UNIVERSITY OF SOUTHAMPTON

SCHOOL OF HEALTH SCIENCES

FACULTY OF ENVIRONMENTAL AND LIFE SCIENCES

"Could be a risk couldn't it": Decision-making, access to, and the use of functional objects for people with a dementia living in a care home

by

Kellyn LEE

Thesis for the degree of Doctorate of Philosophy

October 2019

UNIVERSITY OF SOUTHAMPTON

<u>ABSTRACT</u>

It is argued the use of functional objects and control over personal possessions are important in supporting, maintaining and cultivating identities. By exploring how objects manifest in the everyday lives of people with a dementia in care homes, this thesis focuses on the interactive nature of human and material worlds, often neglected in care home studies.

This ethnographic study included a hanging out period, participant-observations, object-elicitation interviews, in-depth interviews and the examination of documentary sources. I explored who was involved in decision-making relating to personal possessions, who had access to functional objects, how functional objects were used, and by whom. Finally, I examined whether social citizenship was a useful lens to explore such relations.

The study findings are that, people with a dementia are excluded from decision-making relating to personal possessions and the future acquisition of objects, they lacked control over their possessions, had few opportunities to use functional objects, were often denied access to functional objects without a formal risk assessment, and had belongings removed from their rooms without their knowledge or agreement. By viewing object-person relations in dementia care through a citizenship lens, the material citizenship framework was developed. The material citizenship framework has the potential to support a rights-based approach to dementia care by using functional objects as an enabler to balance risk management and protection, and empowerment and social citizenship. I argue that object-person relations are important to the advancement of dementia care and citizenship practices.

Table of Contents

List of Tables

List of Figures

DECLARATION OF AUTHORSHIP

I, Kellyn Lee declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

"Could be a risk couldn't it": Decision-making, access to and use of functional objects for people with a dementia living in a care home

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission

Signed: Kellyn Lee

Date: 3rd October 2019

Acknowledgements

I would like to thank Professor Alan Costall for our many conversations about ecological psychology. I would not have embarked on this PhD study without your encouragement.

I would like to thank my supervision team Dr Ruth Bartlett and Dr Rebekah Luff for your considerable encouragement, interest and engagement with this project. I would also like to thank the Alzheimer's Society who funded this project.

I would like to thank past colleagues who popped up at exactly the right time (how did you know!). Dia for your words of encouragement, Louise for reading this thesis in your spare time and Ruth for proofreading my chapters. To fellow PhD students Pippa, Emily W, Amelia and Emily O, without you this experience would not have been so rich.

Thank you to my children Oliver and Finlay. It has been a very long road and you have both been with me every step of the way. Thank you for your patience when you have had to wait for my attention and for the quiet when I needed it. Most of all thank you for showing unwavering confidence in my abilities, neither of you ever questioned why but instead told me I could. Thank you to my mum for always being on the end of the phone when I needed a chat. Thank you to my partner Joe for making the good times amazing and the tough times easier, also for your words 'my girl's gonna change the world!'

I would like to thank Jane for our conversation about the flask, and all of the people who kindly took part in my research. I am always so humbled by the way people open their hearts and minds, it is always a privilege to hear your stories.

Finally, I would like to dedicate this thesis to the best storyteller of all, my grandad Peter. I am so sad that you did not make it to the end with me, but I know my story would have become one of your stories, albeit an embellished version!

Definitions and Abbreviations

ASSM   Adult Services Service Manager

AUM   Assistant Unit Manager

DoLS   Deprivation of Liberty Safeguarding

MCA   Mental Capacity Act

MCF   Material Citizenship Framework

RM   Registered Manager

Preface: Me, the researcher

Locating the researcher is a critical issue in qualitative research. This is particularly important when researchers develop and establish relationships by understanding how participants make sense of their personal and social world. Placing the researcher as present also emphasises the dynamic role of the research exercise (Smith & Osborn, 2008). As the researcher in this project, I will set out my agenda and the experiences that led me to undertake this doctoral study.

My time spent working as a care assistant in a care home in the early 1990s had a bearing on this study. The care home was a privately-run care home situated in an affluent area with sea views and attracted high-end fees. It had a good reputation and the owners visibly demonstrated care for the residents living there. Even within these optimum conditions, I was acutely aware that residents were limited in decision-making, restricted in their everyday movements, and required to 'fit in' with the routines of the home. Residents who attempted to take control, make decisions and have things done their own way, were often labelled by care home staff as difficult or cantankerous. I left the care home thinking that care practices did not meet the psychological needs of those living there.

Following the completion of a psychology degree in 2011, I worked as a research assistant on projects related to ageing and dementia. The evaluation projects examined the usefulness of creative arts for people with a dementia, and the sustainability of community art classes for people with a dementia. The art classes ran for one and half hours on a weekly basis taken by a qualified art teacher. Many of the informal carers believed the art classes would not be suitable for people with a dementia. Carers gave reasons such as, the attendees would not sit for long enough, concentration would not be maintained, and the paintings would not be of an acceptable standard. The outcome of the classes was that the paintings created by people with a dementia far exceeded everyone's expectations; most attendees concentration lasted for the duration of the class and some attendees complained the classes were not long enough. Observations showed attendees demonstrating signs of pride, making connections with staff and other attendees, and developing friendships that extended outside of the group.

Some of the most powerful reactions came from those who did not have a cognitive impairment. Their shock at what people with a dementia could achieve, given the right conditions. The subtle shift in how those who were cognitively fit thought about people with a dementia, had a profound effect on me. One support worker from the Alzheimer's Society commented how awful she felt. She told me how she ran art classes that consisted of providing people with a dementia pieces of paper that once wet, became a coloured picture. She had not conceived that people

with a dementia could achieve this level of art. The study raised questions for me in relation to how people with a dementia were positioned and issues such as competence, participation, dignity and respect. If people with a dementia were given opportunities to show what they can do, this could change how others positioned them.

Combining my experience of working in a care home, and the creative arts projects for people with a dementia, it is of little surprise that I embarked upon a study that focuses on the empowerment of people with a dementia living in care homes through the use of objects.

Chapter 1: Introduction

"We live today in a world of ever more stuff – what sometimes seems a deluge of goods and

shopping. We tend to assume that this has two results: that we are more superficial, and

that we are more materialistic, our relationships to things coming at the expense of our

relationships to people… in many ways, the opposite is true; possessions often remain

profound and usually the closer our relationships are with objects, the closer our relationships

are with people." (Miller, 2008, pg.1)

This thesis explores object-person relations in care homes for people with a dementia. Firstly, it critically examines how decisions are made about the personal possessions people take into a care home; and who is involved in the organisation and transferral of personal possessions. Secondly, it explores the functionality of objects by examining how functional objects are imbued in everyday activities; how functional objects are used and by whom; and whether functional objects enable a person to take action in a care home environment. Finally, this thesis explores whether a material lens is useful in locating social citizenship in the context of a care home. This is an ethnographic study and includes methods: participant observations, semi-structured interviews, object-elicitation interviews and documentary analysis of policy and practice documents.

This thesis draws on and combines three conceptual ideas; object-person relations, materiality and social citizenship for people with a dementia. The combination of these three theories has the potential to reposition care home residents as passive recipients of care and instead, view people with a dementia as agentic beings. To focus on the importance of object-person relations in everyday life, it is important to understand how a person may express identity through objects. It is also important for care homes to understand the importance of materiality and how objects are imbued in everyday life. This means understanding the social structures that facilitate how objects are used in a care home by drawing on who has access to which objects and whether this enables or denies agency. The way in which object-person relations are viewed within an institutional setting and the access people have to use objects to carry out everyday tasks, may have the potential to mobilise social citizenship from a theoretical concept to an applied practice. In doing so it seeks to ensure that people with a dementia have the same entitlements as anyone and reduce discrimination and marginalisation (Bartlett & O'Connor, 2010).

The term functional objects places object-person relations as active, that is, people do things with things. My working definition of a functional object is:

'An inanimate item which a person can use to perform a task (not
necessarily to completion or to any perceived standard) which maintains
and supports her/his identities'

Functional objects offer a mechanism with performative qualities that can enable a person to act and in doing so, can demonstrate the presence of agency. Until recently, the meaning of objects for older people and people with a dementia have been considered in terms of sentimentality rather than functionality. Researchers have tended to focus on objects described as 'cherished' objects or objects that have a 'special' value (Chapman, 2006; Sherman & Newman, 1977-78; Wapner, Demick, & ReDondo, 1990). The sentimental view of objects places objects as important for providing comfort and familiarity rather than for their functionality in enabling people to carry out every day routine and rituals. By concentrating on the objects people with a dementia have, how they are used, and by whom, this explores whether people with a dementia have agency, autonomy and self-determination.

To my knowledge, this is the first study to explore who is involved in decision-making practices relating to the objects a person with a dementia takes into a care home, how objects are used and by whom. Whilst significant advances have been made in dementia care over the last two decades, practices remain focused on person-person relations and overlook the importance of object-person relations. It is important to explore the use of objects in dementia care as they may play a crucial role in further advancements in dementia care, particularly as object-person relations can help shape the human experience and support identity.

1.1   Introduction to the study

The central objective of this opening chapter is to orientate the reader to the structure and content of the thesis. It explains in broad terms why the exploration of the phenomenon of object-person relations is important to dementia care practice.

1.1.1   Orientation to the structure of the thesis

This thesis comprises of nine chapters in total. Chapter 1 outlines the focus of the study and states the research questions. Chapter 2 provides the main justification for the study by making clear the gaps in understanding regarding object-person relations for people with a dementia. Chapter 3 introduces and critically reviews the theoretical construct of social citizenship in dementia care. A key question raised in this discussion is whether a material lens is useful in the location of social citizenship. Chapter 4 presents an overview of the methodological design; the range of methods used to collect and analyse the data and consideration of the complexities of

the ethical aspects of this study. Chapter 5 provides further methodological and contextual information about the care homes and the people who took part in the study. This chapter is organised into two sections, the first section discusses how access was gained to the research sites. It sets out the aims of conducting a pilot study to trial the methodological design and presents the findings of the pilot study. The second section provides a comprehensive description of the main research site and the study participants who kindly took part in the study.

Chapters 6, 7 and 8 present the findings of the study. Each chapter sets out specific findings addressing the research questions. Chapter 6 reports the initial and ongoing decision-making practices relating to the objects a person has in a care home. Firstly, it focuses on who was involved at the initial stage of decision-making relating to the personal possessions a person took when moving into a care home. It focuses on who was involved in the organisation and transferral of personal possessions upon relocation. Secondly, it reports who was involved in ongoing decision-making relating to objects once a person resides in the care home. This includes both existing personal possessions and the purchase of new functional objects. The chapter concludes by examining how decision-making practices relating to personal possessions effect citizenship for people with a dementia living in a care home environment.

Chapter 7 presents the findings relating to the access to and use of functional objects. Firstly, it examines who has access to functional objects, how they are used, and by whom. Secondly, it explores the reasons for residents' access to, or the denial of, certain functional objects in everyday life. Finally, Chapter 7 explores whether a material lens can offer a way of locating the presence or absence of social citizenship in dementia care practice.

Chapter 8 introduces a conceptual framework: Material Citizenship Framework. This chapter explains how the findings presented in Chapters 6 and 7 contribute to this conceptual framework. I argue that a Material Citizenship Framework (MCF) provides three important elements in advancing dementia care practice; (1) a mechanism for locating citizenship in dementia care; (2) an educational tool for supporting a rights-based approach to care and; (3) a mechanism which highlights institutional policies and procedures that are designed to meet physical care needs rather than promote rights and citizenship.

Finally, Chapter 9 draws together the key findings from this study, discussing its contribution to knowledge and its relevance and usefulness to social science research and dementia care practice. The chapter concludes by setting out the implications for policy, practice and research.

1.2 Focus of the study

At the heart of this study was my interest in why people in care homes tend to be viewed as passive recipients of care rather than active citizens (Bartlett & O'Connor, 2010). At the time of developing the research question for this study, I was engaged in conversations with a woman whose mother had moved into a care home. Jane was struggling with the changes in their relationship since her mother had moved into a care home. Although Jane visited her mother frequently, she often felt worse for it. Her mother would tell her she did not want to live in the care home and wanted to return to her own home. Jane often left the care home with feelings of guilt, inadequacy and sadness. However, on one occasion Jane left the care home in good spirits. It had been brought to her attention that her mother liked it when she took a flask into the care home when she visited. I asked what it was about the flask her mother liked, but Jane did not know. I asked Jane whether she would consider buying her mother a flask to have in the care home. Jane replied, "What would be the point, she would forget to drink the tea, she has dementia". I suggested that it might be less about drinking the tea and more about the affordances the flask offered her mother. It might be that for a moment this functional object offered her mother choice, independence, dignity and control. The choice to have tea or not; the ability to act independently without the assistance of staff. The flask could help her mother regain some feelings of control. It could support her identity by enabling meaningful social engagement. The seemingly mundane object may provide her mother options not readily available to a person living in a care home.

My interpretation of the flask-resident-daughter relation may support Miller's (2008) assertion that "the closer our relationships are with objects the closer our relationships are with people." The flask could offer Jane's mother the ability to enact her identities as a mother and a host, something she did prior to moving into the care home.

Care home websites, brochures and service user information packs encourage new residents to bring in personal possessions from home. This is often to make the care home feel more homely. Whilst this appears common practice, there is a lack of understanding of how decisions are made about what objects are brought into care homes, and who is involved in making the decisions. There is also a lack of understanding in relation to whether residents have opportunities to interact with objects to complete everyday tasks. To understand object-person relations for a person living in a care home, the study intersects psychological understandings of object-person relations with sociological ideas of materiality in care homes. The *use* of objects is particularly important when considering object-person relations, as the interactions that take place between person and object can reflect and support the maintenance and cultivation of a person's identity (Belk, 1988;

Csikszentmihalyi & Rochberg-Halton, 1981; Miller, 2010; Rochberg-Halton, 1984; Rubenstein, 1987).

Historically, the meaning of objects for older people and people with a dementia has remained a passive practice. Researchers have tended to focus on objects described as 'cherished' or that have a 'special' value (Chapman, 2006; Sherman & Newman, 1978; Wapner, Demick, & ReDondo, 1990). However, there has been a recent increase in interest in materiality literature exploring the active nature of object-person relations in older age. The idea that the passive presence of an object is enough for a person relocating to a care home has been questioned (Lovatt, 2018). Lovatt (2018) argues the interactions between older people and their objects are important in creating feelings of being 'at home'. This may be because objects enable people to maintain routines, and in doing so provide continuity at a time of change. Buse and Twigg (2014) observed women with a dementia living in a care home taking action with their handbags. The women would 'rummage' in their handbags and rather than viewing this as a symptom of dementia, Buse and Twigg suggest it was an intentional action. The act of 'rummaging' enabled women to create boundaries of privacy in a public place such as a communal lounge in a care home. The handbag and the intentional act of rummaging can offer feelings of control. Similarly, Sabat (1992) discussed the action a man with a dementia took when leaving the day centre he attended. His wife had arrived to collect him and so he went to the closet to look for his coat. He opened the closet door and began looking through the coat pockets of the coats hanging in there. Staff initially viewed this an inappropriate behaviour and a symptom of his dementia, what the man was doing was looking for his keys. He could not remember the coat he had worn to the day centre that day but he knew his keys were in the coat pocket; if he found the keys he would find his coat (Sabat, 2001). The objects in both Sabats's (2001) and Buse & Twigg's (2014) studies provide a mechanism with which a person can take action. In doing so a person can use an object to initiate an action, execute a performance, control a situation and act with volition.

The importance of object-person relations in older age is not reliant on an object having a sentimental or special purpose. Objects that hold a functional value are important for carrying out actions which maintain a sense of self and purpose. Kroger and Adair (2008) conducted a study that involved 20 individuals living in one of two residential communities for older people. One of the female participants reported a dining table as an important object. The importance of the dining table was not merely for its conventional purpose of facilitating family meal times, but that it afforded her the opportunity to continue 'hosting'. She could enact her identity; it facilitated agency and provided continuity. Nord (2013) also found that 'mundane' objects were important to people relocating to assisted living accommodation as the objects enabled older people to

perform household chores, maintaining routines and rituals. This is something particularly important for older women (Hellström, Eriksson, & Sandberg, 2014). Relocating to a care home can result in significant life changes that can disrupt the routines and rituals of everyday life. The access to and use of functional objects may be useful in minimising these changes and maintaining continuity. In turn, this may minimise negative psychological affect of transitioning from domestic living to communal living. Access to objects that encourage routines and rituals once performed at home may make life easier in a new environment. The maintenance of routines and rituals, the preservation of sense of self, and feelings of purpose are perhaps even more important for a person who has a dementia, as the world may already seem like a strange and confusing place.

1.2.1   Timeliness of the study

This study is timely for two key reasons. In the first instance, My Home Life (myhomelife.org.uk) is an initiative for developing best practice in care homes. Whilst the initiative recognises that older people moving into care homes have very little input in decision-making (myhomelife.org.uk,), there is no mention of personal possessions or functional objects. There has also been a call for people with a dementia to have their social rights upheld (Cahill, 2018). The last few years has seen a growing momentum of people with a dementia campaigning for social change. Both Ireland and Scotland have dementia working groups led by people with a dementia, for people with a dementia. The groups both campaign to improve services and challenge the stigma surrounding a diagnosis of a dementia. Dr Helen Rochford-Brennan and Agnes Houston MBE, both women diagnosed with a dementia, hold seats on these respective groups and raise awareness at both national and international conferences. The working groups also lobby government and senior government officials on the needs of people with a dementia. The Alzheimer's Society UK have also recently turned their attention to a rights-based approach, presenting this as a new focus at the Alzheimer Europe conference 2018. The emergence of the dementia rights movement is a positive step to bringing about positive change. However, this alone is not enough. It is important to construct a practical application alongside a legal framework, ensuring that human rights are practiced and upheld in the activities carried out in everyday life.

In the second instance, care home care is in need of a social revolution (Theurer, Mortensen, Stone et al., 2015) which is particularly relevant as traditionally residents are viewed as passive recipients of care (Bartlett & O'Connor, 2010). This means care home provision is often based upon care being given *to* residents, and things done *for* residents. Whilst the physical safety of care home residents is of paramount importance, there is a lack of psychosocial care provision. A

tradition of 'light' activities and social events such as trips out on a mini bus, planned social gatherings and organised fun continue to be viewed as meaningful events. Whilst these activities provide enjoyment for some, depression and loneliness persist and the lack of resident input perpetuates the stereotypical view of those living in a care home (Theurer et al., 2015). Residents continue to report a lack of purpose and meaning in their lives, have limited opportunities and describe feeling frustrated by the paternalistic communication with members of staff (Theurer et al., 2015). Theurer et al (2015) argue for the revolutionisation of care home provision, swapping practices focusing on entertainment and distraction for practices with enhanced reciprocal relationships and social productivity.

1.2.2   Care homes, dementia and risk

The care of people with a dementia is of global concern (Alzheimer's Disease International, 2010; World Health Organisation and Alzheimer's Disease International, 2012). In the United Kingdom there are approximately 416,000 people living in care homes; of them, around 322,000 are estimated to have a dementia of some type (Alzheimer's Society, 2013). The term care home refers to residential long-term care settings providing communal living and personal and/or nursing care for older people and adults. Care homes can be divided into two types: residential homes that provide personal care only, and nursing homes that provide nursing care. Within both categories, homes can be registered as specialising in dementia care, often referred to as Elderly Mentally Infirm (EMI) in which a greater number of residents have moderate to severe dementia (Luff, Ferreira, & Meyer, 2011). For the purposes of this study, the term care home refers to residential care. The study examined the access to and *use* of functional objects to perform everyday tasks; therefore, I felt it reasonable to presume those in residential care would have higher levels of independence than those in nursing care.

It is important to be aware of the factors influencing care home practices. These may be factors such as; the circumstances by which a person relocates to the care home, a person's age, and a person's medical condition. As many people living in care homes have a dementia, this may be an influential factor in the way care is provided. As dementia progresses, people with the illness are increasingly disabled by the impairment but also by their environment. This can present itself through various observable symptoms. Evidence is steadily growing to show the physical design of internal and external spaces can compound symptoms of dementia through the disorientation that people feel, and the impact this has on psychological well-being (Blackman et al., 2003; Day, Carreon, & Stump, 2000; Topo, Kotilainen, & Eloniemi-Sulkava, 2012). The design of the building and the general perception of what a care home is and what a care home does will have an impact

on what happens within that environment. It may also impact on what objects are available to a person living there and how objects are imbued in everyday life.

People relocating to a care home may often find themselves having to adjust their day-to-day activities to fit the task-orientated routine of care home life (Luff, Ellmers, Eyers, Young, & Arber, 2011). The lack of personal possessions and access to functional objects can result in barriers for residents to reach their optimal performance (Van't Leven & Jonsson, 2002). This can result in people being at risk of reduced independence and a loss of autonomy. Decision-making often becomes a grey area for care home staff and relatives and conflicts can arise in the practice of maintaining autonomy whilst ensuring health and wellbeing is not compromised (Evans et al., 2018; Whitlatch & Menne, 2009). It is argued that there are few areas in health care practice that are more complex and contended than the management of risk in dementia care. Whilst some risks are obvious and tangible others are less obvious, and 'perceptions of what constitutes acceptable risk can often be problematic between managers, staff and family' (Clarke et al., 2009 pg.92). Health and social care tend to operate a 'safety first approach', according to Titterton (2005) this approach while aimed at achieving a safe physical environment can have the following consequences it:

- Ignores the other needs of vulnerable people;
- Denies them the right to choice and self-determination;
- Leads to a loss of a sense of self-esteem and respect;
- Can lead to a form of institutionalization with the loss of individuality, volition and an increase in dependence;
- At worst, can lead to the abuse of vulnerable people. (Titterton, 2005 pg.15)

Examining the opportunities people in care homes have to use objects may be useful in addressing some of the above points. Particularly as objects can enable a person to take action and can provide a sense of importance and meaning (Hellstrom, Eriksson & Sandberg, 2014).

