prevented burnout for them. However, for some residents, they felt this resulted in family members visiting them less and therefore feeling abandoned in the care home. Although residents no longer relied on family for care, many residents still relied on family members and friends for social contact and resources from outside of the care home as well as emotional support and transport. In cases where family was less engaged, or when

they did not visit as often as the resident thought they should, residents would become frustrated.

> *Resident 31: I just get wee bit upset. My daughter [...] has done a tremendous lot for me, but she doesn't come much to take me out in a week. I get a wee bit... [...] So I get a bit distressed at that. But I don't want to have a row with her.*

This was particularly difficult as residents were often trying to balance their perception that their family should want to be with them, with their concern that they were being too demanding of their families. Therefore, if this relationship became strained, residents felt they had adhered to the family member's opinion or schedule in order to maintain the relationship, rather than voicing their upset. Indeed, even for this research, a handful of residents did not wish to participate in the study unless their family members gave them 'permission' first. This was not because they needed permission, but because they relied so heavily on them for other things, they felt the need to ask for permission for all decisions in their lives. Thus, although residents voiced their appreciation for family members, some residents were very aware of the importance, and indeed, the control that family members had on their lives while in the care home.

> *Resident 54: I'm always asking, 'Please will you buy me a phone?' but I think she [daughter] thinks that I would be making a nuisance of myself by phoning up too often. But maybe I'll persuade her tomorrow.*

The control that family members had sometimes resulted in residents feeling as though they were a burden and therefore residents felt that they should not ask for things they wanted, they did not want to bother their relatives or that they should restrict their requests to only those that were 'necessary'. Thus, relationships with family, in particular, were not *always* beneficial for a resident's wellbeing. Although they were greatly valued by residents and most were very supportive, this also gave family members a lot of power and influence over residents. This was especially apparent for residents who relied on their families a lot. Thus, the family's control and influence could sometimes have a negative impact on residents' wellbeing because it took away some of their own control and autonomy.

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Thus, family members not only had a change in caring role, which in many ways could be a benefit to the families and residents, but they also had increasing control over the residents as residents often relied on them greatly for other support. Thus, this change in relationship between residents and family members could affect the residents' wellbeing both positively and negatively. If residents felt abandoned in the care home or felt as though they were very reliant on family, this could have a negative effect. Conversely, if this change in role resulted in family and residents feeling relieved and less strained, this could have a positive effect on a resident's wellbeing. Arguably, these changes in relationship between family and residents stemmed from the addition of staff members being the main source of care and having to adhere to the organisational practices of the care home (i.e., going out with supervision, etc.). However, these changes also had a positive effect for residents.

7.4.5.2. Adoption of organisational practices

Moving to a care home also meant that residents entered into a place that had different norms and rules. The adoption of these practices had both positive and negative effects on the wellbeing of residents. This largely depended on whether residents felt that the practices of the care home were controlling and restricting, or whether it brought them relief and a feeling of safety. As staff members became the main sources of their personal and medical care, this could result in a great deal of relief for the resident. Firstly, care home life relieved them of responsibilities that they had in their own home, and, additionally, it partly relieved them of the stress experienced from having to manage their own care.

> *Resident 13: I'm inspired to do things I didn't do before. Before I came in here, you know? Like today I'm going for a trip up the town. Then back to my lunch, then I'll probably watch the football. Quite a nice life.*

> *Resident 19: It was a panic attack that brought it on and that's how I came in here. The social [worker] said I needed to find somewhere. So I'm glad my daughter's found here, I'm glad they picked this place it is lovely. I love it. They're [staff are] so supportive.*

For some residents, the scheduling and organisation of care home life relieved them of the stress of organising their own life and home. They were then free to participate in whatever scheduled activities they wanted and not have to worry about things such as cooking, cleaning and the maintenance of a house.

> *Resident 33: All I really want to do is read newspapers and books – watch television – play Scrabble – I just do whatever has been organised.*

> *Resident 56: We have a programme of events – Monday to Saturday. And I always have a look to see what is on each day – that's nice. I would say I look forward [to each day] often.*

However, this satisfaction with the organisational practices of the care home seemed to arise from friendly, trusting relationships with staff. Residents who had a supportive relationship with staff would note that they liked the environment in which they were living, and some would mention particular staff members who they felt especially close with, which made their time in the care home especially pleasant.

> *Resident 11: I feel quite safe in here.*

> *Resident 19: Judy [carer that recently left care home] came to visit me last night and she was the best carer I've had in here. And she gave me cake and chocolate and I said, 'Oh I love you, Hen.' And she said, 'Aye. Well I love you too.'*

Conversely, those who had a negative relationship with staff were not trusting of them, and therefore tended to spend more time in their rooms or trying to avoid integrating into the care home. They would also note feeling more anxious or stressed in the care home and would tell stories about why the staff acted badly and therefore made them frustrated.

> *Resident 27: R: I wasn't here very long and I buzzed about quarter past eight and somebody came and I said 'I'm needing my ... seen to'. 'Well we'll be about ten minutes' [said the carer]. An hour past, and nobody came. I buzzed again.*

Another one came in 'We're on our way around' [said the second carer]. 20 past 11 [they eventually came in].

Resident 42: I'm stressed when I'm in here because a) It's maybe not my business but they're not attentive to things that should be done, b) they should spend more time … it's just the way they talk to people.

Many residents would frame this uneasy relationship with staff members as them being 'lone wolves' or being disinterested in activities and other people in the care home, however, they also voiced that they were sometimes lonely or bored.

Further to this, resident who had bad relationships with staff would often discuss how they felt restricted by the rules of the care home and felt that the staff were controlling what they could do. In particular, many residents noted that they were not allowed to do simple tasks, which they felt they could easily complete. For example, being told not to walk without assistance, not being able to go outside without a staff member and not being able to help other residents.

Resident 15: Until a few weeks ago, if I came round to the door I would have said I'm going along to the shop for a box of biscuits or something or even a bottle of red wine and I had money – that would have been allowed – but no – I don't get out anymore. These days have gone so I just know that.

Resident 35: Well it is out of your control and you must do what they want. I don't always want that. [...] You have to have a nurse and you can't take your own car [to go out with a friend]. You have to have a nurse's car. She has to go everywhere with you, but she won't invade your space, and I said, well, that's a funny thing. How can somebody go with you and not invade your space? Not interfere in the conversation? You might have confidential things you want to tell them [her friends]. So that annoyed me a bit.

Resident 42: I take pride if I'm helping somebody, but the thing here is that you're not allowed to help somebody. [...] You're not allowed to cut [fellow resident's food]. You know?

Some residents felt as though the care home staff were often being over-cautious and overbearing with rules they required them to follow. This left residents feeling frustrated and restricted, which negatively affected their wellbeing.

Thus, care home life relieved residents of the concern that their families were going to have to take care of them. Residents also appreciated not having to worry about organising their day-to-day lives, because the care home staff did this for them. Thus, many residents had settled into care home life because it gave them a safe and comfortable place to live, without having to worry about their care or life maintenance.

However, although for some residents living in a care home brought relief and safety, others felt it was restricting and resulted in them becoming more isolated because they did not want to be associated with others in the care home. Considering that residents lived every day with staff, these relationships are especially important to residents' day-to-day lives and having a positive relationship with both staff and other residents could make a difference in a resident's participation in the care home, satisfaction with their life in the care home and wellbeing.

7.4.6. Summary of mechanisms

The analysis of the wellbeing interviews with residents identified six mechanisms that could be considered either personal or structural/cultural mechanisms.

The personal mechanisms identified that affected an older person's wellbeing were; stability of bonding social capital, reduction of bonding social capital, and difficulty making new connections. Further, structural and cultural mechanisms included; the affluence of the care home, adoption of care home practices, and the effect that moving into a care home had on family relationships.

Although these mechanisms are not directly linked with the network characteristics measured in resident's networks, some links can be drawn between the importance of particular supportive people and the mechanisms identified. For example, where the importance of bonding social capital is highlighted as a mechanism, we can see that the presence of family members in an older person network has a positive effect on an older person's wellbeing score. However mechanisms such as the changing relationship with family ties is difficult to observe in the networks because we only have a snapshot of a person's network and do not observe change over time.

Despite this, these mechanisms go some way in explaining the wellbeing of residents living in care homes, and thus, by identifying these mechanisms, ways to improve the wellbeing of residents can be explored.

7.4.6.1. Micro-level Mechanisms

Stability of bonding social capital

Responses from residents suggested that having contact with family and close friends had a positive effect on the residents' wellbeing. Residents discussed how much they valued time with family members and expressed how much being a grandmother, grandfather, etc. meant to them.

Reduction of bonding social capital

Additionally, a reduction in bonding social capital was detrimental to a resident's wellbeing. Dealing with death and loss was a common occurrence for residents. Due to their age, they would often discuss the death of partners, siblings and friends, which was very distressing for residents. Further to this, residents experienced a loss of bonding social capital in other ways. Due to increasing health ailments in themselves, and in family and friends, this meant that residents could no longer visit these close ties and vice versa.

Difficulty of making new connections

This also affected those making friends within the care home as many people living around them would have physical and cognitive impairment. This reduced the likelihood of them making friends because residents were not well enough to participate, or they felt

they could not make friends with people who had cognitive impairment. Further, some residents voiced resentment for others who took up more staff time or an unwillingness to make friends with people who had more advanced physical and cognitive impairment to their own. Thus, residents were not only likely to have a reduction in already established bonding social capital, but they were also less likely to make new connections that may have provided new forms of bonding social capital.

7.4.6.2. Meso/Macro-level Mechanisms

Care home affluence

Care homes recognised the importance of this bonding social capital, however, they facilitated the coming together of residents and close ties to a greater or lesser extent. All care homes had events throughout the year, however, care homes which had a larger budget could facilitate more events and host them in multiple communal spaces, which they could open to all families and friends. In contrast, less-resourced care homes had fewer events and relied on supporting families through informal contact when visiting their loved one. Having regular contact with family and friends was very important for residents' wellbeing, and, as such, care homes should be facilitating time with these contacts.

Changing relationship with family ties

Residents also acknowledged the effect that joining a care home had on their wellbeing. Firstly, it had changed their relationship with their family, and this had differing effects on a resident's wellbeing. For some residents, this brought relief because they no longer had to rely on their families for medical and personal care. However, some residents discussed frustration at their families because, as a result of moving into the care home, they had started to see them less and felt abandoned in the care home. Further, by moving into the care home, residents' families had gained more control of a resident's life because they relied on them for contact from outside the care home and to run errands for them. This meant that if families did not have time for the resident, or if they did not want to carry out these tasks, residents felt they did not have much control and therefore became frustrated.

Adoption of care home practices and norms

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Another consequence of living in a care home was adhering to care home rules. Some residents described how moving into a care home meant that they were free to live their lives without worry any longer and that this move had allowed them to be cared for in a safe and comfortable place. They also voiced that care home routines suited them, as many enjoyed the activities that were organised and were allowed to participate as much as they wanted. Further, some residents had made friends with staff and this meant that they had continued companionship when family members and friends went home. This all brought joy and relief to residents, which positively affected their wellbeing. However, others described care home culture as restricting and frustrating, which meant that, rather than feeling safe, they felt trapped. Residents gave examples of bad care, rules and experiences in the care home that they did not agree with. This resulted in residents feeling out of control, angry, frustrated and, in some cases, scared. Thus, the care home staff, environment and culture could have varying effects on the wellbeing of older people.

