

Research

Cite this article: Dudman J, Meyer J, Holman C, Moyle W. (2018) Recognition of the complexity facing residential care homes: a practitioner inquiry. *Primary Health Care Research & Development* 19: 584–590. doi: 10.1017/S1463423618000105

Received: 4 September 2017
Revised: 8 December 2017
Accepted: 12 January 2018
First published online: 15 February 2018

Key words:

care home staff; district nurses; dementia; residential care homes

Author for correspondence:

Dr Jenny Dudman, North East London Foundation Trust, 69 Albert Road, Ilford, London, IG1 1HP, UK.
E-mail: Jennifer.Dudman.1@city.ac.uk

Recognition of the complexity facing residential care homes: a practitioner inquiry

Jenny Dudman¹, Julienne Meyer^{2,3}, Cheryl Holman⁴ and Wendy Moyle⁵

¹North East London Foundation Trust, London, UK, ²Professor, School of Health Sciences, City, University of London, London, UK, ³Executive Director, My Home Life Programme, London, UK, ⁴School of Health and Social Work, University of Hertfordshire, Herts, UK and ⁵Menzies Health Institute Queensland, Griffith University, Brisbane, QLD, Australia

Abstract

Aim: To explore the experiences and challenges for residential care home staff when managing the healthcare needs of their residents, in particular those living with dementia. **Background:** Increasing number of older people, with complex health and social care needs are living in residential care homes. Yet there is limited appreciation of why staff sometimes struggle to manage residents' healthcare needs, or understanding of their working relationship with district nurses (DNs), whose responsibility it is to provide nursing support. **Methods:** This PhD study, in a metropolitan area in the United Kingdom, was conducted by an experienced DN and involved three phases. This paper focuses on the first two phases. Phase 1 data included: semi-structured interviews ($n=8$), reflective field notes based on non-participant observation, documentary analysis of policies, procedures and assessment tools and other contextual data from one care home (case study site). The practitioner researcher reflected on the findings from the case study, in relation to her own knowledge and experience as a DN, focusing in particular on findings that were familiar, or which surprised. In Phase 2 she fed these findings back to other care homes ($n=11$) to check whether the findings from the single case study were unique or resonated with others. She gathered their feedback through semi-structured interviews with senior care staff ($n=14$). Data were analysed using thematic data analysis. **Findings:** Findings highlight the complexity facing residential care homes: high levels of healthcare needs amongst residents, the demands of caring for residents living with dementia, variations in the knowledge and skill set of care staff, inequity in the level of healthcare support, the challenges of building a good relationship with DN's, and funding pressures facing care homes. **Implications:** Any, or all of these factors can prevent care home staff from managing the healthcare needs of their residents.

Introduction

Care homes are the major provider of long-term care for frail older people in the United Kingdom, caring for those who would previously have been the responsibility of the NHS (Bowman, 2009; Handley *et al.* 2014). There are ~18 000 care homes in the United Kingdom, caring for over 400 000 older people. It is a diverse sector, varying in terms of ownership, size, funding sources, organisational culture and nursing support, with the majority of care provided by the independent sector (mainly for-profit providers) in homes with 35 beds or less (Iliffe *et al.* 2016; National Institute for Health Research, 2017). Fewer than 5000 care homes are registered for nursing. Most are residential care homes (non-nursing) providing accommodation and support with tasks such as washing, dressing and eating, with medical and nursing care provided mainly by General Practitioners (GPs) and district nurses (DNs). A typical resident is female, aged 85 years or older and is living with cognitive impairment. High levels of depression, immobility, co-morbidity and dependency are common (British Geriatrics Society, 2011; Alzheimer's Society, 2014). As a result, large numbers of severely impaired people, often with complex health and social care needs, are being cared for in the residential care home sector (Alzheimer's Society, 2014). A literature review conducted by Dudman (2014) suggests that many of these residents have healthcare needs, which are under-recognised and often poorly managed, and there is little understanding of why this might be, as the experiences of staff in care homes are rarely sought.

