Facilitators and barriers to personalisation in care homes in England: evidence from Care Quality Commission inspection reports

Abstract

The personalisation of residential care services is based on three broad principles of valuing personal identity, empowering resident decision-making and fostering care relationships. We analysed 50 Care Quality Commission care home inspection reports to identify factors that the reports indicate facilitate or hinder the delivery of personalised residential care in England. Findings suggest the provision of personalised services is affected by staff skills, attitudes and availability, and the quality of care home leadership. Future care policy should consider addressing external pressures facing the care home sector, including inadequate funding and too few staff, to mitigate barriers to delivering high quality, personalised care.

Keywords: personalisation, person-centred care, care homes, Care Quality Commission

Introduction

Townsend's (1981) stark characterisation of the desolate – even punitive - state of institutional care for older people led to a response which tried to promote more personalised approaches to care for older people. Fuelled by the disability movement, the following decades ushered in a fundamental shift of the ethos of "care" services, away from a paternalistic "professional gift" (Duffy, 1996) towards more flexible approaches that consider – and promote - the agency of individual service users (Barnes, 2011). However, until recently, personalisation policies in adult social care focused chiefly on domiciliary care. While the Care Act 2014 (Department of Health and Social Care, 2014) stipulates that all service user groups should benefit from personalised care, including those residing in care homes (Ettelt et al., 2020a), to date, few policies have explicit goals and outcome measures for personalised residential care.

Development of more personalised care practices in residential care has been supported by three prevailing concepts of person-centred care. The first is the consumer-driven "Public Value" concept that champions choice, control and autonomy (O'Dwyer et al., 2013). The second is the psychosocial model, born of Kitwood's (1997) seminal work, *Dementia reconsidered: The person comes first*, which recommends a reorientation of care away from a focus on immediate behaviour management of people with dementia towards considering individuals' "personhood" through personalised therapeutic interventions and an appreciation of their personal and social circumstances. The third emanates from the North American "culture change" movement, which introduces a strong focus on the environmental aspects of residential care, paying heed to the influence of the physical features and resources of care facilities on the promotion of resident independence and interpersonal

relationships amongst the care home community (Thomas, 2003). In this paper, we use the term personalised care to encompass all three concepts of care as they all centre on the autonomy and well-being of the person in need of care.

The individually focused nature of personalised care opens scope for considerable variability and ambiguity of interpretation and implementation. Furthermore, describing personalisation as a process of care is challenging as it is by definition both an individual and a subjective experience that runs counter to standardised approaches to providing care in many communal settings. In an attempt to distil the various definitions of person-centred care across different care settings and services, Wilberforce et al (2017) developed a framework of twelve attributes organised into three overarching themes covering both personalised and person-centred care: nurturing individuals' "personhood" as defined by their personal history, values, preferences, and aspirations; empowering individuals' self-determination in their daily lives through decision-making, either autonomously or in collaboration with carers and family members; and promoting individuals' care relationships (Box 1).

[BOX 1 HERE]

Wilberforce et al.'s (2017) organisation of personalisation into themes and attributes is useful as it relates both to the public value and psychosocial concepts of personalised care in a practical way. Also, the framework stresses the importance of interpersonal relationships and the development of trust and reciprocity amongst staff and residents that are essential in intense care settings. The Wilberforce et al (2017) framework is used throughout the current paper to identify examples of personalised care in care homes in England.

Personalisation in Residential Care Policy in England

In the English care context, the policy promoting personalised domiciliary care is rooted in the "citizen-consumerist" discourse in which service users are seen as informed market actors with an interest in optimising choice and control over their care (O'Dwyer et al., 2013), who are in a position to make use of local care markets to purchase high-quality services that meet their individual needs (Clark et al., 2007). Policy outlining standards for personalised residential care is comparatively less developed. However, elements of the psychosocial model of person-centred care have shaped recent versions of service quality and regulatory frameworks. For instance, the "My Home life" concept of relationship-centred care (Nolan et al., 2006) forms the basis of the quality standards for residential care issued by the Social Care Institute for Excellence (SCIE) and those underpinning the Care Quality Commission's (CQC's) inspection protocols (CQC, 2017a; SCIE 2017).

There are currently 15,400 registered care homes in England which vary in size, ownership and type of care service provided, of which 70% cater for people aged 65 years and older (CQC, 2021). All residential care services in England are required to register with CQC, the independent social care regulator. Since the repositioning of its mandate from setting minimum standards of care (Towers et al., 2019), the CQC's statutory powers have expanded to include the protection of the health, safety and wellbeing of people who use health and social care services by holding service providers to account through regular monitoring, inspections and enforcement of the quality of care of all registered services in England (CQC, 2015; CQC, 2017b). As purveyors of health and social care services all residential and nursing home services are subject to regular *in situ* inspections by CQC staff.

