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Research Article

A Multiple Case Study Exploring Person-Centred Care in Care Homes

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Background: There are 14,228 care homes in England with a population of approximately 372,035 residents, many of whom are living with frailty or multiple and complex comorbidities. Policy and international literature advocate that care homes provide high-quality person-centred care that meets each person's specific needs. This study aims to provide an exploration of person-centred care in care homes in the South West of England from the perspective of all those involved.

Methods: A qualitative multiple case study design was used across seven care homes in a region of South West England. Semistructured interviews were conducted with 61 participants (residents, family and health and care professionals). Non-participant observations were undertaken in communal areas to understand the practices and cultures of the care homes. All data were analysed using reflexive thematic analysis.

Findings: The findings are presented as six themes, they are adjusting to the transition into a care home; people at the centre of care; the place we call home with the people we call family; working across the boundaries of care; supporting, valuing and empowering care home teams; and managing complex and challenging moments of care.

Conclusion: This study demonstrates a whole system understanding of person-centred care across seven care homes. The main components of person-centred care appear to be relational. These relationships take place in cultures and systems that are complex and challenging with care boundaries that need to be navigated. Navigating these care boundaries requires a people-centred care approach built on partnerships and mutual respect.

Keywords: care homes; carers; case study; nurses; person-centred; residents

1. Introduction

There are 16,726 care homes in the United Kingdom and 14,228 in England [1]. There is a population of approximately 372,035 residents in care homes in England [2]. Compared to the rest of Europe, England has the highest private (for-profit) care home provision and the largest over 80's population living in care home settings [3]. Most residents living in care homes are older people living with dementia, frailty and end-of-life care needs [4]. These conditions can be complex, with multimorbid presentations and cognitive decline being common.

Supporting the needs of care home residents requires care home professionals to act as advocates and facilitators for those unable to access health services and treatments independently [5]. Meeting the needs of this resident population necessitates a move from reactive health and care delivery, towards a proactive, collaborative and integrated approach to care provision [6]. In England, the implementation of the Enhanced Health in Care Homes Framework (EHCH framework) [7, 8] has been rolled out as part of the National Health Service (NHS) long-term plan [9]. The EHCH framework is a whole system approach to delivering health and care in care homes. It identifies seven

core elements and focuses on quality and person-centred care as driving factors for change. Evaluations of the early vanguard (trial) sites emphasised that the whole (rather than individual elements) was essential to improved service delivery [10]. There have been repeated calls for context-specific research, with residents' involvement, to define and measure what good care looks like [10–13].

International research that has explored quality [14, 15] and person-centred care provision [16, 17] in care homes has highlighted the importance of residents feeling part of a community [14] that is familiar [15] and safe and homely [16] whilst being supported by care staff who work as a team [17]. Although Johs-Artisensi and colleagues research [14] included multiple stakeholder perspectives on the quality of care residents received, there has been little other research that has considered the perspectives of all stakeholders in care homes (residents, families and friends and health and care professionals). There has also been limited research exploring the perceptions of residents themselves [18]. This paper aims to provide a whole system and multistakeholder understanding of person-centred care across seven care homes in a region of South West England.

2. Methods

2.1. Study Design. This study used a qualitative case study design [19, 20]. The case studies included an ethnographic approach to understand the care home cultures and the social relationships that existed within them.

2.2. Settings. The study took place in seven care homes in the South West of England, a region with a rapidly ageing population and a large number of care homes [21]. Care homes were invited to participate in the study through regional care home collaboratives and their health and care partners and networks. Seven agreed to participate; six provided residential-only care, and one provided both residential and nursing care. The care homes varied in capacity from 20 to 50 beds. All participating care homes primarily provided long-stay (rather than respite) care. The majority of long-stay residents were aged 75 or above and had a dementia diagnosis (see Table 1).

2.3. Ethical Approval. Ethical approval for this study was sought and obtained from the University of Plymouth's Health Faculty Research Ethics and Integrity Committee, and the Health Research Authority through the Social Care Research Ethics Committee (REC ref: 22/IEC08/0009).