As there is no registered nursing presence in residential care homes, they are reliant on primary care for nursing support. DN's are the main providers of nursing in care homes and residents can have a significant impact on their caseload (Goodman *et al.* 2003a; 2003b). However, there is no clear definition of how DN's, or care home staff define their roles and responsibilities when an older person develops a healthcare need. As a result, professional and organisational preoccupations, rather than residents' needs, can dictate how care is organised (Goodman *et al.* 2005). Few studies have sought to explore, in any depth, the working relationship between care home staff and DN's (Goodman *et al.* 2003a; 2005), with most focusing on either the nurses' experiences (Goodman *et al.* 2003b; Dobbie, 2010), or the views

of nurses and care home staff sought as part of a wider study (Evans, 2007; Goddard *et al.* 2011; Handley *et al.* 2014). This PhD study was divided into three phases. The present paper focuses on Phases 1 and 2, which explored the experiences and challenges for residential care home staff in managing the healthcare needs of their residents, and in particular those living with dementia. The results from Phase 3, exploring the experiences and challenges for DNs are discussed elsewhere.

Methodological approach

This study used a practitioner research (PR) approach, where research is carried out by a practitioner, using their applied knowledge and skills to conduct the research, with the general aim of generating new knowledge from practice (Meyer *et al.* 2006). In PR the researcher serves as the 'instrument' through which data are collected and analysed, bringing their own frame of reference to the interpretation (Mulholland, 2007; Meyer *et al.* 2009). The tacit knowledge and skills of a practitioner researcher enables them to engage in a deeper level of reflexivity, reflecting on data and findings in a way that may vary from that of a non-practitioner, resulting in a unique and different form of understanding, that is 'practical knowledge', which may have more relevance to the practice setting and other practitioners. In this study the practitioner researcher drew on her skills and expertise as an experienced DN to inform both data collection and analysis. This expertise was developed over 20 years working in the community and with care homes, first as a community nurse and then a DN team leader (TL). Being a practitioner allowed the researcher to build trust, rapport and credibility with participants. In terms of analysis, she reflected on the findings, paying close attention to those which surprised, or challenged previously held assumptions, as a DN (Tracy, 2010).

Participants

Phase 1 gathered qualitative data from a single case study of one residential care home. This home was purposefully selected as it provided specialist care for residents living with dementia, giving the researcher the opportunity to gain an in-depth understanding of the issues involved in caring for the healthcare needs of residents with this particular illness. The size of the home could provide access to a larger pool of care staff and it had received a 'good' rating from the Care Quality Commission. This meant that residents were experiencing good quality outcomes and staff participation in the research was unlikely to cause an unnecessary distraction. The home was relatively new, purpose built, and was owned by a not-for-profit organisation. It was home to 60 residents, all of who had a diagnosis of dementia and was staffed by 60 permanent (included) and 40 bank staff (not included). The majority of participants interviewed were female, with an average age of 37 years and 54% ($n=7$) were non-EU nationals. Just under half had worked in social care for between six and eight years. All but one had at least one formal qualification, such as a National Vocational Qualification (NVQ), or a professional qualification from their home country.

Phase 2 explored whether the case study findings were unique to the case study site, or resonated with managers of other residential care homes ($n=11$), and if there were any additional issues raised, thereby adding strength to the findings and their transferability. Phase 2 care homes included: all provider types and varied in size between 3 and 58 beds. All apart from one were

registered to provide care for older people living with dementia; with the majority of residents, in all participating care homes, reported to be living with some degree of cognitive impairment. Again, the majority of participants were female, with an average age of 51 years and 28% ($n=4$) were non-EU nationals. In total, 79% ($n=11$) had worked within social care for over 15 years. All had formal qualifications, with 71% ($n=10$) holding the Registered Managers Award.

Data collection methods

Phase 1 data were collected from the case study site during a period of researcher familiarisation (Barley, 2011), to deepen understanding of the context, the care provided and any challenges facing care home staff. Data gathered during this phase included: reflective field notes based on non-participant observations ($n=17$), formal semi-structured interviews with staff ($n=13$), including the care home manager (CHM), TLs and other care home staff, together with documentary analysis of policies, procedures, assessment tools and contextual data. Carrying out research within a care home setting can be challenging (Luff *et al.* 2011). Interviewing staff in this study proved difficult, with appointments and interviews cancelled at the last minute, due to work pressures. The researcher had to take any opportunity offered, for example interviewing staff when attending and taking a break from training. An interview guide was used which was based on topics drawn from the literature. Interviews typically lasted 45–60 mins and were digitally recorded and transcribed verbatim by the researcher. In Phase 2 the remaining 14 residential care homes in the local authority were approached, but three declined to participate. Semi-structured interviews ($n=12$) were conducted with CHMs ($n=9$), and/or their deputies ($n=3$) and TLs ($n=2$) from a total of 11 care homes. In this phase the interview guide was further informed by the findings of the case study and the additional reflections of the researcher.