7.5. Conclusion

Maintaining the wellbeing of residents is arguably one of the main priorities for the care home industry. Previous research discusses the link between having greater social capital and better wellbeing for older people (Tajvar *et al.* 2016; Nyqvist *et al.* 2013), however, this link is underexplored in care homes and has not previously been addressed from a networks approach.

Thus, this chapter aimed to answer three research questions:

> *4a. What is the relationship between the personal networks of older people living in care homes and their wellbeing?*
>
> *4b. Do different types of personal networks affect wellbeing more than others?*
>
> *4c. What mechanisms underline the wellbeing of older people living in care homes?*

The first section of this chapter explored the relationship between support network characteristics and wellbeing measures, before going on to explore the differences between types of support networks. It explored nine network characteristics: size;

density; number of components; presence of family, friends, and staff; and count of family, friends, and staff. These characteristics were correlated with the full wellbeing score and individual wellbeing elements.

This chapter found that the compositional measures of the network seemed to have a larger effect than the more structural measures on wellbeing.

Structural measures

All of the structural measures had a positive, but weak, effect on the full wellbeing score of residents. Thus, having a larger, and denser network benefitted residents' wellbeing. This finding aligns with past research that suggests that having more supportive contacts would positively affect wellbeing as supportive alters can help buffer stressful events and offer more resources to overcome obstacles (Thoits 2011). Similarly, having a denser network means that supportive alters can pull resources together and coordinate to support the resident.

However, when looking at the individual wellbeing questions, structural characteristics had mixed effects. For example, although it was clear that having a larger network had a positive effect on aspects of control and autonomy, it was also associated with feelings of distress and being afraid. Similarly, having a denser network (or having a network consisting of one component) had a positive relationship with life satisfaction, but not with being satisfied with their current circumstances. These structural effects on wellbeing therefore require further investigation through larger samples, and a more in-depth look at the effect that the structure of support networks has on individual facets of wellbeing.

Compositional measures

From earlier chapters, the importance of family and staff members for support had already been highlighted, however, this chapter has also explored their importance on wellbeing. Having a great number of family members and staff in a resident's support network had a positive effect on residents full wellbeing score. However, friends (both being present and having a higher number) had a negative effect on a resident's wellbeing score.

This is an interesting finding from this study, as previous research has only highlighted the importance of friends, especially long-term friends, for older people and people living

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with dementia (Forsman *et al.* 2011). When looking closer at the effect of having a friend present in a resident's support network on individual questions of wellbeing, it had a negative effect on an element of life satisfaction and control and autonomy while having more friends only had a negative effect on life satisfaction. This may confirm our interpretation that having friends in later life are valued less that family members, and thus, being in an environment that values family highly, may in fact have a negative effect on one's wellbeing if they have more friends than family. However, having a higher count of family and friends seemed to have a negative effect on aspects of control and autonomy and life satisfaction.

Considering that this chapter found an association between nominating staff for support and higher wellbeing, as well as residents whose support networks are comprised of one component having better wellbeing on average, it is perhaps not surprising that the 'Integrators' had a higher mean wellbeing score than other support network types. However, this can only be said of the average wellbeing score, but not that there was a significant difference between any of the support network types. Thus, more research is required to better understand the network characteristics that partly affect the wellbeing of older people living in care homes.

In addition, these correlation results between the support networks and wellbeing are potentially limited if individual residents may have interpreted single wellbeing questions in different ways. For example responses to wellbeing indicators such as 'I feel left out of things' could be interpreted differently if the residents thought of activities inside the care home, or if they thought of being excluded from their community by living in the care home. As the researcher, I did not give examples, as this was not the instruction of the wellbeing collection tool, however in hindsight these may have helped to standardised the responses from residents.

Overall, this chapter shows that having a larger and denser support network has a positive effect on the wellbeing of older people living in care homes. The results suggest that having more family members and staff members in a resident's support network has a positive effect on wellbeing. This is especially true for facets of life satisfaction. In contrast, having more friends has a negative effect, in particular with facets of life satisfaction and control and autonomy.

Mechanisms underlining wellbeing

The last section of this chapter identified six mechanisms which had an impact on the wellbeing of older people living in care homes.

Micro-level mechanisms

- Stability of bonding social capital
- Reduction of bonding social capital
- Difficulty of making new connections

Meso/Macro-level Mechanisms

- Care home affluence
- Changing relationship with family ties
- Adoption of care home practices and norms

These mechanisms exist at micro-, meso- and macro-levels, thus, while some mechanisms exist at the resident level, many are due to the culture of the care home and structure that it exists within. As such, it is important to consider how these findings add to the existing literature and what implications they have for the wellbeing of older people living in care homes.

Micro-level mechanisms

Social capital has been highlighted in several studies as having a positive effect on wellbeing, and this relationship has proven to be especially strong among older people (Forte 2009; Pinquart and Sörensen 2000). Arguably, older people who live in care homes are at a higher risk of lower wellbeing as dementia and disability have both been highlighted as key factors in reduced social interaction and social networks, which could have a negative impact on wellbeing (Grenade and Boldy 2008; Pinquart and Sörensen 2001).

The findings of this chapter suggest that bonding social capital is especially important for the wellbeing of older people living in care homes. This is perhaps particularly emphasised because these older people have moved away from their previous homes, and thus connections to people who understand their identity and history are particularly important for residents. Responses from residents suggested that having contact with strong ties such as family and close friends has a positive effect on a resident's wellbeing. Residents discussed how much they valued time with family members and expressed how

much being a grandmother, grandfather, etc. meant to them. Additionally, the loss of bonding social capital, and, arguably, the higher rate of loss, was detrimental to wellbeing. Dealing with death and loss was a common occurrence for residents. Due to their age, they would often discuss the death of partners, siblings and friends, which was very distressing for residents.

However, it was not just the loss of bonding social capital, but also the reduction in contact with these emotional ties which was detrimental. Due to increasing health ailments in the residents, and in family and friends, this meant that residents could no longer visit these close ties and vice versa. This also affected those making friends within the care home as many people living around them had physical disabilities or cognitive impairment. This reduced the likelihood of them making friends because residents were not well enough to participate, or they felt they could not make friends with people who had cognitive impairment.

Meso/macro-level mechanisms

At the meso-level, care home norms and practices had a two-fold effect on the wellbeing of residents. Firstly, the impact of being in the care home environment meant that residents felt their relationship with their family members had changed, especially with those family who were once their carers. For some residents, this brought relief, because they no longer had to rely on their families for medical and personal care. However, some residents voiced frustration at their families because, as a result of moving into the care home, they had started to see them less and felt abandoned in the care home. Further, by moving into the care home, residents' families had gained more control of a resident's life because they relied on them for contact from outside the care home and to run errands for them. This meant that if families did not have time for the resident or did not want to carry out these tasks, residents felt they did not have much control and therefore became frustrated. Thus, being involved in the practices of the care home meant that their relationships within their support network changed, which could have a positive or negative effect on wellbeing.

Another consequence of living in a care home was adhering to care home rules. Some residents described how moving into a care home meant that they were free to live their life without worry any longer, and that this move had allowed them to be cared for in a safe and comfortable place. They also voiced that care home routines suited them, as

many enjoyed the organised activities and were allowed to participate as much as they wanted. Further, some residents had made friends with staff and this meant that they had continued companionship when family members and friends went home. This all brought joy and relief to residents, which positively affected their wellbeing. However, other residents voiced that the care home culture was restricting and frustrating, which meant that, rather than feeling safe, they felt trapped. Residents gave examples of bad care, rules and experiences in the care home that they did not agree with. This resulted in residents feeling out of control, angry, frustrated and, in some cases, scared. Thus, the care home staff, environment and culture could have varying effects on the wellbeing of older people.

Lastly at the macro-level, whether the care home was well resourced/in an affluent area, and therefore more likely to be able to facilitate better spaces and more events and trips, was important for residents' wellbeing. Appropriate and wide-ranging events were important to engage and give purpose to a diverse care home population. All care homes had events scheduled throughout the year, however, care homes which had a larger budget could facilitate more events and host them in multiple communal spaces, which they could open to all families and friends. In contrast, less-resourced care homes had fewer events and relied on supporting families through informal contact when visiting their loved one. This inequality in provision was evident and had a great impact on the wellbeing of residents who resided in less well-resourced care homes.

This chapter has explored a main aim of this thesis, which was to explore the relationship between support and wellbeing in the care home context. This was achieved by correlating the network characteristics of residents support networks and their wellbeing score, as well as exploring the differences in wellbeing between different types of support networks. Additionally, this chapter analysed qualitative data from the wellbeing interviews with each resident. This data gave residents explanations of why they had answered the wellbeing questions in such a way and thus gave light to events, changes and situations that had impacted their wellbeing. The exploration of these aims gave a greater understanding of how support networks affect the wellbeing of older people. The final chapter will bring together the main themes of each empirical chapter and embedded these findings within the context and literature of care homes and ageing.

Chapter 8 Discussion and Conclusion

Chapter 8 Outline

The purpose of this chapter is to synthesise the findings of this thesis, which has explored the support that older people living in care homes receive and the relationship that this has with their wellbeing. Firstly, it will revisit the main aims of the research before moving on to explain how the results of the thesis challenge and concur with current literature, as well as address gaps in the literature. It then discusses the implications for future research and explores the impact that this research will have on policy and practice with regards to care homes and supporting older people.

8.1. Review of the research aims

The relationships that older people living in care homes have has been shown to influence wellbeing (Bowling *et al.* 2002, 1994; Brown-Wilson and Davies 2009) and, overall, are central to good care (Goodman *et al.* 2013; Nolan *et al.* 2006). Despite previous studies having outlined *why* these relationships are important (Brown-Wilson 2007), there has been little understanding of what support looks like for individual residents. Given the growing support needs of the future care home population (Froggatt *et al.* 2009) and the aim of care homes to help maintain and improve wellbeing (Care Inspectorate 2019), understanding more about the relationship between support and wellbeing could help to address weaknesses in this area to improve overall support. Therefore, this thesis explored the support networks of older adults in care homes to build understanding of how this shapes support and, subsequently, the wellbeing of residents. Exploring how the egocentric networks of residents are composed and structured has clearly enhanced our understanding of how family, friends, staff and others come together to support residents. Further to this, exploring whether there are patterns to this support and what is driving these patterns has led to a better understanding of support in care homes and how to improve this.

When exploring how people access support, past research has focused on the social ties of individuals, rather than incorporating the influence of organisations in society (Small

2009). This thesis is unique as it not only explores the individual's support network, but also goes further to consider how the care homes influence that support. Given that residents live in the care home (organisation), it has a particularly strong influence over the support and resources that the older person can access. Hence, when discussing the support that residents receive, it is important to explore the influence that the care home and its staff will have on support.

Thus, this project sought to explore three main aims:

1. To better understand the support networks of older people living in care homes.

2. To better understand how care homes support older people.

3. To explore the relationship between support and wellbeing, in the context of care homes for older people.

Consultation with methodological literature informed a mixed method design, which used both egocentric network analysis and a critical realist approach to qualitative data analysis. The research involved conducting interviews with selected residents, staff and visitors of seven care homes. The interviews with residents collected network data, a wellbeing score and qualitative data in order to understand how the support network of a resident was composed and structured, as well as provide an understanding of the meaning behind these connections, and what effect support has on wellbeing.