Popham and Orrell (2012) examined the extent to which the care home environment met the requirements of people with a dementia. They found that when people with a dementia in care homes wanted to carry out domestic chores, staff tended to refer them to organised activities. This resulted in residents feeling frustrated at the lack of freedom afforded to them; however, staff and relatives believed people with a dementia should be kept safe. Whilst staff and managers recognised a lack of control and choice was a source of frequent conflict between people with a dementia and staff, their main focus was to ensure that people with a dementia did not take risks. There were clear differences in views between staff, relatives and people with a

dementia in terms of the importance of independence versus safety. To add to the complexity, professionals not only need to be mindful of these different views but also of the health and safety legislation (Clarke et al., 2009) by which they are regulated.

Physical safety is often explicit and easily understood, whereas psychological harm is often less immediately visible. For example, care home staff may view a resident making a hot drink as a risky proposition and therefore prevent them from doing so by removing their access to such objects. The psychological risk of preventing a person using functional objects to carry out the task may result in feelings such as a lack of control, loss of agency and a diminishing sense of self. However, physical harm such as being scolded by hot water is more tangible, explicit and immediate than the decline in self-esteem, self-worth and psychological wellbeing.

The management of care homes is filled with complexity. On one hand care homes are driven by regulatory concerns for the safety of residents, whilst on the other hand, there are demands from advocacy groups and policy makers not to lose sight of the person's agency and free will. A citizenship approach may go some way to balance these complexities as it puts the rights of the residents at the heart of care delivery. However, citizenship lacks a practical application, questions such as what does citizenship look like in care homes and how is it practiced have not been fully addressed. Furthermore, whilst there is growing literature on the subject of citizenship regarding people living with a dementia, it remains under-theorised and lacks a material lens (O'Connor & Nedlund, 2016; Österholm & Hydén, 2014). This study will critically examine how object-person relations maintain and reconstruct a person's identities, supporting agency through the subjective and material worlds in which we live and perform. Thus, an examination is highly relevant to people living with a dementia in care homes where institutional policies and procedures are designed to meet care needs and minimise risk, rather than promote rights and citizenship of those living there.

1.3   Developing the research question

Research questions do not happen spontaneously, they are influenced by literature, experience, and ideas we have about the world. Questions develop as researchers begin to think about what issues are important and how knowledge can be gained (Lune & Berg, 2017). The central objective of this study was to understand the concept of object-person relations in a care home setting for people with a dementia. A number of specific questions were developed to guide my understanding of these relations. This resulted in the following two assumptions:

1. The importance of objects could be examined by the decision-making practices relating to 'functional objects'.

2. The location of social citizenship could be examined by exploring how functional objects were imbued in everyday activities.

A number of specific questions were developed to guide my understanding of these relations. The research questions are set out in Box 1.

Box 1   **The Research Questions**

1. How do object-person relations manifest in care homes for people with a dementia?

    1a. Who is involved in decision-making relating to personal possessions?

    1b. How are functional objects used in a care home setting, and by whom?

And

2. Is social citizenship a useful lens to examine such relations and if so how?

    2a. How can the presence or absence of social citizenship be located through a material lens?

1.4   Summary

This chapter has provided the reader with an orientation of how the thesis is organised. It has also provided a personal example; Jane, her mother and the flask, to give some insight into how the idea for this project developed. The chapter concludes with the research questions which are explored and examined throughout this thesis. Chapter 2 will now present the main justification for the study.

Chapter 2: Object-person relations

2.1   Introduction

This chapter begins by giving a brief overview of the object-person literature. It draws upon the key concepts that have traditionally divided material and human worlds, which could explain why dementia care typically focuses on person-person relations. It discusses the concept of affordances of the environment; a theory that sets out to reduce the division of objects and people, which is then considered in relation to its applicability in a care home context. It highlights how the affordances of the design of an environment have been given much consideration and yet the use of objects within the environment are rarely directly mentioned. This chapter presents a review of object-person relations in later life, particularly in relation to relocating to a care home. Finally, this chapter draws on two key ethnographic studies that examined the importance of objects in care homes (Buse & Twigg, 2015a; Lovatt, 2018).

2.2   The importance of object-person relations

Object-person relations have been a source of interest for consumer research scholars for many years. The purpose was often to understand why people purchase certain objects, how objects are imbued in everyday life and how individuals assign personal meaning to them (Epp & Price, 2008; Miller, 2008; Price, Arnould, & Folkman Curasi, 2000). Psychological research has viewed objects along a similar vein but has focused less upon the consumer perspective and more on the management and maintenance of identity (Belk, 1988b; Mihalyi Csikszentmihalyi & Rochberg-Halton, 1981; Mccracken, 1987; Rochberg-Halton, 1984a; Rubenstein, 1987). Both approaches recognise that objects and people are relational and acknowledge the affordances of the material world in shaping the human experience.

Social psychologist Helga Dittmar argued that 'possessions can provide actual and perceived control and mastery, a source of comfort and emotional adjustment, a concrete record of our achievements, past experiences or future goals' (Dittmar, 1992 pg.95). All of these could be considered crucial for developing dementia care practices that support a person's identity. Dittmar (1992) suggested two perspectives of material possessions and identity as useful in exploring the importance of possessions. One is the 'actor' perspective, in which individuals are expressing themselves through their possessions; in other words, 'I am what I have'. The other is the 'observer' perspective. This is concerned with how others make inferences based upon the material possessions a person has. Both perspectives are important to this study. The actor

perspective places object-person relations as active rather than viewing objects as sentimental or decorational. The actor perspective allows an individual to use objects to demonstrate past, present and future identities. The observer perspective concentrates on the inferences of others whilst still maintaining an active role for object-person relations. The observer perspective facilitates the management of identity, enabling an individual to manage how others perceive them. A potential problem with the actor and observer perspective in relation to dementia care is that it assumes a person has control over their possessions. When a person relocates to a care home, it is often the relatives who are left in control of a person's possessions (Innes, Kelly, & Dincarslan, 2011; Lindley & Wallace, 2015).

Disciplines such as occupational therapy have long viewed objects as useful in health care practices (Cipriani et al., 2009; Hocking, 1997). Hocking (1997) suggested the presence of objects can help support self-image and assist occupational therapists in understanding the person as an occupational being. Dementia research has largely focused on objects as tools for intervention development such as reminiscence groups in which memories are elicited by objects such as photographs and memory books (Woods, Spencer, Jones, Orrell, & Davies, 2009). Ageing studies have focused on the impact of possessions for older people living in their own homes or relocating to smaller assisted living environments. They have explored the retention of objects, object disbandment and the desire to acquire new objects (Ekerdt, Sergeant, Dingel, & Bowen, 2004; Kroger & Adair, 2008; Larsson Ranada & Hagberg, 2014; Nord, 2013). A common reason for the loss of personal possessions in later life was the act of downsizing. A relocation from a multiple room domestic residence to a care home or long-term care facility resulted in a required reduction of belongings (Kroger & Adair, 2008; Nord, 2013). However, this may not be the only reason; another reason might be the lack of understanding in dementia care of the importance of object-person relations when making a significant and often life changing transition.

Anthropologists have pointed out that objects are full of culturally laden meaning and value (Miller, 2008). A few psychologists have emphasised the ecological features and the dynamic role of objects, but most social psychologists devote their attention to the individual within the interaction (Kay, Wheeler, Bargh, & Ross, 2004). This tends to dismiss the functionality of the object and what the use of the objects achieves, placing it at best in a secondary position. Therefore, it is important to understand why there exists a material world and human divide, and why the material world appears to hold a lesser value in the exploration of shaping the human experience.

2.3   An overview of the material and human divide

For centuries, a divide has existed separating the human and material worlds. A divide underpinned by the French philosopher Rene Decartes (Mehta, 2011). Cartesian dualism created a division that conceptually kept body and mind distinct. A view inherited by modern social science disciplines who have applied this dualism to people and objects. This is evidenced in the way the natural sciences deal with the material world whilst social scientists deal with agents. A premise that serves to continue the divide between people and material things (Alan Costall, 1995).

American psychologist James Gibson's (1986) concept of affordances was an attempt to undermine the traditional dualism of the objective and subjective. Whilst this was not entirely achieved, it did encourage a different way of thinking, and an introduction to the idea that environmental affordances were relational (Gibson, 1986). This meant that the suitability of the environment would depend on the intentions and capabilities of those in it. Intentions are key to understanding affordances as they explain how the same environment can provide different affordances for different people. A good example of this is the care home. A care home environment serves to provide two different affordances; for care home staff it is a place of work, for residents it is their long-term residence or home. The dual representation of the care home environment offers different action possibilities, which can differ between care home staff and residents. For example, care home staff may be able to access all areas of the care home and yet a locked door may prevent residents accessing different parts of the building. Care home staff may have the ability to access functional objects to perform household chores, and yet residents may not have such opportunities to do so.

It is here that affordances of an environment and importantly the objects in the environment are key to object-person relations, particularly in dementia care where people are at risk of marginalisation. Gibson (1986) argued that individuals are 'active agents', that a person can take action, and that these actions are largely based upon capabilities. Objects are engaged with on a daily basis often with minimum effort in a space in which a person has made home often for many years. The home environment affords a repetitious use of that space, allowing the formation of personal rituals and routines to be carried out. These rituals can provide individuals with meaning in terms of 'who they are, where they are, what they do and why they do it' (Pastalan & Barnes, 1999 pg.83). Moving into a care home often disrupts these routines as the 'new home' sometimes hinders this (Cooney, 2012).

When considering the care home environment, it is important to understand that the societal structure of a care home represents a place in which care is provided. It positions those living in

the care home as people *requiring care* and those employed by the care home as people *providing care*. This can result in those who live in the care home positioned as being less capable, whilst those who work in the care home are positioned as more capable. This psychological positioning can produce inequalities to different groups occupying the same space (see Sabat, 1992).

2.3.1   Environmental affordances

Environmental affordances are the affordance an environment offers an individual, in other words, the way in which a person can act within a certain context (Jones, 2003). For example, a care home can afford or restrict affordances dependent upon the access people have to the physical space and the access they have to the objects within that space. Environmental affordances are highly relevant to dementia care. This is due to the potential problems an unsuitable environment may cause and the benefits a suitable environment may bring (Chaudhury & Cooke, 2014). Despite evidence that environments can promote independence, engagement, increased levels of functioning and reduce agitation, aggression and restlessness (Day et al., 2000), care home environments often have features that do not enhance the wellbeing of people with a dementia. Many care homes are not purpose built but buildings adapted from houses.

Topo, Kotilainen and Eloniemi-Sulkava (2012) carried out a study that explored the affordances of the care environment. The purpose of the study was to gather information to understand what positive features already existed and what could be improved. Although they considered the actual performance of a person with a dementia within a residential care home environment, there was a lack of focus on object-person relations. The is an important point as it shows the tendency for studies that explore environmental affordances to overlook object-person relations. The study was the assessment part of a randomised controlled intervention using non-pharmaceutical methods to reduce behavioural and psychological symptoms of people with a dementia. Qualitative methods were used, which included fieldnotes and photographs taken at half-day visits to the care homes. The study involved the use of the Residential Care Environment Assessment tool (RCEA) which included objects in two of the six areas being assessed. The first area including objects was titled 'attached objects'. These were items such as handrails and supports, laundry with easy to use and safe machinery possibilities, kitchen with safe equipment, surveillance, lighting, curtains and open/locked cupboards. These were linked with affordances such as 'balance, feeling of a "full life"', 'participation in domestic activities and daily chores', 'freedom of moving around and fussing if desired', 'visible despite strong sunlight, support of vision' and 'a safe living environment'. The second area, which included objects, was titled

'moveable objects'. These were items such as furniture, familiar crockery and cutlery, bedclothes, curtains, carpets, rugs, pictures, paintings, photographs, clocks, TV and indoors plants. These were linked with affordances such as 'comfortable seating', 'participation in daily chores', 'independent eating', 'warmth comfort', 'stimulation of memories', 'safety', 'entertainment' and 'support of identity'.

Although many items were included in the tool under the titles 'attached objects' and 'movable objects', the way in which they were used to participate in everyday activities or how they were used to support identity was not discussed. Instead, the objects were discussed in relation to the firmness of the chairs and that they had detachable washable cushions. The chairs were also discussed in relation to where they were positioned in the care home, whether this was by a window and if it was facing the window or restricting access to the window. Televisions and CD players were mentioned, and although it was noted that this object might be important for connecting a person to a previous life, they were only discussed in relation to their positioning within the room rather than how they were used and by whom.

Topo et al (2012) reported that whilst some kitchens were designed for residents to use, the kitchen drawers and cupboards were locked, this would suggest that residents did not have access to use the items in the drawers and cupboards. In two of the units, large metal rollers were pulled down when staff were not using the kitchen and in another two units residents were not allowed in the kitchen. This shows that although areas may be designed for residents to use, if a resident has restricted access to the area, or the items that would typically be used in that area, the area cannot be used for its intended design. The explicit territories demonstrated by the locked drawers and cupboards, the metal shutters showing a closed kitchen and the denial of access to kitchen areas provides insight into a care culture which can potentially marginalise certain groups. Spatial marginalisation has been explored in relation to people with a disability and was found to keep disabled people 'in their place' (Kitchin, 1998). Denying people access to use functional objects can prevent them from opportunities to demonstrate their capabilities. In turn, this denies a person the right to be what Gibson (1986) termed an 'active agent'. It is therefore argued that whilst it is important to design care homes that are user friendly, the design alone is not enough to actualize agency or self-determination.

Innes, Kelly, and Discarlan (2011) conducted a study exploring the design of care homes for people with a dementia. Their study carried out an enquiry reporting on the views of people with a dementia who lived in care homes in Northern Ireland and Scotland. The study sought to understand the aspects of care home design that were important to people with a dementia and their family carers by carrying out six focus groups. Forty people participated in the focus groups.

Twenty-nine people had a dementia, and eleven were family carers. The results of the study suggested that the actual design of the care home was of lesser importance than the people who provided the care. People with a dementia who lived in the care home were more concerned about how they would be supported to live the life they wanted to lead. Relatives would remark that staff were of primary concern rather than the design of the building.

People with a dementia and their family carers spoke of having a choice of places to go within the care home and the importance of their own possessions. Making the new space homely tended to be achieved by having familiar and treasured objects and they were believed to create a sense of security and association with the new space. Personal possessions also helped residents to create a space that was individualised and often loosely referred to as homely. People with a dementia spoke of their photographs and 'knick knacks' and how they enjoyed having these objects but not all residents had access to their possessions; one resident reported only having her clothes.

Whilst relatives saw the importance of making the environment homely, some were reluctant to bring in items of furniture or certain valuable possessions. It was believed that personal possessions would go missing or be claimed by other residents. Powers (2003) reported that objects are likely to go missing in care homes as people with a dementia lose things, put objects away and cannot remember where they have placed them, or take things that do not belong to them. Innes, Kelly and Discarslan (2011) reported that families controlled the objects a person with a dementia was able to have access to. There were the odd exceptions whereby some relatives wanted to bring in a person's possessions. This again suggests that the design of the building is just one of the factors of a care home becoming home. Objects within the care home were also identified as an important factor for a sense of familiarisation and homeliness. It was unclear from this study which objects were welcome in the care home, however it was reported that families controlled the objects the person living in the care home were able to have with them.

Chaudury, Cooke, Cowie, and Razaghi (2018) recently conducted a literature review examining the influence of the physical environment on residents with a dementia. The review included 103 articles, 94 were empirical studies and nine were reviews (six systematic and three narrative). The primary aim was to conduct a comprehensive review of empirical work that had been published since 2000. A secondary aim was to present a preliminary discussion which linked 'empirical findings and conceptually-orientated therapeutic goals associated with dementia care design' (Chaudhury, Cooke, Cowie, & Razaghi, 2018). The areas identified as major issues, findings and recommendations of the physical environment were: Unit size; Spatial layout and orientation

cues; homelike/institutional character, sensory stimulation, dining area, bathing area and outdoor area. The intention of the review was to examine the literature concentrating on the physical environment however; objects within the environment were also mentioned. Within the area 'homelike/institutional character', objects were considered important for decorational or furnishing purposes and attempts to make the space appear homelike similar to the finding of Innes et al (2011). Dutch facilities that took a group living approach to care tended to have greater participation in task-related activities. Although functional objects may be required to carry out task-related activities, object-person relations are rarely the central topic of studies exploring the physical environment, and yet they are clearly important.

2.4   The affordances of objects in care homes

The performance affordances of objects to enable individuals to carry out routines and rituals that have been developed over a lifetime have been overlooked. The affordances of objects in gerontological and dementia care, tends to place objects as comforters, biographical history markers and tools for instigating conversation. Whilst evidence suggests that objects can support the maintenance, cultivation and demonstration of identity (Belk, 1988; Mihalyi Csikszentmihalyi & Rochberg-Halton, 1981; Dittmar, 1992; Rubenstein, 1987), object-person research relating to older age and life in care homes have tended to focus on cherished possessions and possessions that hold a 'special' meaning. Functional objects such as a hairdryer, beard trimmer and a flask have received little attention. Functional objects are objects with which a person can take action, whatever that action may be, and can hold multiple meanings. For instance, a hairdryer has a functional value but may also hold sentimental value. Functional objects can be used in both conventional and unconventional ways, for example, a woman contacting her neighbours by knocking on the ceiling with her walking stick (Forchammer, 2006). The woman was using her walking stick as a telephone to call her neighbours. The way in which the woman used her walking stick at that moment may not have been the intended design of the stick; however, it enabled her to take the action she needed. Chapman (2006) explored objects and ageing well through a 'new materialist' lens. Her view was different from much of the person-object research in that it directs researchers to look more closely at the physical dimensions of objects. To see the object as equal to the person enables a micro-level enquiry by looking at the affordances objects can bring to a person's interpersonal environment.

2.4.1   Objects and identity when relocating to assisted living or care home environments

Kroger and Adair (2008) explored the symbolic meaning of objects. They conducted interviews with 20 individuals aged between 65 and 89 years within an 18-month period of moving to a

supervised care facility. The focus of the interviews was to understand the participants' life history and cherished possessions. The study reported that the most common symbolic link was the association between cherished possessions and cherished relationships with others. The objects most frequently identified were either framed photographs or pictures. The framed photographs seemed to provide a link to the family unit and were reported as enablers in keeping memories alive, symbolising relational links and provided a level of comfort for the individual.

Kroger and Adair (2008) reported that objects could help preserve relationship ties over generations. Similar to other studies, they reported objects as important in the continuation of identity, despite the changes institutional relocation inevitably brings. The study reiterated the ability of objects to link the individual with past events, the self in different phases of life, and as an archive of memories. Whilst this study largely concerned itself with the way in which objects provided a link to significant relationships, it also highlighted how objects can often have more than one value. The study reported how an object such as a dining room table held both a sentimental value and a functional value. They reported how a woman had to give up her beloved large dining room table when she moved into a residential facility. The table held significance for the maintenance of her identity. She had presided at many gatherings with the table throughout her adult life but now resided in a single room and was dependent on communal meals. Sitting at a table had shifted her role and her social status. She described her experience now as being a guest at a table while another served the meal (Kroger & Adair, 2008 p.19). Removing the dining room table resulted in the removal of her role as the provider of meals, her social status as host at meal times and a loss of agency.

Objects such as photographs, a tray, a clock, and a television were not considered sentimental and did not hold a special meaning but were still considered valued objects to the participants (Cooney, 2012; Kroger & Adair, 2008; van Hoof et al., 2016). These objects did not hold a rational explanation as to why they were valued, but they did provide owners with a sense of pleasure, attachment and comfort. This highlights the importance of exploring *all* objects as significant for understanding object-person relations.

2.4.2   Functional objects

The tendency to focus on cherished and special objects in later life results in a narrowing view of the importance of objects, thus overlooking objects which do not fall into these categories. Much of life contains mundane tasks, the things people do each day that are not necessarily discussed but are integral to psychological well-being. Tasks are often performed with taken for granted functional objects. The most ordinary objects have been reported as being the most significant

for everyday life and a providing a sense of independence (Cram & Paton, 1993; Nord, 2013). A sewing machine, although no longer used, reminded a person of a past hobby (Van Hoof et al., 2015). A television in a person's own room reduced boredom, gave feelings of connectedness to the outside world by keeping up to date with developments in the world, and was one of the few activities a person could carry out independently (Cooney, 2012).

The performance of tasks, such as cooking and eating around a table, as mentioned in Kroger and Adair's (2008) study, hold a huge significance in continuity of identity and agency. The performance of these tasks are influential in providing a person with a sense of purpose and meaning, but also the ability to demonstrate to others what a person *can* do.