Ethical considerations

Ethical approval was granted by the South East London Research Ethics Committee (Ref. 10/H0807/7). All participants were given verbal and written information about the study. Written informed consent was obtained from participants. They were reassured about confidentiality of their data; with codes used in place of names and any identifiable data withheld, and that they could withdraw their participation at any time.

Data analysis

The qualitative data were analysed using a thematic approach outlined by Braun and Clarke (2006). NVivo software (version 9) was used to store and organise the data. All transcripts were read several times by the researcher, until she felt she was familiar with the data. Descriptive codes were written next to words, lines, or sections on each transcript. The emergent coding framework was informed by the research questions and professional knowledge and experience of the researcher. Transcripts were revisited upon a number of occasions throughout the study. Next, codes such as 'just a carer', 'provide support' and 'poor communication' were regrouped under broader themes, for example 'working with DNs'. Analysis took place initially within, and then across, the different data sets, comparing the data from Phase 1 with that from Phase 2. New codes were added as additional themes

emerged, with the practitioner researcher identifying findings that she would have expected, as well as, findings that were a surprise. A number of data display models were drawn in NVivo such as: 'issues facing care staff' and 'factors impacting the meeting of healthcare needs'. The use of visual displays proved useful, as it provided a clearer picture of the data overall and a better understanding of the challenges that these care homes appeared to be facing. These challenges were grouped into themes that were reviewed and refined, for example 'dissatisfaction with the DN relationship', with six themes emerging from this analysis. Throughout analysis regular academic supervision sessions were held, with possible interpretations of data explored, findings and analysis challenged, and possible biases discussed.

Findings

The practitioner researcher became increasingly aware from the case study that, as a DN, she was largely ignorant of, and surprised by, the breadth of the challenges that care home staff were faced with in managing residents' healthcare needs. Many of the Phase 1 case study findings were confirmed by the other Phase 2 care homes (findings resonated), whilst others were not confirmed (findings unique). In addition, five new issues emerged from the Phase 2 (see Table 1). Findings addressed the high levels of healthcare needs amongst residents, the demands of caring for residents living with dementia, variations in the knowledge and skill set of care staff, inequity in the level of healthcare support, the challenges of building a good relationship with DNs, and funding pressures facing care homes.

High levels of healthcare needs amongst residents

The resident population has changed significantly in residential care homes and staff are faced, on a daily basis, with high levels of healthcare needs. A result, interviewees suggested, of government policy, encouraging care to be provided at home for as long as possible. In the past people were admitted largely for social care reasons and needed little assistance with healthcare. Whereas those admitted today are much frailer, older and sicker than ever before, with many in a poor state of health on admission.

You are looking after a completely different group of people; you are looking after people who are sick, not healthy anymore. They have mobility problems, or mental health problems...doubly incontinent, diabetic, high blood pressure, high cholesterol. How are you meant to deal with all of this?
(P32, CHM)

Co-morbidity is common and the care needed is often 'bordering on nursing'. Residential care home staff were not only managing physical needs, but were also dealing with psychological, behavioural, social and emotional needs of residents. In addition, many were also, for example, managing simple wounds, recording baseline observations, checking blood glucose levels and were increasingly involved in the provision of palliative care. This suggests that residential care home staff need support in developing their healthcare knowledge and skills and/or access to healthcare professionals to help them meet their residents' needs.

Demands of caring for residents living with dementia

Caring for a resident living with dementia brings additional challenges. Care home staff need to 'know' residents, that is read

Table 1. Challenges facing care home staff in managing the healthcare needs of residents

Phase 1		Phase 2		
Themes from the case study	Sub themes	Confirmed findings	Unconfirmed findings	New findings
High levels of need and degree of complexity present		✓		
Added complexity that caring for a resident living with dementia brings	Importance of 'knowing' the person	✓		
	Difficulty providing care	✓		Struggle to provide respite care
Level of healthcare skills needed by care staff	Dealing with complex healthcare needs	✓		
	Benefit from access to healthcare training		✓	Accessing care staff training an issue
	A hidden workforce	✓		
Level of healthcare support needed to manage residents' needs	Accessibility of healthcare support is good		✓	Difficulty accessing medical information
	Accessibility of GP support problematic	✓		
	Benefit of specialist support		✓	
Dissatisfaction with the care home/DN relationship	Reluctant to criticise	✓		
	Dissatisfied with the service received	✓		Not working in partnership
	Ignorant of the DN role	✓		
	Service offered needs to change	✓		
Funding pressures		✓		Impact of vacancies Unable to fund improvements

GP = General Practitioners; DN = district nurse.

and understand non-verbal cues and behaviours, so that problems can be picked up and managed early. Unfortunately, getting to 'know' residents is getting harder, as a result of people being admitted much later in their disease process; often with limited verbal communication skills, or outliving family and friends, so little background information is available. Frustration was expressed that healthcare professionals do not always recognise the importance of such knowledge. As a result care home staff report difficulty convincing health professionals that a resident is unwell, or has a problem.