8.2. Main findings

The aim of thesis, to explore the support networks of older people living in care homes and the relationship between this support and residents' wellbeing, is important, given the emphasis that past research, and the health service, has put on the importance of relationships and community in care (Care Inspectorate 2019; Brown-Wilson and Davies 2009). The key findings are that family members were the biggest support to residents, and, in particular, adult children provided the most support. Residents who had friends would talk about their importance in their lives, however, only half of residents nominated any friends as sources of support. Many discussed how moving into a care

home prevented them from seeing friends, and many of their friends could not visit due to their own health reasons.

The majority (two-thirds) of residents did not nominate staff for support, despite staff members feeling that they were providing support. Residents identified not having enough time to get to know staff (especially time outside of care tasks) and negative staff–resident engagement as key factors that prevented residents and staff from establishing meaningful, supportive relationships. This suggests that approaches to care, such as person/relationship-centred care, are not achieving some of their main goals, including the development of meaningful relationships between staff and residents.

Further analysis revealed four different types of support networks, which were characterised by residents nominating staff and their supporting alters being connected in one component (or not). This analysis showed that having a meaningful connection with a staff member and that staff member being connected to an older person's family was very important for them feeling supported in the care home, as well as having a better experience there. In particular, this showed that creating relationships with individual staff had value beyond just providing a service and that creating a meaningful relationship between residents, staff and family members was beneficial for the resident's experience in the care home.

Care homes were able to source a wealth of resources for residents, however, the label of being a care home resident also had less desirable results. Where Small (2009) found that '*unanticipated gains*' were obtained through organisations, the present study has found unanticipated barriers to support, where care specialists gave less priority to care home residents, which left staff having to advocate for residents' care needs. Care homes located in less affluent areas were also disadvantaged due to cuts to local authority-funded community services, which reduced the number of groups and events that residents would previously have attended.

Associations between social network characteristics and wellbeing suggested that compositional measures, such as the presence of certain supportive alters, had a greater effect on wellbeing than did structural network measures. These findings were supported by the qualitative analysis, which highlighted similar themes in the mechanisms that

emerged, such as the maintenance and loss of bonding social capital. This analysis also revealed macro-level mechanisms which had an impact on wellbeing, such as adapting to care homes rule and norms.

Overall, the mixed method approach used in this thesis allowed for effective triangulation of qualitative and quantitative data to answer research questions relating to how support networks affect older people living in care homes. The use of mixed-methods approaches enabled viewpoints of support to be challenged to reveal patterns, which were analysed to form novel typologies that can be used in future research. This allowed a deeper understanding of why various types of support received from particular actors were so important to residents and their wellbeing.

8.3. Discussion

The following sections will discuss the importance of the results presented in this thesis. This will be considered in accordance with current literature and in relation to the contribution of novel findings to address gaps in the literature. Finally, the implications of these findings for practice and future research are presented.

8.3.1. Relationships

Relationships have been described as being essential to the caring process (McCormack 2003; Brooker 2003; Nolan *et al*. 2004; Brown-Wilson and Davies 2009), however, this thesis has shown that residents rely highly on family members, and many residents felt that staff members were not supportive. This section will discuss how key relationships contribute to the support and wellbeing of residents, and how this relates to past research.

Family

The characterisation of networks in the present study revealed that the majority of alters nominated for support were family members and that family members were more highly correlated with emotional support (such as discussing personal matters and giving advice). This finding is similar to those of Cheng (2009), who found that the majority of supportive ties for nursing home residents in Hong Kong were family and close friends. The present study also found that having more family members in an older person's

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support network has a positive effect on wellbeing. This may indicate that emotional support has a greater effect on wellbeing, as family members were more likely to be associated with emotional support, than other types of support, for older people in this study. This is also reported in previous research which found that having more close friends and family had a positive effect on the quality of life of older people living in the community (Gallegos-Carrillo *et al.* 2009; Bowling and Browne 1991). It has also been suggested that older people value family and close friends more than other ties (Forsman *et al.* 2011; Cook 2006; Cummings and Cockermouth 2004; NHS Health Scotland 2004), as friends and family provide social support, mutual trust and a sense of security, which, for older people, was far more important than formal ties in organisational life (Forsman *et al*. 2011, 2013).

The current study also found that adult children provided the most support to many residents. Past research has also emphasised the importance of adult children for the support of older people, and even when moving into long-term care, daughters in particular are likely to continue caring for their parents (Friedemann *et al.* 1999). However, other studies indicate that, rather than continuing to care for parents, adult children are more likely to 'keep an eye' on the staff caring for their parent, and only step in when they deem the care to be inadequate (Sandburg *et al.* 2002). Further to this, adult children have been found to facilitate connections between their parents and wider society (Li *et al.* 2000) and that they try to make visits special by changing the activities they did together during visits (Sandburg *et al.* 2002). This present study had added to these findings by suggesting that adult children provide the most support from the resident's perspective and are often considered the most supportive person in their support network.

Friends

Just over half of the sample nominated a friend, and many of these friends were not seen regularly. Retaining connections to friends seemed to be difficult for residents due to friends being less likely to visit due to ill health or an inability to obtain transport to the care home. Examples of the care home helping to maintain these connections were not common, and often these friendships were only maintained if the friend could visit, or if family or a friend could facilitate the coming together of both the resident and friend. Conversely, measures of friendship ties (presence and count) had a negative correlation with wellbeing. This contradicts previous research which suggested that close friends are

important for the wellbeing of older people (Forsman *et al.* 2011; Cook 2006), however these past studies did not take place in care homes. It could be suggested that older people living in care homes, those who rely more heavily on friends, are less able to rely on their family, which has great value to residents living in care homes. Therefore, being more reliant on friends may be an indication that these ties to family have broken apart or are less present in an older person's life. However, given that friends are more likely to be of similar ages to the resident, it might be the case that these supportive friends may become less reliable as they also get older. Therefore, despite them being a key source of support, they may also be less likely to visit as often or provide more help. This interpretation might also corroborate with what residents said about their friends. Many noted that when they were able to see friends they were excited and enjoyed their time together. Few friends managed to visit more regularly, but most only visited for special occasions, or not at all. Thus, this negative correlation with wellbeing and friendship ties could indicate that residents are frustrated and unhappy about not being able to see their friends as often, or not at all, especially when they consider them to be supportive.

There is a perception that older people living in care homes will have other residents and staff members to talk to, which could reduce the likelihood of loneliness (Dickens *et al.* 2011). This study also found that no resident made a new friend with another resident in the care home. The findings add further support to those of Moyle *et al.* (2011), who suggest that older people living in long-term care, and especially those living with dementia, are at risk of being socially isolated and lonely (Moyle *et al.* 2011). Previous research has found that residents can, and do, make friendships in care homes (Powers 1992, Moyle *et al.* 2011), however, this was not the case in this study and was not the case for all residents in previous studies.

The current study found that residents did not want to interact with other residents because they did not want to be associated with people living with dementia, or the other residents had health issues preventing them from interacting often. This adds to past research which found that residents who made friends in assisted living housing tended to make friends with people of similar 'cognitive status' (Abbott and Pachucki 2016). However, as the current study found that no residents made new friends, this was a difficult aspect to explore, and, as such, future research should explore what is preventing, or encouraging, residents to make friendships in care homes.

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Alternatively, the lack of friendship in care homes could be explained from the findings of previous studies that found that older people found their interactions with fellow residents to be unsatisfactory (Mattiasson and Andersson 1997) or believed their interactions were very superficial and therefore did not create strong connections (Powers 1996). Hubbard *et al.* (2003) looked at how residents interact together and found that interactions can be mixed, with some residents using humour, flirting, teasing and hostility to communicate with one another. However, it could be argued that interacting with someone on a day-to-day basis, compared to recognising them as an actively supportive alter, are very different relationships. This thesis argues that friendship with other residents is an untapped source of support which residents could benefit from by being able to relate their experiences with people who are going through similar changes to them. Previous research has found that there is an inability of family members and staff to commit quality time to residents (Moyle *et al.* 2015), and thus, being able to able to make friends in care homes is of great importance. Although the sample in this study is small, the fact that no residents in the study made a new friend in the care home is concerning. Within care homes, older people eat together multiple times a day, spend time doing activities together and sometimes visiting local areas. Care home staff can only do so much to encourage relationships between residents, however, more research into why friendships are less likely to be created in care homes and what can be done to encourage this potential source of support is needed.

Staff

This study found that staff ties were less likely to be associated with types of emotional support such as 'discussing personal matters' and 'socialising' but were more likely to be associated with instrumental or informational support such a 'providing help' (House and Khan 1985). This indicates that residents view staff as providing more practical support, rather than emotional support. Although care and support is a large element of what is provided by care home staff, only a third of residents nominated a staff member for support. As well as demonstrating a discrepancy between the purpose of a care home and residents' experiences, this thesis addresses a gap in previous research which has not clearly reported the proportion of older people who nominated staff members (Cheng 2009). There is potential for many extra supportive ties to be established for people living

in care facilities, yet residents have not felt that they receive support from staff and staff hold little importance in their lives.

By drawing on previous research, it could be suggested that residents are less likely to nominate staff for support because they view bonding social capital as more important, when compared to younger people (Forsman *et al.* 2011). Thus, the support given by family and friends could be valued more by older people and considered as more important to nominate. This is perhaps confirmed by the findings in the present study, where residents described staff members that had aided them in different tasks, but chose not to add them to the target, even when asked if they would like to do so. Arguably, this finding is supported by previous research which found that residents of long-term care benefitted from having personal relationships with staff when their personal needs were attended to in a caring way, however, these relationships were hindered when they did not feel respected by the staff members (Tester *et al.* 2004). Furthermore, Brown-Wilson (2007) found that residents had a better relationship with staff when they deemed their relationships with staff to be more reciprocal, and when staff and residents shared personal information with each other. Relationships were more positive when staff, residents and families had to work together to find solutions to residents' care. Thus, it could be argued that residents are more likely to perceive staff as supportive if they have a more personal and reciprocal relationship with them, which, in this study, many did not.

This may also speak to research on ambivalent relationships which acknowledges that relationships are not in a duality of harmony or conflict at any one time (Luscher 2002). Instead ambivalent relationships are not necessarily negative, "but rather implies a task of structuring relationships that is more or less created by structural, situational, and personal conditions." (Luscher 2002) As such, residents who may feel that staff support them, but did not want to place the staff members on the target may have ambivalent relationships due to the barriers to creating a meaningful relationship which have been discussed previously. The reason for so many staff not being placed on the target was not the main focus of the project, and thus was pursued rigorously when data was being collected. However, the effect of ambivalence in relationships in care homes should be explored further in future research, especially when discussing staff and residents relations.