Nord (2013) conducted a study involving older people residing in assisted living accommodation. The participants had a range of medical conditions and disabilities, but all were in good cognitive health. The intention was to understand the importance of *all* possessions rather than narrowing the exploration to a certain type of object. Whilst recognising the significance of objects as anchors to the past, she was interested in how people were active with their objects in the present and how older people arranged their objects in the new environment. Nord (2013) reported that older people were active with objects; they expressed satisfaction with how they had decorated their new living space and how they had organised their furniture. Items such as bookcases, armchairs, sofas, tables, chests of drawers, pictures for the walls and glass cabinets were transferred from their previous homes to the new living accommodation. Nord (2013) reported that the objects maintained connections to the past but were also important in their present everyday lives. The objects were placed into three categories types: memorabilia (some of which were cherished objects), representations (objects signifying the older person's role and status) and mundane things (important to everyday living). Nord (2013) was interested in how objects were *used* and found mundane objects such as a telephone enabled residents to stay connected to social networks. She concentrated on the interactions between people and their objects, recognising object-person relations as important for everyday functioning.

Nord (2013) concluded that objects revealed that although life was often circumscribed for a person with a disability living in assisted living accommodation, it was also dignified. Whilst people often lived in solitude, they were able to pursue various interests and complete small-scale activities. They had objects with which to perform tasks and their lives were organised by themselves showing self-determination and agency. This is something that may not be available for a person with a cognitive impairment living in a care home.

2.4.3   Object-person relations and dementia care

The literature relating to object-person relations in care homes for people with a dementia is sparse. Although a plethora of dementia research has examined the usefulness of organised activities for people with a dementia, many of which include objects, this has been from the perspective of activities delivered *to* people, rather than the objects that are used in the activities. It has also tended to take a more therapeutic stance (Loboprabhu, Molinari, & Lomax, 2007) continuing to pathologise people with a dementia. This can often result in interventions using objects that are created *for* people and activities delivered *to* people. Whilst activities such as music, art and reminiscence groups are valuable (Brooker & Duce, 2000; Vink, Bruinsma, & Scholten, 2003; Woods et al., 2009; Zeilig, Killick, & Fox, 2014), they tend to take the shape of organised fun or are led by caring attempts to engage with a person with a dementia. The importance of using objects, in everyday activities, to support agency and self-determination are overlooked.

2.5   Ethnographies in residential and nursing homes

There has recently been a change in direction emerging from fields such as sociology and social policy, and human ecology. Studies applying a material lens, placing people and their objects as active are surfacing in ageing and dementia research (Buse & Twigg, 2014, 2015a; Lovatt, 2018; Nettleton, Buse, & Martin, 2018). The emerging object-person literature relating to objects in care homes and dementia care has shifted from a widely used qualitative interview method, to an ethnographic methodological design. The shift is an important one as it includes a variety of methods. Ethnography enables the observation of people interacting with their material world. It can elucidate inconsistencies between what is spoken and what is practiced. Finally, but crucially, the methods can provide scope for more inclusive practices of participant recruitment. This means people with a dementia, throughout the dementia trajectory, can be included in research. Two recent ethnographic studies will now be examined. The first ethnographic study employed clothing as a tool for exploring the life stories of people with a dementia. The second examined the idea of becoming *at home* from a material culture perspective for older people living in a residential care home.

2.5.1.1   Clothing as a topic of enquiry and a method with which to enquire

Buse and Twigg's (2015) study 'Dementia and Dress' explored the significance of clothing and dress in the everyday lives of people with a dementia, their informal carers, and formal care workers. The ethnographic study included 17 people who lived in one of the three care homes in

Kent (England) recruited to the study, and 15 people who lived in their own homes with family carers. This study is of particular interest as it included people with a dementia assessed as lacking mental capacity and viewed clothing as a performative object. The items of clothing enabled a person to take action, demonstrate their identity, and positioned people with a dementia as active in their own lives. According to Buse and Twigg (2015), clothing tells stories of personal histories and identities. Material objects such as clothing and handbags can act as tools for structuring and encouraging narratives, and clothing can act as a link to a particular time and draw on particular events in a person's life. As a result, clothing has the ability to support a person with a dementia to share their narratives both verbally and non-verbally. A person may share their experiences through their clothing but also demonstrate their identity by wearing certain types of clothing. Clothing can evoke memories of where items of clothing were purchased, at a time in life or for particular events, all of which support a sense of self. Buse and Twigg (2015) argue that clothing is not only a topic of enquiry, but also a method with which to enquire. This is particularly relevant to this thesis as it explores the lives of those living, visiting and working in care homes through the objects they talked about and the objects that were present.

Buse and Twigg (2015) presented the story of a husband and wife, who together, provided an insight into the importance of objects and identity. Tom, a self-employed builder who was forced to give up work due to his dementia, lived at home with his wife Jane. Tom kept a row of work clothes covered in holes and plaster hanging in his wardrobe. He struggled to articulate why he kept these clothes, but Jane explained that he loved to get his work clothes on. He would wear them whilst pottering around the house carrying out tasks that were meaningful to him, feeling like he was at work. The clothing enabled him to stay connected and demonstrate his identity. The clothing acted as tool for Tom to explicitly show his readiness to take action. Tom could demonstrate Dittmar's (1992) 'actor' perspective by wearing the clothes and enacting his identity. Tom could also take the 'observer' perspective of managing his identity with others viewing him as Tom the builder.

The difference between remaining in a domestic sphere compared to a care home context is the freedom of retaining objects, such as Tom's work clothes, and the accessibility he had to use them. It is likely that his work clothes would be considered surplus to requirements in a care home setting. It is also likely that clothing with holes in may be frowned upon in a care home environment as this could give rise to concerns relating to poor care. The plaster attached to his clothing would not suit care home life. It is possible that the industrial washing machines found in care homes, operating at high temperatures to ensure infection control regulations are followed, might remove the plaster attached to the work clothes. This would change the symbolic nature of

the clothing. Many objects are viewed as unnecessary and are lost when relocating to a care context in later life.

Buse and Twigg (2015) found the loss of possessions was not simply about space, but items perceived by others as having no practical value. This idea relates to Gibson's discussion at the beginning of this chapter in which the requirement of objects are based upon perceived capabilities. Work clothes would not be required for a resident in a care home. People with a dementia are viewed as passive recipients of care (Bartlett & O'Connor, 2007) and are not expected to *do* things within a care home context.

Another insightful finding of the 'Dementia and Dress' study was the importance of handbags for women. Whilst handbags held similar affordances to previous object-person relations literature in their embeddedness with memories, histories and identities (Belk, 1988; Kroger & Adair, 2008; Nedlund & Nordh, 2015; Phenice, 2013; Rochberg-Halton, 1984), they were also useful in enabling a person to take action. According to Buse and Twigg (2014) handbags are significant objects for identity in terms of the image they convey, their appearance, their embodied relationship and the items that are stored inside. The items inside a handbag can serve as aspects of a person's identity in that moment but also as an historical of biography. Buse and Twigg (2014) highlighted the importance of handbags for women by the narratives told by the participants in their study.

Alice lived at home with her husband and had a large assortment of handbags that she had collected over the years. Many of the handbags had been acquired as a result of special occasions, such as weddings and family happenings. Although Alice no longer attended events that required the need to take glamourous evening bags, she was adamant that she could not throw the bags away. The significance of throwing away a handbag was to Alice like throwing away a part of herself (Buse & Twigg, 2014, p.7). Her husband felt that the functionality of the handbag had now gone therefore a large number of handbags were no longer needed. The functional use of objects appears to override the psychological need for maintaining one's identity. This is where significant objects are at risk of being lost. Objects that are viewed as no longer useful for their intended functional value may be disposed of without fully understanding the object-person relation. This point is particularly important for a person with a dementia relocating to a care home where opportunities to retain objects are restricted, relatives often decide which personal belongings are transferred (Lindley & Wallace, 2015; Innes, Kelly & Dincarslan, 2011), and the perception of what is needed is based upon capabilities, space and monetary value. There may be many other functional objects that are important to men and women with a dementia that we know very little about.

Buse and Twigg (2015) reported the ways in which women living in a care home used their handbags. They observed women constantly carrying their handbags around with them. This is not something people would generally do in their own domestic sphere. The granddaughter of a woman living in one of the care homes remarked that since moving into the care home, her nan carried her bag for security. She no longer left the bag by the side of the sofa but carried it around with her like glue. This may be a stark demonstration of the anxiety of living in a care home environment in which residents lack control and security over their possessions. The granddaughter also mentioned that her nan would not cope if she did not have her bag. This shows the manifestation of objects in coping strategies when faced with substantial lifestyle changes. Buse and Twigg suggested the embodied habitual practice of carrying handbags was something ingrained in many women. They also suggested that the handbag afforded the sense of continuity, something important to care home transitions (Dankl, 2012).

The ethnographic design of the 'Dementia and Dress' study allowed the authors to observe interactions between women and their handbags. This provided insight into how women with dementia experienced the care home environment. Women carried their handbags everywhere often asking when they were going home. The handbag was a prop. It showed that the women did not consider the care home to be their home and were waiting to return to their own home. Handbags were also used as territory markers, the intentional act of placing a handbag on a chair gave a clear indication to others that the chair was taken. They observed women 'rummaging' through their handbags in communal lounges. Whilst many might view this act as a symptom of dementia, the researchers viewed this as an intentional act. The act of rummaging set out personal boundaries and provided a sense of self-determination. It was a way of avoiding unwanted attention. If a person looked busy, they were less likely to be bothered by others, thus providing an area of privacy in what is a public place. To rummage in a handbag could provide women with a distraction; the act of being busy and purposeful when sitting alone in a public space could put them at ease. The handbag could provide a way of managing one's identity and a sense of control when in a position where levels of agency, control and autonomy are at risk.

The point here is that objects can be used for their intended design but can also be used in a variety of ways for various reasons. For example, a pen can be used to write, it can also be used to stir a cup of coffee in the absence of a spoon. Whilst this may seem a reasonable, rational and logical action in the hands of a cognitively fit person, in the area of dementia, the unconventional use of the object may be misconstrued as a symptom of dementia. This loses sight of what a person is doing with that object and what the action means. The actions discussed by Buse and Twigg (2015) are intentional and indicative of what is happening for that person at that time. The ability to have access to and use objects could be considered imperative for improved

psychological well-being. For the purposes of object-person relations in care homes, simply having objects to make a space homely is not enough.

2.5.1.2 Material Culture

The term material culture refers to the material objects found in a care home environment. The objects that belong to residents, care home staff and the organisation; objects that are used by residents, care home staff and relatives. The use of objects is further considered by reviewing Lovatt's (2018) study exploring material culture. This study focused on the interactions that took place between people and objects in everyday social practices. Lovatt's (2018) doctoral study explored how older people living in residential care homes experience feelings of home and their everyday interactions with material culture. The study was ethnographic in its design and recruited care home residents who did not have a dementia. The study sought to understand how personal possessions from former homes become 'at home' in a care home setting. It also included objects acquired once a person moved into the home. Although this study excluded people with a dementia, it explored material culture in a care home from an active perspective. That is, it placed objects and residents as relational, concentrating on the interactions between the human and material worlds.

Lovatt (2018) presented two key themes that suggest 'becoming at home' as an ongoing process that can be observed through social and material interactions. The first key finding was the theme 'material temporalities of home' (p.370). Lovatt (2018) discussed how the objects taken into the care home were chosen either directly by residents or more often by relatives. This is concurrent with the assertions made by Lindley and Wallace (2015) that relatives often deal with a loved one's personal possessions when relocating to a care home. However, Lovatt (2018) discussed how a participant called Annie clearly identified how she chose the objects present in her room. Annie emphasised the reasons for bringing in certain objects. The practical and necessary items such as her drawers and a television, but also the items she needed such as her collection of crystals. Annie was clearly involved in deciding which objects were moved from her home into the care home. This however, is not always the case, particularly for people with a dementia who often move directly from a hospital admission to a care home, never returning home.

Lovatt (2018) also discussed a woman named Dorothy who had taken her deceased husband's pipe stand and pipes into the care home. Unlike Annie's description, the pipes and a pipe stand had no practical need for her but had once served a practical purpose for her husband. Their functionality now was something by which to remember him by. This suggested the meaning or purpose of an object could change over time, as can the object-person relation. Lovatt (2018) argued that it is of little use to categorise a person's possessions as 'cherished', 'sentimental' or

'mundane' as done by previous studies (Cram & Paton, 1993; Csikszentmihalyi & Rochburg-Halton, 1981; Kroger & Adair, 2008; Nord, 2013) as the meaning of objects can changing over time. Furthermore, objects can have multiple meanings and be used for many purposes. Objects do not always neatly fit into a set category, they often overlap but the historical categorisation of objects has been influential in current care home practices. Thus, there is a fundamental requirement to deal with the problem of existing categories by balancing this with an active category. It is on this basis that I suggest the category of 'functional objects' is useful.

The second key finding was the theme 'practising being at home' this suggests it is the interactive nature of object-person relations that facilitate feelings of home, their mere presence is not enough. Lovatt (2018) reported that people found the initial weeks and months difficult and that it took time for people to settle in to the new environment. To help manage this change some residents employed coping strategies such as establishing regular routines and rituals practiced by using objects. Many residents chose to spend time in their own rooms and demonstrated control and responsibility over their space by tidying and cleaning their room. This type of activity is similar to that found by Nord's (2013) study whereby older people who had moved into assisted living accommodation reported 'mundane' objects as important for facilitating routines and organising the new space. Hellstrom, Erikson and Sandberg (2014) argue that activities such as household chores were important to women in maintaining identity in later life.

Lovatt reported two residents had appliances to ensure they could keep their rooms clean. Susan had a Carpetmate cleaner which she used to clean her carpet each day and Polly specifically asked her daughter to get her a Dust Buster. Both objects were functional objects which afforded the opportunity for the women to maintain a sense of self and agency. Having access to the carpet cleaner demonstrates freedom from discrimination and opportunities to participate in life (Bartlett & O'Connor, 2010) something not readily available to all in a care home context. Lovatt's (2018) study suggests that the requests of the women for carpet cleaners were taken seriously, as both women had access to the objects they requested, and both used the objects to carry out household chores.

In addition to household chores some residents in Lovatt's study demonstrated their 'home-ness' through hosting visitors in their rooms. This was a relational practice accomplished through interactions with objects. Some residents had a fridge or a kettle and were able to offer their visitors a drink. These often taken-for granted objects enable the facilitation of social interaction and meaningful engagement. They also support the management of identity within relationships. This was highlighted in section 1.2 when talking of Jane who visited her mother in the care home and how her mother enjoyed it when she took in a flask. The seemingly unspectacular object

brought enjoyment at a time when both women were struggling with the changes care home life had brought to their relationship. The flask had enhanced feelings of well-being for both mother and daughter. Jane's mother enjoyed it when she brought in the flask, and Jane took pleasure in knowing her mother enjoyed it. The object had brought closeness in their relationship with each other (Miller, 2010).

Lovatt's (2018) study showed that people in the care home were supported to complete everyday tasks with functional objects. It is important to note that the participants in this study did not have a cognitive impairment, therefore are more likely to be in involved in everyday activities as they are less likely to be malignantly positioned (Sabat, 1992). Although the participants in her study were involved in decision-making relating to what they wanted to take into the care home, we still know very little about how these decisions were made and whether certain objects were not permitted.

2.6   Summary

From the literature reviewed, much of the research has focused on objects that are considered 'cherished' or 'special'. The importance of object-person relations in maintaining identity and functionality of objects have been overlooked. The literature dating back to the 1980s and 1990s speaks of older people and people with a dementia as passive. Nursing and health literature still have a tendency to view people with a dementia as receivers of care rather than active in their own care. Research in the late 2000s has started to look at how older people are active with their material world and how they experience this (Kroger & Adair, 2008; Dankl, 2012; Nord, 2013; Buse & Twigg, 2014, 2015; Lovatt, 2018). Sociological and ageing literature is beginning to present a different, more active view. The affordances of a dining table to maintain a sense of dignity, control and agency; clothing as a tool to maintain a sense of self; handbags used to create boundaries of privacy; carpet cleaners to maintain routines and rituals in maintaining a sense of self, all demonstrate that objects help shape the human experience. It also shows that these taken for granted objects are less than ordinary. The use of objects can support agency by enabling people to act independently, make their own choices, and carry out routine tasks. Functional objects enable the enactment of identity, maintain a sense of self, influence how other people view them and support people to take part in their own lives.

Buse and Twigg (2015) took a more innovative approach; they were interested in objects as a topic of enquiry but also used objects as a method of enquiry. They utilised the clothing of participants to gain a deeper understanding of a person's historical biography and present identities; they also included people who were assessed as lacking capacity, a group often

overlooked. This demonstrates how the exploration of object-person relations can contribute to dementia research throughout the entire dementia trajectory. By exploring how people use objects, we can gain a better understanding of how to support others in accordance with Miller's (2008) assertion that 'the closer our relationships are with objects, the closer our relationship are with people' (p. 1). Therefore, understanding object-person relations is crucial in the advancement of dementia care for people relocating to a care home.

Following the review of relevant literature, four areas have been identified as important for further exploration for a person with a dementia relocating to a care home. The first is object-person relations; although care home websites, brochures and information packs encourage personal possessions into the home, little is known about what objects enter the home, how these decisions are made, and who is responsible for a person's possessions once a person is living in the care home. The second is the use of objects in care homes; whilst the importance of care home design has received much attention, the way in which objects are used within purpose built or redesigned spaces are overlooked. The third is the functionality of objects; the tendency for scholars to focus on objects viewed as cherished or special, overlooking the dynamic relationship between human and material worlds. The fourth and final area for exploration is the inclusion of people with a dementia in research; although dementia studies have increased in the past decade, the inclusion of people with a dementia in research relating to object-person relations is sparse.

Chapter 3:   Citizenship and Dementia

3.1   Introduction

The way in which functional objects are imbued in everyday life can provide insight into whether people with a dementia have the same opportunities as anyone else (Bartlett & O'Conner, 2010). A social citizenship lens was considered useful in exploring object-person relations as both concepts seek to include people in decision-making and support the actualisation of agency by positioning people as active citizens rather than passive recipients of care.

Although there has been increasing interest in the concept of citizenship as a lens to understand dementia practice it is under theorised and currently lacks a material lens (Baldwin, 2008; Bartlett & O'Connor, 2010; Bartlett, 2014; Bartlett & O'Connor, 2007; Brannelly, 2011; Österholm & Hydén, 2016). The citizenship debate seeks to reconfigure power relations to ensure that people who have a dementia are not discriminated against (Bartlett & O'Connor, 2010). Much of the citizenship debate has understandably focused on larger issues such as rights and responsibilities, social inclusion and a citizen's relationship to the state or society within which they live. More recently, the boundaries of citizenship have changed the conceptual focus from civic responsibilities and legal rights to the social practice of citizenship (Barnes, Auburn, & Lea, 2004). This positions citizenship as a social practice, rather than a status which is bestowed from above, something which can be achieved within a social context through the power dynamics of everyday talk and by taking action (Barnes et al., 2004). A problem with this conceptualisation of citizenship is it has not been fully conceptualised or adequately explained.

Questions such as what does citizenship look like in care homes and how is it practiced have not been fully addressed.   This thesis examines whether citizenship can be located in the context of a care home by exploring how objects are imbued in everyday activities.

3.2   The conceptualisation of citizenship for people with a dementia

There has been an increased interest in the concept of citizenship across political and academic arenas in the past decade. One reason for this is that as a concept, citizenship provides a tool for marginalised groups struggling for social justice (Lister, 2007). Calls for the social inclusion of people with a dementia have been an important theme in citizenship studies (see Baldwin, 2008; Baldwin & Greason, 2016; R. Bartlett & O'Connor, 2010; Bartlett & O'Connor, 2007; Birt, Poland, Csipke, & Charlesworth, 2017; Boyle, 2008; Brannelly, 2016; Nedlund & Taghizadeh Larsson, 2016). The introduction of the Charter of Rights for people with a Dementia and their Carers in

Scotland (2009), and global changes to policies emphasising the rights of people with a dementia as citizens are positive steps forward (World Health Organisation, 2012).

Sweden takes a stronger standing on citizenship and dementia by supporting an adult's right to self-determination as a practice with a legal construct emphasised in regulations, and policies. For example, Swedish adults cannot be declared as incompetent in making decisions about social care or their right to self-determination (Nedlund & Larsson, 2016). Whilst the European Convention of Human Rights has set out the rights required to promote an individual's autonomy or freedom, particularly rights to life, liberty and expression (European convention on human rights, 1971) they have denied the civil and political rights of people who have a 'mental disorder'. Adults considered to be of unsound mind in particular, can be deprived of their liberty (Article 5.1). Before we can understand how citizenship can be encouraged with any legal or social construct, a brief look at the legal framework that is already in place in the country this study was conducted is required.

3.2.1 The Mental Capacity Act

The Mental Capacity Act 2005 (MCA) has been in force in England and Wales for over a decade. The MCA (2005) aims to support and safeguard adults who are considered vulnerable when making decisions about their lives. It was a response to a growing recognition that the legal frameworks governing situations, in which a person was assessed as lacking mental capacity, or the ability to make decisions, were inadequate. The aim was to ensure a person's capacity was evaluated using functional diagnostic tools. Although the MCA (2005) provides a framework for decision making, evidence suggests that in some respects it remains unsatisfactory for the following reasons: the presumption of capacity is not always upheld; assessments are not always carried out correctly; and the legal framework for proxy decision making is not always clear (Taylor, 2015). Whilst the legislation promotes the liberty and self-determination of people who have been assessed as lacking mental capacity, it does not assign a right to have their voices heard; it does not assign a right to have their choices respected such as whether to remain at home or move to a care home (Boyle, 2008); and it has no provision to ensure a person has opportunities to be included in decision-making relating to their personal possessions.