I have had people who came in with a little forgetfulness...we have been able to adjust to them and they have been able to trust us...We are now getting people, because of the pressures on social services, that are in the advanced stages of Alzheimer's, and therefore they cannot understand us and it takes us longer to get into their psyche.

(P31, CHM)

Caring for a person living with dementia is demanding, and an individual's needs are often not the same two days running. As a result, care home staff have to be flexible and continually adapt their care practices, which some staff found hard. Staff reported that it was difficult when residents continually refused to accept assistance with personal care, to take medication, to eat or drink, or if they were extremely distressed, agitated, or continually calling out. This was especially true for those residential care homes not offering specialist care, or if staff had limited understanding of dementia. They were more likely to find that managing agitation, aggression, or vocalisation was 'challenging'. Short-term respite care can bring additional challenges, with residents unable to settle, and staff struggling to settle them. Care provision is not helped when a resident's GP is reluctant to provide information concerning a resident's medical history, or practical support. This seemed to be more common when the GP was based in a different NHS trust. Challenges such as these had even resulted in safeguarding reports raised against care homes on occasion.

Variations in the knowledge and skill set of care staff

The knowledge and skill set of care home staff varied greatly. First, not all staff were able to access the training needed for their role. Staff at the case study site received a raft of healthcare training. However, such levels of training were not universal. Cost was an issue for some homes, which resulted in staff not always being paid to attend training, and many being expected to undertake training on their days off. Training was often undertaken in-house and given by CHMs, especially in the smaller, privately owned care homes, who found it harder to release staff to attend training off-site. The language and literary skills of some care home staff raised concern, with some managers reluctant to send staff with a poor command of English language on any training.

Second, care home participants reported that there was an external perception that care home staff are unqualified and were negatively viewed as 'just a carer'. Yet in reality, many care staff were highly qualified, with a significant nursing presence reported amongst both managerial and care home staff. However, their qualifications were either not recognised, as they were obtained in a different country, or they were contractually employed as care staff and not as nurses. It would seem naïve to assume that their knowledge and skills were not being used, and in fact many suggested that unregistered nursing staff brought hidden benefits. For example, they often identified healthcare problems earlier and as a result hospital admissions were prevented. Some of the homes were even actively seeking to employ unregistered nurses

as care home staff, in response to the complexity present amongst the residents.

What has been brilliant for me is the bank Filipino staff that have come over to this country and do an NVQ. However, they have been a qualified, probably a senior nurse back home...they are brilliant to have because of their knowledge...especially where we get residents with such complex needs.

(P23, CHM)

Inequity in the level of healthcare support

Care homes need access to good healthcare support, given the levels of healthcare needs that are present (British Geriatrics Society, 2011), yet this study demonstrated inequity in the level of support provided. The case study care home received support from a range of healthcare professionals, including monthly visits from a geriatrician and an old age psychiatrist. However, issues were reported with GP support. For example, the GP failing to turn up when a visit had been promised, or questioning whether a visit was necessary. Not all residential care homes had such support. Most only had access to the geriatrician if a referral was made and then it would only be as a one-off visit. Not receiving specialist support was mitigated for some, through weekly GP visits. However, others faced a continual struggle to access the medical support they needed, reporting that GPs were unwilling to visit, or engage at all with their home.

They don't really have time to come and they want us to come there. But we tell them people with dementia, people being frail, they are not really in good health, it is very difficult to get them to the surgery...They don't think about the weather, they don't think about how physically good (sic frail) they are.

(P28, Deputy CHM)

In terms of allied healthcare services the situation was similar. Some residential care homes referred directly to these services, whilst for others the GP would act as a gatekeeper, significantly slowing down the process. For a home situated on the border of two trusts, accessing services could prove even more problematic, with professionals continually questioning who should be visiting. Difficulty accessing information concerning a resident's medical history was an issue raised by some, with certain surgeries reluctant to provide such information, which had resulted, on occasion, in treatment omissions, or hospital admission.