2.4. Sample. A purposive sampling method was applied to each case study to provide a whole system and multi-stakeholder understanding of person-centred care in care homes. Potential interview participants were people who had lived in the care home for at least 3 months plus their family and friends, care professionals who had worked in

care homes for more than 3 months and visiting health and care professionals with more than 3 months care home visiting experience. We did not include people who were in very poor health, under 18 or unable to speak English (see Table 2).

2.5. Recruitment. The initial research setup phase involved face-to-face visits and presentations to care home managers. Once participation was agreed, recruitment posters and participant information sheets (PIS) were placed in care home reception areas, staff rooms and communal spaces at least 2 weeks before study commencement. Interview invite letters and PIS were also sent to family and professional participants via email by the care home managers and given directly to residents by the care home manager if they met the inclusion criteria. The letters invited people to contact the care home manager, who would inform the researcher that they would like to participate in the study. Two residents who wished to participate were considered to lack mental capacity. A personal consultee declaration [22] was obtained for both residents from a family member as required by the Social Care REC (ref: 22/IEC08/0009).

Everybody living in or visiting the care home had an opportunity to opt out of being observed. This meant the researcher would not be in the communal rooms at the same time as them. An opt-in agreement was required by the Social Care REC (ref: 22/IEC08/0009) for observations of residents who were deemed to lack mental capacity by personal or nominated consultees (a family member or the care home manager) [22]. Two residents without mental capacity were opted out by family members. Both residents were being cared for in their own rooms and were in the last days of life.

2.6. Data Collection. Data were collected between September 2022 and August 2023 by a researcher (GH) who was a registered mental health nurse with previous experience of working with older adults in both a clinical and a research capacity. Interviews were semistructured and took place at times that were convenient to participants using private and confidential spaces within the care home. An online interview option was also offered for family members and visiting professionals. Interviews were audio-recorded and then transcribed verbatim, anonymised and checked for accuracy.

Nonparticipant observations took place in communal lounges, dining rooms, activity spaces and gardens during the spring and summer months. The researcher was not directly involved in care but would join in activities, engage in conversations and inform staff if a resident needed help. No personal or clinical care environments were observed. Field notes were recorded on the day-to-day activities of the care home, interactions or contextual factors in a reflective journal by the researcher during breaks and at the completion of daily observations. This allowed the researcher to be present in the moment and not disrupt the daily routine and rhythm of the care home. The researcher wore a badge

TABLE 1: Care home demographics.

Care home identifier	Residential/nursing care	Care home bed capacity	Resident number at time (long-stay/respice)	Gender (male/female)	Age range (years)	Dementia diagnosis (long-stay residents)
CH1	Residential	45	Permanent = 39 Respice = 6	M = 19 F = 26	69–102	29 (74%)
CH2	Residential	44	Permanent = 36 Respice = 3	M = 9 F = 30	77–99	25 (69%)
CH3	Residential	22	Permanent = 20 Respice = 2	M = 5 F = 17	77–100	19 (95%)
CH4	Residential	21	Permanent = 20 Respice = 0	M = 6 F = 14	74–98	20 (100%)
CH5	Residential	23	Permanent = 19 Respice = 1	M = 4 F = 16	71–99	13 (68%)
CH6	Residential	20	Permanent = 15 Respice = 1	M = 4 F = 12	79–102	10 (67%)
CH7	Nursing a residential	50	Permanent = 48 Respice = 0	M = 27 F = 21	56–98	38 (79%)

TABLE 2: Interview exclusion criteria.

Exclusion criteria	
Residents	< 3 months residency Too physically unwell Non-English speaking
Family/friend	Relative resided in care home < 3 months Not visited or contacted care home > 1 month < 18 years of age Non-English speaking
Care professionals	Worked in care home < 3 months Works < 2 days/week < 18 years of age No involvement in any care capacity Non-English speaking
Visiting professionals/stakeholder	Worked with or in care home < 3 months (stakeholders < 6 months EHCH involvement) < 18 years of age Non-English speaking

denoting they were a researcher and introduced themselves and their role on the commencement of any observations.