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Residents who suggested that they were supported by a staff member also had positive emotional relationships with them. These relationships had often taken adequate time to build trust and get to know one another. Therefore, spending quality time with staff is important. The staff/resident relationship is often identified as a key facilitator of support (Canham *et al.* 2017). Factors such as knowing an individual resident's preferences, needs and emotions can allow staff members to respond appropriately to each resident's needs (Canham *et al.* 2017; Hung *et al.* 2015, McGilton and Boscart 2007; Berdes and Eckert 2007). Further, delivering care in such a way that is seen as caring, respectful and, when appropriate, having fun at the same time, can facilitate more positive relationships (*ibid.*). In this thesis, staff described having meaningful conversations with residents, getting to know their likes and dislikes and building this relationship up over time. However, for the majority of residents in the study, this emotional connection was not the norm. This disconnect between the two narratives is interesting, and may indicate that staff are discussing what they *believe* relationships should be like in care homes, but perhaps not exactly how they play out in reality. Conversely, staff may be trying to make these meaningful connections, but residents remain hesitant towards these relationships. However another possibility is that residents and staff define support differently and therefore residents perceptions of what support is does not match with what staff provide (e.g. perception that staff helping them is a service, rather than support). In any case, there is disconnect between staff and residents in their perceptions of meaningful relationships in the care home. This is concerning, given current views on the importance of promoting positive, meaningful relationships in care homes:

> *Where these [positive] relationships are absent, residents are at risk of being unseen, unheard and treated as 'objects of care', rather than active participants in decisions that affect them.* (My Home Life 2012).

Thus, more needs to be done to encourage these supportive, communicative and coordinating relationships between staff and residents. Especially as the presence of staff members, and having more staff members, in a person's support network, had a positive effect on their wellbeing. This may indicate that residents who nominated staff trusted these staff members and thus, felt safe in their care, or in the care home in general. This positive effect may also suggest that they have spent time with these staff members and

have formed friendly relationships with them, which gives them more emotional support and better wellbeing.

8.3.2. Community in care homes

Chapter 6 described how further analysis of the support networks revealed four different types of support networks, which were characterised by residents nominating staff and their supporting alters being connected in one component (or not). This analysis showed that having a meaningful connection with a staff member, and that staff member being connected to an older person's family (one component), was very important for allowing residents to have a better experience in the care home.

In some ways, the typology that emerged has similar characteristics to previous typologies of the social networks of older people. Most typologies created in previous studies analysing the social networks of older people have a family-centred type of social network. For typologies created for older people in general; Wenger (1992) included a 'family dependant' type, and both Litwin (2015, 2001) and Fiori *et al.* (2008, 2006) included a 'family network' type. The two previous typologies created for older people in care facilities described a kin-centred network (Powers 1992), and Alayon (2019) included a child-centred one, both of which were partly characterised by having a greater proportion of family ties. Thus, this would seem to be a clear theme within typologies of social/support networks for older people, regardless of whether they are in care or not, and this would suggest that there are a proportion of older adults who are very family orientated.

The typology created in this study would suggest that those who feel supported by staff, and also feel like the staff have made a connection with their families, have the best experience in the care home. This would suggest that, for older people living in care homes, having support networks where, structurally, all of their supporting alters are connected directly or indirectly (one component), and consist of at least one care home staff member, is best for the resident's care home experience. Davies and Nolan (2004) found that, as families and staff interacted more regularly, they develop a 'respect and appreciation' for each other and are more likely to work together to support residents.

Furthermore, Brereton (2005) found that family members were more likely to trust staff when they felt *their* needs were also taken into consideration.

In this thesis, some residents who had positive relationships with staff also felt that the staff were connected to and knew their families. In particular, the work of Brown-Wilson (2008) discusses the importance of staff, residents and families working together in order to facilitate better care. She argues that relationships which are 'reciprocal and responsive' result in the most positive experiences for all stakeholders. Further evidence-based recommendations of past research include that staff should consider families as partners and experts in their residents' care in order to provide the best care (Davies and Nolan 2006). Furthermore, Killet *et al.* (2016) found that the best care was displayed in care homes where residents, families and staff worked together, and there was a sense of community in the care home. They provide examples of when staff really showed they cared about both residents and relatives, or when staff were more transparent about their day-to-day work and, therefore, residents and relatives were more understanding of the staff's time and practice. Conversely, in care homes that did not have a 'community feeling', families were more likely to make shorter visits and their time spent with the staff was mainly based around checking up on their loved one's care. Thus, the current and previous research would suggest that staff members should be considering how to support family members and should include them in the care of their loved one, in order to create better day-to-day living for residents.

This thesis found that there were qualitative and structural differences between different types of support networks, however (perhaps due to the small sample size), there was not a clear difference been the wellbeing scores of residents with different types of wellbeing, with the exception of a slight increase in the average wellbeing of those who had an 'integrators' type of support network. Litwin and Shiovitz-Ezra's (2011) study created four network types of older people living in the community in Israel. They found that those who had a diverse network type were less likely to feel lonely. They found that family-centred networks, which were characterised by high numbers of children and family ties, were not associated with loneliness, nor happiness. Although there is not a clear difference between the types of support networks, exploring whether people who have more diverse network types (inclusive of family, friends and staff) and those who

have more closely connected networks, would be interesting to explore with a larger sample size in future research.

8.3.3. The care home

Chapter 5 established a number of ways in which the care home supported residents as well as the role that care home practices and wider factors may have in creating barriers for the support of residents. As such, overcoming these barriers to support is essential to aiding an industry whose main aims are not being achieved (i.e., supporting residents through staff) and which is expecting to have to support more people in the future.

Activities

Activities were a key way in which residents felt they were supported in the care home. When care homes provide meaningful activities, residents can maintain their sense of self (Tester *et al.* 2004) and the social participation that comes from meaningful activities leads to a better quality of life (Bowling *et al.* 2002).

However, the residents interviewed in this thesis described how activities lacked meaning as they were more appropriate for some residents, rather than others. Some residents felt that activities were patronising, and many men felt that most of the activities were directed towards women. This thesis also found that this was compounded in some care homes where staff felt that they did not have the appropriate training to deliver activities for people living with more advanced dementia. Other studies have noted findings similar to these, but have suggested that, as long as residents had the opportunity to opt-out of these activities freely and that there were alternatives for them to engage with later, then residents remained satisfied (Hubbard *et al.* 2003; Tester *et al.* 2004). Thus, in order to support all residents, a variety of activities must be freely offered in order to maintain a person's autonomy, purpose and sense of self.

Adoption of care home practices and norms

This thesis described how moving into the care home positively affected the wellbeing of some residents as it offered relief for the residents and their families. Some residents felt they gained more independence and enjoyment in their lives as they did not need to

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worry about getting medical attention, maintaining a house or cooking. This meant that residents were able to enjoy the visitors who came to see them, rather than worrying about hosting them. This brought great satisfaction for residents, however, for others, moving into a care home was not as easy. Other residents voiced how they found the care home environment frustrating and constraining. In the care home, they experienced bad care and described how it was frustrating that they saw staff not being attentive to other, more vulnerable, residents. This all contributed to a negative perception of staff and thus, a negative view of the care home. Residents also described finding the care home rules constraining, especially when they believed they could carry out said tasks. Previous research has found that older people feel restricted by the organisational rules and norms of the care home, and studies reported that older people felt that these rules controlled the delivery of care and activities (Palacios-Cena *et al.* 2013). Wikstrom and Emilsson (2014) discussed how care home staff had ageist views of residents, and this resulted in bad communication of events and activities because staff viewed communicating said information to residents as futile or a waste of time. They found that staff would keep information from residents because 'they didn't want to worry them'. This resulted in residents becoming confused about why they were being taken to different events, or frustrated because they did not have time to prepare. Tester *et al*. (2004) also found that residents would become upset if they felt they were being watched as they felt they had lost their freedom.

These themes can be transferred to the present study, where residents sometimes felt restricted in their day-to-day activities because staff believed that they did not have the ability to carry them out. This finding was also present in Jakobsen and Sørlie's (2010) research, which described how there were tensions between safeguarding residents and promoting their autonomy. In some cases, staff would have to take over from residents when they were not able to carry out a task and were putting themselves at risk, but, on other occasions, staff would take control of the situation if they felt it was taking too long. Staff justified this action by describing how it was disrupting their routines and therefore taking time away from other residents, however, this was clearly detrimental to the autonomy of the resident. Also, residents felt as if they had lost their freedom if they thought they were being watched and this would then upset them (*ibid.*). Thus, the organisational practices of the care home were either relieving or restricting for residents. This could either make residents feel at ease in the care home, and thus, have better

wellbeing overall, or could lead to increasing frustration and the entrenchment of negative attitudes towards staff.

Resourcing

Care homes were seen as a hub of potential knowledge and resources on which residents could capitalise, gathered from the perspectives of residents, relatives and staff. This could come in the form day-to-day support, such as meals, activities and personal care, but could also come from the expertise and help of the staff. However, often residents would mention that there was not enough staff, they were too busy or the care home could not retain staff members. Killet *et al.* (2016) found that there were staff shortages in some care homes, more than others, and that this affected the provision of care. However, although care homes may be affected by this at different times, it was their response to these issue as an organisation that determined whether they were resilient to them. For example, solutions such as the manager being willing to help on the floor when short-staffed, showed that the staff, regardless of their seniority, were willing to work as a team, rather than the care staff ending up spending less time with residents. Therefore, a care home's organisational resilience to 'finite resources', such as staffing, could be buffered by effective management. However, it is important to be sceptical of this concept of resilience in an industry that is woefully underfunded and in great demand. Arguably, there is a balance to be struck between an organisation being resilient to the pressures of demand and not having enough funding in order to function effectively.

The current study found that, although there were complaints, from staff and residents over a lack of staff and an increase in administrative pressures in most care homes, the use of agency staff was more common in care homes in less affluent areas. Previous research found that nursing shortages and lack of retention diminished the likelihood of developing meaningful relationships between staff and residents (Coughlan and Ward 2007). Thus, in order to build meaningful relationships, it is important to have consistent staffing, where both parties have the time to get to know one another. Further, Ryvicker (2011) looked at how socio-economic disparities between nursing homes were reflected in the quality of staff–resident interaction in different nursing homes in the USA. He found that nursing homes, which served middle-class communities, delivered a much more person-centred approach to care, while care homes, which served lower-income communities, supplied a more tasked-based approach to care. In this case, he argues that

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the nursing homes in higher-income areas were able to supply better training and more qualified staff when compared to the lower-income community. Thus, the socio-economic disparities between these nursing homes changed the quality of care that the residents received.

Further to this, the care homes' access to local community funding and resources was notably different between care homes in more or less affluent areas. Care homes that resided in less affluent areas were more likely to experience a loss of resources due to community funding being cut. This resulted in less entertainment and community connection options for care homes to offer. As well as this, the funding of the care home also seemed to be a bigger barrier to support in less affluent care homes. Differences in restrictions to budget meant that some managers were under pressure to keep the care home at full capacity, while others were encouraged to find innovative methods to improve the wellbeing of residents without the worry of overspending. Thus, residents who resided in care homes in more affluent areas were more likely to receive support as and when they needed it, whereas, in less affluent areas, there was more compromises made when support was costly (e.g., consistent staff, local community resources and extra supports).

8.3.4. The outreach of care homes

In the current study, managers and senior staff, in particular, discussed not only supporting residents through their own expertise but also liaising with a number of specialists so that residents obtained a wide range of specialist care. This finding aligns with those of previous research on the benefits of organisational ties, which claim that organisations are key institutions that can gain resources for people who would otherwise not be able to reach these resources outside of their own social circles (Small 2009, 2008). Applying this to care homes, it was not that residents would not be able to access health care outside of the care home, but that the care home was able to manage this care, arrange for it to come to them and to monitor how care was being delivered. However, care home managers reported having to fight for specialised support from NHS staff, as it was felt that older people living in care homes were not a priority for these external staff. This restriction from external experts is troubling, considering that a key aim of the My Home Life (2012) recommendations is to encourage partnership working within care homes, in

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order to maintain the care and support of residents. However, if other organisations and specialist teams are displaying a reluctance to prioritise residents, this may in fact be a disadvantage for older people.