Challenges of building a good relationship with DNs

Residential care homes rely on DNs for nursing support and whilst, on the whole, the relationship was reportedly good, building these relationships was not always straightforward. DNs had little understanding of the role and skill set of residential care home staff. As a result they could question why care had not been provided, or expected staff to take on care that went beyond their skill set. On the other hand, care home staff had little understanding of the DN role, and the service provided was said to be 'task-focused'. One TL suggested 'we sort of do everything. They normally come and do the basic things like dressings that we can't do' (P25, TL), implying little understanding of what the service can offer the home, or their residents. DNs could be judgmental and quick to criticise when problems arose, especially in regard to the development of pressure ulcers. Not taking into account that care home staff are caring for increasingly frail residents, many of whom were nearing the end of their lives, or the staff's need for timely support and advice. Such perceived criticism risks staff being unclear of what they should be doing, or reluctant to ask for advice, or support, in the future.

I had a very bad experience 2 years ago where a district nurse came in, the client had a red spot, I rang them immediately, told them to come in... that happened on Friday and they didn't come in until Monday and obviously the skin had broken, it had become grade 2, grade 3 and was reported to safeguarding.

(P37, CHM)

Care home staff were frustrated by DNs who were continually rushing, appeared to spend little time in the home, and there was little continuity of nurses who visited. Communication was often poor and DNs did not always give feedback to care home staff after a visit. It was felt that a newly introduced referral process had made it harder to access the service, with some nurses reportedly refusing to see a new resident until a written referral had been received, even though they were visiting other residents at the time. It was also suggested that DNs were failing to take into account the particular needs of residents living with dementia, with nurses expecting residents to fully comply with treatment, trying to rush care provision, and the perception that district nursing practice was not person centred.

CHMs felt they had little say in the type of service they would like, with one commenting '*you are the first person to ask me that*'. Suggestions to improve the service included: greater partnership working, holding regular meetings with DNs to discuss issues or concerns regarding any residents, continuity of nurses, the provision of *ad hoc* training, and a better understanding of the needs of people living with dementia.

I would appreciate it if my staff and the DN team sit together and find out what is expected of me and what I expect from them, so we can maintain a good relationship, one that won't have any misunderstanding.

(P36, CHM)

Funding pressures facing care homes

Finally, many of the care homes were struggling to survive, as a result of the financial pressures they were facing, and were concerned about their viability. This was especially true for the small 'family' run residential care homes.

I have 7 empty beds, multiplied by £500 minimum; I am losing £3000 a week...how can I survive? I am trying to maintain my good staff, I don't want to lose them...So on the rota I have to keep giving them shifts otherwise they will leave.

(P32, CHM)

Pressures included: no significant rise, or even a decrease, in the levels of fees paid by local authorities, at a time when other costs were rising. The use of block contracts, with the local authority refusing to countenance sending someone to a residential care home, other than to ones with whom they had the contract, and managers accepting residents, as a result of high levels of vacancies, whose needs they then struggled to manage. Managers of homes seeking to make a profit faced additional pressures and were increasingly being asked to run their businesses for less money. Such pressures had a knock-on effect on care provision, with residential care homes struggling to give staff pay rises, funding any external training, provision of services such as specialist equipment, or funding capital improvements within the home.

Discussion

The findings of this study provide a greater understanding of the experiences and challenges for residential care home staff when

managing the healthcare needs of their residents, in particular those living with dementia. The insight that this study offers is unique, as it is from the perspective of a practitioner researcher. The use of PR allowed the researcher to draw on her previous experience and tacit knowledge as a DN, and in so doing, uncover findings that others with a different background may not have felt to be of significance.

The findings suggest that the needs of residents, and in particular those living with dementia, are increasingly complex and that care staff can sometimes struggle to deal with such complexity. A view that is supported by the literature (Heath, 2007; Royal College of Nursing, 2010; British Geriatrics Society, 2011; Care Quality Commission, 2016). The impact of dementia is also widely acknowledged, with dementia, or cognitive impairment, the biggest cause of disability and dependence and, in high income countries, the strongest determinant for admission into long-term care (Prince *et al.* 2013; Alzheimer's Society, 2016). The findings suggest that caring for residents with dementia is becoming harder for care home staff, especially with people admitted late in the dementing process. The findings also indicate that care home staff are providing increasingly complex care, due to the unpredictable nature of the work, the complexity of residents' needs, and taking over care that was once the domain of registered nurses (RNs). This challenges the assumption, given the repetitive nature of the care provided, or the definition of 'personal care' in The Health and Social Care Act (2008), that their work is somehow simple, routine or unskilled (Sandvoll *et al.* 2013). An argument supported by the Cavendish Review (Cavendish, 2013), which agrees that any suggestion that social care staff are providing 'basic care' clearly underestimates the care they are providing.