The purpose of the CQC inspection is to appraise and monitor the quality of the service. Inspections typically take place over two to three days and include observations of the daily operations of staff, a document review and inspection of the amenities. Inspectors also interview a small sample of care home residents, family members, staff members and the managerial team, to ascertain their impressions of different aspects of the service. Inspection reports include citations from the interviews to support inspectors' observations on the quality of the care. The quality of the service is appraised according to five key domains of safety, effectiveness, caring, responsiveness and leadership (Box 2). After every service inspection, a report is published on the CQC website, which summarises the findings and provides a rating of the service's performance overall and in each of the five domains according to a four-point scale: outstanding (O), good (G), requires improvement (RI) and inadequate (INE) (CQC, 2017b).

[BOX 2 HERE]

The inspection reports describe perceptible events, decisions, approaches to care, and resident and staff behaviours together with the quality ratings. They also list breaches in regulations under the 2008 Health and Social Care Act and include recommendations for improving the service. They provide an appraisal of the quality of the service, independent of the care home and the local authority. Thus, their aims are threefold: to support care homes to improve their service; to ensure a minimum standard of care quality; and to support user choice by providing publicly accessible information about individual care providers.

Personalisation of services is not an explicit focus of service inspections, but aspects of personalisation are reflected in the Key Lines of Enquiry (KLOE). All domains investigate the flexibility of services in relation to residents' personal needs, their expressed views, pursuit of their interests and independence. Moreover, threshold criteria for achieving outstanding and good ratings require

strong, explicit evidence of a person-centred culture throughout the service (CQC, 2017a). Therefore, good or outstanding CQC ratings should indicate a higher level of personalised care than ratings of 'requires improvement' or 'inadequate'.

Studies suggest that providing personalised care while managing the practicalities of caring for vulnerable people is fraught with challenges, even in well-resourced, highly rated facilities. For instance, Towers et al. (2019) noted that, whatever the home's CQC rating, residents' quality of life was lower in domains reflecting personal control and social aspects of daily life than in domains measuring the functionality and comfort of the physical environment such as safety and cleanliness. This suggests that care homes continue prioritising safety, security and comfort over creating an environment that optimises individual choice, control and self-actualisation.

Barriers and facilitators to implementing personalised care

Several factors affecting the implementation of personalisation in residential care settings have been identified in the international literature, including those related to residents, care staff, care home organisation, and wider policy and societal influences.

Staff attitudes have been identified as key barriers to implementing personalised care as well as staff's knowledge and assumptions about older people and people living with dementia (Cooney et al., 2014; Fernandez-Ballesteros et al., 2016). Mullan and Sullivan (2016) reported a significant positive relationship between staff attitudes towards the behavioural and psychological symptoms of dementia and staff members' sense of competence and willingness to provide personalised care. Hunter et al. (2015) found that staff understanding of residents' personhood was significantly and positively associated with their ability to build trusting, therapeutic relationships with residents, as well as to empathise with, respect and promote residents' sense of personal and social identity.

Elfstrand-Corlin and Kazemi (2017) suggested that individual personality traits affect staff's approach to care. Significant, positive correlations were found between kindness, empathy, social confidence and conscientiousness, and staff actively listening to residents and recognising residents' individuality, which are crucial elements to adopting a personalised approach. Similarly, Barbosa et al. (2015) indicated a tendency for care homes that adopt explicit personalised care principles to employ staff who are emotionally resilient, calm and self-aware. Abbott et al. (2016) showed that staff displaying a lack of accuracy and scrupulousness erected barriers to fulfilling residents' preferences and Elfstrand-Corlin and Kazemi (2017) found that staff traits such as anxiety and irritability were negatively correlated with adopting a personalised approach.

Numerous studies point to the impact of staff skills and continued training on the successful adoption of personalised care. Barbosa et al. (2015) observed that training in person-centred dementia-care helped staff both improve their knowledge about dementia and related behaviours and become more familiar with residents. Sjogren et al. (2017) confirmed that care facilities with a higher proportion of staff with specific dementia-care skills delivered more personalised care than homes with a lower proportion of similarly qualified staff. Similarly, Argyle (2012) observed that a lack of specific dementia-care skills amongst staff led to marginalisation, stigmatisation and at times neglect of residents with dementia.

The main factors related to personalised care within the care home itself, as opposed to the staff, centre on staffing levels and quality of leadership. Several studies described the negative effects of staff shortages and high staff turnover on workloads and on staff's ability to understand individual residents, to provide continuity of care and to engage with resident's emotional needs (Barbosa et al., 2015; Oppert et al., 2018; Kolanowski et al., 2015, Abbott et al., 2017). Ducak and Denton (2018) and Rockwell (2012) observed that low staff-to-resident ratios created difficulties for staff to provide residents with the necessary one-to-one attention needed to embrace a personalised approach, leaving some residents feeling bored and lonely. Staffing shortages and increased workloads were also associated with poor levels of resident stimulation and engagement in meaningful activities (Argyle, 2012) and a tendency for care staff to adopt a task-oriented approach to care (Ducak and Denton, 2018). Similarly, high staff turnover rates were related to a lack of staff understanding and awareness of individual residents' changing needs (Griffiths et al, 2019) and to a reduced likelihood of delivering personalised care (Passalacqua and Harwood, 2012).