Maintaining links to community

One of the novel findings of this thesis was that residents not only wanted to be connected to the community outside of the care home, but they purposely wanted to be connected to the community within which they had previously lived. Although previous research has found that family members sometimes connected residents to the wider community (Tester *et al.* 2004), this is not always the case in the current study, and, therefore, connections to previous communities are being lost, which negatively affected the residents' wellbeing.

Burge and Street (2010) found that residents of assisted living facilities, which had regular contact with external social supports, had better relationships with other residents who were already well connected in the assisted living facility. However, this could also be an indication that people who have the ability to maintain these connections are also able to maintain social connection within assisted living. Abbott and Pachucki (2016) also made the same assertion for older people living in assisted living in the USA, where they saw that people who had smaller friendship networks also had lower MMSE scores. Despite this, older people living in care homes clearly want to maintain their links to their communities. For example, the current study found that residents wanted to keep links to churches, community centres and previous neighbours, and therefore care homes should be doing more to maintain these connections through visits, or perhaps technology, if appropriate. Past research has suggested that care homes should help maintain links to people within these communities by helping them to write letters and make phone calls (Cook 2006). Although this is a good method for retaining connection, this may not encompass the kinds of connections that people want to retain, such as visiting churches and community centres. Further, it does not acknowledge that people value being in each other's company, rather than solely letter-writing or calling.

8.4. Methodological implications

This thesis has added to the growing literature that includes the voices of older people living in care homes. There is little research completed in care homes, and even less completed with the residents of care homes themselves (Law 2018). Rectifying this is crucial, given that researchers need to produce more evidence-based research to support policy and practice changes, which, by including the opinions of older people, makes this evidence base stronger. This thesis has shown that carrying out a complex mixed-method approach with older people living in care homes, who may or may not have some memory problems, is not only viable, but meaningful. The mixed method approach adopted in this thesis has displayed how using qualitative methods can enhance the network data collected and can be especially beneficial for those with mild memory problems, as telling stories about their supportive relationships can also act as a reminder for revealing other supportive ties.

This thesis provides one of the few examples of using network analysis in care homes. Previous examples have either been conducted in other countries or other types of care facilities (Ayalon 2019; Cheng 2009; Powers 1991), or employed whole network analysis (Abbott and Pachucki 2016) and thus, were not explored from the resident's perspective. Egocentric network analysis gives an individual's perspective on their wider network and shows which relationships matter for residents. Previous studies have either focused on specific relationships in isolation or have examined how individual factors affect specific relationships. Without the egocentric network analysis in this study, the lack of priority for staff relationships and the high priority of family relationships would be less apparent. Moreover, the input of ties that were seen less often, or not at all, by residents may not have been explored. Further, by creating a mixed method typology, this study has added to the understanding of what drives the composition and structure of the support networks of older people living in are homes. Future research could go on to validate this typology through replication and to further develop the typology of support networks in care homes in order to achieve a better understanding of which factors drive support in care homes.

A critical realism approach supplies a toolkit for gaining a deeper understanding of the mechanisms driving the social world, and provides a fuller picture of the connections between all these layers of mechanisms (Danermark *et al.* 2005). In particular, due to the wider impact of mechanisms at the micro to macro level of reality (Danermark *et al.* 2005), these mechanisms can be compared to wider studies looking at the support of older

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people in other contexts, or indeed the support that organisations provide in general (organisational ties). Due to this, the mechanisms identified, and thus the findings of this thesis, have portability to wider contexts within social care and beyond. The thesis has shown how a critical realism approach can reveal mechanisms which underline support and wellbeing in a care home context. Thus, more researchers should be using this approach to create a deeper meaning and better implications of what works and does not work in care homes.

8.5. Policy and practice implications and recommendations

This section presents a series of recommendations that have emerged out of the findings and which offer valuable insights to inform the future development of policy and practice in care homes. First, it is important to state that all of these implications should be considered alongside the wants and needs of the residents in mind. Each resident and each care home environment is different, and understanding that these recommendations may not work for every resident and care home is imperative to the care home industry for building a community in which residents are valued and engaged members.

Recommendation 1: Create diverse spaces for people to connect with friends and family in the care home and provide transport for residents to reciprocate that visit.

Family and friends were of great importance to the support of residents. Care homes should look at including these family and friends in the care home community as much as possible. In particular, it is important to consider how space is used within the care home to allow residents and family and friends to come together outside of their rooms. This would also encourage other families and friends to integrate. Care homes, in this study, provided space for family and residents to meet; in particular, the use of cafés and lounges were well received. However, lounges were often large areas in which many residents slept, were female-dominated spaces, or were 'quite busy', and this meant that some residents did not want to meet their families in these spaces. In the future, care homes could facilitate friends and family visits through creating private spaces in the care home, which are not the resident's room, or, going further, they could arrange transportation for them to visit, or for the resident to visit them. Two care homes had internal cafés to bring visitors, including family and friends, into the care home, which was often discussed as a great feature of the care home. When renovating or designing

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care homes, spaces such as cafés and private lounges should be included to be used for this purpose.

Recommendation 2: Vary care home event and activity times to encourage other family and friends to visit and be part of the community.

In this research, care homes showed that they were trying to engage families and friends through formal events, such as activities or relatives' meetings. However, many of these events were being scheduled within normal working hours and therefore people who worked full time were not able to attend. Care homes should considering altering the times when these activities are held so as to include as many families and friends as possible at alternative times of the day.

Recommendation 3: Implement befriending policies in care homes to encourage staff–resident relationships, and create time in staff schedules to spend quality time with residents and families.

This study found that there were few staff members being nominated for support. Care homes should continue to put resources into person-centred/relationship-centred approach to care. This should also include giving carers and nurses more time to spend with residents through purposeful activities. Residents who had good relationships with one or more staff members often had an example of when staff had been particularly attentive or had gone out of their way to help them. For example: helping them move rooms, including the resident in the move and being attentive with all their belongings. These examples stood out for residents and they described these instances to their families and friends, as well as to me. These experiences helped solidify their relationships with particular staff members and therefore meant that they had at least one staff member they knew they could rely on, which was very beneficial.

Introducing a befriending system between staff and residents, or even just having a named carer in the care home, could encourage reciprocal relationships between residents and at least one staff member, which could improve the residents' attitudes towards staff. Although befriending with volunteers has been piloted in previous research, with positive effects reported for residents and staff (Downey 2011), it seems that this is an area lacking in exploration. Designing a study to explore whether having a named/befriending staff member had an effect on the trust or perception of support could be of interest to care homes and researchers.

Staff should be encouraged to make connections with each resident's family, as this has consistently been described as a very important value for residents. Staff should be encouraged to get to know families in the presence of the residents, and not just for the sake of care planning, as this could encourage trust between the three parties.

This recommendation in particular resonates with the Scottish Governments' (2018) recent 'Connected Scotland' framework which aims to reduce loneliness and social isolation among all people living in Scotland. Within this framework the Scottish government specifically recommends promoting befriending schemes, however practical examples of how to implement this in a care home is lacking. My recommendation of having a named carer for each resident, or between residents, and having protected time between these two people, is a practical action which could be an added recommendation to this framework which would be specific to care homes.

Recommendation 4: Investment should be made in implementing solutions to alleviate time spent on paperwork.

One of the main barriers described by staff was the amount of time they had to spend on paperwork, rather than with residents. Future research should explore the development of technological solutions and the creation of a cost-effective system which enables people to conduct the paperwork on tablets whilst with the resident, rather than completing it in a tiny office at the end of their shift.

Recommendation 5: Care homes should invest in maintaining links to residents' local communities through transportation, events, spaces and technology.

Uniquely, this study highlighted that residents not only wanted to be connected to the community surrounding the care home, but also to their previous communities, if they are not one and the same. Care homes could help maintain connections to old neighbours and friends in previous neighbourhoods, as well to their local churches and community centres. Some residents managed to maintain their connections through local newspapers and other mediums, however these were largely facilitated by family. Care homes could aid the maintenance of these connections by discovering what residents did in their previous communities and trying to find ways to connect residents to these activities or places. Care homes should try to find ways to bring these communities into the care home, too, such as asking community centres to demonstrate what they do for an afternoon or inviting church members to provide a service/sermon in the care home as a guest of the

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resident. This links back to a previous point discussing how care homes should have diverse spaces in order to facilitate the inviting of these groups into the care home, thus creating a larger community for residents to engage with.

Transport is an issue for some care homes and therefore it would perhaps not be practical to facilitate going to church often, however, arranging visits to special services or events at the resident's local church could be considered. Going further, care homes need to be challenged as to why these connections are being lost. The cost and time of arranging transport, and perhaps a carer to attend a service, is not a great expense if arranged a couple of times a week. My thesis has shown that this is a key connection that is being lost and is one that residents wish to keep. Therefore, funds to maintain these connections should be made available.

The 'Fairer Scotland for Older People' Framework developed by the Scottish government (2019), was developed to address and tackle the barriers that older people face due to their age across all sectors. Older people highlighted that remaining connected and involved in their communities is important to them and this has resulted in this being one of the main action points of the framework. In particular, this framework notes that connections to community could be maintained through intergenerational activities and increased opportunities for older people to participate. Despite this being a key action point for the Scottish government, this study has shown that many care home residents do not feel connected to their communities. Thus, this study offers specific recommendations for care homes in order to keep residents connected to their communities. These care home specific recommendations, such as increased funding for transport and the linking of community groups and care homes, should be proposed and added as particular solution to keeping older people living in care homes connected in Scotland.

Recommendation 7: Care homes should create contacts lists of friends and family who residents may wish to invite to social events.

This thesis found that only half of the residents who were interviewed nominated a friend for support, and many were not seen often. Care homes should try to maintain the friendship ties of residents by providing transport and investing time in inviting these friends to events. When events are organised in care homes, invitations are usually only sent out to the next of kin because these are often the only details that the care home

records. Efforts could be made by care home staff to collect the details of important friends when residents first arrive, with the permission of the friends concerned. The care home could have a list for each resident and record who is appropriate for contacting under different circumstances. This may not only help maintain friendships ties, but would also increase the community reach of the care home.

Recommendation 8: Every care home staff member should have dementia training.

This study found that not all staff had dementia training, in particular, activities coordinators, and this resulted in staff feeling unsure about the activities they were arranging for residents living with dementia. Every staff member should have dementia training in order to support people living with dementia as best they can, as well as providing activities that are appropriate for all residents.

Recommendation 9: Training for specialist and NHS staff should emphasise the importance of their services to care homes and the value of residents as equal citizens.

This research found that NHS staff and external specialist did not give older people living in care homes priority. Future research should address why this has occurred and whether it may be driven by ageist views or budget restrictions. NHS and external staff should be providing a benefit to the residents by being able to come directly through the care home, rather than it being similar to where an older person is living at home and is therefore having to access specialist care through hospitals, and navigating referrals. In reality, NHS and external staff are creating disadvantages for older people living in care homes as they are giving them less priority, resulting in care home staff having to advocate for residents to obtain the services that they need. The social care system should view the care home population as citizens with the same rights, concerns and level of priority as the 'at-home' population, rather than assuming that 24-hour care provision will resolve all of their issues, or at worst, viewing them as a lost cause.