2.7. Data Analysis. Data analysis followed Braun and Clarke's six steps of reflexive thematic analysis [23, 24] presented in Table 3. Interview transcripts and reflective journal entries were (re)read and inductively coded line-by-line using NVivo version 12 Pro software. Each case (care home) was coded individually using both descriptive (semantic) and interpretative (latent) coding [25] (GH, GP). These codes were then combined into candidate themes within each case and then across combined cases to generate final themes (GH, SP). The themes presented in this paper are the combined (multiple case) thematic findings. Regular discussions and debriefing took place with the research team during data analysis. Saturation was not validated by sample size, or when no further codes or themes could be generated from the data. Instead, saturation was achieved when the

research team reached an interpretative judgement that the goals of the analysis were complete [26] and a whole system and multistakeholder understanding had been achieved.

3. Results

Sixty-one participants took part in interviews. These included care professionals (CP) ($n=34$), visiting professionals and stakeholders (VP) ($n=11$), residents (R) ($n=5$) and family and friends (F) ($n=11$). Interview participant characteristics are presented in Table 4. The breakdown of participants taking part from each case (care home) is presented in Table 5. Visiting professionals are not included in Table 5 as they worked across several care homes.

Fifty-seven interviews took place face to face, with four online. Interview data were collected over a combined period of 41.8 h (average interview = 41 min). Nonparticipant observations ranged between 46 and 68 h per care home, totalling 401.5 h across the seven care homes.

TABLE 3: Reflexive thematic analysis six steps.

Analytical steps	Description of process
Step 1: become familiar with the data	Transcribe data (if required), repeatedly (re)read the data, search for meaning and make notes of any initial ideas
Step 2: generate initial codes	Produce initial codes (labels) across the whole data set, highlight text/extracts manually or with coding software and search for patterns
Step 3: searching for themes	Revisit codes (labels) and arrange highlighted text/extracts into themes (patterns) using tables/mind maps, etc., and look for relationships between codes and themes
Step 4: reviewing themes	Review candidate themes, collapse/combine/separate/discard/create new themes to begin to generate/map a coherent pattern/meaning across the text/data extracts
Step 5: defining and naming themes	Review thematic map/tables, refine/name/rename themes, ensure related text/extracts offer a consistent account of theme, add accompanying narrative to support theme, finalise the theme titles and identify the story
Step 6: producing the report	Set out the final themes and create an analytical narrative using data extracts to tell the story

TABLE 4: Interview participant characteristics.

Participants code	Number	Gender	Age (years)	Ethnicity	Time range (mean)
Care professionals (CP) ^a	<i>n</i> = 34	M = 3 F = 31	Range 20–69 Mean (48)	White British (<i>n</i> = 24) White other (<i>n</i> = 6) Asian (<i>n</i> = 2) Hispanic (<i>n</i> = 1) Not disclosed (<i>n</i> = 1)	Working in care homes Range = 8 months–36 years Mean = 16.7 years
Visiting professional/stakeholders (VP) ^b	<i>n</i> = 11	M = 1 F = 10	Range 29–64 Mean (48)	White British (<i>n</i> = 11)	Working with care homes Range = 3 months–35 years Mean = 12 years
Family/friends (F)	<i>n</i> = 11	M = 3 F = 8	Range 48–81 Mean (66)	White British (<i>n</i> = 9) White other (<i>n</i> = 1) Not disclosed (<i>n</i> = 1)	Visiting care home Range = 6 months–4.5 years Mean = 2.2 years
Residents (R)	<i>n</i> = 5	M = 1 F = 4	Range 78–99 Mean (87)	White British (<i>n</i> = 5)	Living in care home Range = 3 months–4.5 years Mean = 1.8 years

^aCP (manager (7), deputy manager (3), head of care (4), team leader/senior carer (8), activity coordinators (4), carer/care assistant (6), nurse (2)).

^bVP (nurse (5), student nurse (1), GP (2), mental health practitioner (1), social worker (1), pharmacy technician (1)).

TABLE 5: Interview participants/care home (case).