The role of care home leadership in the implementation of personalised care is another important recurring theme (Brownie and Nancarrow, 2013). Stein-Parbury et al. (2012) and Li and Porock (2014) conclude that a whole system approach, steered by strong leadership from managerial staff, is required to focus the home on residents' humanity and on the professional growth of care staff. Backman et al. (2016) confirmed that care home leadership is positively associated with the priority given to personalised care and the psychosocial climate of the care home. Similarly, Jacobsen et al. (2017), Ducak and Denton (2018) and Rockwell (2012) suggested that effectual care home management is a crucial factor in the effective promotion of a personalised care culture.

Other studies noted that negative leadership characteristics such as an absence of engagement with, and support to, care staff, adoption of top-down hierarchical reporting structures, poor management of staff relationships and communication, and lack of promotion of a personalised care

culture acted as barriers to the effective delivery of personalised care (Griffiths et al., 2019; Quasdorf et al., 2016; Rockstad et al., 2015; Jacobsen et al., 2017). Similarly, a lack of management feedback, supervision, incentives, role modelling and positive reinforcement was associated with a poor understanding of and lack of interest in personalised care principles amongst care staff (Argyle and Kelly, 2015; Chenoweth et al., 2015).

Overall, the body of relevant literature indicates how a whole systems approach, including continued training and development of staff at all levels, is essential for ensuring the understanding of, and commitment to, the delivery of personalised care.

Objectives

The main objective of this paper is to refine the understanding of factors that help or hinder the provision of personalised care services in residential settings in England. To achieve this objective, we conducted a review of 50 CQC inspection reports of residential facilities for indications of barriers and facilitators to personalised care that were identified in the wider body of literature. The review formed part of the larger *Personalisation in care homes for older people* study, undertaken by the Policy Innovation and Evaluation Research Unit (Ettelt et al., 2020a). Briefly, the study recruited 24 care home managers across six regions in England for an interview to discuss approaches and challenges to delivering personalised care. Among the participating care homes, three were rated as outstanding, 15 as good and six as requiring improvement at the last CQC inspection. In order to improve the diversity of care homes participating in the study, both in terms of geographical reach as well as quality rating, we drew on CQC inspection reports of 50 care homes.

Methods

This study presents findings from an analysis of the CQC inspection reports of 50 care homes published between January 2017 and December 2018. Reports were purposively sampled from each of the 15 regions of the NIHR Clinical Research Network (CRN) and from homes in each of the four CQC quality categories in each region. Four reports were selected from each CRN region, except that only three reports were selected from regions where no care home meeting the inclusion criteria received a rating of outstanding or inadequate. Table 1 presents the number of reports selected from each CRN region.

[Table 1 HERE]

We selected reports within each CRN region according to the location (urban, town, rural) of the care homes and the size of the care home (small, medium and large) as defined by the CQC (2017), where small care homes care for fewer than 11 residents, medium care homes house between 11

and 49 residents and large care homes have more than 50 residents. Table 2 displays the distribution of care home characteristics, by inspection rating.

[Table 2 HERE]

Analysis

We applied the Framework approach to analysis of qualitative data for policy-related, applied research developed by Ritchie and Lewis (2003) in two steps. First, we identified examples of personalised care as defined by the three themes and twelve attributes of the Wilberforce et al. (2017) framework (Box 1). Two researchers (JD, AS) familiarised themselves with the material by carefully reading through each report. Two reports were subsequently re-read line-by-line and relevant passages were broadly coded according to the twelve attributes (and three overarching themes) of the Wilberforce et al. (2017) framework. Coding criteria were refined and applied to the remaining reports. Coded excerpts were inserted into a Framework analytical matrix.

Next, we identified the supporting and inhibiting factors to implementing personalisation from the excerpts extracted in the first phase of the analysis. Using an open coding technique (Gale et al., 2013), excerpts were reread line by line and codes were applied to passages that described barriers or facilitators. Guided by themes emerging from the literature, codes were subsequently grouped into dominant themes related to barriers and facilitators. Analysis was conducted using NViVO 12 (QRS International, 2020).

Each report was given a unique identifier consisting of a combination of a number (randomly assigned) and letter(s) indicating the CQC rating: O (outstanding), G (good), RI (requires improvement) and INE (inadequate). For example, “1O” refers to the care home report assigned number 1 that received a rating of “outstanding”. Report identifiers are used after citations from the relevant report and when referring to a specific report.

Findings

To address the first objective of this paper, we outline the facilitators and barriers to implementing personalisation identified in the CQC reports, according to the three overarching themes of the Wilberforce et al (2017) framework: ‘*understanding the person*’, ‘*engaging in decision making*’, ‘*promoting the care relationships*’ (Box 1).

Understanding the person

Wilberforce et al (2017) define the ‘*understanding the person*’ theme as the acknowledgement of each person as an emotional and perceptive individual, with a unique set of needs and ambitions,

irrespective of the similarities in pathology or disability they share with others, which is achieved by '*understanding a person's personal experience of illness*', '*knowing the aspects of the person's life that require support', 'understanding the individual's values and preferences for care'* and what is '*important to the person's identity and wellbeing'* (p.90).

Facilitators

Facilitators to 'understanding the person' recurring in the inspection reports centred on staff skills, attitudes, design of the physical environment, and use of equipment and local community resources.