8.6. Future research

This thesis has explored the relationships between support and wellbeing in the care home context, however, there are a number of ways in which future research could explore this relationship further.

Family and friends living too far away to visit regularly was another issue for residents and, therefore, interventions using technology to connect residents with their families should be considered. As this will likely becoming more common in the future, recent research has explored the benefits and barriers of implementing video calling into care facilities (Zamir *et al.* 2018). Overcoming barriers to implementing these technologies would be advantageous if it allowed residents to connect with close friends and family who lived too far away to visit. However, this is an emerging research area, and therefore more investigation into how this may work in care homes needs to be completed. Future research should consider how friends could be included in the care home community, and what is driving friends to be more or less available.

Relationships between residents were not common in the current study. Care homes used activities and mealtimes to bring residents together, however, future research should explore how relationships between residents could be encouraged and sustained by the care home, not just how residents interact (Hubbard *et al*. 2003). Future research could consider the qualities that residents look for in new friends made in the care home, and what deters a person from making friends. As well as this, future research could explore what care home activities are effective for creating friendships between residents, and whether there are different types of activities that care homes should be considering in order to encourage friendships between residents.

The lack of staff nominations for support is particularly concerning for the care home industry, and the care home industry's approach to care. Care homes in the UK aim towards a person-centred care framework, if not a relationship-centred care framework (Care Inspectorate 2019). These frameworks encourage personal relationships between staff and residents, where staff know the likes and dislike of residents, have a knowledge of their background, and understand their wishes and values. To learn this information, staff and residents are encouraged to build meaningful, reciprocal relationships with one another. If these approaches to care were succeeding in care homes, we would expect to see supportive relationships between residents and staff. However, in this study, only a third of residents believed that a staff member had 'talked to them about personal matters', 'given them advice', 'socialised with them', 'provided help', or 'are important in their life'. If these approaches to care were succeeding in care homes, supportive relationships between residents and staff would be more readily perceived. By applying an egocentric network approach to residents' relationships, this thesis has found that these

approaches to care are not necessarily manifesting into practice, with only a third of residents nominating staff. This suggests that perhaps there are issues regarding the day-to-day implementation of these frameworks and, indeed, that care homes may be paying lip service to these frameworks. More research needs to explore the implementation of person/relationship-centred care in care homes. Research should consider whether these frameworks are being implemented effectively and why these frameworks are not producing supportive relationships between staff and residents.

Alternatively, this thesis also showed that care staff and residents did not always get along, and some residents actively distanced themselves from staff. This may indicate that staff members are not necessarily the type of people with whom residents want to socialise, and vice versa. Given this, it may suggest that care homes need to invest in a more diverse staff body, in which carers of different social backgrounds and ethnicities are employed. Future research should consider whether employing a more diverse staff body would contribute to residents feeling that they are more supported by staff.

Finally, a key finding of this thesis was that some care homes were more disadvantaged than others, due to budget pressures and lack of local authority funding. These inequalities between care homes need to be emphasised to the Scottish Government, and government funding should try to reflect this resource inequality. More research needs to be conducted to explore how these inequalities between care homes can be alleviated. Furthermore, these findings should be disseminated and specially directed at the Scottish Government.

8.7. Original contributions

1. Not only does this thesis add to a lack of research in care homes (Law 2018), but it has also applied a novel approach to collecting, and analysing, network and qualitative data with older people living in care homes. This shows that a qualitative approach to network data collection can be completed with older people with mild memory problems, and can enhance the analysis of network data through added qualitative meaning.

2. Uniquely, this study explored how measures of support networks affect the wellbeing of residents. Thus, enhancing and expanding the current understanding

of the relationship between support networks and wellbeing by applying this in a care home environment.

3. This thesis originally applies the concept of organisational ties to care homes. By exploring the support provided by care homes, through the lens of organisational ties, a better understanding of the benefits and disadvantages of living in a care home emerged. It highlighted the wealth of knowledge and resources that the care homes could provide, the role staff played in order to obtain resources from elsewhere and the effect that being labelled a care home resident had on their access to care. Interestingly, exploring this concept exposed a negative aspect of moving into a care home, and by extension, a potential negative effect of particular organisational ties on support.

4. This thesis offers a typology of support networks of older people living in care homes in Scotland, which has, to the best of my knowledge, never been attempted before. This has added to the few studies using a mixed method approach towards creating typologies of support networks and develops an understanding of the types of support networks that older people build in order to receive support.

8.8. Concluding remarks

As older people living in care homes are becoming frailer with more complex care needs in Scotland, care homes need to be able to support these people effectively. Thus, overcoming barriers to support, highlighted by the work presented in this thesis, is crucial to improving the care and support received by residents, as well as for creating sustainable support which can enable residents to have greater wellbeing.

This thesis addresses a gap in social care research by exploring how residents feel they are supported and how these forms of support work together to maintain a person's wellbeing. This thesis has displayed how a qualitative approach to network analysis offers a powerful viewpoint for analysing the relationships that residents develop and maintain in care homes, what residents consider as important to their support, and what barriers there are to providing these forms of support.

The main findings that have emerged from this thesis are that residents believed that family members provided a lot of support, and in particular, adult children provided the

most support. Given this, it is unsurprising that friends are also important to residents, but moving into a care home created barriers to seeing them. The majority of residents did not believe that staff members were supportive. However, those who nominated staff for support, and believed these staff members were connected with their families, had a better experience in the care home. Care homes were a key source of knowledge and resources for older people, but residents could be disadvantaged if they became less of a priority for specialist external staff or if they lived in a care home in a less affluent area. Finally, in relation to wellbeing, this thesis found that the composition of an older person's support network had a larger effect on their wellbeing, when compared to the structure of the support network.

A number of recommendations for practice have been made, stemming from the findings of this thesis, for example, care homes should create different spaces and opportunities for people to connect with residents. Furthermore, it recommends that care homes should create time for staff and residents to get to know one another, as well as for staff to get to know the residents' families. This thesis also highlights that, although improving relationships within care homes is important, measures to integrate the care home into the wider community (and vice versa) should also be implemented.

In sum, moving into a care home for the increased support of care needs should not limit or stop older people having access to a varied support network. Supportive relationships are key to improving and maintaining the wellbeing of residents, thus care homes should be promoting and investing in these relationships to ensure that future residents receive the support they need to thrive.

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Appendix 1

Wellbeing Data Collection Instruments sheet

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Social Support and Wellbeing Study

The data collection instruments included are;

1. *Wellbeing Measure-* three separate scales which measure three different facets of wellbeing.
2. *Network Data Collection Tool-* which includes the network target and name generator questions, as well as an alter attribute and relations module.

Wellbeing Measure

Prompt:

> I am going to read you a number of statements and I would like you to tell me if you feel this way *1. Often 2. Sometimes 3. Not Often* or *4. Never.*
> [Participant will have a prompt card in front of them so they can point to their answer or say their answer. A card with the statement will also be shown]

CASP-10 MEASURES	Often	Sometimes	Not Often	Never
I feel that what happens to me is out of my control				
I feel left out of things				
I can do the things I want to do				
I feel that I can please myself in what I do				

I look forward to each day				
I feel that my life has meaning				
I enjoy the things that I do				
I feel full of energy these days				
I feel that life is full of opportunities				
I feel that the future looks good for me				

Prompt:

I am going to read you a number of statements and I would like you to tell me how strongly you agree or disagree with the statements.
[Participant will have a prompt card in front of them so they can point or say their answer. A card with the statement will also be shown.]

Satisfaction with Life Scale	Strongly agree	Agree	Slightly agree	Neither agree nor disagree	Slightly disagree	Disagree	Strongly disagree
In most ways my life is close to ideal							
The conditions of my life are excellent							
I am satisfied with my life							
So far, I have gotten the important things I want in life							

300

If I could live my life again, I would change almost nothing						

Prompt:

Thinking about yourself and how you normally feel, how often do you generally feel…
[items in order]
[Participant will have a prompt card in front of them so they can point or say their answer. A card with the statement will also be shown]

PANAS (Krecher 1992)	Never 1	2	3	4	Always 5
Upset					
Scared					
Alert					
Distressed					
Inspired					
Nervous					
Determined					
Enthusiastic					
Afraid					
Excited					

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Social Support and Wellbeing Study

My name is Jennifer Ferguson, and I'm a doctoral researcher in the Faculty of Social Sciences at the University of Stirling. My project is supervised by Professor Alison Bowes and Dr. David Griffiths.

Within this project I am looking at resident's social relationships, and how these relationships might help an older person maintain high wellbeing. I am particularly interested in what it is like to live in the care home, and how the care home provides resources, information and support to help residents. As of yet, there is little research that takes a 'network perspective' on wellbeing in care homes, and I hope that by investigating wellbeing in care homes in this way I can add to the growing knowledge about maintaining high wellbeing in care homes.

What does the study involve?

This study will look at the experiences of residents in care homes, their social contacts and wellbeing. I will be interviewing some residents within the care home about their social contacts and wellbeing. Those who may be interested have been given information sheets to inform them of what the study is about and what they might be required to do if they join the study.

Although this project is mainly surrounding the residents of the care home, it is important to explore the views and experiences of the family members, friends and staff who may be connected to the care home. As staff are an integral part of the care home network you play a part in keeping the care home environment a happy and supportive place for residents to live.

Therefore I would like to invite you to come talk to me about some key topics I would like to discuss. I am very interested in the resources that the care home provides to the residents and the day-to-day workings of the care home. I would like to talk about how *you* use the care home

environment, and what you think is most important to help maintain high wellbeing among residents. These topics would be discussed as part of a 'semi-structured interview' which means I would have some questions prepared, but that we do not have to talk about those questions *only*. In fact I would encourage you to talk about other things that come to mind when we have our discussion.

I would like to audio record these interviews so I can remember what we have discussed at a later date.

If you would like to be part of the study then you would need to sign a consent form to acknowledge that you understand what the requirements of the study are and you consent to the interview being audio-recorded.

Do I need to take part?

No, your participation in this research is completely voluntary. You do not to take part and you are free to stop at any time without giving a reason.

What will happen to any information I give?

I would like to record the conversation we have, but will ask your permission to do so. All recordings will be treated with strict confidence, and any information that might identify you (such as your consent form) will be stored separately. When the interview is transcribed, all information that identifies you, others or the care home will be removed so that the transcripts are anonymous. Transcripts will be kept for 10 years in line with the University of Stirling data protection policies. Any quotes which are used for my PhD thesis, presentations or publications will also be anonymised to protect your privacy. However if at any stage you tell me about any harm that is affecting you or residents, I may need to tell someone. This is the only occasion when information will need to be passed on.

How will participating benefit me?

By participating in this research you are able to give your own views on working in the care home and how the care home helps the residents. You are aiding academic research which will inform policy and care practice in care homes. Most importantly, by telling me how your care home helps maintain wellbeing, you are passing on essential information which will help improve the wellbeing of future residents living in care homes.

If you would like to contact either myself or my supervisor with any concerns then please feel free to contact us on:

Contact Details:

Jennifer Ferguson
 	
Phoning 01786 466307
 	
Emailing Jennifer.ferguson1@stir.ac.uk
 	
Mailing Room 3s28
         Faculty of Social Sciences
         Colin Bell Building
         University of Stirling, Stirling
         FK9 4LA
	Prof. Alison Bowes
	
	Phoning 01786 467713
	
	Emailing a.m.bowes@stir.ac.uk
	
	Mailing Room 4S21
	         Faculty of Social Sciences
	         Colin Bell Building
	         University of Stirling, Stirling
	         FK9 4LA

Social Support and Wellbeing Study

This form is designed to help the researcher, Jennifer Ferguson, assess whether a resident has the capacity to participate in the social support and social wellbeing study.