Participants code	Number of participants	Case number/care home (CH)
Care professionals (CP)	<i>n</i> = 34	CH1 (<i>n</i> = 6), CH2 (<i>n</i> = 6), CH3 (<i>n</i> = 4), CH4 (<i>n</i> = 5), CH5 (<i>n</i> = 4), CH6 (<i>n</i> = 4), CH7 (<i>n</i> = 5)
Family/friends (F)	<i>n</i> = 11	CH1 (<i>n</i> = 1), CH2 (<i>n</i> = 3), CH3 (<i>n</i> = 1), CH4 (<i>n</i> = 3), CH5 (<i>n</i> = 2), CH6 (<i>n</i> = 1), CH7 (<i>n</i> = 0)
Residents (R)	<i>n</i> = 5	CH1 (<i>n</i> = 1), CH2 (<i>n</i> = 1), CH3 (<i>n</i> = 0), CH4 (<i>n</i> = 1), CH5 (<i>n</i> = 0), CH6 (<i>n</i> = 1), CH7 (<i>n</i> = 1)

The reflexive thematic analysis process generated six themes. They were, adjusting to the transition into a care home; people at the centre of care; the place we call home with the people we call family; working across the boundaries of care; supporting, valuing and empowering care home teams; and managing complex and challenging moments of care.

3.1. Adjusting to the Transition Into a Care Home. The adjustment to moving into a care home was challenging for many of the residents. This was particularly apparent for

some of the residents with dementia because of the challenges dementia brought in orientating to new environments, or recalling why they had needed to move:

‘It appeared to me that she had found herself in a care home with no idea how long she was staying and no access to home comforts, money, and therefore in many ways no sense of self and identity’ (researcher reflective note).

Many residents had not personally made the decision to move into a care home setting with acute illness, cognitive decline, frailty or a breakdown in their care networks being

the deciding factor. As one family member shared their thoughts on how they reached this decision:

‘it’s the actual. . . that decision. Because you keep thinking, no, no, it’ll be alright. They have better days won’t they, then you think, oh, no. I can’t cope with this’ (F6 CH4).

Care professionals shared the importance of supporting new residents as they transition into a care home, especially when they are unsure of why they were there:

‘Some feel dumped, don’t they? They don’t remember they’ve been told and it’s, it’s trying to get it across to them, no, you haven’t been dumped. . . Well, I was in such-and-such. They’ve forgot they’ve come from somewhere else, but they remember being at home and suddenly being here and their families have had to go back home’ (CP12 CH2).

Some residents shared their sense of uncertainty of what the future might bring as they first moved into a care home. One resident recalled

‘It felt quite sad. To be honest I didn’t think I’d be here long. . . I didn’t think I would last very long. . . I’m surprised I’m still here’ (R1 CH2).

Residents, and their family members, stressed the importance of maintaining long-term and established social and community relationships. Nevertheless, one family member captured the difficulty in maintaining these relationships:

‘When she became a full-time resident. . . I said, do you like it here? and she said, yes. And I said, anything you would like to be different? and she said, well, just as long as I can see my friends. Do you know, not a single bloody friend has been to see her’ (F2 CH2).

Many family members shared their own struggle to adjust to their loved one’s move into the care home. Having recently been a carer to their loved one, they were suddenly a visitor and their role and relationship had changed. One participant stressed the importance of remaining part of his wife’s life and care:

‘I come in, yeah, four or five days depending on what my daughters are doing. . . They’re (care professionals) looking after her for the majority, but I want that. I still want that bit to say I’m still doing something’ (F7 CH4).

3.2. *People at the Centre of Care.* Care professionals agreed that person-centred care was essential to what they did and what they wanted to provide to residents:

‘Person-centred care. . . It should be—from the start, from day one—it should be purely about that individual’ (CP29 CH6).

However, what person-centred care meant to care professionals varied. Some highlighted the importance of keeping residents clean and well-nourished, whereas others cited their relationships with residents as central to person-centredness. Many emphasised the importance of getting to know residents as individuals:

‘[You need to] look at them as an individual. Not just a resident in room 12. . . What can we do for that person. . . people’s interests; people’s happiness; their relationships with the staff, with the families. To me, that is so important’ (CP21 CH3).