Some inspection reports suggested that staff skill-level and "*understanding about person-centred care*" facilitated their ability to "*[know] the people who used the service well and [understood] their needs*"(7RI). For instance, acute communication skills such as reading body language helped staff achieve a holistic understanding of residents' needs:

> "Staff were skilled at reading [residents'] body language and their behaviours which helped them to pre-empt and understand behaviours which could be perceived as challenging. In one case, reading the person's behaviour and responses to things helped staff support the person through the loss of their spouse. Staff had been thoughtful and sensitive in how they approached this by slowly removing items in the room which triggered distress in the person." (6RI)

Reports also commented on the contribution of disease-specific training towards staff's understanding of the breadth of residents' needs. For example, external dementia-care experts, such as Admiral Nurses (Dementia UK, 2020), trained staff on how to "*improve the experiences for those people living with dementia*" and "*ensure the environment was as dementia friendly as possible*" (14G). Other reports described the impact of immersive psychoeducational programmes such as Dementia Care Mapping™ (Downs, 2015) (2O), Namaste Care ™ (Simard, 2007), "dementia suits" (1O) and the Virtual Dementia Tour® (1O, 6O, 17G), on staff's appreciation of residents' personal history and experience of dementia:

> "The dementia training was so good I asked to do it again. I learnt how important it was to know people's history. I used to get upset when one person was really bossy. I read their file and found out they used to be an executive […]. Now when they're like that I act as one of

their employees because I know that's the time they are in." (8O)

Positive attitudes towards residents also helped staff to understand residents' needs, preferences and individuality. Several care homes demonstrated how staff members displaying empathy and insight enabled honest, open communication with residents, which in turn facilitated the understanding of residents' individual needs, preferences, and aspirations:

> "We saw numerous examples of staff delivering kind and caring support. We saw a person with dementia getting distressed. Staff recognised this and responded to it quickly by sitting down and sharing jokes with the person. The person instantly relaxed and was laughing and joking with the member of staff. […] Staff clearly knew [the residents] well and were able to use this knowledge to have meaningful conversations." (10RI)

Other citations illustrated how highly motivated staff who went the "*extra mile*" (7O) were able to identify residents' personal interests and to respond to their requests accordingly:

> "[A] member of staff told us how they knew that one person enjoyed model making and so they gave them some marzipan to create something […]; this was in addition to their own job role. This demonstrated to us that staff were motivated to provide care based on people's needs and preferences." (5O)

Some Reports described how the physical layout of the care home facilitated personalised approaches to care. For instance, accessible and dementia-friendly environments enabled staff's understanding of residents' needs and experiences. The "*layout and design of the building*" (8RI), and " *signage and calming colour schemes*"(1RI; 6O, 6RI, 10RI, 2O, 13G, 14G, 2O, 16RI, 18G) were amongst some of the features designed to help residents with cognitive and physical limitations orientate themselves and to move freely throughout the premises. Reports also described care home efforts to "*personalise resident bedrooms with their belongings, memorabilia* (9G)", "*personal pictures*" (2G, 2INE, 14RI, RI, 5G, 13G) and "*memory boxes*" (2O, 4G, 5O, 8RI, 11RI, 12G, 14G); facilitating staff's understanding of residents' personal history and identity:

> "People's bedrooms were decorated according to their wishes and were very individual. […] We saw that some people had brought their own furniture with them. For example, one person was previously an antiques shop owner and wanted all of their own furniture in the room. The service respected this and removed all of the standard items from the room."

(7RI)

Reports also described care homes' use of other resources that enabled staff's response to - residents' personal social, spiritual, therapeutic and leisure needs. Examples included the deployment of the internet and tablet computers to help residents remain connected to friends, family and religious groups (1G, 8G, 2O). One report described the use of a digital exercise programme to encourage residents to remain active (4G). In another, a care home provided devices to create "*personalised playlists, to help [residents] relax if they became anxious*" (2O).

Special amenities provided by some care homes were reported as facilitating comprehensive responses to residents' varied needs and lifestyles. In-house transport services (2O, 3G, 6O, 8O, 14RI), sporting facilities (2O, 4G), "*protected [resident-only] areas*" (17RI), purpose-built resident cafés (1RI, 3G, 4O, 6O, 17RI) and a "*Memory Lane*" garden (1O) illustrated the efforts some care homes made to acknowledge and accommodate the various aspects of their residents' lives, beyond their physical and cognitive limitations. Other care homes drew on resources from local community groups, such as dementia support groups, children's nurseries (1O, 2G, 2O, 4G, 7O, 8O, 14G, 15G) and places of worship (1G, 6O, 10RI, 16G) which helped residents to "*improve social engagement, encourage [uptake] in activities,*" (17RI), and to continue participating in - and contributing towards - their local community and leisure pursuits.

Barriers

Barriers to the '*understanding the person*' theme of the Wilberforce et al. (2017) framework mirrored the facilitators in terms of staff skills and attitudes. Reports referred to the state of decay of some care homes, lack of digital equipment and few links with local community resources, but such observations were not directly associated with their ability to provide personalised care. Reports also commented on the impact of staffing ratios on the capacity of staff to develop a keen understanding of residents as individuals.