It will be used before informed consent has been given, but after the resident has shown an interest in said study.

The green text will be said aloud to the potential participant, whilst the black text will be used as notes, or reminders, for the researcher.

If at any point it is established that the resident does not have the capacity to participate in the study, then the researcher will move to section 6.

Section 1

Introductions and Participant Orientation

Hello. My name is Jennifer, and I am here to talk to you about my project. Today I just want to tell you what would be involved in the project and collect some details from you. Is that okay?

Is the potential participant orientated in time, place and person?

Can you tell me your full name and what the date is (approx.)?

(The researcher should use their discretion here. Even in the early stages of dementia it is possible that people may get dates and years wrong, this shouldn't be a 'test'. The point is to ensure that the participant is orientated to the here and now, can tell us who they are and more or less the time of year.)

Section 2

Study information and potential involvement

At this point I would like to tell you about my study and give you some information about the study. Is that okay?

This study will look at the relationship between your social contacts and your wellbeing. I am particularly interested in the important people in your life and what they do to help you on a day-to-day basis.

To do this, I would like to visit you and ask you some questions about your wellbeing and the people you talk to most days. My visits can be longer or shorter, and they will probably span over multiple days.

I might be in the care home multiple times to visit other residents as well.

I will ask you questions about your wellbeing and we will fill out a sheet about your wellbeing, which you can see at any time.

I will ask you questions about the people you talk to most days. We will draw a map of the people you talk to most days and how they are connected to you.

We will then discuss what we have drawn, and how all the people you talk to most days are connected to you, and each other.

If it is alright with you, I would like to record these meetings with an audio recorder so I can remember what we have talked about after the meeting.

I might make notes as I ask you these questions. This is to help me remember what has happened during my visit, what I was thinking, and anything else that might be useful in my next visit. You can ask to see my notes at any time.

If you wanted to stop a visit early, or to stop being part of the study entirely, you only have to let me know. It is your right as a participant to withdraw from the study at any time. You do not have to tell me why you want to stop if you don't want to.

Are there any questions you would like to ask me?

If you would like to talk to a family member, friend or staff member about the project, you can. You can show them the information sheet, talk to them about the study and discuss whether you would like to be a part of the project, or not.

If you do not want to be part of the project you only need to let me know next time we meet.

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Section 3

Establishing capacity and evidencing capacity

The researcher will go through the information sheet and answer any questions that the participant may have about the project.

Following this, the researcher will ask four questions (see below) in accordance with the Mental Capacity Act (2005).

The questions will establish whether the person has the capacity to participate in the study and on the follow page the researcher will record the response of the resident to ensure that the researcher has provided evidence that the resident can participate.

1. Has the person understood the information?

2. Is the person able to retain the information?

3. Are they able to use the information given to weigh up their choices and use it to make a decision?

4. Are they able to communicate to you what their decision is?

Evidencing Capacity

It is important that the potential participant is able to evidence that;

1. They understand the study, and can relay some information about what the study is about.

Yes ☐
No ☐

How did they do this?
_____

2. They can retain information about the study.

Yes ☐
No ☐

How did they evidence this?
_____

3. They can use the information (verbal information and information sheet) given to weigh up their choices and use it to make an informed decision.

Yes ☐
No ☐

How did they evidence this?
_____

4. They can indicate to the researcher that they are happy to join the study.

Yes ☐
No ☐

How did they do this?
_____

Section 4

Informed Consent

Has the potential participant provided evidence for all of the above points in accordance with the Mental Capacity Act (2005)?

Yes ☐
No ☐

If *no*, the researcher should explore whether the person is feeling unwell or if there is another reason when they might not be able to display capacity at this point. If there is such a reason, the researcher will make an effort to discuss with staff and/or family to establish if another meeting should be scheduled to carry out informed consent. If the person does not have capacity, then the resident will not be recruited to the study.

If *yes*, the researcher will ask if the resident would like to be part of the study. If confirmed, they will be asked to initial and sign a consent form (see. Resident consent form) or confirm their informed consent in an audio recording.

Section 5

Process Consent

At each subsequent research meeting the researcher will undertake a verbal assessment of the participants' desire to remain within the research study.

The researcher will remind them that their participation is voluntary and that they are free to stop the interview at any stage, or to withdraw completely from the study at any time, without prejudice.

The researcher will remind participants that the data will be confidential and of how it will be stored.

The researcher will check that the participant still wishes to continue with the research project and the next data collection step.

Section 6

Participant without Capacity

If a participant is deemed not to have capacity, the researcher will explain to the resident that unfortunately they have not met the criteria for the study and they will no longer be able to participate in the study.

The researcher will invite the resident to have a cup of tea or coffee with them and a short discussion. The resident will be given support materials, with a list of people that they can contact for support within and out with the care home.

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& SOCIAL
RESEARCH
COUNCIL

Social Support and Wellbeing Study

Background

1. Gender

Male	Female

2. Age

In Years	

3. Do you know how your residency is funded in the care home? For example, are you local authority funded?

Self-Funded	Partially Funded	Local Authority Funded

   If resident does not know their funding category permission will be sought from the resident to find out this information from a third party.

b. Is it okay if I ask a staff member or a family member what funding category you are?

Permission Given?	Yes	No

c. If answered YES to 3b ask: Is there anyone in particular you would not like me to ask? Or anyone in particular you would like me to ask?
   List of people the resident would not want me to contact to gain this information:

   _____

4. Length of time in the care home

In Months	

Wellbeing Measurement & Network Data

This part of the interview will follow the Data Collection Instrument Sheet, which will collect data on the resident's wellbeing and personal network.

Semi-structured Interview Section

The topic guide will then focus questions around the network data collected and meaning behind those connections. The aim of this section is to understand who the resident thinks helps them of a daily basis, with what tasks and how this help maintain their wellbeing.

Family

Are there any people on the target that are family?

How often do you see them? Would you like to see them more?

What do you normally do with them if they visit?

Do you go out of the care home often with them?

Tell me a little bit about your family.

Do they help you with things around the care home sometimes?

[The next question(s) is/are in reference to the name generator question(s) the person was nominated for]

Why did you nominate [select person] for [name generator question 1-6]?

[The next question(s) is/are in reference to where the residents place their family member on the target (very close - not close)]

Why did you place [select person] in this part of the target?

Friends

Are there any people on the target that are friends?

Do they live in the care home? If not, how often do you see them? Would you like to see them more?

What do you normally do with your friends?

Does the care home help you get together with your friends more often? In what ways do they help you?

Do you go out of the care home with your friends?

Tell me a little bit about your friends?

Do they help you with things around the care home sometimes?

[The next questions are in reference to the name generator question the person was nominated for]

Why did you nominate [select person] for [name generator question 1-6]?

[The next question(s) is/are in reference to where the residents place their family member on the target (very close - not close)]

Why did you place [select person] in this part of the target?

Staff

Are there any people on the target that are staff in the care home?

[The next questions are in reference to the name generator question the person was nominated for]

Why did you nominate [select person] for [name generator question 1-6]?

[The next question(s) is/are in reference to where the residents place their family member on the target (very close - not close)]

Why did you place [select person] in this part of the target?

Others

Who are the other people on your target? How do you know them?

[The next questions are in reference to the name generator question the person was nominated for]

Why did you nominate [select person] for [name generator question 1-6]?

Subjective Measure of Memory Problems

Did the resident have any problems recalling information? [This question is for the researcher only.]

No = Very few problems remembering details, names, places and times, and little confusion.

Yes = Many problems remembering details, names, places and times, and some confusion.

Yes	No

Social Support and Wellbeing Study

You

Full name

How old are you?

What is your job title? How long have you worked at this care home?

Tell me about your job? What is a typical day like?

The care home

Can you name some ways in which the care home encourages family and friends to be involved in the care home? Visiting hours? Events? Programs? How many are actually involved? In what way are they involved in the care home? Do any volunteer? Are there any volunteering schemes in the care home?

Give me some examples of how the care home supports the residents. For example- independence? Freedom to choose? Physical exercise? Friendships?

Tell me a little bit about the specialised care that happens in the care home? Are there extra staff that come into the care home from time to time to help the residents? What expertise do they bring? Do residents go out for specialised care? How did they get these appointments?

Are there other people that come into the care home to help or do other activities? [Examples: physical therapist, speech therapist, dementia, stroke, cancer nurse, activities co-ordinator, entertainer, volunteers, community partnerships]

Does the care home put on activities for the residents? What type of activities? How many normally attend? Do you have an activity calendar?

Is there some areas in the care home that you think there could be more resourced to help support residents? Is there something you would like more of?

The residents

Do you ever get to go on outings with residents? What type of outings? Do you have any issues whilst on outings?

Name a few ways in which you think you help support your residents on a day-to-day basis?

How often do you get to interact with residents? Do you know any of them particularly well?

Other Organisations

Do you know of any other organisations that are involved in the care home? Do any charities, care organisations, entertainment agencies come into the care home? How are they involved? How often do you think they are there?

Social Support and Wellbeing Study

You

Full name and age.

What do you work as?

The resident

What is the full name of your loved one? Tell me a bit about your loved one.

How often do you get to see them? What do you normally do in the care home? Are you involved in the care home much? Is there anyone else that often visits your loved one?

Do you know what your loved one gets up to on a day to day basis? Do they have many friends in the care home? What do they do with them? How long do you think they have known each other?

How much contact do you have with the staff? Do you talk to them much? What do you talk about? Does your loved one get on with the staff? What do the staff mostly help your loved one with? Do they ever go 'the extra mile' for your loved one in some way? Is there something that the staff routinely do that is particularly helpful for your loved one?

How much support do you think your love one gets in the care home? With care? With day to day tasks? Can you give me some examples?

Does your loved one attend outings? Where have they been in the past? Are they planning anymore? Do they have many issues getting people to go on outings? Does your loved one attend most events? What stops them going to outings?

The care home

How does the care home encourage socialisation? Do they involve you in any way? Perhaps they invite you along to events with your loved one?

How well do you know the staff at the care home? The manager? Do you know if they get on well with your loved one?

Does the care home facilitate space where your loved one can hang out with their friends?

How well resourced do you think the care home is? What is it lacking in resources? Do you think there is a type of resource the care home needs more of? Do you think the resources of the care home are well distributed?

Are there events held at the care home? What type? Are they only on special occasions? Does your loved one attend most events? Which events are they most keen on?

Other Organisations

Do you know of any other organisations that are involved in the care home? Do any charities, care organisations, entertainment agencies come into the care home? How are they involved? How often do you think they are there?

Appendix 7
GUEP approval letter

Jennifer Ferguson

University of Stirling

FK9 4LA

Jennifer.ferguson1@stir.ac.uk

16 January 2018

Dear Jennifer

Re: Ethics Application: *The Wellbeing and Organisational Ties of Older People Living in Care Homes* **- GUEP292**

Thank you for your submission of the above to the General University Ethics Panel.

I am pleased to confirm that GUEP has approved your application, and you can now proceed with your research.