Others emphasised the importance of advocating on behalf of residents, especially if they were unable to do so themselves, or had no family to support them:

‘We are the ones fighting for these residents. You know, nobody else on the side—yes, the [visiting] professionals help, you know. Social services come and help. It’s not the same though. Because if you don’t stick up for those residents, nobody else will’ (CP22 CH6).

Although their primary focus was on residents, care professionals also talked about considering the needs of family members. This included giving them time to talk and keeping them informed of their loved one’s care:

‘Family. . . sometimes. . . things can be worse for them, I think, than perhaps the person, you know. They can be finding it hardest probably sometimes’ (CP7 CH2).

They were also aware of their work colleagues needs. There was a strong sense of loyalty to one another in the findings, as this care professional expressed:

‘I like to make a difference. I love the people I work with. I just I love the fact that you can make a difference to people’s lives. And—both sides. Staff and residents’ (CP10 CH2).

However, a combination of staff shortages and increased resident acuity meant that what care professionals could do for residents sometimes fell short of their aspirations:

‘We try our best. . . when it comes to personal care and things like that but when it comes to activities and spending that quality time with them, that’s where we fail, I think. That’s where we fail a lot’ (CP14 CH4).

Many care and visiting professionals believed that the only way these challenges could be addressed was if everyone worked together, with a common aim of providing the best care possible:

‘I would just like to see the day when we [health and care professionals] actually all work together for actually what we’re here for. And that’s those people. Because I’m not here for any other reason’ (CP5 CH1).

3.3. *The Place We Call Home With the People We Call Family.*

There was a strong feeling amongst professionals and family members that care homes should feel like a home to residents. This included providing a comfortable and homely environment:

‘This desire to turn what are in effect a communal and complex institutions into homely environments is approached in a variety of ways from decoration (environment) to behaviours (family & relationship focused), and everything in between. Some care homes are more successful than others’ (researcher reflective note).

Care professionals shared their pride in how they welcomed residents and their families into their care homes:

‘I think we do a good job in making it person-centred and person-friendly in the fact that this is their home; anybody comes in here is a stranger but soon it’s their home’ (CP19 CH4).

This was also important to family and friends, as this family participant shared:

‘I mean, they’re going to feel despair because they’re going to feel like they’re letting that loved one down by sending them into a home. Now, when you come to know the home and realise it actually is a home, you know, in the best sense of the word, that’s a lot better’ (F3 CH2).

The sense of being at home was less evident amongst some of the residents. Even those who had accepted their move to a care home did so with a sense of loss:

‘When people say where do you live, I say, I live here. It’s my home now. I haven’t got anywhere else. . .’ (R1 CH2).

Alongside feeling like a home, a sense of being a family was also considered important. This extended beyond the care professionals and residents’ relationships and reached into the relationships between care professionals themselves and family members:

‘I love this home that I work in. Love the people. The residents are actually—I almost see them as like they’re part of my family now’ (CP25 CH5).

‘When I tell them (other family members) about my dad and the care, I say—This place is like family to me’ (F5 CH4).

3.4. *Working Across the Boundaries of Care.* Providing the right care, by the right service, in the right place [8] required health and care professionals to cross the boundaries of care that existed between them. Cultural and organisational boundaries across health and care and across professions were often demonstrated in the language used. Care professionals referred to residents as living with them, whereas most visiting professionals referred to residents as patients

who had been ‘admitted’ to care homes. Although these language and cultural barriers may appear trivial, they stymied working relationships and communication between health and care professionals:

‘Sometimes doctors will talk to you in this very clinical way, and you have to say, Hold on. I think that’s something I’ve learnt. . . Before I’d write it down and then research. . . now, I say, can you explain that?’ (CP12 CH2).

Care professionals reported that their (social) caring role was often considered secondary to the work done by health professionals:

‘I feel sometimes, we’re still the—well, we’ve always been the Cinderella. . . . I think if you’re in the NHS you feel that. . . I don’t know. I don’t want to say, “Special,” because that’s not quite what I mean. But they feel that they are superior to us’ (CP10 CH2).