The literature tends to focus on the complex nature of the residents and yet, as indicated by this study, residential care homes face a number of additional challenges, including financial pressures, the nature of the workforce, and issues with healthcare support, which are adding to the complexity care home staff are dealing with and their ability to manage the needs they are now routinely faced with. Many care homes struggle because of pressures on social care funding, over which they have no control, but which can have a significant impact on their ability to provide a service. A concern repeatedly raised over the years (Dudman, 2007; BUPA, 2011; Owen *et al.* 2012). Training opportunities in the study care homes were highly variable, a finding supported by Eborall *et al.* (2010) and Skills for Care (2015). Eborall *et al.* (2010) also suggested that many staff may possess no social care qualifications. However, in this study the majority of participants held at least one NVQ, although given that most were in managerial positions they may not be typical of the wider workforce. Many care home staff were also reported to hold a professional qualification from their home country, resulting in what appears to be a 'hidden' registered nursing workforce, bringing with them knowledge and skills that appear to benefit both the residents and other staff. No mention appears to have been previously made of this 'hidden' workforce in residential care homes. Yet studies exploring the contribution of RNs in nursing homes (Jones *et al.* 2007; Heath, 2010; 2012) highlight the benefits that RNs bring to the health and well-being of residents. These findings raise issues of workforce exploitation, and lead one to question what would happen if these particular staff no longer chose to work in this setting.

With no national specific standards or models to guide the provision of primary, medical or allied healthcare support to care homes, it is left to individual services, at a local level, to determine

the level of support offered (British Geriatrics Society, 2011). This means, as this study found, that support is often inadequate and inequitable. DNs are the main providers of nursing support to residential care homes, yet little is known about the relationship between care home staff and DNs. Although largely positive, the findings indicate an undercurrent of dissatisfaction with the relationship. There is little recognition, or acknowledgement by DNs, of the knowledge and experience of care home staff. A poor understanding of the care home staff's role can result in unrealistic demands placed on them, and there is little evidence of partnership working. These findings suggest that the service offered by primary care, and DNs in particular, need addressing. Something that is beginning to happen, through recent initiatives, such as 'Vanguard sites' (NHS England, 2016), and the 'Optimal' study (Gordon *et al.* 2014), tasked with shaping future healthcare support of care homes.

In addition, the findings also suggest that the complexity facing residential care homes needs to be recognised, acknowledged and better understood, in particular by healthcare services, if adequate levels of support are to be provided and the challenges identified addressed. Complexity thinking offers a possible solution (McMillan, 2004; Lindberg and Lindberg, 2008). Bringing about change often fails because the complex nature of a system is overlooked (McMillan, 2004). All organisations have their own unique culture, environment, and set of rules (Cilliers, 2000; Lindberg and Lindberg, 2008). For this reason, one cannot simply transfer one model of service delivery to another and expect it to work. We have to move away from the idea that we can simply 'change' a system, and instead encourage it to 'evolve'. By, for example, developing an understanding of the complex nature of that system, a greater awareness of the contextual and behavioural issues that may need to be addressed, and introducing small changes, at a local level, from which much can be learnt; rather than the introduction of wholesale change, which too often fails.

Strengths and limitations

One of the main strengths of this study is its use of PR, which has given unique insight from the perspective of a DN, into the complexity faced by care staff when dealing with the healthcare needs of residents. However, there are limitations associated with PR which is carried out by an 'insider' (Blythe *et al.* 2013), who, for example, may feel they know the culture, or hold certain beliefs or assumptions that can prevent objectivity during data collection and/or analysis. The use of reflexivity in conducting the study has hopefully addressed this issue. Whilst the use of a single case study carried out in one local authority is another reason to treat the findings with caution, the process of checking the resonance of the case study findings more widely with other care homes in the local authority and situating the findings in the context of the wider body of knowledge has hopefully helped address this issue. Not all the participating homes provided specialist dementia care, but as most residents were living with dementia, or cognitive impairment, this was not perceived to be an issue. Whilst it is acknowledged that Phase 2 feedback was only gathered from managerial and senior staff and may not necessarily reflect the experiences of other levels of care home staff, it is believed that participating staff were able to share relevant issues not previously identified.