Please ensure that your research complies with Stirling University policy on storage of research data http://www.stir.ac.uk/is/researchers/data/afteryourresearch/

Please note that should any of your proposal change, a further submission (amendment) to GUEP will be necessary. If you have any further queries, please do not hesitate to contact the Committee by email to guep@stir.ac.uk.

Yours sincerely,

Pp
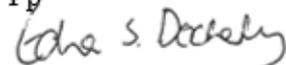
On behalf of GUEP

Professor Helen Cheyne

Deputy Chair of GUEP

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Social Support and Wellbeing Study

Participant Consent Form

Please initial:

I have read and understood the information sheet. I have also been given the chance to think about the information, ask questions and receive satisfactory answers about the Social Support and Wellbeing study.	
I know that my participation is voluntary and that I can choose to stop or withdraw at any time, without giving a reason. However that the information that I have given before I withdraw may be used in the study.	
I understand that all information will be kept confidential.	

I agree to allow the researcher (Jennifer Ferguson) to take notes during her visits.	
I agree to interviews being audio recorded.	
I know that the researcher will not use any information that can be used to identify me in published work.	
I give my permission for the researcher (Jennifer Ferguson) to contact other people who I may be connected with. However I do not given the researcher permission to contact the following people: _____ _____	
I agree to the use of anonymised quotes in publications.	
I agree to take part in the above study.	

Participant Name _____

Signature _____

Date _____

Researcher Name _____

Signature _____

Date _____

If I become unhappy, stressed or unwell during one of Jennifer Ferguson's visits, I would like her to contact:

Name _____

Telephone _____

Relationship _____

Appendix 9
PCA Results

Table 0.1. Percentage of variance explained by the first four principle components of the wellbeing scale.

	Percentage of variance explained by principle components
Component 1	24
Component 2	14
Component 3	9
Component 4	9

Table 0.2. Correlation matrix between first four principle components and wellbeing variables.

	PC1	PC2	PC3	PC4
CASP1	-0.54	-0.13	0.02	-0.41
CASP2	-0.01	0.16	-0.11	-0.71
CASP3	0.28	-0.27	0.17	0.28
CASP4	0.57	-0.34	-0.35	0.14
CASP5	0.46	0.00	0.34	-0.51
CASP6	0.36	-0.31	0.44	0.31
CASP7	0.59	-0.10	-0.39	0.43
CASP8	0.76	0.03	-0.06	-0.08
CASP9	0.73	0.00	-0.38	-0.20
CASP10	0.64	-0.27	0.04	-0.07
SWLS1	0.61	0.07	0.34	-0.04
SWLS2	0.72	-0.14	0.42	-0.04
SWLS3	0.66	-0.06	0.34	-0.10
SWLS4	0.43	0.15	0.55	0.28
SWLS5	0.42	0.11	0.28	0.30
PANAS1	-0.33	-0.74	0.19	-0.04
PANAS2	-0.08	-0.78	-0.14	0.05
PANAS3	0.06	0.01	-0.59	0.49
PANAS4	-0.35	-0.66	0.20	0.29
PANAS5	0.60	-0.33	-0.28	-0.32
PANAS6	-0.39	-0.69	0.32	-0.29
PANAS7	0.29	-0.08	-0.04	-0.13
PANAS8	0.43	-0.36	-0.36	-0.30
PANAS9	-0.42	-0.70	-0.03	0.11
PANAS10	0.40	-0.56	-0.25	-0.12

^Shaded cells indicate correlations over 0.6.

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Appendix 10

## Network Data Collection Instrument

Prompt:

> In this section I am going to ask you to name people that are important to you. I will then write down their name on a post-it and then you can place them on the target (see below). You are in the middle of the target- the bullseye. When you place the post-it on the target, the closer they are to you, the closer you feel to them.
>
> For example if I was to place a post-it in the outer ring I would not feel close to them. If I was to place a post-it in the inner ring then I would feel very close to them.

Name generator questions;

1. From time to time, most people discuss important personal matters with other people. Who are the people with whom you discuss matters that are important to you? (Davis *et al.* 2007)

2. From time to time people socialise with other people, for instance they visit each other, go out for an outing or for a meal. Who are the people you really enjoy socializing with? (Kogovsek *et al.* 2012)

3. From time to time, people ask other people for advice when a major change occurs in their life, for instance, a change in location or a serious accident. Who are the people you usually ask for advice when such a major event occurs in your life?

4. Could you name anyone who has provided you with help recently? (Abbott *et al*. 2012)

5. Please list anyone who is especially close to you who you have not listed in one of the previous questions. (Marin and Hampton 2006)

Network Target:
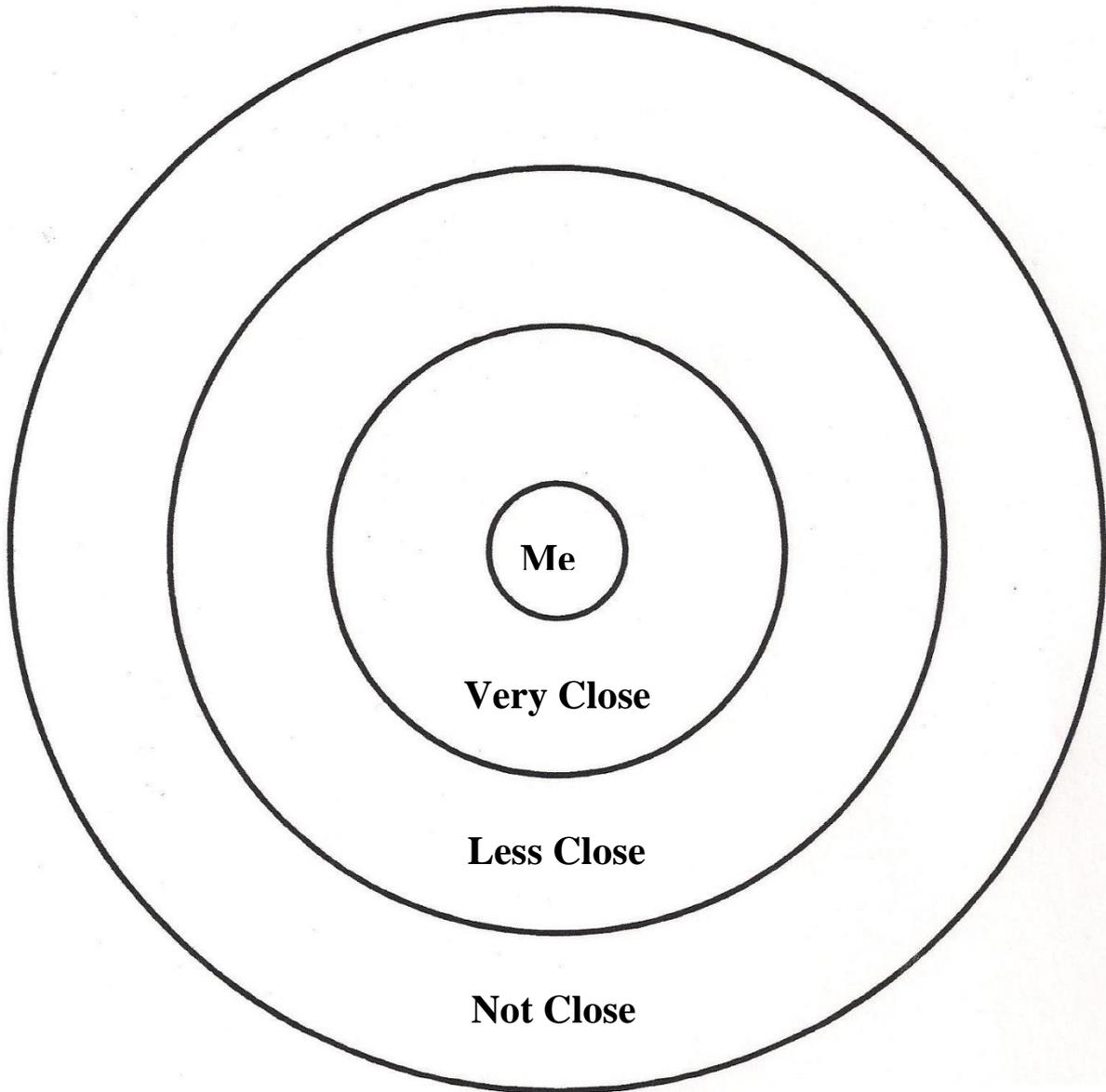
Alter Attributes

I would like you to tell me a little bit about each of the people on your target.
If you are unsure, that is okay, you do not have to answer.

- Are they a man or woman?
- What is the person's age?
- Do they work? What do they work as?
- How often do they come to the care home?

Alter Relations

In this section, I am going to ask you if the people in your target know each other.
For example, my mum and dad obviously know each other, but they do not know any of
my friends from university.
If you are unsure, that is okay, I'm just asking if *you think* they know each other.
Shall we start with [select person]? Does he/she know [select another person]?

Appendix 11

EGO ID	Care Home ID	Network Type	Wellbeing Score	Size	Density	Proportion of Staff
39011	1	The Integrators	0.34	9.00	0.83	0.11
39013	1	The Integrators	0.64	8.00	0.57	0.50
39015	1	The Units	0.44	7.00	1.00	0.00
39016	1	The Units	-0.27	7.00	1.00	0.00
39018	1	The Integrators	0.34	4.00	0.67	0.25
39019	1	The Integrators	2.47	15.00	0.52	0.33
39022	2	The Units	1.15	2.00	1.00	0.00
39023	2	The Units	0.64	2.00	1.00	0.00
39024	2	The Social Managers	-0.17	8.00	0.43	0.00
39025	2	The Social Managers	1.15	4.00	0.50	0.00
39026	2	The Units	0.24	4.00	1.00	0.00
39027	2	The Social Managers	-1.08	6.00	0.27	0.00
39031	3	The Integrators	1.56	9.00	0.42	0.44
39032	3	The Compartmentalisers	0.75	6.00	0.47	0.17
39033	3	The Social Managers	-0.47	8.00	0.32	0.00
39034	3	The Social Managers	-1.68	3.00	0.33	0.00
39035	3	The Units	-1.28	1.00	1.00	0.00
39041	4	The Units	-1.18	1.00	1.00	0.00
39042	4	The Compartmentalisers	0.04	11.00	0.22	0.09
39043	4	The Units	-1.58	7.00	1.00	0.00
39044	4	The Integrators	0.14	6.00	0.80	0.17
39048	4	The Units	-0.87	2.00	1.00	0.00
39051	5	The Units	0.54	11.00	0.98	0.00
39052	5	The Units	0.44	2.00	1.00	0.00
39053	5	The Compartmentalisers	-1.48	17.00	0.16	0.18
39054	5	The Compartmentalisers	-1.38	5.00	0.40	0.20
39055	5	The Social Managers	-0.06	3.00	0.00	0.00
39056	5	The Units	-1.08	6.00	1.00	0.00

39057	5	The Social Managers	0.14	7.00	0.48	0.00
39058	5	The Units	0.95	7.00	1.00	0.00
39061	6	The Units	-1.58	2.00	1.00	0.00
39062	6	The Compartmentalisers	0.34	14.00	0.52	0.71
39063	6	The Units	0.85	4.00	0.50	0.00
39064	6	The Social Managers	-0.47	9.00	0.25	0.00
39071	7	The Integrators	0.75	8.00	0.79	0.88
39072	7	The Social Managers	0.75	4.00	0.50	0.00