However, where health and care professionals had built relationships based on trust and rapport they worked well as a multidisciplinary team:

‘On the whole, all of the other professionals that are involved are very supportive, and it feels like it’s proper teamwork’ (CP30 CH7).

Health professionals who had experienced this were positive about it:

‘What I would also say is that it is the exception, not the norm, for the care home staff to attend [Multi-Disciplinary Team meetings] . . . when they attend, it is brilliant. As in, for me as a GP, their insights, knowledge of the resident, knowledge of what is a realistic ask of them, is invaluable’ (VP2).

For others, the challenges of trust and communication between professionals were stark, as shared by this visiting professional:

‘. . . you could ring the home one day, and one person would say, oh, they’ve been fine. No issues. The next day you’d ring, and you’d talk to somebody else, and it would be, Oh, absolutely terrible. We can’t cope’ (VP7).

3.5. *Supporting, Valuing and Empowering Care Home Teams.* As highlighted above, care professionals working in care homes believed they were an undervalued workforce and at times felt isolated from healthcare colleagues and their local community. This perceived isolation, and the nature and demands on them meant that staff needed supportive managers and colleagues:

‘I think the staff need a bit more support. . . I know some of them do have like—are mentally drained at times and they end up having like a bit of anxiety or just feel down cause

they feel like they're doing a rubbish job or...cause there's not much positivity' (CP11 CH1).

It was important to the care home professionals that their commitment to residents' care was also recognised and respected:

'I do appreciate them; they're not, just carers, in my eyes...I always, you know praise them if they've...gone above and beyond or just...I recognise what everybody's done' (CP29 CH6).

Care professionals reported that receiving praise about what they brought to the care team was key to them feeling part of that team:

'I feel good when, when my manager says to me, it's great having you on the team. You bring lots of different qualities to the team' (CP31 CH7).

As was being empowered and trusted:

'I was empowered—The manager is empowering me...because she trusts me. So, that's how I trust my team. And then that's how you build the teamwork; build on trust' (CP33 CH7).

However, even when care home teams were supported, valued and empowered, other factors such as poor pay, the emotional and physical demands of the role or family care commitments meant that keeping that team together was difficult:

'I think as long as it is draining, it is emotionally and physically...just sometimes I'm exhausted because I do feel...over the years, you're just giving and giving and giving and giving to everybody, sometimes you get to a point you've got nothing left to give to even your own family' (CP29 CH6).

'I've had girls come in and we've trained them up and they go...the pay's rubbish. We're overworked, underpaid. And that's always been the care industry' (CP24 CH6).

3.6. Managing Complex and Challenging Moments of Care. Having the time and space to facilitate person-centred care was found to be particularly challenging during complex and challenging moments of care. These tended to be when residents were acutely unwell, had entered their last phase of life or presented with behaviours that challenge in dementia. The researcher's field notes describe one of these moments:

'I was sat with a group of residents when we heard a male resident shouting—immediately two female residents got up to see if everything was Ok...A little later the carers came into the room. I could see that one carer's knee was cut and her trousers ripped—she said, "it's not his fault, it's just what we do." I guess she is right in many ways...'(researcher reflective note).

These challenging moments impacted not only care professionals but also residents:

'I think we've got some people that are really bad, and curse and...hit them (care professionals) and stuff like that' (R2 CH1).

Managing end-of-life care for residents was another challenging time in the care homes, as this care home manager reflected:

'We recently had a meeting and when somebody's nearing their end of life, there's some staff that said they can't cope with that. They don't—they don't know how to look after someone and their family. And I thought that was quite a big thing to admit, actually' (CP12 CH2).

This was particularly evident for care professionals who were new to working in care homes:

'So, I'll hold my hands up. There was one gentleman...I've never actually seen a deceased body. Never walked in on one or anything. that really hit me. Like, I didn't know what to do. Like, all that training of what to do when someone's passed just blew away sort of thing...Everyone was really nice about it and calmed me down...just put a brave face on. Like, unfortunately we're in that job where it's going to happen' (CP9 CH1).