Conclusion

This study set out to explore the experiences and challenges for residential care home staff in managing the healthcare needs of

their residents, in particular those living with dementia. Staff were faced with a number of challenges in managing the healthcare needs of their residents. The focus of previous literature has been on the complex nature of the residents. Yet as this study has shown, residential care homes are faced with additional challenges, many of which can prevent care home staff from managing the healthcare needs of their residents. Whilst this study has provided a greater understanding of the challenges and complexity facing care home staff, what is not known is how to resolve these, in a system that is fragmented and under resourced. Further research is needed, which may uncover even more complexity. In the interim, if healthcare needs are to be better met, health and social care practitioners need to be more sensitive to the complexity that is present and to work in better partnership with residential care homes, who are caring for some of the frailest and sickest members of our society. For example, by providing support that is equitable, easy to access and responsive to the needs of the present population. This study also has implications for the future education of health and social care professionals. Care staff need to be prepared, in terms of knowledge and skills, including healthcare skills, to care for older people, especially those living with dementia, and the complex health and social care needs they are routinely faced with; whilst healthcare professionals need a greater understanding of the independent sector and the needs of the resident population.

Acknowledgements. The authors would like to thank all the care home staff who took part in this study.

Financial Support. This research received no specific grant from any funding agency, commercial or not-for-profit sectors.

Conflicts of Interest. None.

References

- Alzheimer's Society (2014) *Dementia 2014: opportunity for change*. London: Alzheimer's Society.
- Alzheimer's Society (2016) *Fix dementia care NHS and care homes*. London: Alzheimer's Society.
- Barley R (2011) Why familiarise? *Social Research Update*, 201, 1–4. Retrieved 24 September 2014 from <http://sru.soc.surrey.ac.uk/SRU62.pdf> <http://shura.shu.ac.uk/4924/> <http://shura.shu.ac.uk/4924/1/SRU62.pdf>.
- Blythe S, Wilkes L, Jackson D and Halcomb E (2013) The challenges of being an insider in storytelling research. *Nurse Researcher* 21, 8–13.
- Bowman C (2009) Are care homes the community hospitals of the future? *Journal of Care Services Management* 3, 375–379.
- Braun V and Clarke V (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology* 3, 77–101.
- British Geriatrics Society (2011) *Quest for Quality: British Geriatric Society Joint Working Party into the quality of healthcare support for older people in care homes: a call for leadership, partnership and quality improvement*. London: British Geriatrics Society.
- BUPA (2011) *Funding adult social care over the next decade: who cares?* London: BUPA.
- Care Quality Commission (2016) *The state of health care and adult social care in England*. London: Care Quality Commission.
- Cavendish C (2013) The Cavendish review: an independent review into healthcare assistants and support workers in the NHS and social care settings. Retrieved 6 February 2014 from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/236212/Cavendish_Review.pdf
- Cilliers P (2000) What can we learn from a theory of complexity? *Emergence* 2, 23–33.
- Dobie J (2010) Palliative care provision for older people in care homes. *British Journal of Community Nursing* 15, 170–176.