A small number of reports offered examples of unfavourable staff characteristics, such as a lack of knowledge and skill, which prevented them from developing an appreciation of the residents they cared for. For example, inspectors noted a lack of "*evidence that specific training needs were being addressed to reflect some of the conditions experienced by people that staff were expected to manage[…],*"leading staff to "*not understand how to support people living with dementia, people with changing mental capacity and people at risk of specific health conditions."* (6INE). Similarly,

reports suggested that skill gaps in dementia care resulted in ineffective interventions that did not acknowledge residents' identities or promote their wellbeing:

> "We found the one-to-one activities were simple conversations by staff with the people involved and were not motivating. We did not observe evidence of appropriate activities such as reminiscence, reading, poetry, massage or similar events in this unit. Staff we spoke with also were not aware of appropriate social stimuli for people living with dementia." (3G)

Some reports described the inhibiting effect of undesirable staff attitudes on their understanding of residents' identities and personal needs. For example, residents explained that some staff, who were demonstrably disagreeable, failed to acknowledge them as individuals and at times even held their needs in contempt:

> "One carer is rough and pulls me around when she is doing personal care. I think they think I am a nuisance to them". […] "Some rush too much and it makes me feel unsafe" and "There's two or three that should not be here, you know the minute they put their hands on you, they're rough" […] "they see you more as an object than a person". […] "The quality of personal care is very low as they have no interest in you as a person." (11RI)

The undermining effect of staffing shortages on staff's ability to identify and respond to residents' personal needs was also noted in reports. Reports explained that "*staff deployment during busy periods did not always consider people's dependency levels*" (14G) and constrained staff's ability to adopt holistic responses to individuals' needs and wishes. Some residents similarly said that staff were "too *busy*" (1INE, 11RI) to recognise their emotional and intellectual needs or to engage in "*meaningful activities*" (2RI, 4INE, 5G, 5RI, 9RI, 12RI, 17RI, 5INE, 6INE).

Engaging in decision making

The '*engaging in decision-making*' theme of the Wilberforce et al. (2017) framework encapsulates the inclusion of service users in choices about their care and the influence they have over shaping the quality of the service. Accordingly, care staff adopted a personalised approach by '*involving the person in the decision-making process*', ensuring the '*person's wishes shape decisions and care plans*', providing '*flexible care services are tailored to individual preferences*', and ensuring that '*information and options are [communicated clearly]'* (p.91).

Facilitators

Staff knowledge, training, communication skills and technological aids were identified as the main facilitators for engaging residents in decision-making in the reports.

Several reports referred to the staff skills that enabled residents to engage in the decision-making process. For instance, reports described the collaborative decision-making processes during end-of-life care planning, where staff devised plans with residents and family members that reflected residents' goals and wishes. Several reports made explicit references to accredited training programmes such as *Six Steps End of Life* (Six Steps, 2021) and the *Gold Standards Framework* (The Gold Standards Framework, 2021) that enhanced staff's skills in co-developing sensitive, personalised end-of-life care.

Several reports also remarked on staff's understanding of their professional duty of involving residents in decisions, including people who lacked capacity. In one case, a staff member demonstrated both an understanding of the implications of the Mental Capacity Act (2005) on residents' decision-making and of residents' experiences of taking decisions:

> "Staff told us they always ask consent each time they provide care and demonstrated their knowledge around decision making for some people who live with dementia by adding, "I always ask each time as people can make a decision one day and then not the next." (9RI)

Some reports commented on the versatility of staff's communication skills that helped to ensure residents were adequately informed about their choices and could genuinely engage in decision-making. Various communication techniques were shown to be effective in engaging residents in decision-making such as giving residents "*time to process and respond to information*" (16G) and "*[observing] people's body language to gauge their reaction and choice*" (4O). Empathic communication skills (McEvoy, 2014), for instance, were often employed to ensure residents were clear about their choices, as demonstrated by staff in a care home rated inadequate, despite reported concerns about low staffing levels and staff working long hours:

> "Staff took time to check on people's comfort, knelt down and made eye contact when speaking with people […] Staff communicated with people and gave information to

> [residents] in ways they could understand." (2INE)

Other reports mentioned the use of visual and tactile aids to help residents *"[…] who found it difficult to communicate verbally make informed choices about the food they ate and activities they might like to engage in*" (2O) which in turn helped staff to "*to help with communication to ensure people's understanding and to ensure people's care plans were followed*" (6O). Examples such as "*pictures and objects of reference to assist with verbal communication*" (16G), "*information technology"* (6O) and "*[…] a magnetic board with different letters and numbers*" were also used to "*meet residents' communication needs*" (15G) and enabled residents to actively engage in planning their care and leisure activities.