Care professionals reported that when they sought health professionals' advice during these complex and challenging care moments, it was not always available:

'For me, when you have a person that's coming to the end of their life and you can't even get a doctor to come out and see them face-to-face, there is something seriously wrong with the system' (CP5 CH1).

Generally, these challenges were intensified when healthcare and emergency care services were stretched beyond capacity. There were several incidents observed and discussed where there were significant delays for care home residents to receive medical help. One professional said

'We've just had a lady waited 60, six zero, hours. As she has got a fractured hip and a fractured shoulder. And we've had to care for her in her bed from Monday until Wednesday night, because there's no ambulance available as an emergency to take her to hospital. That is not the right care or the right place' (CP2 CH2).

4. Discussion

This multiple case study explored person-centred care from the perspective of those who live, work and visit care homes. This provides a whole system understanding person-centred care in care homes that is situated in policy, including the principal aims of the EHCH framework [8]. The themes identify the need for adjustment to take place during the

transition into a care home; for care homes to be recognised as places where home and family can be important; all people are central to person-centred care, care boundaries will need to be crossed, care home teams must be supported, valued and empowered; and finally, complex and challenging moments of care place demands on already stretched resources. These themes offer a UK regional perspective, which build on international research that highlights the importance of care homes providing safe, homely and relationship-focused environments [14–17] where care professionals act as advocates for residents [5] and are supported by collaborative and integrated health and care services [6].

The difficulties faced by residents and their families during the transition into a care home support the findings from other studies, which stress the importance of residents having a choice around their move into a care home, time to prepare and the support to maintain their identity during this transition [27, 28]. However, evidence suggests that these transitions tend to happen after an acute illness or when carers reaching their breaking point [28]. Maintaining family relationships during transition is key to the residents maintaining their self-identity, not only within their family but also within the care home and the local community [28, 29]. In doing so, residents are more likely to have a sense of belonging and feel more ‘at home’ [30]. This family-centred ideology is fundamental to person-centred care and is supported by the EHCH benchmarking, a planning and resource guide that describes person-centred care as ‘putting individuals and their families at the heart of all decisions’ [31]. However, this study also found that for many care professionals, the concept of family stretches beyond their relationships with the residents and extends into their relationships with each other and residents’ family members. The benefit of developing these extended ‘familial’ relationships within the care home is that it supports the delivery of person-centred care [32].

Although the principal aim of the EHCH framework [8] is the delivery of high-quality personalised care in care homes, it also highlights the importance of providing the right care, by the right service, in the right place through the effective use of available resources. This requires a multi-disciplinary, collaborative and responsive approach to person-centred care delivery [33]. This is particularly important when care professionals are seeking support from healthcare providers to manage complex and challenging moments of care. This study found that these moments tended to be when residents became acutely unwell, entered their last phase of life or presented with behaviours that challenge in dementia. Recognising, responding and managing these acute deteriorations in a resident’s physical and/or mental health well-being is complex and multifactorial, and yet protocols and procedures to manage these events are inconsistent and poorly evaluated across the United Kingdom [34]. These complex and challenging moments can place significant pressures on already stretched health and care resources and in turn impact the ability to provide high-quality, safe and effective person-centred care [35].

The British Geriatrics Society [4] has highlighted a number of areas to address some of the challenges highlighted above. These include the roll out funded enhanced healthcare to all care homes, funding for care staff development in complex care skills management, a standardised definition and provision of care home multidisciplinary teams (MDTs) and improved access to in situ care that would otherwise be provided by hospital settings. However, there is also some essential work required to understand and value what care homes and the professionals who work with in them do. Care professionals are often working in settings where there are significant physical and emotional demands placed on them, and at times, they do not feel appreciated. A recent systematic review [36] found that managers who appreciated and empowered their staff were more likely to develop cultures where teamwork was valued, and relationships and staff retention were positive. Although these internal care home team relationships are important, so are the external relationships with healthcare professionals.