3.3 Citizenship in a care context

Citizenship can be located within political or civil domains (Marshall, 1987) but is yet to make a substantial impact on dementia care practice (Kelly & Innes, 2013). One reason for this may be that citizenship remains an elusive concept and an ideal to strive for (Bartlett, 2016). Putting

citizenship into practice requires a practical application that is inclusive of people with a cognitive impairment. An analysis of object-person relations provides one such potential application. For example, people with a cognitive impairment do not meet the ideal for political citizenship, in which a person is required to independently meet their responsibilities and have autonomy. Craig (2004) reminds us that it is the practices of organisations and agencies such as governmental, local authority, and voluntary sector organisations, to ensure its presence or absence. However, the ideal that these organisations work from can marginalise certain groups including people with a dementia (Brannelly, 2016). To meet the ideal a person is required to be seen as socially active and connected. It is difficult for a person with a dementia to be seen as socially active in a context such as a care home which may operate restrictive practices (Popham & Orrell, 2012).

Although there has been a positive shift concerning participation and inclusion in care (Barnes, 2006; Gilleard & Higgs, 2010), it is recognised that health and social care practitioners hold the active citizen position as employees of regulated organisations. It is also acknowledged that practitioners are bestowed the responsibility of making decisions relating to another person's care but should seek to involve those receiving care in decision-making. However, a recent care home market study (Care Home Authority, 2017) reported it is typically the relatives, spouse or a friend of an older person who make the decision for a person to move to a care home. This suggests that older people are treated as passive recipients of care. It could also be suggested that if a person has not made the decision to move into a care home, they may not be included in decision-making relating to which objects they take with them. Whilst relatives, spouses and friends may be helpful in providing a historical biography, particularly with people with a dementia, it can also begin a trajectory of exclusion for the person with a dementia in future decision-making about things such as their personal possessions.

The idea of citizenship has proved a useful lens for analysing decision-making between health care professionals and people with a dementia. For example, Brannelly (2011b) conducted a study examining the attitudes and actions of social workers and nurses when working with people who have a dementia. The aim of the study was to explore the potential of social framing in supporting the citizenship of people with a dementia. The study sought to understand the motivations of social care and health practitioners through the concept of 'social death' in a care context. She adapted the work of Sweeting and Gilhooly (1997) by changing the terms 'social life' and 'social death' to 'social regard' and 'social disregard'. Hence, the idea of citizenship draws attention to the importance of respecting a person with a dementia.

Brannelly explored whether health care professionals included people with a dementia in decision-making. A total of 15 practitioners comprising eight community psychiatric nurses, seven

social workers and 50 people with a dementia were recruited to the study. The study included observational and interview methods, the observations took place with people with a dementia, a nurse practitioner or social worker, and at times relatives. Those with dementia involved in this study were from various residential locations, such as their own homes, hospital, or a care home. The observations took place in the environment in which the person was resident or at day centre which they attended.

Within the research period, ten people with a dementia who had moved into either residential or nursing home care. A number of them had done so unwillingly or were initially willing but changed their mind after some time. It is not clear whether they moved directly from their own home or from a hospital admission. Brannelly (2011b) expected to observe practitioners practice higher levels of inclusion in decision-making with people who had a milder dementia, predicting these levels would lessen with people who had more advanced dementia. This was not the case. Of the 15 practitioners taking part in the study, two did not attempt to include people with a dementia in decision-making suggesting they were incapable of making a decision. However, nine made every attempt to include people with a dementia. The other four practitioners judged the level of inclusion on a case-by-case basis, based upon their perception of the person's ability to participate. Their decision to include or exclude were influenced by the practitioner's preference and personal experience of multi-disciplinary meetings, and the person with a dementia requesting an advocate or another nominated person.

In conclusion, Brannelly argues that citizenship cannot be facilitated where practitioners are unable to offer a person with a dementia social regard and include them in decision-making. Given that some practitioners within the study did offer social regard to people with a dementia suggests that citizenship in practice is possible. It also demonstrates that citizenship is heavily weighted on the side of practitioners and that it remains a matter of bestowment. This is highly relevant to people with a dementia in a care home context for two reasons: decision-making is known to be a grey area for care staff and relatives of people with a dementia (Evans et al., 2018; Whitlatch & Menne, 2009) and health care practitioners have a tendency to position people with a dementia as passive recipients of care (Bartlett & O'Connor, 2010). If a person with a dementia is not included in decision-making relating to their care, it is likely they will not be included in making decisions about their personal possessions.

To understand how citizenship can be achieved it is important to understand the conditions by which citizenship can be facilitated. Ursin and Lotherington (2018) conducted a recent study that examined the conditions required for people with a dementia to achieve citizenship in their everyday lives. Their contribution to the citizenship debate aimed to eradicate the individual as

the holder of citizenship and encourage a collectivist conceptualisation. Ursin and Lotherington (2018) suggested that by concentrating on care-collectives, 'a configuration of agents brought together in time and space which can shift alongside with the change in the relations comprising them' their relations could provide insight into the necessary conditions for citizenship for people with a dementia (Ursin & Lotherington, 2018 p.63).

The ethnographic study included following family members of young people with a dementia (younger than 65 years) and conducting ethnographic interviews. The interviews had a strong focus on materiality and kept the enactment of everyday practices at the forefront. This was achieved by focusing on everyday situations with questions about the actions and features of an ordinary day. These were followed up with questions exploring the actions that took place, who was involved in the actions, when, where, and any changes in everyday life. A total of 15 family members, comprising 14 spouses (seven males, seven females) and one daughter took part. Twelve of the participants were interviewed twice (nine to twelve months apart). Twenty-seven healthcare professionals from auxiliary care, day-centres, home care, respite and nursing home care were recruited from a pool provided by family members. A total of 54 interviews were conducted.

Ursin and Lotherington's (2018) study explored everyday routines and although object-person relations were not the main focus, they reported the importance of a mobile phone to a couple involved in the study. A young person with a dementia who had moved to a nursing home used his mobile phone each day to maintain independent communication with his wife. He carried the mobile phone in his pocket and on two occasions, the phone was found in the laundry. His wife provided him with a new mobile phone as from the couple's perspective, maintaining contact was more important than the cost of replacing a mobile phone. Although she informed the nursing home that she was willing to take the risk of the phone ending up in the laundry again, on bringing the third mobile phone to the nursing home she was informed by staff that it would be kept in the staff room. Staff also suggested she did not call him on the mobile phone as they could not hear it ring. Whilst the young person's wife understood the functional affordances of the mobile phone in supporting independence, agency and feelings of connectedness, the mobile phone was considered a problem by care home staff. Whilst the restriction of access to this functional object may have minimized the risk of damage to the object, it overlooked the risk to the psychological well-being of both husband and wife. It could be argued that citizenship was removed from the young man as he could no longer take action and contact his wife independently.

Ursin and Lotherington (2018) discussed objects in relation to 'the dynamic practices of citizenship'. They argued that it was important to detach from the individualist view of agency and citizenship and shift to a view in which agency can be achieved through *networks*. Furthermore, that agency and citizenship could be better understood as collective achievements expressed through continuous enactment and re-enactment (Ursin & Lotherington, 2018 p.68). Citizenship may be achieved under conditions in which care-collectives are socio-material networks of relations that are set up to facilitate the achievement of agency and citizenship. This means the conditions under which socio-material networks operate must balance on the premise of viewing the person with a dementia as an active agent. For example, in the case of the mobile phone, viewing the young man as an active agent and supporting independent contact with his wife facilitates agency and citizenship.

Ursin and Lotherington (2018) concluded that much work still needs to be done within care-collectives and social-material networks to facilitate agency if citizenship is to be achieved. Citizenship must be viewed as an ongoing process of achievements and should include the transfer of knowledge of both researchers and practitioners if it is to be accomplished (Ursin & Lotherington, 2018). By combining research, which adopts a material lens, and practices which view functional objects as an important element of care practices, this could begin to identify the conditions for developing dementia care practices which facilitate social citizenship.

3.4   Social citizenship for people with a dementia living in care homes

The idea that people with a dementia are not socially alive or treated by the cognitively fit as less than human (Kitwood, 1997) is no longer acceptable practice. Discrimination in relation to people with a dementia is recognised as a public health issue (Link & Phelan, 2006)as it compounds neurological related problems. This in turn reduces opportunities for personal growth and self-expression (Clare & Woods, 2001) which is opposed to the working definition of social citizenship:

> *"Social citizenship is a relationship, practice or status, in which a person*
> *with dementia is entitled to experience freedom from discrimination, and*
> *to have opportunities to grow and participate in life to the fullest extent*
> *possible. It involves justice, recognition of social positions and the*
> *upholding of personhood, rights and a fluid degree of responsibility for*
> *shaping events at a personal and societal level. (Bartlett & O'Connor,*
> *2010 p.37).*

To date, citizenship has lacked both a material lens and a practical application for successful implementation in a care context. Bartlett (2015) suggests two developments within citizenship

studies that have the most promise. These are concerned with understanding citizenship in ordinary places and potentially enacted within a domestic sphere. This however does not address citizenship in a care home environment, which intends to be a domestic sphere but is situated within an institutional setting, making it extraordinary. Furthermore, the institutional policies and procedures in operation in this context are designed to meet care needs rather than promote rights and citizenship. Therefore, it is important to understand the conditions that are required to support social citizenship within an institutional context.

Bartlett and O'Connor (2010) suggest the use of language as important in developing how people think about dementia. It is also important for people with a dementia to have opportunities to act and enact their identities if we are to reframe dementia positively. The objects people own, and the objects people use, tell us something about the person. The way in which decisions are made about objects and the opportunities afforded to people to use objects provide an insight into how that person or group of people are viewed. Therefore, the material world is a method of inquiry but also the method with which to enquire (Buse & Twigg, 2014, 2015). Given the focus of this thesis relates to dementia care within a care home setting, a key consideration is how citizenship might be operationalised within an organisational context.

3.5   Citizenship in organisations

Baldwin and Greason (2016) contributed to the citizenship debate relating to dementia by introducing concepts grounded in organisational studies. They combined two studies, a study by Baldwin (2008) examining ethical issues for family carers of people living with a dementia and a study by Greason (2015) examining ethical reasoning amongst long-term care staff. Whilst neither study intended to examine citizenship, both brought to light issues for, and about, citizenship for people with a dementia. Particularly issues surrounding participation, rights, inclusion, engagement, dignity and respect.

Baldwin and Greason (2016) introduce concepts of midi and micro-citizenship as a means by which to link the political and the personal. Midi and micro-citizenship refers to action taken at the organisational level by either collectives or individuals. Midi-citizenship is the action of collectives who take action to improve the general performance of an organisation. This may be the care home staff or relatives of residents in a care home setting. Micro-citizenship refers to action taken by individuals. This could be actions such as a resident showing a willingness to support others and participate in day-to-day tasks, or a resident providing care for another resident. The aim is to develop alliances between care staff and people with a dementia in a long-term care setting. The importance of this contribution is the recognition that a citizenship

framework needs to be sensitive to the context with which it will take place. A framework void of context can result in what Porksen (1995) refers to as a 'plastic word'. An example of this is the widely used term 'person centred'. Although person-centred care is written in policy documents, educational programmes, mission statements, job descriptions, care planning and protocols in almost every part of the dementia care sphere, whilst politically correct, is not what is experienced by those living in long-term care (Killett, Burns, Kelly, et al., 2016)

From an academic perspective, person-centred care is a theory driven practice which seeks to provide a practical way of improving care for people with a dementia (Kitwood, 1997). Person-centred care is human-human relation centric and is often reliant on the cognitively fit to make care decisions for the cognitively impaired (Evans et al., 2018; Fetherstonhaugh, Tarzia, & Nay, 2013). This means that a person with a dementia is provided person-centred care and is therefore at risk of the bestowment of citizenship rather than the right to citizenship. Baldwin and Greason (2016) sought to avoid plasticity by drawing on the work of Vigoda-Gadot and Golembiewski (2004) who established four types of citizenship behaviour/engagement: meta-citizenship, macro-citizenship, midi-citizenship and micro-citizenship.

Baldwin and Greason (2016) adapted the four types of citizenship for the purposes of applying it to people with a dementia in a long-term care setting. They show how overlaps occur between the four types of citizenship and how an action taken in one type can have an effect in another type. They then discussed features of micro-citizenship in more detail. The term micro-citizenship refers to:

> *'those actions and practices of individuals, in immediate relationship,*
> *which hold the liberties and freedoms of those involved while*
> *generating or supporting a sense of identity and belonging' (Baldwin*
> *& Greason, 2016 p.293).*

Micro-citizenship embraces Bruner's (2004) dual landscapes of action and consciousness. This consists of action focusing on participation, engagement and events, and consciousness focusing on identity, meaning and the inner world. Thus, attention focuses on the activities in which people engage, the meanings attributed to this and how this affects identity and a person's sense of self. Action, meaning and identity are combined to establish a meaningful narrative of identity experienced through that life story. The ability to participate in life encompasses individual agency and collective decision-making about being in the world. For people living in long-term care facilities, or in the case of this thesis a care home, the act of independently participating in life is more difficult with older people having to adjust to the way in which care is provided (Van't Level & Jonsson, 2002). However, participation can be realised on several levels. Baldwin and

Greason (2016) suggest the relationship between participation/engagement and identity/meaning in micro-citizenship is the clearest. The two concepts come together in decision-making relating to how a person wishes to be cared for. A person's biographical history and values often become a focus for the realisation of micro-citizenship, bringing together a person's wishes and sense of self.

Again, what has been overlooked is the relation between human and material worlds. The objects a person uses in their daily life to maintain routines and rituals, to care for themselves independently, to make choices and demonstrate identity are absent. This oversight is important for two reasons. Firstly, it lacks a full understanding of what a person does to maintain identity, engage, and participate. Secondly, the usefulness of objects as an analytical tool with which to assess the presence or absence of citizenship is not recognised. This is particularly important for the advancement of citizenship practice in the context of dementia, when participation and engagement is contended upon the perception of capacity (Graham, 2004). Baldwin and Greason (2016) refer to the act of non-verbal indicators, such as refusing food or drink, as a means of communicating care needs. Whilst this shows a rejection of the care being given and demonstrates a level of self-determination, it lacks a positive active stance. It also places micro-citizenship on a precarious platform as it shows a heavy reliance on others, similar to person-centred care. If we move away from micro-citizenship as solely realised through personal relationships, but conjoin this with object-person relations, this may elucidate attitudes and behaviours that obstruct citizenship.

Many care homes operate risk-averse practices (Clarke et al., 2011) as demonstrated in section 2.3 with locked cupboards and drawers, and a lack of access to kitchen areas. In turn, opportunities for resident participation is largely determined by the members of staff on duty, and their perception of risk. Residents often requested to take part in domestic chores but were discouraged or prohibited for reasons such as competency, risk of harm, or that it was not their job. Baldwin and Greason (2016) found in one case that engagement was only permitted when a relative signed a waiver of liability. The encouraging component to take from this is that a resolution was found in the form of the waiver. It does however highlight that citizenship was offered to the relative not the resident.

3.6   Summary

Whilst there has been an increased interest in the concept of citizenship across political and academic arenas, it has yet to make a substantial impact on dementia care practices. Citizenship lacks a practical application with which to implement, measure, and sustain social citizenship

practices in dementia care. The review of literature identifies a gap in the literature relating to the materiality of citizenship. Care practices tend to focus solely on person-person relationships, which has implications for citizenship. Person-person relationships rely heavily on the attitudes and views of those who provide care for people with a dementia. Object-person relations have been overlooked in both dementia studies and citizenship studies. By drawing both together and applying a material lens, this can provide an analytical device to locate either the presence or absence of citizenship in everyday practice.

The way a person is involved in decision-making, the access people have to objects and the way in which they are used can illuminate how a person is thought about. It elucidates individual and collective views, allowing objects to act as analytical tool with which to locate citizenship in practice. This supports the assertion of Baldwin and Greason (2016) to pay attention to the activities a person engages in and the meaning of these activities. The stronger the sense of engagement, the more active and deliberate a person's involvement in the world is, it is more likely citizenship is present. The weaker the sense of engagement the less active and more passive a person's involvement in the world is, it is more likely citizenship is absent. From an organisational perspective, micro-citizenship is the responsibility of reframing behaviour from a heavily symptomatic view to exploring how a person interacts with their environment and what that tells us. The access to and use of objects provides an analytical tool to ensure care is provided that is the least restrictive. It enables the development of practices that uphold the ideology of the Mental Capacity Act (2005) in England and Wales that argue for a balance of protection and empowerment. Object-person relations in dementia care have the potential to change care home culture by repositioning dementia from a deficit, to a discourse of agency and interdependence (Birt, Poland, Csipke & Charlesworth, 2017).

Chapter 4: Methods of Enquiry

4.1   Introduction

The aim of this chapter is to clarify the methodological design and practical deliberations that were taken into account when formulating the research questions.

Ethnographic research questions are generally concerned with understanding what naturally occurs in a setting of interest. It provides voluminous unstructured data from fieldnotes, interview transcripts, diaries, notes, memos and documentary evidence (Jones & Smith, 2017). The aim of this study was to develop an understanding of the decision-making practices relating to functional objects and explore whether social citizenship could be located through a material lens.

The methodological rationale was to explore how decisions are made, and who is involved in decision-making relating to personal possessions when a person with a dementia relocates to a care home. It was also to examine how functional objects are used and by whom, and to examine whether the theoretical concept of social citizenship could be empirically observed through a material lens.

This chapter will firstly provide the reader with a comprehensive account of the qualitative and analytical methods used to explore and address them. It will then be organised into two sections. The first section explains and presents an overview of the methodological design and the range of methods used to collect and analyse the data. The second section considers the complexities of the ethical aspects of this study and the ethical procedures that were followed.

4.2   Psychology, sociology and qualitative methods of enquiry

This study intersects psychological understandings of object-person relations with sociological ideas of materiality in care homes. Psychological and sociological research methods have similarities in their curiosity for social issues but have differences in their methodological approach. Historically, psychology has tended to take a more positivist approach whilst sociology favoured an interpretative approach.

This ethnographic study takes an interpretative relativist approach. The ontological position of interpretivism is relativism. Relativism is the view that reality is subjective and differs from person to person (Guba & Lincoln, 1994), in doing so believing there is no absolute truth, our experiences and the meaning they hold formulate knowledge. These experiences are embedded within the

culture by which it occurs, that society is a social construction, and empirically observable data is open to interpretation.

Researching a social issue within a relativist paradigm means that the social constructions empirically observed are situated within the context in which they naturally occur. In this study two assumptions were made (1) the importance of objects could be examined by exploring object-person relations and decision-making practices relating to the access to and the use of functional objects; (2) social citizenship could be examined by exploring how functional objects are imbued in everyday activities. Therein lies the fundamental reason for conducting an ethnographic study, it would allow an understanding of how everyday life unfolds between human and material worlds, how decisions are made relating to functional objects, and by whom.

Broadly defined, ethnography is 'a form of research that asks questions about the social and cultural practices of groups of people' (Buch & Staller, 2007, p.187). It originated from nineteenth century Western anthropology but crossed over to sociology in the 1920s and into human geography and psychology in the 1960s. The aim of ethnography is to explore the actions and accounts of people in their natural environment. Data are gathered from a range of sources, methods are mainly unstructured, and the researcher normally focuses on a few cases or a group of people. This is in keeping with an interpretative paradigm of understanding how individuals construct, manage and sustain social reality (Gubrium & Holstein, 2000). An ethnographic design would enable a deeper understanding of the social construction of care home culture. Rather than a superficial overview, it would provide insight into what was going on within a specific environment, and for the purposes of this study, how objects were imbued in everyday activities within a care home culture. By spending time in the environment, it would provide an understanding of how residents, care home staff, and relatives constructed the social reality of a care home setting for themselves but also for others who occupied the same space. It would illuminate contradictions in what was said and what was done. Finally, it would enable a deeper understanding of how objects were managed both individually and collectively by those occupying a space that adopts specific cultural practices. All of which was important to my study if I was carry out a thorough exploration of object-person relations within a care home setting.

4.3   Overview of study design

The primary objective of the study was to understand how functional objects manifest in the everyday lives of people with a dementia living in care homes. A secondary objective was to examine whether social citizenship was a useful lens to examine this. Given how little is known about the phenomena of object-person relations in dementia care, and that citizenship lacks a

material component, this ethnographic study was highly exploratory. This doctoral study comprised of a pilot study and a main study. The pilot study aimed to test the methods being used; as well as provide me with some experience of conducting research in a care home setting. This was particularly useful in a complex environment such as a care home in which research skills from other settings do not guarantee high quality research (Luff et al., 2011). The main study aimed to collect data to address the research questions.

This following section will explain the data collection techniques and sources used in the pilot study, the method of analysis chosen and the ethical process.

4.4 Data collection techniques and sources

4.4.1 The hanging out period

The hanging out period is an ethnographic method in which the researcher spends a period of time in a research setting taking part in everyday activities (Bernard, 1995). The ability to take time to understand a care home before research takes place is recommended (Luff et al., 2011). The purpose of hanging out is to build rapport with those who occupy the space in which the research is taking place; it is not a data collection period. Spending time just being in the research site is considered a crucial part of the ethnographic process as the researcher is not in too much of a hurry to ask questions (Bernard, 1995). In doing so, this can build trust between the researcher and those who occupy the space in which the research will take place. In turn, ordinary conversations can begin to take place (Bernard, 1995). All of which was important for my study because I wanted to collect data that was as natural as possible.

4.4.2 Participant observations

Participant observations are the foundation of ethnographic methodology (Bernard, 1995). The role of the participant observer is to take part in and get close to the everyday activities and experiences of a group of people the research is interested in (Emerson, Fretz, & Shaw, 1995).