- Dudman J** (2007) Ch 1: Context. In Owen T and The National Care Home Research and Development Forum, editors. *My Home Life: quality of life in care homes – review of the literature*. London: Help the Aged, 11–23.
- Dudman J** (2014) Not just a simple dressing: a practitioner inquiry exploring the complexity within residential care homes and the district nursing response. Ph.D. Thesis. London: City, University of London.
- Eborall C, Fenton W and Woodrow S** (2010) *The state of the adult social care workforce in England, 2010*. Retrieved 11 August 2010 from <http://www.skillsforcare.org.uk/Document-library/NMDS-SC,-workforce-intelligence-and-innovation/Research/Research-Reports/social-care-workforce-report/SOASC-2010-exec-summary-for-web.pdf>
- Evans C** (2007) The analysis of experiences and representations of older people's health in care homes to develop primary care nursing practice. Ph.D. Thesis. London: King's College.
- Goddard C, Stewart F, Thompson G and Hall S** (2011) Providing end-of-life care in care homes for older people: a qualitative study of the views of care home staff and community nurses. *Journal of Applied Gerontology* 32, 76–95.
- Goodman C, Robb N, Drennan V and Woolley R** (2005) Partnership working by default: district nurses and care home staff providing care for older people. *Health and Social Care in the Community* 13, 553–562.
- Goodman C, Woolley R and Knight D** (2003a) District nurse involvement in providing palliative care to older people in residential care homes. *International Journal of Palliative Nursing* 9, 521–527.
- Goodman C, Woolley R and Knight D** (2003b) District nurses' experiences of providing care in residential care home settings. *Journal of Clinical Nursing* 12, 67–76.
- Gordon A, Goodman C, Denning T, Davies S, Gladman J, Bell B, Zubair M, Handley M, Meyer J, Bowman C, Gage H, Iliffe S, Martin F, Schneider J and Victor C** (2014) The optimal study: describing the key components of optimal health care delivery to UK care home residents: a research protocol. *Journal of the American Medical Directors Association* 15, 681–686.
- Handley M, Goodman C, Froggatt K, Mathie E, Gage H, Manthorpe J, Barclay S, Crang C and Iliffe S** (2014) Living and dying: responsibility for end-of-life care in care homes without on-site nursing provision – a prospective study. *Health & Social Care in the Community* 22, 22–29.
- Heath H** (2007) Ch 8: Health and healthcare services. In Owen T and The National Care Home Research and Development Forum, editors. *My home life: quality of life in care homes – review of the literature*. London: Help the Aged, 96–117.
- Heath H** (2010) Outcomes from the work of registered nurses working with older people in UK care homes. *International Journal of Older People Nursing* 5, 116–127.
- Heath H** (2012) How to optimise the registered nurse contribution in care homes. *Nursing Older People* 24, 23–28.
- Iliffe S, Davies S, Gordon A, Schneider J, Denning T, Bowman C, Gage H, Martin F, Gladman J, Victor C, Meyer J and Goodman C** (2016) Provision of NHS generalist and specialist services to care homes in England: review of surveys. *Primary Health Care Research and Development* 17, 122–137.
- Jones TS, Matias M, Powell J, Jones E, Fishburn J and Looi J** (2007) Who cares for older people with mental illness? A survey of residential aged care facilities in the Australian Capital Territory: implications for mental health nursing. *International Journal of Mental Health Nursing* 16, 327–337.
- Lindberg C and Lindberg C** (2008) Ch 2: Nurses take note: a primer on complexity science. In Lindberg C, Nash S and Lindberg C, editors. *On the edge: nursing in the age of complexity*. Bordentown, NJ: Plexus Institute Press, 22–47.
- Luff R, Ferreira Z and Meyer J** (2011) Methods Review 8: Care Homes. Retrieved 25 February 2011 from http://eprints.lse.ac.uk/41191/1/SSCR_Methods_Review_8_web.pdf
- McMillan E** (2004) *Complexity, organizations and change: an essential introduction*. London: Routledge.
- Meyer J, Ashburner C and Holman C** (2006) Becoming connected, being caring. *Educational Action Research* 14, 477–496.
- Meyer J, Noble H, Kilbride C, Holman C and Bridges J** (2009) Doing qualitative research as a practitioner: processes, issues and understandings. *The Malaysian Journal of Qualitative Research* 2, 35–51.
- Mulholland J** (2007) Ch 5: Understanding the self as instrument. In Taylor J and Wallace P, editors. *Contemporary qualitative research: exemplars for science and mathematics educators*. Dordrecht, The Netherlands: Springer, 45–57.
- National Institute for Health Research** (2017) Advancing care: research with care homes. Retrieved 2 November 2017 from http://www.dc.nihr.ac.uk/themed-reviews/advancing-care.htm?utm_campaign=Research+and+Innovation+bulletin+Vol+8+Issue+17&utm_source=emailCampaign&utm_medium=email&utm_content=
- NHS England** (2016) New care model: Vanguards – developing a blueprint for the future of NHS and care services. Retrieved 27 April 2016 from https://www.england.nhs.uk/wp-content/uploads/2015/11/new_care_models.pdf
- Owen T, Meyer J, Cornell M, Dudman P, Ferreira Z, Hamilton S, Moore J and Wallis J** (2012) *My home life: improving quality of life in care homes*. London: Joseph Rowntree Foundation.
- Prince M, Prina M and Guerchet M** (2013) *World Alzheimer report 2013 – journey of caring: an analysis of long-term care for dementia*. London: Alzheimer's Disease International.
- Royal College of Nursing** (2010) *Care homes under pressure – an England report*. London: RCN.
- Sandvoll AM, Kristoffersen K and Hauge S** (2013) The double embarrassment: understanding the actions of nursing staff in an unexpected situation. *International Journal of Nursing Practice* 19, 368–373.
- Skills for Care** (2015) *The size and structure of the adult social care sector and workforce in England in 2015*. Leeds: Skills for Care.
- Tracy S** (2010) Qualitative quality: eight “big-tent” criteria for excellent qualitative research. *Qualitative Inquiry* 16, 837–851.