Health and care professionals shared the challenges they sometimes faced when crossing care boundaries, some of which could be wide. The Care Quality Commission (CQC) document, ‘Beyond Barriers’ also found these interprofessional and interprovider barriers, reporting that some health and care performance measures and regulations had created competition rather than collaboration [37]. To achieve effective and high-quality person-centred care health and care services need to move away from operating in silos, towards provision that is integrated, collaborative and coordinated [38]. This requires care environments that can build bridges across these care provider boundaries, heal relational fractures and focus on people rather than provision [37]. This will allow reciprocal relationships to be built, which stretch beyond the care home and reach into outside health and care support networks [32].

A key finding of this study is that person-centred care should encompass ‘all of the people’ in care homes. Person-centredness should not only focus on the residents but must also consider the needs of their families and the professionals that work in and with care homes. A person-centred culture is established through the formation of healthy and productive relationships that form not only between those receiving the service but also between those providing it through a mutual respect and understanding of one another [39]. This can be achieved by moving from a model of person-centred care towards a culture and philosophy of people-centred care (PCC). This will allow care cultures to transcend beyond the needs of individuals and pivot towards meeting the needs of the community. However, PCC requires a shift from illness- and disease-focused healthcare to a strategy that puts people and communities at the centre of health systems [40]. PCC empowers people (individuals, families and health and care professionals) to lead and manage their own care within coordinated and responsive health systems [41] in care environments that operate as a partnership of equals [40].

4.1. Limitations. The study is limited by only taking place in one region of South West England. However, seven settings were included within this study to provide a cultural context to person-centred care across multiple cases. Therefore, the findings of this study are transferable to comparable populations [42]. Recruitment of care home residents to the study was relatively low; this was despite the presence of the researcher in the setting to build trust and familiarity. A recent scoping review [43] found that most barriers to recruitment and inclusion of care home residents in research were predominately outside the resident's control. One barrier is the legal and ethical challenges of recruiting residents who lack mental capacity [44]. One of the challenges faced in this study was the time, process and extensive documentation required to include people without mental capacity [43, 45, 46]. These innate challenges to including people without mental capacity in research compounded by a lack of knowledge of the legal requirements can erode researchers' confidence, leading to the exclusion of this group from research, rather than inclusion [47]. However, even considering these factors, the lack of resident voice in this study is acknowledged as a limitation. Finally, some participants reported to be reassured by the observer being a registered mental health nurse, with experience in working with older people. However, it must also be acknowledged that for some participants, this information may have also affected their behaviour. Nevertheless, the researcher was able to build trust and rapport with participants through reflexive practice, which somewhat minimised the observer effect.

4.2. Implications for Practice, Policy and Research. The study findings suggest that a multidisciplinary, responsive and collaborative approach to care is required to achieve high-quality person-centred care in care homes. This could be supported by health and care cultures that put people and relationships at the centre of its care provision. Future care home policy should aim to guide practices that can visualise care which goes beyond meeting the needs of individuals and aims to meet the needs of the whole care home community. Further research is required to explore how a people-centred care culture can be built and sustained in care homes, and with the wider multidisciplinary team across all boundaries care. It is important that research in this area includes all of the voices of those receiving and delivering that care, especially residents. However, as this and other studies have highlighted, challenges remain in recruiting care home residents to research. This requires further exploration with new and creative methods considered.

5. Conclusion

This paper presents six key themes that illustrate a whole system understanding of person-centred care across seven care homes in the South West of England. The main components of person-centred care appear to be relational. These relationships take place in cultures and systems that are complex and challenging with care boundaries that need

to be navigated. Navigating these care boundaries requires a different approach to care. An approach that is built on the foundations of people, partnerships and mutual respect. These foundations are the building blocks of care cultures that are not only person-centred but also people-centred.

Data Availability Statement

The data that support the findings of this study cannot be publicly shared due to ethical or privacy reasons.

Disclosure

The funders played no part in the design, execution, analysis and interpretation of data or writing of the study. The views expressed in this publication are those of the author(s) and not necessarily those of the National Institute for Health Research or the Department of Health and Social Care.

Conflicts of Interest

The authors declare no conflicts of interest.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. (*Supporting Information*)
Supporting File 1: SPQR checklist.

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