Within the context of care home research, the participant observation method offers unprecedented access to the routines and rituals of the residential environment (Bowling, 2009). Participant observations is a method in which the researcher is known to those being observed. It is the practice of conducting research in a natural setting whereby those the researcher comes into contact with are aware research is taking place, giving them the opportunity to consent (McCurdy & Uldam, 2014). Participant observations are considered the ideal, as they are ethically pleasing and offer transparency, thus avoiding deceptive practice. In practice, however this may

not be as simple as it may seems, particularly when working with people with a dementia of which a symptom can include short-term memory loss. This means a person may not recall recent events, such as agreeing to take part in this research study. To remedy this, a process consent method was used at every participant observation. Process consent is an ongoing practice that involves mutual decision-making by the researcher and participant, a practice often used in mental health nursing (Dewing, 2007). At each data collection point I made it clear to all participants with a dementia, who I was, what I was doing, and asked them whether they were willing to participant or not.

The process of observing people in their own environment over a period of time had the advantage of seeing how people interact with functional objects. I could observe interactions between staff, residents, relatives and objects. Taking part in day-to-day activities, sharing everyday life with a group of people (Emerson, Fretz & Shaw, 1995) allowed for creativity in research methods. I could ask residents if they wanted to take part in activities involving objects to see what happened. A few examples of this were instigating the activity of playing spyder solitaire on my iPad, attempts at completing a jigsaw puzzle and working together to complete a word search. Although this provided insight into the activities people could engage in when offered the opportunity, there were parts of their social world which were not permitted for observation. One of these activities included opportunities to observe the functional objects a resident used when getting ready in the morning and evening.

It is widely accepted in ethnographic studies that a researcher cannot attend to everything at all times. A researcher must selectively prioritise, to some degree, those activities that will address the research question. As a result, the researcher is not determining a truth but the multiple truths apparent in the complexities of other's lives (Emerson et al., 1995). That said, these multiple truths drawn together can give a more rounded understanding of the complexities of care home living, and in particular, the way in which decisions are made about the objects people have and the access they have to them. Whilst carrying out the participant observations, I made notes on an iPad of the interactions observed between residents and functional objects. Initially this caused me some concern as the frequency of interactions between residents and functional objects were low; however, this provided a picture of how objects were imbued in everyday life. The fieldnotes allowed a record of the reality of care home life to develop which related to how and who used functional objects rather than relying on verbal meanings alone (Bond & Corner, 2001).

4.4.3 Photo-elicitation interviews

Given that object-person relations might be considered an abstract concept, I thought it might be useful for participants to bring photographic images of objects they had at home that were important to them. The images could include any object which was a personal possession, rather than stipulating it would need to be a functional object. I hoped the request to provide photographic images of objects that were important to staff and relatives would provide a precursor for thinking about objects prior to the interview. The photographic images could act as an icebreaker to help relax care home staff and relatives, build rapport, help keep the focus of the interviews on objects and aid exploration of the importance certain objects held for participants.

Photographic images have been utiltised in photo-elicitation interviews (PEI). This is a technique which was developed in anthropology and sociology and mainly used in ethnographic and social studies research (Banks, 2001; Harper, 2002) to " invoke comments, memory and discussion in the course of a semi-structured interview", (Banks, 2001p. 87). It is thought that photographic images can evoke a deeper response eliciting a different kind of information (Harper, 2002) rather than merely superficial thought. This was important to my study as I wanted people to begin to think about objects for their functionality in maintaining or cultivating identity, rather than material things that hold a secondary value to person-person relations.

4.4.4 In-depth interviews

Combined with the photo-elicitation interview was an in-depth interview approach. This type of interview is also often referred to as a semi-structured interview, which are popular in social science research (Howitt, 2016). The advantage of the in-depth interview is that its conversational characteristics can allow a deeper understanding of the person's world. Similar to the informal conversations that took place within the participant observation method, the in-depth interview allows for a two-way exchange. This can result in a mutual understanding being formed. It gives the ability for interpretations to surface and be checked and can unfold the complexities of each other's answers (Weir & Costall, 2015). This can provide more than a one-sided exercise (Howitt, 2016) and is important in understanding how people think about object-person relations.

The art of in-depth interviewing is to actively engage with the person taking part, in essence it becomes an 'active interview' (Gubrium & Holstein, 1997). That said an interview guide was developed to remind the researcher of the topics relating to the research question set out in section 3.6. In order to keep the interview active, the guide was not followed in any particular order and some of the questions were not asked at all as they were covered spontaneously within the conversations. The questions included in the interview guides (Appendices 4, 5 and 6) were

developed to fit with each participant group. For example, residents were asked questions such as 'Do you have many belongings here that you brought from home?' and 'Are there any belongings you wanted to bring but did not?' Care home staff were asked questions such as: 'Are you aware of people with dementia or relatives requesting to bring in more belongings once they have moved in?' and 'What would you say are the most common belongings brought into the care home?' Whilst relatives were asked questions such as 'When moving into the care home was your relative able to bring many belongings with them from home?' and 'Can you talk me through how decisions were made about what to take into the care home and what to leave behind?'

The in-depth interview method was appropriate for the residents, care staff and relatives taking part as the topic was of a sensitive nature and therefore could generate emotive responses. Allowing people time to explore their own thoughts and feelings was imperative particularly for people with a cognitive impairment who may have to work harder to recall, construct and articulate their answers. Gathering data through a dialogic exchange meant that the interview could focus on the subject of objects whilst remaining broad and flexible.

4.4.5   Object-elicitation interviews

Objects were a critical point of the exploration in this study; therefore, it was important to incorporate them as much as possible within the interviews. Object-elicitation interviews facilitate ways of discussing concrete objects but also sensitive topics such as power dynamics and embodiment (Iltanen & Topo, 2015). It was assumed that as the care home was the residence of the people with a dementia taking part in this study, their objects would be available to carry out object-elicitation interviews. It was also considered reasonable to expect to see residents using functional objects throughout their day. Buse and Twigg (2015) employed objects as method to explore the significance of clothing for people with a dementia, their carers and care staff. They conducted 'wardrobe interviews' to gather data relating to the meaning the clothing held and the narratives told through dress. Buse and Twigg (2015) used the clothing within the wardrobes when interviewing people with a dementia and their carers about the clothing found inside. These interviews were guided by topics such as memories, the meaning of clothing, decision-making, identity, challenges and difficulties. The objects in this study would be used to guide interviews themes such as the meaning of objects present in the care home, the access people had to objects and how decisions were made about the objects that were both present and absent in the care home.

4.4.6   Documentary sources

Contemporary ethnography includes a diverse range of sources including documents, diaries, newspaper cuttings and other material data. I drew upon *personal* and *organisational* texts to examine the presence or absence of object-person relations within care practices and policy.

Personal texts consisted of private care records and daily support plans, these were private documents the care home are legally obliged to maintain. The data included in the private care records was information relating to medication, mobility, medical diagnosis, visual and hearing impairments and dietary requirements. It also included personal details such as date of birth, marital status, children, previous occupation, likes and dislikes. This was useful as it provided biographical information that might not have been reliably accessible elsewhere. The personal texts also included written inventories which come care home staff completed of personal belongings and provided information of the objects brought into the home. The inventories were used to manually examine whether any patterns existed in the objects brought into the care home. They also provided an insight into how care home staff viewed objects by the way they were recorded and in what was recorded. The inventory records were compared with both observation and interview data, relating to what participants identified as necessary or desirable in care home life but also the objects present in the care home. Daily support plans were examined to see whether care home staff recorded any information relating to objects, objects requested, objects lost, or the way in which objects were imbued in daily living. This again provided another piece of data that could be compared with observation and interview data, enabling a fuller picture of object-person relations in care home life.

Organisational texts consisted of public documents such as care home brochures, organisational policies, Department of Health guidelines and commissioning and regulatory inspection reports. The rationale for collecting and examining these documents was to explore how institutional structures, procedures, and cultural practices impacted on decision-making relating to the access to and use of functional objects. The public documents were considered 'social artefacts' which were critically examined rather than passively accepted. It was important to understand the role of documentary sources and what they offered the research questions (Richards, 2015). To make this clear, the questions asked of the documentary sources data are shown in Box 3:

Box 3 Ethnographic questions asked about the text

Personal texts

1. What is the intention of the text?

2. Who has generated the text?

3. Who is the intended audience?

4. Are objects mentioned in the records?

5. In what context are the objects talked about?

6. What would be the take home message from the text?

Organisational texts

1. Who has generated the text?

2. Who is the intended audience?

3. What is the intention of the text?

4. Are objects mentioned and if so how?

5. What would be the take home message from the text?

Dividing the documentary sources into two categories enabled an examination within groups of the importance of objects from an organisational and policy perspective. It also enabled an examination of how objects manifest in the everyday lives of those living and working in the care home. These sources provide data uncovering how events are socially constructed and why people do the things they do in certain contexts, acting as a rich vein for analysis (Hammersley & Atkinson, 2007). Combining artefacts such as photographic images with interviews and observations can also result in consistencies and inconsistencies being illuminated (O'Toole & Were, 2008). This helped ensure trustworthiness and confidence in the analysis of my data.

4.5   Method of analysis

The aim of this research study was to understand how decisions were made relating to personal possessions and functional objects, and to understand how objects were imbued in everyday activities. A framework analysis approach was chosen, as a prime concern was to describe and interpret what was happening within a particular context whilst also asking structured and factual questions of the data (Srivastava & Thomson, 2009).

Framework analysis is a method developed in the 1980s by applied qualitative researchers Ritchie and Spencer (1994). This method has been increasingly used in social and health sciences and is aptly suited to applied policy research. It is best applied to research with specific questions and a

priori issues yet has the flexibility and freedom to explore. Richie and Spencer (1994) suggest four types of research questions they believe can be addressed using a framework analysis as shown in Box 4:

Box 4   **Type of research questions suitable for a framework analysis**

- Contextual: identifying the form and nature of what exists
- Diagnostic: examining the reasons for, or causes of, what exists
- Evaluative: appraising the effectiveness of what exists
- Strategic: identifying new theories, policies, plans or actions

---

The research question for this study "How do object-person relations manifest in care homes for older people with a dementia and is social citizenship a useful lens to examine such relations?" fitted within the 'contextual', 'diagnostic' and 'strategic' categories respectively. The contextual category of framework analysis would identity the current practices that existed within the care home context relating to functional objects. The diagnostic category of framework analysis allows both interview and observation data to be examined, providing reasons behind why certain decisions are made and by whom. Through documentary sources, I could examine what processes were in place supporting these decision-making processes and the decision makers. The strategic category of framework analysis would allow flexibility and freedom to explore, allowing for the unexpected (Parkinson, Eatough, Holmes, et al, 2016). This would enable an innovative and thoughtful process exploring whether social citizenship is a useful lens to examine object-person relations. Framework analysis was also considered a suitable choice for its compatibility with the computer assisted qualitative data analysis software (CAQDAS) programme NVivo 11.

4.5.1   Using NVivo 11

NVivo 11 was used to support data management and analysis. It provided transparency of the analytic process and an audit trail. This means that any decisions or interpretations can be traced back with relative ease (Parkinson, et al., 2016). It also enables comparisons to be made across data and the interrogation of patterns and relationships within data sets (Lewins & Silver, 2014). This study comprised of three participant groups (people with a dementia, relatives, and care homes staff) and four types of data (interviews, observations, documentary sources and photographic images), therefore these functions were considered highly beneficial. NVivo produced codebooks that provided details of all codes and descriptions. This was useful in organising and reorganising the data. Queries were run through NVivo isolating certain categories of data, which would have been difficult to achieve if carried out manually. I was able to go back

to the data at any time, drawing out certain parts of text to compare across groups to interrogate my interpretations. A disadvantage was having to learn a new computer package, to understand the language it used and to gain a comprehensive understanding of its functionality. That being said, by using the organisational functionality of NVivo it provided the ability to code and compare voluminous data, which would have been difficult to achieve manually.

4.5.2 Steps to conducting a framework analysis

Framework analysis follows a five-stage process (Ritchie & Spencer, 1994). Box 5 sets out the five steps taken to perform a framework analysis on the data collected within this study.

Box 5	**Five steps in framework analysis**
Step 1	**Familiarisation -** get to know the data extensively to generate an overall feel
Step 2	**Identifying a framework –** organising data in a meaningful and manageable way for subsequent retrieval and exploration
Step 3	**Indexing –** organise the individual transcripts into framework categories
Step 4	**Framework matrices -** organise the data into a more manageable format
Step 5	**Mapping and interpretation –** pull together key characteristics of the data, find patterns, then map and interpret the data set as a whole

Familiarisation with the data set

The first stage of the analytical process was getting to know the data. This is what is often termed as 'immersion' (Ritchie & Spencer, 1994 p.179). The interview data were transcribed by a professional transcriber, so whilst it is not necessary in framework analysis to review all of the data (Srivastava & Thomson, 2009), I made the decision to review each piece of material to remain close to the data. This meant listening to the interview recordings while simultaneously reading the transcripts (transcripts were transcribed verbatim including laughter and pauses). This was carried out alongside examining policy and practice documents, inventory details, images taken of objects, and inspection reports. It also involved reading through the reflexive diary entries, which documented the thoughts and feelings resulting from collecting data as a participant observer.

From the interview transcripts a set of 336 preliminary codes were created with illustrative extracts from the data for each one. Annotations were attached to each extract to record what I was thinking and why the extract was of interest. This enabled me to draw on what I had experienced in each interview, recalling each interview conversation and the visual cues that were not captured by the audio recording.

Identifying a framework

The second stage of the analytical process was to organise the data in a meaningful and manageable way. This would aid future exploration and the retrieval and examination of data during the fifth mapping and interpretation step. Ritchie and Spencer (1994) suggested the formation of framework categories informed by a priori concerns and emergent issues arising from the previous steps allows the identification of categories that best fit the research questions. It also allows flexibility to ensure the framework included the interests of the researcher and those issues pertinent to the participants. Given a set of 336 preliminary codes were produced in step one, this proved difficult to group them together to form a set of framework categories. I decided to refocus on the key areas of the research and ask specific questions related to the research question. Box 6 sets out these questions.

Box 6   Questions asked to develop the framework

1. How are decisions made relating to personal possessions and who is involved in decision-making?
2. Who is responsible for bringing personal possessions into the care home, and how are future objects acquired?
3. How are functional objects used in care homes and who uses them?
4. Are measures taken to control objects in the care home and if so what measures and by whom?

While reviewing the preliminary codes it became apparent that overlaps existed, and codes could be merged. For example, objects were coded individually and although this provided an initial idea of the type of objects that were prominent in the care home, I did not intend to conduct a comparison of objects. Therefore, the individually coded objects were merged and categorised as 'objects'. The types of objects were also coded for each of the three participant groups, as I had not intended to compare objects within or between groups these codes were also merged as 'objects'. Discussing which objects were important to a person's everyday life was a useful interview technique to start a conversation about decision-making relating to the way that people

use objects. It enabled a deeper level of thinking about the objects people used in everyday life and to contemplate what life might be like without having access to those objects. The initial total of 336 codes were funnelled down to create manageable data sets through the process of developing a framework. Codes created thought the interview data and observational data were merged, and codes that overlapped were collapsed. The codes were revisited several times and resulted in a total of 54 codes. These were then further reorganised and placed within one of four categories. The four categories were: (1) decision-making - this included codes such as 'choices and decision making', 'policy and practice', and 'responsibility of objects'; (2) access to objects - was generated by combining the codes 'routines and rituals', 'requests for objects', and 'participating in life'; (3) safety - was generated by combining the codes 'positioning of people', and 'exclusion in decision-making', and (4) relationships with objects - was generated by combining the codes 'management of objects', and 'things go missing'. A summary of the framework categories is presented in box 7.

Indexing

The third stage of the analytical process was to organise the interview transcripts into framework categories (Ritchie & Spencer, 1994). This involved systematically applying each interview transcript to each framework category.

Box 7   **Framework categories**

1. *Decision-making* relating to the ownership and use of functional objects
2. *Access to objects* functional objects to participate in everyday life
3. *Safety* or the perceived risk of having or using functional objects
4. *Relationships with objects* the ownership and use of functional objects

---

The advantage of this was the ability to accommodate both a priori and emergent issues arising from the data. It also provided the necessary flexibility to ensure the data focused on the research questions but incorporated the issues most pertinent to the participants. Indexing was not a linear process but a multi-layered process of organising and re-organising codes and funnelling references. The first category captured data that revealed who was involved in the decision-making process, how these decisions were made and by whom. It also revealed whether decision-making practices were led by policy guidance. The second category captured data that revealed how people used functional objects in the care home and the access people had to functional objects. The third category captured data that revealed reasons why access to some

objects was offered whilst access to other objects was not. The fourth and final category captured data that revealed the relationships that people had with the objects they owned. This process prepared the data for the next stage of forming a framework matrix.

Framework matrices

The fourth stage of the analytical process was to generate a framework matrix (See appendix 12 for an example). The framework matrix initially provided a simple summarised version of the qualitative data. This was advanced by performing further searches using a combination of attributes, such as participant groups and coding categories or multiple participant groups and coding categories, at the same time isolating other groups and coding categories. Text queries were run in NVivo to explore the most popular words used by the different participant types with coding categories. It was at this stage that I made the decision to work on the data manually as I wanted to remain close to the data. My inexperience of using NVivo started to become clear and whilst the framework matrices were useful to compare within and between group, the text queries did not isolate groups. This meant that if a query was run on the most used words this would also include the words I had spoken. This could have also influenced the words participants used and as a result, I decided this was not a meaningful way of analysing the data.

Mapping and interpretation

The fifth and final stage in the analytical process was to map and interpret the framework matrices. Having reduced and simplified the data using NVivo, the mapping and interpretation stage moved beyond the management of data by looking *across* coded data to identify patterns and trends. Ritchie and Spencer (1994) described this as a way of pulling together the key characteristics to map and interpret the data as a whole. This stage initially involved testing out preliminary assumptions by comparing the framework categories. It was later advanced by including descriptions and clarification of concepts, representing the range and nature of the phenomena within the data, explanations of why it should be of interest to others and establishing relationships in the data. The purpose of this final stage of analysis was to identify how decisions were made about personal possessions and functional objects and who was involved in decision-making practices. It identified the objects that were used and the access people with a dementia had to functional objects in everyday life. It would also pull out the contradictions in the narratives told within groups, between groups and within single narratives. This stage was conducted by using the framework matrices generated by NVivo; but the interpretation and mapping was carried out manually.

4.6 The ethical process

Due to the potential vulnerability of participants and emotional nature of care home research four important steps were taken to protect the welfare of participants, as well as my own. These were gaining: (1) formal ethical approval for both the pilot study and the main study; (2) informed consent from participants taking part in the study; (3) agreement from personal and nominated consultees for participants who had been assessed as lacking mental capacity; completing process consent at each data collection and (4) setting up frequent meetings with the supervision team to provide emotional support throughout the data collection period.

4.6.1 Gaining ethical approval

Before recruitment could begin, formal ethical approval was required from the University of Southampton Faculty of Health Sciences Ethics Committee (**ERGO 22894**), the NHS Health Research Authority Social Care Research Ethics Committee (HRA Social Care REC) (**Reference number: 17/IEC08/0003**) and the Local Authority who owned the care homes taking part. A favourable decision was received by the HRA Social Care REC on the 25th April 2016 with three caveats attached. The first caveat related to the purpose of the pilot study. Given the rationale for the pilot study was to test the methodological design and choice of methods, the data collected within the study could not be used in the write up of this thesis. The only information from the pilot study that could be included were any amendments made to the methodological design and choice of methods. These are discussed in section 5.4. The second caveat was that people who had been assessed as lacking mental capacity could not be included in the interview method of data collection. They were only permitted to take part in participant observations, but informal conversations could take place. The conversations however, could not be audio recorded, as the recording of the conversations would be considered a formal interview. However, fieldnotes could be written relating to the informal conversations. The third caveat was that I would not be permitted to observe personal care, this was to ensure that dignity and privacy was always maintained.

4.7 Gaining consent for participation

Gaining informed consent is central to the research process involving human participants (RCN Research Society, 2011). It is essential to safeguard the welfare of the researcher and the participants, helping to prevent coercion or deceptive practices. It ensures all participants are given the opportunity to decide whether or not they are willing to take part in the research process (RCN Research Society, 2011). It was useful to draw on the guidelines produced by The

Royal College of Nursing Research Society (2011) to ensure an ethical and legal framework was followed. This took into account informed consent in special circumstances, it ensured the information given to participants was written in an accessible manner, it was clear about how the data would be used and by whom and that participants could withdraw from the research study at any time and without repercussions.

The first step to gaining informed consent was to identify potential participants for the study. As the study planned to include people who are considered vulnerable, gatekeepers were approached to support the recruitment process. Gatekeeping often occurs in health care research to ensure vulnerable people such as patients, families and staff are protected (Holloway & Wheeler, 2002). The local authority Adult Services Service Manager (ASSM) and a Registered Manager (RM) from each care home were recruited as gatekeepers. A meeting was held by the ASSM for care home staff to inform them of the research study. It was made clear at this time that they were under no obligation to take part. Given the multiple methods used in this study, potential participants were informed that participation in each data collection method was not required. Participants could choose whether they were willing to take part in the interview process, participant observations, documentary sources, or a combination of the three methods of data collection.