Barriers

A small number of reports described barriers preventing residents' engagement in decision-making. Mostly apparent were negative staff behaviours and attitudes, and poor leadership. Attitudes described as unhelpful to residents' decision-making included task-oriented approaches to care (1RI, 2INE, 2RI, 3RI, 4RI, 5INE, 5RI, 6INE), a disrespect for residents' 'personhood' (4INE, 5INE, 11RI, 12RI) and staff prioritising their preferences over those of residents, as described in one report:

> "One person told us they did not have a choice in when they went to bed or when they got up. […] A staff member told us this was because the night staff would not support people to bed when they got on shift and they had to wait until midnight [to receive support]. This meant day staff supported people to bed early, some people [lay] in bed from around 6–6.30pm until 10.30am the next morning." (3INE)

Some reports discussed service providers' failure to institute an inclusive culture that encouraged residents' participation in shaping their care plans and in influencing the how the service was run (5INE, 11RI, 12RI, 3INE, 6INE, 14RI). One example demonstrated how poorly implemented feedback mechanisms prevented residents' input into decisions about their care and displayed a generalised disregard for residents' concerns:

"People us that they did not have any input into their care plans. They said they had not been consulted about the renovations that were taking place and that they were not encouraged to have a say in the running of the home. A residents meeting had taken place but we were told was a "Waste of time because nothing ever got resolved". Complaints that people had were about not

being introduced to new staff, clothes missing in the laundry; wanting to go outside more; and better food". (3RI)

Promoting the care relationship

The '*promoting the care relationship*' theme of the Wilberforce et al. (2017) framework focuses on the quality of interpersonal relationships between care staff and residents. In contrast to the individual-focused models of personalisation typified in "hotel-style" care home services (Ettelt et al., 2020b), relationship-centred models consider the authenticity of care staff's interactions with service users, which are built on compassion and profound knowledge of service users, and which facilitate residents' choices and control over their daily life.

Facilitators

Several reports recorded observations of caring relationships between staff and residents, which were facilitated by staff's attitudes and behaviours, leadership's commitment to - and promotion of - building caring relationships and adequate staffing levels.

Reports indicated the formation of social bonds between staff and residents through the ease and familiarity with which staff interacted with residents, by using "*humour*" (6INE, 9O, 18G) and "*banter*" (1INE, 2INE, 4O, 5O, 6INE). In some reports, the depth of the staff-resident relationships was attributed to care staff's regard for - and treatment of - residents as members of their own family (15RI, 17RI, 1O, 3O, 14G):

> "One support worker told us, "You need to care for people like they are your own mother." Another support worker said, "By caring for my own family I am caring. I put my family in the place of people here and would always want people to be cared for." (13G)

There were also indications that staff's emotional investments into their relationships with residents engendered residents' trust (1O) and reciprocal feelings towards staff as "*part of my family*" (4O). In some cases, residents expressed the view that the care home had become "*like our home*," and that the care home community was "*like a family*" (4O; 3G, 4INE, 5G, 5O, 8G, 8RI, 9G, 9O, 17RI), suggesting the care home environment enabled residents to reach a reasonable balance of autonomy, privacy and interpersonal connectedness (Molony, 2011; Klassens et al., 2015).

Inspections also noted the active influence of the care home management on the development of

caring relationships. Some reports attributed the success of relationship-centred approaches adopted by staff to effectual "*hands-on*" (1G, 1RI, 2O, 4O, 7O) managers, who "*led by example*" (1O, 2O, 2RI, 3G, 4O, 5G, 14RI), and articulated a vision of "*dignified*" and "*relationship-centred*" (2O, 3O) care. Other reports commented on the value of managers who motivated their staff to build personal connections to residents (7O, 4O):

> "[Management] tried to encourage a "positive culture" […] and aimed to be visible, for example, working alongside staff and encouraging regular communication. It was seen as important to "try to keep staff moral high," for example "by saying thanks to staff and helping them to feel valued". Management also tried to be flexible with staff […], which was felt to encourage staff to subsequently feel more committed to the service." (1G)

The impact of care homes having "*sufficient numbers of staff on duty*" (1O) on the development of nurturing relationships was commented on in several reports. Adequate staffing was linked to a "*calm, relaxed atmosphere*" (6G, 9O, 1O, 1RI, 2RI, 4G, 4O, 4RI, 7O, 9G) throughout the home, which facilitated "*continuity [of care] for people*" (9G) and mutually beneficial relationships between staff and residents (13RI), as observed in one report:

> "People were cared for by staff who really valued the person and the relationships they had with them. This applied to all staff as we watched the chef in one lodge greet people with smiles and hugs and heard them chat to people about their families […]. [Another] staff member told us, "Do you know the feeling you get when you go home from work? Well, that is the feeling I get when I come to work in the morning." (8O)

Barriers

Conversely, a small number of reports of care homes rated as requiring improvement and inadequate illustrated how a lack of relevant training (1INE, 3INE, 5INE, 5RI, 6INE) and unhelpful staff attitudes (2RI, 3INE, 11RI, 5INE) prevented the development of caring relationships between staff and residents. Poor attitudes stifled communication between staff and residents, preventing staff from developing a comprehensive understanding of residents as individuals, and in turn, from cultivating a deeper rapport with residents. Gaps in staff training in topics such as "*dignity and respect, equality and diversity, dementia […] mental capacity and challenging behaviour,*" prevented staff from having a "*good understanding of treating people with dignity and respect,*" (3INE) and

from acknowledging their independence and personal goals, and, as a result, they adopted task-oriented routines (5INE, 5RI).

The most frequent barrier to developing caring relationships was staffing shortages. Reports of care homes experiencing staffing challenges described the dispiriting effects these had on caring staff-resident relationships. Excessive workloads and high staff turnover meant staff "*don't sit and talk to [residents]*" (5RI; 1INE, 3INE, 5INE, 6INE) and were unable to engage meaningfully with residents "*on a one-to-one basis*" (11RI):

> "The problem is chronic turnover of staff, many barely lasting six months. The consequence is lack of continuity, superficial rapport between staff and patients and not many activities," (12RI)

Excessive workloads also impacted on staff's training and professional development. One inspector noted a shortfall in staff receiving training, which the manager explained was because:

> "[…] we're all running around just trying to cover shifts." (4INE)

Some reports also acknowledged how staffing shortages superseded staff's good intentions and their disposition to provide personalised care. For instance, reports (2INE, 3RI) recounted residents' and family members' praise of staff for being "*very good and caring, and treat us with the utmost kindness*", but expressed disappointment that staff lacked "*time to socialise*" (6INE) and were thus unable to establish a more profound connection with staff:

> "The care staff here are quite good and help me a lot and know how I like things done. The problem isn't the care they give it's more that they're so busy." (4INE)

These examples suggest that staffing shortages could be the underlying cause of other barriers to the development of caring relationships between staff and residents that are characteristic of personalised approaches to care. If so, impatient staff behaviour is more likely to be the result of stressful working environments than indicative of negative staff personality traits or incompetence.

Discussion

Using the Wilberforce et al. (2017) framework to review CQC inspection reports helped to identify factors in English care homes that facilitate and inhibit the delivery of personalised care in terms of understanding residents' identity, enabling resident decision-making and promoting caring relationships.

As observed in earlier studies (Elfstrand-Corlin and Kazemi, 2017; Abbott et al., 2017; Mullan and Sullivan, 2016; Hunter et al., 2015, Cooney et al., 2014; Fernandez-Ballesteros et al., 2016, Barbosa et al., 2015; Argyle, 2012), staff characteristics, including skills and attitudes, were found to have an important effect on eliciting open communication with residents, which allowed staff to learn about residents as people, to develop meaningful relationships, and to respond to residents' individual needs and preferences. It is noteworthy that positive traits were observed in care homes across the quality rating spectrum. Moreover, despite egregious failings in some care homes with poor quality ratings, some reports (2INE, 4INE) highlighted incidents of affective practice. The "caring" and "responsive" domains of the CQC inspection guidance (CQC, 2017a) require inspections to include commentary on staff comportment and aptitudes. Therefore, such observations are deliberately recorded in each report, which may in part explain the frequency of examples of caring and skilful acts of personalised care, including in challenging care settings. The recurrence of such findings could also be linked to the person-environment fit (Kristof-Brown et al., 2005) of empathic settings to which people with high levels of empathy are drawn and thrive (Elfstrand-Corlin and Kazemi, 2017).

Reports also indicated that effective leadership helped shape staff's attitudes and skills, particularly for "promoting caring relationships". Again, the pervasiveness of findings on the quality of leadership are partially reflective of the CQC's stipulations in the "well-led" domain of the inspection, which appraises managers' aptitude for ensuring staff's understanding and adoption of a person-centred culture (CQC, 2017a, p.19). These findings also corroborate findings of previous studies, which identified leadership as a pivotal factor for raising staff awareness and for instilling relationship-centred values throughout the home (Jacobsen et al., 2017; Abbott et al., 2016; Chenoweth et al., 2015). In contrast to staff attitudes and behaviours, however, indications of leadership's positive influence on staff were predominantly found in homes rated outstanding or good and rarely in care homes with a requires improvement rating or inadequate rating. These differences could underline the weight given to leadership to assess quality in the CQC framework, where leadership is scrupulously dissected in a KLOE domain in its own right. In contrast, staff qualities are evaluated as supporting elements of care homes' broader approach to care.

The barriers identified mirrored the facilitators in terms of staff characteristics, where negative

attitudes and lack of skill were demonstrated to have an impact on implementing personalisation across all three Wilberforce et al. (2017) themes. Also noted were examples of poor systems of communication between residents, staff and management which stymied residents' voice. Underpinning the barriers in most cases, however, were chronic staffing shortages. Other studies noted that poor attitudes and low levels of motivation were symptomatic of the effectiveness of the work environment, rather than a sign of character or skill defects (Passalasqua, 2012; Barbosa et al., 2016). In particular, low staffing ratios and high staff turnover had deleterious effects on staff morale, attitudes and behaviour and the overall care home atmosphere (Oppert, 2018).

Care homes' management of physical space and use of equipment was also found to facilitate the implementation of 'understanding the resident' and 'engaging residents in decision-making' themes of the Wilberforce et al. (2017) framework. These findings align with the central hypotheses of culture change models, such as the Eden Project (Brownie and Nancarrow, 2013), that assert the benefits of supportive and familiar care home spaces for resident personhood, control, autonomy and social engagement (Barnes, 2006; Hung et al., 2016). It is also important to recognise the role of leadership in successfully mobilising resources, especially with regards to identifying and addressing training needs and creating links with community services, which are both criteria of the "well-led" domain of the CQC inspection protocol (CQC, 2017a). Although not explicit in the reports, public funding constraints may also contribute to homes being understaffed, under-skilled and with deteriorating facilities (Argyle and Kelly, 2015; American Geriatrics Society, 2016), and consequently providing less personalised services. Indeed, Jacobs et al. (2018) observed that care homes in regions with more "market resources", such as a higher proportion of potential care home "customers" with higher household incomes, were more likely to provide personalised services.