The gatekeepers distributed participant information sheets to each participant group (appendices 1, 2 and 3). The study included two types of participant information sheet, one paper version (see appendices 1, 2 and 3) and one video-recorded version. I recorded the video-recorded versions by reading verbatim each paper version from an autocue that was transferred on to a DVD when requested. The video-recorded version ensured that person who have difficulty understanding written text had another option of information was available. This would help to ensure that no one was excluded from the study. One important decision made relating to the participant information sheets was to refrain from using the word dementia. Whilst it could be argued that by not using the word dementia participants are not fully informed, this was overridden by the potential harm or distress caused for people unaware they had a dementia (Bartlett & Martin, 2002). Instead, I chose to use the term memory problems in all participant information sheets, video-recorded participant information sheets and posters that were located around the research sites.

Participant information sheets were distributed by hand to people living and working in the care home and posted to relatives. People with a dementia and care staff had seven days and relatives had 10 days (allowing for postage) to consider the information. Once the time had lapsed the Registered Manager made contact to see if further information was required. Details of those

who showed an interest were passed to me and I made contact to discuss the study further and answer any questions.

4.7.1 The inclusion of people assessed as lacking mental capacity

The study included people with a dementia who had received a formal diagnosis of dementia and people who were thought to have a dementia but had no formal diagnosis. Sections 30-34 of the Mental Capacity Act (2005) outline the guidelines for conducting research with vulnerable populations. The most significant implication for research practices following the implementation of the MCA (2005) was the requirement to assess the decision-making capacity of potential participants relating to consent to take part in a research project. Prior to data collection, I carried out an assessment to distinguish would-be participants who possess the capacity to consent to take part in research from those who are assessed as lacking that capacity. The assessment was a two-stage functional test of capacity consisting of two questions: is there an impairment in the person's mind or brain that affects how it works (not necessarily a diagnosis of a condition) and if so, does the impairment stop the person being able to make the particular decision at the time it needs to be made? To answer this second question, the assessment contains four criteria that the person should demonstrate they could fulfil. These are to understand information about the decision; to retain the information for long enough to use it; to weigh up the information and understand the consequences of their decision; and to communicate their decision somehow. A person must demonstrate all four of these criteria to be considered to possess decision-making capacity. Individuals with capacity may then legally consent to participate in the research. For those assessed as lacking capacity to consent, procedures necessitate the researcher to liaise with certain third parties known as Personal Consultees and Nominated Consultees. These individuals provide their perspectives on whether the person assessed as lacking capacity would or would not want to participate in the research, if he or she could provide their own consent (Dobson, 2008).

Given the NHS HRA Social Care Rec's concerns relating to the inclusion of people assessed as lacking capacity, those who had been previously assessed as lacking mental capacity to consent to research were only permitted to take part in participant observations and documentary sources, and only where a consultee had given a favourable opinion. Drawing on the guidance provided by the Royal College of Nursing (2011) and the NHS Health Research Authority guidelines either a relative or an Independent Mental Capacity Advocate was identified to act as a consultee.

4.7.2   Supervision

The NHS HRA Social Care Rec recommended that due to the sensitivity of the study taking place teamed with my inexperience of care home research, two weekly meetings should take place with my supervision team. This would allow me to talk through any difficulties in data collection but also an outlet for discussing any emotional aspects of carrying out research in a care home setting.

4.8   Summary

This chapter has provided a comprehensive explanation of the research design, and the methods chosen. The method of analysis was introduced with a guide to show the steps followed whilst conducting the framework analysis. This was followed by a discussion relating to the ethics process and the ethical approval gained when including people who were both assessed as having and lacking mental capacity in a research study.

Chapter 5: Introducing the pilot and main study research sites

5.1 Introduction

This chapter provides further methodological and contextual information about the care homes and people who took part in the study. The chapter is organised into two sections. The first section discusses how access was gained to the research sites and sets out the objectives of conducting a pilot study. This is followed by a brief overview of the pilot study research site and the participants who took part. Finally, the amendments made as a result of the pilot study are presented and discussed. The second section provides a comprehensive description of the main research site and the study participants who kindly took part in the study.

Section one – Access to research sites and objectives of the pilot study

5.2 Access to research sites

To access research sites, in November 2015, I spoke at a local dementia awareness event about my doctoral study in the context of dementia care research more broadly. After my talk, I was approached by a local authority Adult Services Service Manager (ASSM) and a Registered Manager (RM) of a local authority care home in the South of England. They asked if I would consider their care homes for my study. The care homes were situated in the South of England, they offered both nursing and residential care, and provided care for people with a dementia. I had in the first instance considered the inclusion of different types of care homes, for example a local authority, not-for profit, private and charity care home; however, it became clear that care homes differ from home to home within organisations. The primary interest of the study was to understand how functional objects manifest in care homes for older people with dementia and whether social citizenship is a useful lens to examine such relations. To examine this thoroughly the number of sites was less important than carrying out a full and in-depth ethnographic immersion in one site.

5.3 The objectives of the pilot study

The suitability of the methodological design to the research question is crucial. This study explored an area of research that until now has received little attention. It also included people

assessed as lacking mental capacity who have historically been overlooked in research (Bond & Corner, 2001). The pilot study was to examine: (1) the suitability of the methods in answering the research questions and (2) the suitability of the methods for including people with a dementia who were assessed as having and lacking mental capacity. The objectives of the pilot study are shown in box 8.

Box 8   Objectives of the pilot study

- To carry out interviews with the prepared semi-structured interview schedules for all three participant groups to test suitability
- To carry out photo-elicitation interviews with relatives and care staff
- To carry out observations to gain experience in fieldnote writing and how to record the fieldnotes
- To examine the documentary evidence to assess which documents to include
- To gain experience of carrying out the two-stage functional test of capacity for informed consent
- Consideration of other practical issues, personal development and management of expectations for both the research endeavour and participant experience

---

5.4   The pilot study - Copperfield House

Copperfield House is a large red brick purpose built nursing and residential home located on the South Coast of England. It is situated on a residential street within a five-minute walk from the town centre. The building provides accommodation over two floors for up to 60 older people. The home is divided into two separate units, one nursing care and one residential care, each side accommodating up to 30 residents. The pilot study took place in the residential side of the care home. This was due to the assumption that people living in residential care may be more able to participant in daily activities with objects than those living in nursing care. Each resident had an en-suite room comprising a bed, sink, wardrobe, chair, chest of drawers and a commode. The home was managed by a registered manager who was supported by deputy managers, care staff and ancillary staff.

On my first visit, the registered manager showed me around the residential side of the home, introducing me to residents and staff. I was directed to certain spaces of the home such as three alcoves used as lounges along the main corridor, the main enclosed lounge, residents' rooms, the laundry area, dining areas, kitchen, and office areas. Certain aspects of the home were pointed out to me such as the photographs on the walls. The photographs were of residents on outings

and staff dressed as Santa and elves at Christmas time, there were also laminated posters describing person-centred care. It was pointed out that residents could use the kitchen area in the dining room and drinks were located around the building for people to access. I was directed to the large garden at the back of the building where I was shown the hanging baskets and new seating so that residents and relatives can enjoy the outdoors. I was introduced to the activities coordinator who directed me to the notifications wall that contained a list of activities that were due to take place that week. She then showed me another wall with more photographs of staff and residents on outdoor excursions and a framed certificate of an award presented to the home for the activities that had been provided. The overall impression gained from the initial visit was that the home was clean and light, staff and residents were friendly and chatty and staff appeared proud of the home.

The pilot study lasted a total of twelve weeks. This consisted of a four-week hanging out period that was conducted in February 2017, followed by an eight-week period of data collection between May and June 2017, during which I piloted the chosen methods of data collection. The Adult Services Service Manager and Register Manager acted as gatekeepers.

A total of 27 participants comprising 11 residents[1] (7 female and 4 male), 13 care staff (10 female and 3 male) and three relatives (3 female and 1 male) were recruited. Demographic details such as the ages of participants was not collected as the data was only for exploring the methods for data collection. All residents had lived in the residential care home for a minimum of three months.

The methods piloted were participant observations, the use of photo-elicitation interviews, object-interviews, in-depth interviews and the examination of documentary sources. All participants took part in the participant observations and consent was given to access documentary sources such as daily care records and individual care plans.

Participant observations took place three times per week for four hours each day. This resulted in a total of 96 hours of participant observation data and 28 pages of fieldnotes. The participant observations took place at varying times of the day with a view to capture a comprehensive understanding of the routines and rituals of care home life. Semi-structured interviews were conducted with eleven participants comprising two residents, five care staff and three relatives. The interviews ranged from 20 minutes to 90 minutes. The questions contained in the interview schedules focused on object-person relations, exploring the importance of objects for individuals

---

[1] When talking of 'residents' this refers only to residents who have a dementia, not all residents in the care home.

and exploring which objects were considered important for care home life. The interview schedules were used as a guide and separate interview schedules were developed for each participant group (appendices 4, 5 and 6). Written informed consent was gained for interviews, observations and photographs (appendices 7, 8 and 9). If a person was assessed as lacking mental capacity a personal or nominated consultee process was followed (appendices 10 and 11). As it is recognised that capacity can fluctuate, a process consent method (Dewing, 2007) was carried out through the data collection period.

The pilot study tested the proposed ethnographic methods and explored the inclusion of people at varying stages and with various types of dementia. Amendments to the methods used in the main study resulted from the testing of the recruitment process, interview guides with all participant groups, photo-elicitation interviews with relatives and care staff, experience of fieldnote writing and examining documentary sources.   The amendments are outlined in Table 1.

Table 1. Amendments made to methods

Method	*Amendment*
Recruitment process – inclusion criteria	The inclusion criteria were changed from a person with a dementia having to have lived in the home for three months to a person with a dementia having lived in the care home for any period of time.
	The inclusion criteria were changed from only including care staff to including all care home staff.
Recruitment process – the role of the researcher	Initially I did not openly talk about the research in the hanging out period due to feelings of coercion. This changed to talking openly to staff if they initiated the conversation.
Documentary sources	The daily care records were lengthy and lacked content relating to objects. Daily care records were removed from the documentary source data.
Interview schedule	The interview schedule for people with a dementia was removed from the interview method
Interviews	Increased the time allowed for interviews as the interviews often naturally lasted longer than 60 minutes
Photo–elicitation interview	These were discontinued as participants did not produce photographs at interview

Participant observations	Scheduling observation times to ensure the write up of fieldnotes would take place as soon as possible after the observations took place
	Observations would only take place between the hours of 8am and 8pm

A fuller explanation of these amendments will now be provided in the order in which they are presented in Table 1.

Recruitment

Inclusion and exclusion criteria are a set of predefined characteristics used to determine who will be included in a research study (Salkind, 2010). An initial inclusion criteria for people with a dementia was that they would have resided in the care home for a minimum of three months. This was considered a reasonable timeframe to allow a resident time to settle into care home life and for their belongings to be in the care home. It became clear that residents new to the care home talked about their possessions more than those who had been living in the home for some time. This was an important observation as it showed the importance of objects upon moving to the care home and could give insight into how decisions were made and how objects were transferred. With this in mind the inclusion criteria was changed from a person with a dementia must have lived in the home for a minimum of three months to a person with a dementia must reside in the care home.

Another inclusion criterion was that only care staff were eligible to take part in the study. Initially, I had presumed that care staff were the main employees in care homes to interact with residents; however, other members of staff had frequent interactions with residents. The inclusion criteria was changed to *all* staff following observations of administrative staff chatting to residents, domestic staff assisting with breakfast time and a chef producing a CD from his car for a resident after overhearing a conversation between a resident and a member of care staff. By only including care staff, other important interactions may be lost in the main study.

Two gatekeepers were recruited to this study, one whose role was to choose and grant access to the research sites and one whose role was to identify potential participants interested in knowing more about the study. Whilst seemingly straightforward it became clear that information about the study did not reach all those in the research site interested in taking part. Some staff had not received participant information sheets, other members of staff had not been on duty when the study was discussed by the management team. The recruitment process was altered so that participant information sheets were distributed prior to the hanging out period. This could

provide opportunities for informal discussions to take place regarding the study, if prompted by staff, relatives or residents.

Documentary sources

Care home staff were required to complete daily care records for each person living in the care home. This data was initially considered important to the study as it could provide information as to whether objects were regularly mentioned and if so in what way. After reading two months of daily care records for each participant it was found that very little information related to objects. Reading through voluminous daily care records was considered time consuming, particularly when it would provide a relatively small amount of data. It was also considered an unethical intrusion to view a person's daily care records if objects are rarely mentioned. Therefore, this data source was removed from the study design.

In-depth interviews

Interview guides were developed for all three participant groups. The guides were not intended to create a structured interview as they were combined with photo-elicitation and object-elicitation interview methods. By design, they were to provide prompts for the researcher, questions were not used in a set order and some questions were not asked at all. The guides were a useful tool when interviewing care staff and relatives, but they were not so useful when conducting interviews with people with a dementia. Carrying an interview guide seemed to get in the way of talking about a person's objects. The interview guide restricted freedom of movement. I had to keep putting down the interview guide then picking it back up once the discussion had finished. The act of putting down the interview guide and picking it up seemed to break the spontaneity of conversation. I therefore decided to test resident interviews without the interview guide. This worked much better as it enabled the free flow of physical movement. When conducting the object-elicitation interview it was important to move around the room, pointing or asking to pick up objects, bringing the object over to the resident to touch, looking over and discussing the object. The interview guides were removed from any further object-elicitation interviews with people with a dementia.

Whilst there is no standard or fixed time for conducting in-depth interviews, from my own experience and existing literature, I anticipated each interview would take around 60 minutes. Whilst conducting the pilot study one interview with a resident was terminated at 90 minutes. This was due to the conversation no longer being relevant to the study. Another resident interview took 20 minutes as she had less to say and appeared to tire quickly. Interviews with care staff and relatives tended to take anything from 60 to 90 minutes before natural saturation

occurred. A new timeframe of 120 minutes was built into the main study design to ensure enough time was allocated to the interview method. This also took into account practical implications such as allowing a reasonable amount of flexibility in my time for staff being released from their duties and for relatives arriving to the interview.

Photo-elicitation interviews

Photo-elicitation techniques were considered to have the potential to be useful when talking about an abstract topic such as objects. Care staff and relatives were asked to bring in photographs of the objects that were important to them; these would be used as the focus of conversation. Of the five care staff and three relatives taking part in the photo-elicitation interviews only one member of care staff brought a photograph to the interview. Another member of staff brought in a box of items and the remaining participants attended empty handed. All of the relative participants stated they had either forgotten, could not find anything to take a photograph of, or did not have an existing image of an object important to them. Whilst conducting the photo-elicitation interviews it became clear this method was not as useful as first envisaged. Whilst the photograph brought in by one member of staff was useful to start the conversation, much of the conversation related to other objects. The box of possessions brought in by a member of staff seemed to act as a barrier to engaging in a more active conversation. She appeared to become fixed upon working through the items one by one. Many of the participants who had not brought photographic images to the interviews actively engaged in conversations about objects without having the visual image. Therefore, the photographic elicitation element was removed leaving an in-depth interview method.

Participant observations

Whilst it is good practice to write up fieldnotes in full immediately after the observations had taken place (Emerson et al., 1995), in reality, it is not always possible. Participant observations were to take place at different times of the day; however, I had not accounted for finishing observations in the evening or the tiredness felt from carrying out observations. This teamed with an early start the next morning left little time for writing up. The organisation of observations needed a more systematic approach to prevent the fieldnotes being compromised. This would mean when planning the main study, a time allocation for writing up fieldnotes would be written into the organisation of the participant observations. I intended to collect data at all times of the day as this could give a better idea of all aspects of everyday life. I was unable to observe people receiving personal care, so care home staff suggested I visit the home between 8am and 8pm. The

observation times for the main study were altered to reflect this and fieldnotes were often taken in communal areas or in a person's room when invited.

Finally, the hanging out period was a useful way of building rapport with members of staff. This method remained in the main study, but it is important to note that this method did prove challenging at time. The advantages and challenges will now be discussed.

Hanging out period

The hanging out period gave me the chance to introduce myself to people living, working and visiting the home. It provided opportunities for people to ask me questions about what I was doing in the care home. It also allowed me time to gain some familiarity of the building, to memorise various door codes, to get a feel for how people spent their days, who they spent them with and to experience the routines and rituals of daily life. The hanging out period allowed for dialogue to take place, often candid conversations, allowing me to understand the relationships that existed both inside and outside of the home. The conversations were not audio recorded and fieldnotes were not taken but it provided me with insight into the lives of those who lived in, worked in and visited the home. I sat in on some handover sessions given by staff; this provided me with opportunities to listen to how people were talked about and understand how workloads were assigned to each staff member.

Advantages of the hanging out period

The hanging out period gave rise to some unexpected advantages. As the term suggests, hanging out provided me with no set role. I was just around, chatting to people, having lunch with residents and helping staff at meal times. The purpose of hanging out was to build rapport and experience care home life. An advantage of this was that it offered time for immediate reflection. I could identify pre-conceived ideas I held from my own experiences as a care assistant. I could see societal assumptions play out in front of me. I could identify my own biases and emotional triggers. These could be noted and worked through in the moment or noted and worked through once I had left the building. I could ask myself questions such as, why did I feel a certain way, why did I feel an emotional response to certain practices and how might I deal with this.

Limitations of the hanging out period

A limitation of the hanging out period was a lack of boundaries. Due to not having a specific role this resulted in me taking up different positions dependent upon who I was with. When listening and speaking with residents I would at times take up the position of advocate. Some residents believed they were more likely to have a request fulfilled if I made the request on their behalf.

Although this did not happen often, one of the residents soon knew me as 'the girl who can get things done'. On reflection, I began to understand that in this environment the perception of others was that I carried power. This required careful management as once I started to collect data I wanted to observe realistic care practices, not practices overly influenced by my presence. For relatives I tended to adopt the position of a friendly listener. Some of the relatives would offload their thoughts and feelings relating to their relationships with their loved ones being in a care home. One participant often cried when chatting about how her husband came to be in the care home. She would regularly seek reassurance that she had made the right decision. For members of care home staff my identity seemed to change dependent upon which members of staff were on duty. To some members of staff, I was a friendly outsider, to others I was a spy, whilst to others I was a researcher or educator.

Having no purpose other than getting to know people provided an opportunity for people to share whatever they liked with me as no line of enquiry was currently being followed. The position of giving a resident a voice, providing relatives with emotional support or answering questions about dementia posed by care staff were often precarious and at times incredibly uncomfortable. There were times I felt conflicted by what people had told me and the lack of action they wanted me to take. Although at times the information residents or relatives shared was uncomfortable to hear, unless it was a safeguarding issue, I took no direct action. On one occasion, I took action when observing an incident of excessive restraint. After speaking with the Deputy Manager and Adult Services Service Manager I reported the incident to the local authority safeguarding team who investigated the incident. Although it was uncomfortable returning to the care home, particularly as staff were aware I had lodged a safeguarding incident, many staff welcomed me back to the care home.

5.5   Summary

Carrying out a pilot study with the purpose of testing the methodological design was a valuable process in terms of the people who were included and the methods used to collect data. This resulted in a substantial amendment to both the Faculty Ethics Committee and the HRA Social Care REC. The main study inclusion criteria were altered to allow all people with a dementia in the care home the opportunity to take part in the study regardless of how long they had lived there. It was also altered to include *all* care home staff the opportunity to participate providing they have worked in the home for a period of six months or more. Although gatekeepers were recruited, the researcher could answer questions about the research whilst in the hanging out period. Photo-elicitation interviews were removed with in-depth interviews being conducted with relatives and care home staff and interview guides would only be used for care home staff

and relatives. The time allocated for interviews was extended and the final change was that time to write up fieldnotes would be included in the participant observation process.

Section two – The main study research site

5.6   Introduction

The purpose of the second part of this chapter is to introduce the main research site and provide a comprehensive description of the building and to describe both physical and social features of the care home. It will provide some photographic images of the inside of the building including certain decorative features and objects found in the home. This section will provide a description of the participants who kindly took part in the study including people with dementia, care home staff and relatives who visited the care home.

5.7   Accessing the study site

The primary focus of this study was to understand how decisions are made relating to objects, who is involved in decision making, how objects are used and by whom. As previously described, the Adult Services Service Manager (ASSM) directed the access to the care homes. The only specification from a research perspective was that it would be a residential care home. This was due to the assumption that the people living in a residential home would require less care than people residing in a nursing home. In addition, the site would need to provide accommodation for people with a dementia as this was a dementia focused study. The ASSM's original choice of residential home for the main study fell through but he quickly identified Southcote Manor as an alternative research site.

5.8   Southcote Manor – the main study site

Southcote Manor is a large red brick purpose-built residential home located in the South of England within a five minute walk from a busy town centre. When approaching the drive to the home a doctor's surgery is to the left, following up the sweeping drive there are several independent living buildings on the right-hand side; to the left is situated a car park and to the back left of the building is a day centre for older people who live in the community. The home provides accommodation for up to 35 residents and is set over two floors with a lift and set of stairs providing access to the top floor. Residents living upstairs have limited access to the rest of the building due to a key coded locked door preventing access to the lift or the stairs. There are

five communal living areas in total, each with lounge, dining room and kitchenette. The building is situated in landscaped grounds with a large garden at the back of the building.

Each resident has an en-suite room comprising a bed, sink, wardrobe, chair, chest of drawers and a commode. A registered manager who was supported by a deputy manager and several assistant unit managers (AUM) managed the home. The care home had taken part in a previous research project and as a result had secured funding for more care staff than was typically available in most local authority care homes. It operated a senior care assistant programme in which care assistants could take on higher levels of responsibility. Ancillary staff were employed; some of these staff were both ancillary and care staff and ancillary staff were expected to provide breakfast from 7:30am until 9:00am as well as their other duties. Administration staff were located at the entrance of the building and always provided a warm and inviting welcome.