The analysis of reports also highlighted some discrepancies between the personalisation of care and the quality of care. Several reports reinforced the hypothesis that care homes with favourable quality ratings have constructive systems in place to implement a personalised service and that homes with poor ratings exhibit barriers to the delivery of personalised care. Specialist training, use of technical aids, enhanced facilities and links with community groups were mostly identified in homes rated good or outstanding. However, there were exceptions to this general finding showing that personalised care is not necessarily correlated with recognised quality indicators. Care home 2INE, for instance, demonstrated that, although staff possessed both enlightened understanding and compassionate attitudes, these were outweighed by adverse circumstances including high staff turnover rates, absence of consistent leadership and allegations of bullying amongst staff. Conversely, care homes 3G, 5G and 14G at times fell short of offering aspects of a personalised

service aligned with residents' individual lifestyle choices and requests, despite achieving an overall "good" quality rating. These paradoxes echo findings from Rockwell's (2012) interviews with social workers from residential care facilities, which exposed how staff's good intentions to enact personalised care were often undermined by resource constraints. These findings call into question the extent to which the idealised concept of personalisation is achievable - and sustainable – in residential care practice where, by definition, resources are shared. Towers et al. (2019) noted that Social Care Related Quality of Life (SCRQOL) indicators in subjective domains such as "control over daily life", "occupation" and "social participation" were lower than objective domains such as "cleanliness" and "food and drink" across care homes of all quality ratings, suggesting that delivering personalised care that consistently fulfils residents' emotional and social needs and expectations is not always feasible given the funding and skills deficits within long term care systems.

Overall, several of the factors influencing the level of personalisation of care home services identified here can be ascribed to forces that lie outside the direct control of care homes themselves, such as local labour markets and community resources. This calls into question 'citizen-consumerist' policy ideals, which arguably faulter in care home contexts. Not only are many care home service users, and their families, not genuinely 'informed market actors' but nor do they have agency to influence the quality of the services - or their local care home market - they use to meet their personal needs.

Limitations

It was at times difficult to discern the underlying facilitators for the implementation of personalised care. While it was clear that several care homes made efforts to empower residents to take decisions and to shape their respective care home communities, success – or failure – of these endeavours were not always attributable to an identifiable or recurring cause. These difficulties could be a by-product of employing a different framework for analysis to that used by the CQC for their inspections. Furthermore, the inspection reports are written by others and for a different purpose to that of recording data for empirical research. The CQC inspection protocol has a broad remit to assess the dimensions of care services including physical safety, safeguarding, access to health services and evidence of consistent and efficient care, where level of personalised care is just one aspect albeit an important one of the overall assessment of the care home. Evidence of individualised care is identifiable in the CQC reports, whereas details about the mechanisms for delivering personalised care are less pronounced. The Wilberforce et al. (2017) framework, in contrast, focuses on the relational aspects of care services rather than on medical, legal and institutional issues.

Also, the current analysis does not consider such influences on implementing personalisation in residential care as individual resident experiences and perspectives. Abbott et al. (2017) argued that residents' views on the level to which their care was personalised were affected by their perceptions of the choices and opportunities available to them. Bangerter et al. (2017) suggested that residents with cognitive limitations may have difficulty in assessing the choices they have and may not perceive their care as especially personal. Equally, the analysis does not include community or societal factors that may impact the flexibility of individual care homes to respond to individuals' needs and preferences such as policies around meeting residents' care needs (Slasberg, 2017; Doll et al., 2017; Nordin, 2017; Ducak and Denton, 2018) and societal conceptualisations of community living and ageing (Agotnes and Oye, 2017; Gilleard and Higgs, 2002). Observations of these perspectives are beyond the remit of CQC inspections and comments on them do not appear in the reports.

The CQC reports do, however, represent the views of social care experts who observed staff and resident interactions in care homes and interviewed residents, families and staff and present a valuable source of observational data on the experiences of people living and working in care homes. In addition, the CQC makes available to the public the inspection reports for every care home in England, providing researchers with access to information on the quality of all care homes, far exceeding sample sizes achievable through other methods of obtaining such information.

Conclusion

We identified from the analysis of CQC reports many examples of care homes delivering personalised care in terms of understanding residents, enabling residents to take decisions, and promoting caring relationships between residents and staff. Our review supported previous findings that personalised care is enabled by positive staff attitudes, high levels of skill and effective leadership. The review also reaffirmed the negative effects of staffing shortages on the delivery of personalised care, suggesting that the availability of resources to the care home sector plays an important role in the realisation of personalised care. Further empirical research on the impact of community actors on the quality of residential care services could illuminate innovative approaches to harnessing local resources that enable service providers to deliver responsive, personalised care.

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"The Authors declare that there is no conflict of interest"

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