An introductory visit included introductions to care homes staff and residents by the registered manager. She pointed out certain physical aspects of the home such as the recently fitted kitchenettes in each lounge/dining area, designed for the use of residents.

Photographic image no. 1 Kitchenette in one of the lounge/diner/kitchen

I was shown menus displaying the choice of food on offer each day and pictures on walls, which I was told made the building look homely. I was shown around residents' rooms and told how a lack of space in many of rooms prevented large objects from being brought into the care home.

Photographic image no. 2. James' bedroom

The doors to residents' rooms were 'dementia friendly' doors, which looked like a real front door and came in various primary colours. There were photographs of day trips with both residents and staff on the walls in the corridors and chairs situated around the outside of the living areas. Each lounge had books, puzzles and DVDs either underneath or to the side of the television units; there were machines for playing music, images of the royal family and nostalgic pictures on the walls.

Photographic image no. 3. **A wall in a communal lounge.**
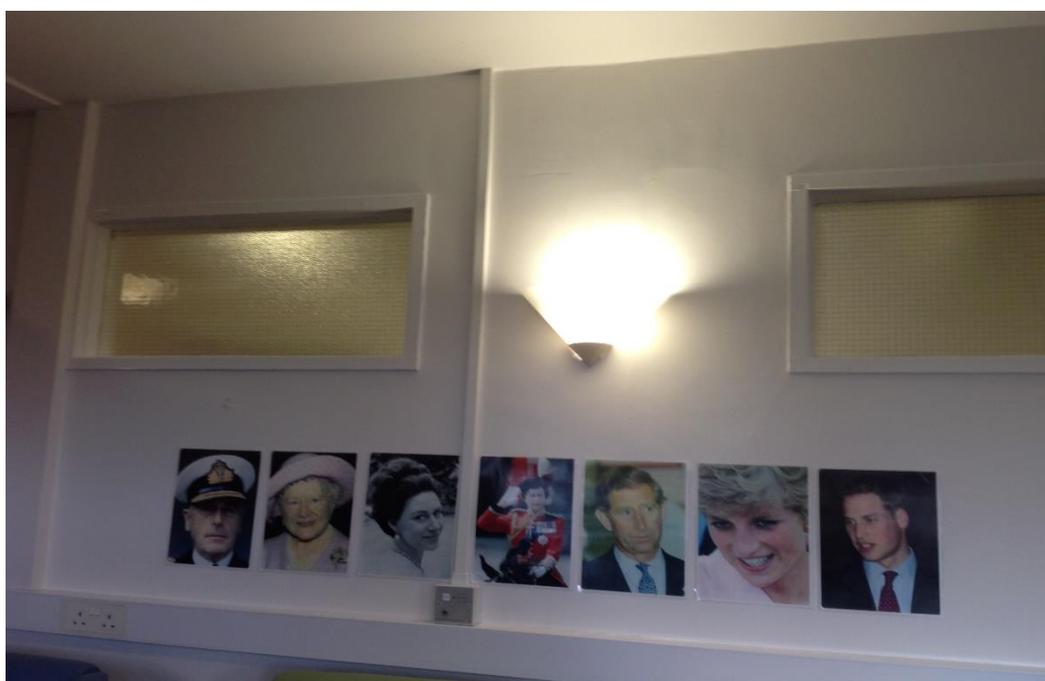
Photographic image no. 4. A wall in a communal lounge

The overall impression of the home was that it was clean and tidy. Whilst many staff appeared happy and welcoming, other staff appeared uncomfortable with my presence. This was apparent as some members of staff would avoid eye contact with me and often leave the room when I walked in. Other members of staff openly stated they would not take part in this research study. To try to ease any discomfort between staff and myself I would always say hello, ask how they were, reiterate that I would answer any questions they had and confirm they had full access to any notes I was writing. I would also reiterate that I was interested in the way objects were used and that I was not assessing the care being provided.

5.9   Participant sample

The study used a convenience sampling technique. A total of 40 participants who met the inclusion criteria took part in the main study. Three types of participant were included: people with a dementia living in the care home, care home staff employed by the care home and relatives who were frequent visitors to the care home. It was important to gain the perspectives of each group as all three groups are involved in decision-making relating to objects and access to objects. These following sections will describe the particular characteristics of each sample group.

Participant group 1 – people with a dementia

A total of 15 residents (11 female and 4 male, average age 88) with a dementia were identified as willing to take part in the study. Four residents were assessed as having mental capacity and gave

written consent. Eleven residents who were assessed as lacking mental capacity and had either a personal or a nominated consultee who had agreed the person would be willing to take part. All 15 residents took part in the participant observations and documentary sources; four residents were eligible to take part in the object-elicitation interviews. Sadly, three participants did not complete the entire data collection process; two participants died, and one participant moved to a nursing home following a fall. The data of these residents is included in the analysis. Resident participants were at varying degrees of cognitive impairment, and the types of dementia included Alzheimer's disease, vascular dementia, mixed dementia and fronto-temporal dementia.

Participant group 2 – care home staff

A total of 16 care home staff (12 female and 4 male, average age 46) were willing to take part in the study; of those participants all took part in the participant observations method and eleven took part in the interviews. The time in which care home staff had worked at the home ranged from the minimum of 6 months up to 17 years. One member of staff withdrew her interview data and therefore this was not included in the analysis stage.

Participant group 3 – relatives who visit the care home

A total of eight relatives (6 female and 2 male, average age 60) were willing to take part in both interviews and participant observations. Seven of the participants were children of a resident and one was a resident's wife. Although all relatives/spouses were willing to take part in both interview and participant observation methods, not all were observed in the home. Of the 39 participants that took part in the study, 38 were of white British origin, one was Romanian.

5.10   Complications in the consent process

Whilst the pilot had been successful in identifying areas for amendment, complications arose at the main study site that differed from the amendments made. The first complication was the distribution of participant information sheets (appendices 1, 2 and 3). A meeting had taken place at the care home to inform care home staff of the study, information sheets had been distributed by hand to care staff residents, and by post to relatives, it became apparent that not all care home staff had attended the meeting and not all care home staff and relatives had received the information. This became clear during the hanging out period when both staff and relatives approached me to ask who I was and what I was doing there. I informed them who I was and gave them a brief overview of the study. It was at this point they mentioned they had not received a participant information sheet. I then located and handed them the appropriate information sheet for them to consider participation in the study.

The second complication was the complexity of anonymity. Within the written text, pseudonyms would be assigned to each participant to help disguise their identity; however, due to participants either living, working or visiting the care home their ability to take part anonymously was difficult. Care home staff were at particular risk, in order to make it easier for them to take part the registered manager had offered for interviews to take place in work time, however this could alert other members of staff working at the same time. Offers were made to care home staff to conduct the interviews elsewhere, these offers were declined. The option of conducting interviews away from the care home were also offered to relatives, this offer was taken up by one relative, other relatives preferred to conduct the interview at the care home. The offer of conducting interviews off site for people with a dementia was even more complicated. Many were unable to leave the care home due to Deprivation of Liberty Safeguards (DoH, 2008) restricting freedom of movement.

The third complication was a difference in interpretation of capacity (Fletcher, Lee, & Snowden, 2019). Following the 'hanging out' period, I had formed ideas about who I thought might like to take part in the research, and who I believed might pass the capacity to consent to take part in research assessment. I received a list compiled by the gatekeeper of those potentially interested in taking part in the study. I noticed many people with a dementia had been considered as lacking capacity to consent. This did not fit with my interactions and resulted in the following dilemma. If I questioned the gatekeeper's assessment of capacity, this could have implications. It could have been viewed as an attempt to influence or coerce participation in the recruitment process and it could disrupt the developing research relationship. If I chose not to question the identified discrepancies, this could result in people with a dementia being excluded from the interviews or at worst, the entire project. Thus, denying them the opportunity to take part in research. I made the decision to question the gatekeeper's assessment of capacity, which proved worthwhile. It allowed us to discuss our interpretations and illuminated that the gatekeeper's assessment of capacity was an opinion rather than an actual assessment. Whilst it was agreed that some people with a dementia were likely to fail the capacity to consent assessment others were not so clear-cut.

What was also clear was that the gatekeeper and the researcher were coming from opposing standpoints. The gatekeeper was erring on the side of caution, that if capacity was questionable, they were likely to fail and so therefore a consultee should be appointed. Whereas I was erring on the side of creating an opportunity for people with a dementia to take part in a research study until the capacity to consent was formally established. By discussing mental capacity and carrying out a formal assessment for research purposes people with a dementia were provided an opportunity to take part.

5.11   The methods used in the main study

The methods used in this study were participant observations for all participant groups, object-elicitation interviews for people with a dementia, in-depth interviews for care home staff and relatives, and the analysis of documentary sources.

5.12   Duration of the study

The main study lasted a total of 16 weeks. This comprised a four-week hanging out period conducted in July 2017, followed by the collection of data in August and September 2017. After a break of four weeks in October, a final phase of data collection was conducted in November 2017.

All participants took part in participant observations. The participant observations were carried out three times per week for four hours each day at varying times of the day. This resulted in a total of 144 hours of participant observation data. A total of 22 interviews were conducted comprising of four residents, eleven care staff, and eight relatives. All participant interviews were prearranged. Interview dates were made with residents but were flexible and were changed if the person did not wish to take part at that time, had another engagement, or had a visitor. The interviews took place in their personal rooms, this enabled conversations to take place which focused on the possessions they had in their room. The interviews with care home staff and relatives took place either in the ASSM's office or in the staff lounge. One interview with a relative took place in their own home.

The observations were carried out in line with ethical restrictions noted in the pilot study section 4.4.5 and took place in communal lounges, dining rooms, the garden and in a person's bedroom if invited. A total of 87 pages of fieldnotes were written with the purpose of capturing interactions that took place with objects, who used them, how objects were used and to make notes of informal conversations that took place. All fieldnotes were written up in full as soon as possible following data collection.

5.13   Summary

This chapter has described how access was gained to both the pilot and main study site. The objectives of the pilot study were explained, and a description of the pilot site was provided. The amendments made to the methods were presented identifying and explaining the methods altered, removed and those that remained the same for the main study. A full description of the main study site, the timeframe of data collection, the method used for participant sampling and participant details were presented.

The next three chapters will discuss the findings of the study and demonstrate the contribution to knowledge this study makes. Chapter 6 presents the overarching categories and focuses on the findings relating to decision-making when a person with a dementia relocates to a care home. It then focuses on how decisions are made about a person's belongings and explores the rationale behind decision-making practices. Chapter 7 concentrates on how functional objects are imbued in everyday life in the care home, exploring how objects are used and by whom. Chapter 8 addresses the research question relating to whether a material lens is useful in locating social citizenship.

Chapter 6: Decision-making practices about personal possessions and functional objects

One of the overarching categories identified in the analysis of data was decision-making practices relating to personal possessions when a person moved into a care home. It was often found that people with a dementia were excluded from decision-making about their belongings and that family members were left to deal with the contents of a relative's home. This is concurrent with previous findings (Innes et al., 2011; Lindley & Wallace, 2015). This study also found that care home staff would both encourage and discourage certain personal possessions being brought into the care home.

This chapter is presented in two parts to separate the initial decision-making about personal possessions that takes place when a person moves into a care home, and the ongoing decision-making about functional objects once a person is resident in a care home.

The first part of this chapter focuses on who is involved in decision-making relating to personal possessions when a person moves to a care home. The context surrounding the circumstances of care home relocation and how this can affect decision-making relating to the possessions a person takes to the care home is discussed. This is followed by a discussion relating to how personal possessions are transferred from a person's private home to a care home and identifies the type of objects that are encouraged and those discouraged from the care home environment.

The second half of this chapter focuses on how decisions are made once a person has moved into a care home. This section provides a discussion relating to who was involved in decision-making regarding a person's existing personal possessions and any future objects they may want to obtain. Included is a visual representation and explanation of the ongoing decision-making practices that potentially take place once a person is living in a care home and examines whether policies or practices exist that support object-person relations.

Section one

6.1   Initial decision-making relating to functional objects

Firstly, the chapter provides contextual information regarding how some of the residents came to live in the care home, and how decisions were made about the objects they brought with them. I provide six pen portraits of residents; three had moved directly from a hospital admission to the care home, one had been on respite when offered a permanent place and two had moved from their own home to the care home. The six residents selected are chosen because of the depth of data collected with them and their relatives.

The stories are told by either the resident themselves or by a relative and focus on whether residents are included in decision-making about their relocation and their personal possessions. The accounts of care home staff are provided to gain an understanding of how decisions are made relating to a person moving into a care home and their belongings. Excerpts of policy and practice documents are included where they provide guidance relating to a person's possessions.

6.2   Decision-making practices when relocating to a care home and personal possessions

The circumstances surrounding a relocation from a private home to care home are important in understanding how decisions are made about personal possessions. Often a person with a dementia will move to a care home following a hospital admission. The decision to move to a care home may not have been made themselves. Decisions to move to a residential care home are often made in haste and viewed by relatives as a fait accompli (Bigby, Bowers, & Webber, 2011). This often leaves relatives with the difficult task of dealing with their belongings (Lindley & Wallace, 2015).

By applying a framework analysis approach to the data, it was possible to explore the contextual information identifying the form and nature of what existed in relation to decision-making when moving into a care home, and the diagnostic information examining reasons for, or causes of, what existed. One of the main aspects identified through the analysis was that people with a dementia were often excluded from decision-making relating to their relocation and were excluded from decision-making relating to their belongings.

Within the framework category: 'exclusion from decision-making relating to relocation and personal possessions', six sub-categories were identified which are presented in Table 2 below.

Table 2. Decision-making when relocating to a care home

Overarching category	Framework categories	Sub-categories
Decision-making	Exclusion from decision-making relating to relocation and personal possessions	I don't know why I am here
		When temporary becomes permanent
		My daughters made the decision
		The opportunity to decide
		Advanced decisions
		Policy and practice

The sub-categories will be discussed in the order in which they are presented in Table 2.

It became apparent while conducting the hanging out period that residents were not always certain why they had moved to a care home or who had made the decision for them to be there. It also became evident that the circumstances surrounding the relocation to a care home had an impact on the personal possessions a person had access to. Analysis of interview data showed that of the 15 residents who took part in this study, two residents were known to have been included in decision-making relating to the care home they moved to, and nine were excluded from decision-making relating to their relocation. Reliable information regarding the remaining four participants was unavailable. This demonstrates a failure of the Mental Capacity Act (2005) in assigning a right to have choice in respect of when a person relocates to a care home and the choice of care home (Boyle, 2008).

It seemed sensible to assume that if a person was not included in decision-making relating to their relocation to a care home, it would be difficult to include them in deciding which objects they took with them when they moved. Analysis of the interview data showed that of the same 15 residents, 11 were excluded from making decisions about their belongings; this included the two residents included in decision-making regarding relocation, for the remaining four participants reliable information was unavailable. The next section introduces six residents, it gives their age, a little information about them and how they came to live at Southcote Manor.

6.2.1   I don't know why I am here

Karen (94) had been a resident at Southcote Manor for one week when I began hanging out. When I first met Karen, she was a lively woman with an infectious smile and a mischievous streak. She enjoyed taking care of her appearance, she loved chocolate, clothes, make-up, hair, sherry, music, the Daily Mail newspaper (although I did not observe her reading it) and dancing. She would often remark on my hair, how she would love to be blonde rather than grey. She remarked that she did not recognise herself with this dull grey colour it made her feel old. She also did not like wearing her hair flat, commenting this was not how she wore her hair. Karen liked to use curling tongs to curl her hair; she told me they gave her hair volume. She told me how she liked to be busy not all this sitting around. She enjoyed shopping and getting out; she liked to see the colours and feel the fabric of clothes even if she could not buy anything. Karen was good company; she took an interest in others and enjoyed chatting about a whole range of topics.

Prior to relocating to the care home, Karen had lived at home caring for her daughter who had a learning disability. Karen was admitted to hospital following a fall. While in hospital her daughter had died, and a decision was made that Karen would move to a care home. Karen told me she did not understand why she was in the care home, that she was taken there from hospital. Karen also did not understand why she was restricted in her movements. She did not understand why she was not allowed out of the care home to pop to the shops. Prior to living in the care home, she was as 'free as a bird' and yet now she was like a 'chicken in a coup'. Karen had not made the decision to relocate and had no family nearby. She had two nephews but neither lived locally however one of them would visit her when he could and was taking care of things. Karen was not involved in making decisions about her belongings and had to wait for her nephew to visit to bring items in for her. Karen would often comment how she was no longer included in making decisions:

> *"It wouldn't, well it's not a case of choosing your life; its thrust on you isn't it really. Hmm, you have to go along with it. And as I'm so old" (Karen, fieldnotes, resident).*

Karen believed the discrimination she experienced relating to her exclusion in decision-making was a result of being "so old." What was clear was that Karen was frustrated at being denied agency, self-determination and social citizenship. She no longer had control over her finances, her belongings or access to her flat. She was not given permission to leave the care home to buy items she wanted such as an eye pencil, hair dye, clothing and chocolates. She was prevented from leaving the building by members of staff unless accompanied by either care home staff, or a relative. However, care home staff were often too busy to accommodate her on a regular basis and as previously mentioned she had no family that lived locally.

It was clear that Karen did not understand how she came to be a resident in Southcote Manor. It was also recognised by care staff that many people moving into the home did not understand why and how they came to live there:

> "*People aren't always a hundred percent sure what's happening I don't think. Because of their dementia until they actually get here*" (Elaine, interview, registered manager).

The extract suggests that the registered manager assumes people are not sure what is happening due to their dementia rather than their exclusion from decision-making. This is important as the idea that the lack of understanding is symptomatic of dementia suggests that it is also unlikely the person will be provided with the necessary information to form an understanding. This prevents conversations regarding advocacy or a right to appeal the relocation decision from taking place. It can therefore be argued that the current practices are systematically discriminatory based upon people with a dementia not being afforded the same rights as those who are cognitively fit. Whether unwittingly or not this is an explicit example of the denial of citizenship for a person with a dementia. It shows that people with a dementia are not fully informed of their rights.

James (86) moved into the care home during the hanging out period. He, like Karen, had moved directly from hospital to the care home. Staff had reported that due to a deterioration in his health, James' wife could no longer cope and so made the decision to move him into the care home. James appeared a conservative man who enjoyed short conversations and the company of his wife. He had been an electrical engineer and told me he had always been sharp which had made it difficult for him to observe his wife making more and more of the decisions. He remarked that this made him question his masculine role in their relationship. James took pride in his appearance. He liked to dress smartly, usually wearing a shirt, a cardigan with a hanky tucked either in the pocket or up his sleeve, and smart trousers. He would at times become disgruntled when he had no socks in his drawer or if he could not find his comb. James liked his beard to be neatly trimmed and his hair combed. On one occasion, James was preoccupied with his hair not being quite right, as he could not find his comb. He was unsettled in the communal lounge/diner, so I offered to help him look for his comb. The comb was in his bedroom by the sink and as he combed his hair, he asked me if it looked okay, his wife usually told him he looked fine. I reassured James that he looked very nice. The use of his comb along with my reassurance seemed to provide him the positive affirmation he needed to carry on with his morning.

As previously mentioned, James had not been included in the decision-making about his relocation to the care home and would often ask why he was there. I would reply 'I am not sure James; I think it might be due to your hospital admission'. On one occasion we were walking

through a corridor when he asked me the same question; I looked to a staff member who was stood opposite us and gestured to her to answer his question; Mandy answered:

> *"You are on holiday love, that's all just a little holiday" (Mandy, fieldnotes, care*
> *assistant).*

Although Mandy was lying to James about his situation, this was a directive from James' wife. She did not want him to be told he have moved into the care home. James often asked why he was in the care home, which may have been a symptom of short-term memory loss but it may have been that the answers he received to this question were inadequate. The 'holiday' narrative may have been confusing, after all James was in a building that was not of his choosing, his wife was absent, and he was prevented from leaving the upstairs floor.

The lack of information and dismissive comments can feed into a narrative of a person with a dementia being confused and repetitive, thus confirming symptomatic behaviour rather than understanding this as an information-seeking endeavour. Rather than a symptom of dementia, the confusion may be a result of things and events not making sense and the misinformation being given by staff and relatives. The topic of lying to people with a dementia is a heavily debated area (Tuckett, 2012). Care home staff view deception surrounding keeping a person safe as acceptable (Tuckett, 2012) however, deception in relation to a person's possessions is not directly discussed. James could not take part in conversations about the transferral of his personal possessions as he was not aware he had moved residence. James did have belongings in his bedroom which his wife brought into the home when she visited. James was not given an opportunity to return home to decide which personal possessions he wanted to take into the care home.

6.2.2   When temporary becomes permanent

Peter (77) had received respite care at Southcote Manor. Respite care is generally for a pre-planned fixed period of time in which a person can stay at the care home. Peter's wife Nicola arranged respite care two or three times a year to provide her with a break. On one occasion whilst Peter was staying at Southcote Manor a vacancy became available in the care home:

> *"Elaine called me one day, I was in there, visiting, on his weekly break, respite, and she*
> *called me and she said oh she said we've got a room she said that Peter could have, she*
> *said if you're agreeable, so talk to your family, if you're agreeable she said, he can have it.*
> *And I really didn't think that he was that bad, if that makes sense to you but my children*
> *said well you know you might have to wait a year or two before he can go in again, let*
> *him go in, which I did" (Nicola, interview, wife).*

Peter was not aware his temporary stay had turned into a permanent relocation, which in turn resulted in Nicola using deceptive strategies to hide the truth. Although Nicola did not tell Peter he was on holiday, she also chose not to tell him he was never coming home again. Given that Peter was not being made aware he had permanently relocated, this created a barrier to conversations about his belongings. Instead, Nicola slowly transferred the belongings she thought he would like bit by bit. When talking to Peter about his belongings he stated that he did know why the objects found in his room where there:

> *"No, I don't know why she brought it in…… It doesn't really bother me. My wife brought them in I think" (Peter, interview, resident).*

Peter also mentioned that he would rather go outside than use the objects in his room. Nicola brought in objects that would make the room look more homely, items that she believed he might like. This shows a difference in perception of Peter's identity, he did not care much for material things. He identified with being an outdoors person and a man who enjoyed spending time with friends in the local pub.

Nicola mentioned that she used this deceptive strategy to prevent distress on her part:

> *"Just to save him making me feel guilty really" (Nicola, interview, wife).*

On the occasions when Peter stayed at Southcote Manor for periods of respite, Nicola would pack his items in a black holdall. When Peter left the care home, the same holdall would be repacked, and he would return home. Following Peter's permanent relocation, Nicola had attempted to take the holdall home with her as Peter no longer needed it in the care home; however, Peter questioned why she was taking it:

> *"And he said to me what are you doing that for, I don't normally take that, I take that one in the bottom of the wardrobe, and I said oh right and he's still got in there. He wouldn't let me bring it home because he'll need it to come home with." (Nicola, interview, wife)*

This suggests the holdall represented more than just an object with which to transfer belongings. Its presence signified his stay was temporary. If Nicola attempted to remove the holdall this would signify Peters return home. The holdall now remains in the drawer. Nicola remarked in her interview that she could not tell him he was not coming home "because I'm a chicken." This is a clear example of how functional objects can manifest in care home life, as here, a holdall became the material manifestation of a lie that was told to the person with a dementia.

Nicola had experienced overwhelming feelings of guilt since her decision to move Peter into the care home. Nicola cried in both the interview and when talking informally around the care home.

She also told me how she cried every day and felt guilty for moving him into the care home. It is common for carers to feel guilt during the transition from domestic home to care home and informal carers of people with a dementia often feel burdened (Müller, Lautenschläger, Meyer, & Stephan, 2017). An important finding of this study was that feelings of guilt or carer burden can create barriers to conversations about the belongings. Including a person in decision-making about their belongings would require a person with a dementia to be informed they were relocating, or that they had moved.

6.2.3   My daughters made the decision

Judy (94) had lived in the care home for approximately six weeks when we first met. Like Karen she had been admitted to hospital following a fall at home. Judy talked about how she had been on the floor of her flat for a few days before her daughter found her. As a result, Judy's daughters had made the decision she would not return home but move into the care home. The care home was close to where they lived and, in the area, where Judy had run her hairdressing business. Judy was a proud woman, who like Karen enjoyed clothing and make up. Judy would spend much of her time in her bedroom. This was partly due to her admission of being 'difficult' with care home staff when she first moved into the care home, which had left her fearing that care home staff might not like her. Judy remained in her room as she felt a lack of meaningful conversation in the communal areas with other residents. Judy had not returned to her property since moving into the care home and had talked of how her daughters were sorting out her flat. Judy was not included in making decisions about which belongings came into the home or how the rest were distributed or disposed of.

Karen, Judy and James had all been moved directly from a hospital to a care home and were not included in decision-making about the relocation. Peter had moved from a short stay respite to a permanent position overnight without being made aware he had permanently moved. None of the residents were provided an opportunity to return home to organise their belongings or included in decision-making regarding their personal possessions.

6.2.4   The opportunity to decide

Pippa (69) had lived at home with her husband until he became terminally ill and moved to a care home for end of life care. Pippa remained at home but visited her husband in the care home. Following his death, care home staff contacted Pippa's children to raise concerns relating to Pippa's cognitive functioning. The children then began to notice Pippa was not managing as well as they had thought and decided she would move to a care home:

"[mum] she was leaving the gas cooker on overnight, obviously forgetting to turn the stuff off, not cooking food correctly, so she wasn't actually cooking any food, so she wasn't eating properly. So, we took the decision that we'd sell up, move her down here. She lived in Cheshire at the time."

"[mum] Had a fair bit of money in the bank, so we stuck her in a private care home. Had a good look round first, obviously to see what it was like. We took her to a few, and obviously she wasn't very keen on some of them and we ended up in a private care home which were very good for her, and we moved her in there" (Finlay, interview, son).

Although Pippa's son included her in choosing a care home, he refers to "sticking her" in there. This term may be indicative of the feeling of being trapped once in a care home, unable to leave. It could also suggest that once in a care home the view is that life stops, you become stuck. Whilst he supported her choice of home selecting one that was 'good for her' rather than a home she was not keen on, he did not include her in decision-making in relation to her personal possessions. Moving his mother into the care home gave him the opportunity to sort through her belongings, discarding much of it:

"that gave me the time to go and sort the house out, two big skips later, I had an empty house. Obviously, the decision on what came down, came down to myself, knowing the things that she always had out, so a lot of the stuff that were out on the side that she saw all the time, came down. The stuff in the attic, that she didn't see, wasn't aware of, a lot of that just went straight to skip, or got sold" (Finlay, interview, son).

Finlay refers to his mother's possessions as 'stuff' both in relation to the stuff out on display that she saw all of the time, and the stuff in the attic she did not see. He does not discriminate between the two different types of objects. This might be because he does not view objects as important. He had mentioned in our interview that he did not need personal possessions. Finlay came from a military background and was ex-military himself. He stated he was used to travelling light and did not feel a need to acquire or retain belongings. To Finlay objects were expendable. However, to view the possessions as just 'stuff' may also provide some psychological distance from the difficult task of having to disband his mother's house. Finlay would often visit him mother in the care home and swap around her ornaments so that she had different things to look at. This would suggest some understanding of the importance of her material world existed.

6.2.5   Advanced decisions

Emily (94) had made an advanced decision to move to a care home while she was cognitively fit. She had decided which care home she wanted to move to when the time came to move:

> *"she used to go visiting her friend and she would say, oh if I need to go into a home that's where I'd like to be. She was compos mentis then. And so that's where she went when she decided that she didn't want to be at home, and we also decided, because it was getting a little bit dangerous when she was you know doing her cooking and then sometimes not turning things off. She had a stair lift thing, which was brilliant, but a couple of times I went in and she was at the top of the stairs, and I said well why haven't you come down, and she said because I can't get up, and I though, ooh we're going to have to sort this out. So, at that point we decided it may be time." (Jess, interview, daughter)*

This suggests that advanced conversations and directives are important to ensure older person's voices are heard and their wishes are carried out; however, there is a lack of advanced decisions being made in relation to health and social care planning (Samsi & Manthorpe, 2011).

Whilst Emily directed her family regarding the care home she wanted to move to, it was her daughter-in-law who decided what possessions she took with her. Her daughter commented how her sister-in-law, who worked in the care home Emily first moved to, had 'taken over' when it came to the possessions she would 'need'. Jess talked of the tensions between herself and her sister-in-law as Jess believed some of the possessions her mother requested such as an address book were thrown away. This highlights how decision-making favours the cognitively fit when choosing a care home but not when making decisions about possessions. This is a stark demonstration of the lack of autonomy and the lack of understanding concerning object-person relations.

6.2.6   Policy and Practice

Whilst the circumstances of each person's relocation to a care home may differ, a common denominator was the lack of involvement in decision-making. It was also common for residents to be excluded in decision-making regarding their personal possessions. Each person moving in to a care home is required to have an eligibility assessment. The following extract describes how an assessment is conducted:

> *"Well usually we're asked to do an assessment, whether that's in hospital or whether that's somebody's house. If we do an assessment we always try if possible, if they want,*

we ask the person if they want family members present. We can do the initial assessment, so that then leads us to make a decision as to whether we can't meet that person's needs, so they wouldn't come here, because it wouldn't be right, or we can meet that person's needs, and then we would say yes we can meet your needs. We give them a brochure explaining all about what we are like. We ask them to come and have a look round. Then you know they can come for lunch, coffee or whatever to start with, so they can actually see the place before they are suddenly brought here, but that's not always possible. If you come from hospital it's a case of you're going from hospital and you're coming to a care home, there's no come for a day, go back to hospital, or come for a day then go home and sort your belongings out and come back, it's all done in one process" (Elaine, Interview, registered manager).

This extract shows the discriminatory practices faced by a person moving from the hospital to care home. A person living at home has an initial assessment, an opportunity to visit the home to test out its suitability and can return home. A person in hospital is assessed to see whether the care home can meet the 'needs' of the patient should they fit the criteria, they are transferred directly from hospital to care home. There is no opportunity to visit the home or return home to collect their belongings. The practices only suit the 'ideal' situation:

> *"A prospective service user should ideally be offered an opportunity to visit the unit and spend time with other service users, perhaps spend a morning and have a meal at the service before making a decision and will have the opportunity of a six-week trial period."* (Documentary source, local authority quality standards)

Many people moving into a care home do not fit this ideal, particularly people with a dementia. This indicates that current practices are not written with people with a dementia in mind. Furthermore, there is a lack of guidance to support health care professionals when assessing people who do not fit the ideal.

The ideal is also laid out in the National Minimum Standards for Care Homes for Older People (DoH, 2006) which provides guidance for care providers by setting out the criteria for the relocation to a care home setting:

Standard 5

5.1   The registered person ensures that prospective service users are invited to visit the home and to move in on a trial basis, before they and/or their representatives make a decision to stay; unplanned admissions are avoided where possible.

> Prospective service users and their relatives and friends have an opportunity to visit and assess the quality, facilities and suitability of the home. Service users and their representatives know that the home they enter will meet their needs.

> 5.2   Prospective service users are given the opportunity for staff to meet them in their own homes or current situation if different.

> 5.3   When an emergency admission is made, the registered person undertakes to inform the service user within 48 hours about key aspects, rules and routines of the service, and to meet all other admission criteria set out in Standards 2 – 4 within five working days.

The first point to be addressed is the tokenistic nature of both the Local Authority Quality Standards and the National Minimum Standards for Care Homes for Older People (DoH, 2006). The documentation presents a vision that is supportive of 'service users', proposing that people are provided with opportunities to decide which care home best suits their needs. This is out of touch with the circumstances by which people enter the service. For example, Standard 5.1 invites people to stay on a trial basis to test out the suitability of the home. For all of the residents discussed so far, a trial basis was not offered. Both Karen and Judy had remarked how they had been 'put' in the care home and were under the impression they could not leave. James and Peter were unaware they had moved into the care home. It is safe to assume they had not been offered an opportunity to test it out for suitability either. It is clear they are not inclusive of people with a cognitive impairment and considering there are approximately 416,000 people living in care homes in the UK, with around 322,000 estimated as having a dementia (Alzheimer's Society, 2013) this is a systematic oversight.

The second point to be addressed is that the analysis of the Local Authority Quality Standards and National Minimum standards documents revealed that the importance of personal possessions and functional objects are not mentioned. Whilst the Local Authority Quality Standards document fails to mention the transferral of personal possessions at all, the National Minimum Standards for Care Homes for Older People (2006) offers a cursory mention.

In Standard 10 – Privacy and Dignity mentions a telephone, mail and clothing is mentioned:

> 10.2   Service users have easy access to a telephone for use in private and receive their mail unopened.

> 10.3   Service users wear their own clothes at all times.

The documents are written *by* organisations *for* organisations in the provision of care however, it seems distant from the reality of care home life. It could be argued that the standards fall short of

seeing the residents as people with social regard (Brannelly, 2011b). Whilst the policy document intends to support social connections such as easy access to a telephone this guidance was not the reality for many residents in this study. Analysis of observation data showed that a resident asked to use a telephone to call her doctor but was discouraged from doing so, care staff assured her they would do it for her. The observation data showed that on one occasion a portable telephone was present on a dining table in the communal lounge. Although this would suggest a resident had used the telephone, analysis of the observation data did not show a resident/telephone interaction had taken place. The location of the telephone offered no privacy to the user. I asked a member of staff whether the portable telephone was for the use of residents, she replied that it was. She then went on to explain that in order to use the telephone residents would need to ask staff to get the telephone. The member of staff would need to locate the telephone, bring the telephone to the lounge and that the resident would need to have 20 pence pieces. Considering staff in care homes are often busy, this situation does not lend itself to the easy access of a telephone. The entitlement to access a private telephone, to connect to people outside of the care home, would require residents requesting the service, having the funds to pay for this service, and relying on staff to take action to organise the installation of this service, much of which is out of the residents' control. Whilst analysis of the document shows an intention to inform care providers of the importance of a person wearing their own clothing, analysis of observation and interview data identified this as problematic in practice. Residents often complained of their clothing going missing, and that clothing would go to the laundry and never be seen again. The topic of clothing is explored in more detail in Chapter 7.

Analysis of The National Minimum Standards document mentioned possessions in two further sections of the document, Standard 11- Dying and Death and Standard 14 – Autonomy and Choice:

> 11.6   Service users are able to spend their final days in their own rooms, surrounded by their personal belongings, unless there are strong medical reasons to prevent this

> And

> 14.4   Service users are entitled to bring personal possessions with them, the extent of which will be agreed prior to admission.

Possessions are considered in the context of end of life than being actively used for living life. This demonstrates the treatment of older people moving into care homes as a combination of what Sweeting and Gihooly (1997) term the 'socially dead', and what Bartlett and O'Connor (2010) term 'passive recipients of care'. Throughout the documents, older people are not viewed as

active citizens, therefore the possessions they require to maintain identity and cope with a significant life change is systematically overlooked.

It is clear from the analysis of the documentary source; Care homes for Older People National Minimum Standards (DoH, 2006) that decision-making is not an equal negotiation. Standard 14.4 shows that autonomy is bestowed upon a person moving into a care home. The statement that 'Service users' are 'entitled' to bring in personal possessions but only those 'agreed' prior to admission, demonstrates the use of a caveat to shift power. Whilst the policy documents attempt to create a fair ideal, the document is intended is for those who are cognitively fit. Policy documents refer to a person having the right to choose which care home to move into and the right to choose which personal possessions to take; however, it is clear that in practice this is often not the case.

Section two

6.3   Decision-making relating to functional objects once residing in a care home

Part two of this chapter concentrates on the ongoing decision-making practices, once a person has become a permanent resident in a care home. This relates to decision-making practices regarding a person's existing belongings and the purchase of new functional objects once they are a 'resident' in a care home.

Taking a framework analysis approach provided contextual information identifying what practices already existed in relation to decision-making about personal possessions. I could ask questions such as: 'What practices currently exist in relation to bringing objects into a care home'; 'Who is involved in those practices?' and 'What would happen if a person wanted to buy a functional object'? By asking these questions, it enabled me to identify and map out a process of care home practices that showed people with a dementia living in a care home lacked control over their existing belongings, and the future procurement of objects. The analysis of documentary sources, such as Care Homes for Older People National Minimum Standards (2006) and Local Authority Quality Standards documents did not provide support or guidance for care home providers to ensure that residents could make independent decisions or take independent action. Instead, practices showed that residents were required to make a request for an object through a member of staff, relative, friend or social care professional. Once a request was made, staff and relatives could employ several decision-making strategies to deal with the request. The decision-making strategies employed by social workers or friends are absent as neither group were recruited to

this study. Figure 1 overleaf provides a visual representation of the decision-making practices and the possible outcomes:
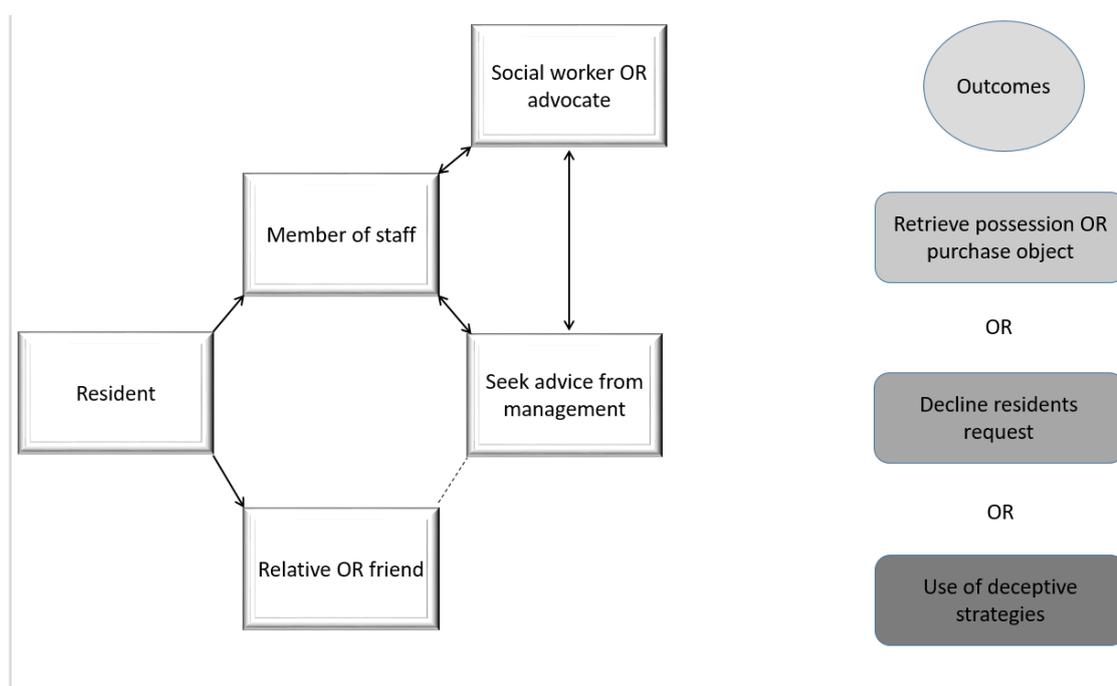
Figure 1. Decision-making practice once a person resides in a care home

Figure 1 shows the negotiations that might take place once a resident makes a request for an existing possession or a new object. It also shows the possible outcomes. Figure1. uses a single arrow connector between the 'resident' and 'staff' and the 'resident' and the 'relative or friend' as the findings suggest the resident was not included in any form of negotiation once the initial request was made. 'Members of staff', 'social workers or advocates' and 'seeking advice from management' have two-way connectors representing the negotiations that take place between the groups. The dotted line between 'relative or friend' and 'advice from management' represents a fragmented practice. There are times in which relatives seek advice from management over what objects they bring into the care home. There are also times in which relatives brought objects into the care home without speaking to staff or management. It was clear from the analysis of interview and observation data that there was a lack of coherent practice in place. Furthermore, there was a lack of guidance in both policy and practice documents.

Figure 1 shows the possible outcomes from an initial request for existing belongings or a new object. A member of staff or a relative could either retrieve the existing possession or purchase a new object, decline the request or use deceptive strategies to avoid the topic. Whilst Figure 1

suggests a systematic practice of accessing objects, the working practices were not clear and filled with contradictions. These are demonstrated through the following framework categories and sub categories developed from the framework analysis that are presented in Table 3.

Table 3. Ongoing decision-making relating to existing possessions or new objects

Overarching category	Framework category	Sub-category
Decision-making	Opportunities to return home	Limited timeframes
	Responsibility	Who makes the final decision?

6.4 Opportunities to return home to collect possessions

The study found that once people have moved into the care home that they were not given opportunities to return home. This meant that many of residents did not have any control over their personal possessions or what happened to them. Given that a contextual understanding was developing relating to decision-making regarding personal possessions, that is; how decisions were made regarding personal possessions in a care home environment, it was important to understand the reasons for, or causes of, what existed. The framework analysis approach refers to this as diagnostic questioning.

6.4.1 Limited timeframes

One reason given for people not being able to have personal possessions was limited timeframes. Care home staff reported that the timeframe within which a person can access their possessions was viewed as problematic. Both relatives and staff talked about time constraints being a problem when retrieving a person's possessions. Once a person had moved into the care home meeting care needs appeared to be the priority, over the objects a person might want to have. If the person lived alone the domestic home would need to be sold to cover the care home fees, or a tenancy would need to be relinquished. It also takes time to disband a whole home of possessions, something that not all relatives had time to do:

> *"[If]I hadn't done it that way, and my mother had been there, I most probably would have still been there today, trying to clear it all out because it would have been, oh no I can't, I don't want to get rid of that; where are you going to put it; there is no room to move a five-bedroom house…. into a one-bedroom home" (Finlay, interview, son).*

Finlay believed that including his mother in sorting through her possessions would take too long. He believed she would find it difficult to reduce the number of possessions she had, particularly as she was moving from a five-bedroom house to a one-bedroom care home. Other complications

were that Finlay lived in the South of England and his mother's house was in the North of England; he worked full-time and was married with two small children. Finding the time to manage this situation was difficult, as was the task of sorting through his parents' belongings:

> *"So it was down to myself that brought her things in…..doing the house, that was the hard bit because that was literally, I was aware that it wasn't just my own childhood that I grew up, this is all the stuff I had seen all my life, but it was also my mother's and her, and Gerry's, my stepfather's life collections of stuff, that they had collected from all over the world, it could be Australia, Cyprus, Egypt, and it was either going for sale or going in a big skip, that was the hardest point" (Finlay, interview, son).*

This suggests it may not be as simple as a physical timeframe but the act of wanting to get a difficult job finished. Finlay felt it was his responsibility to sort through his mother's belongings (his sister would find it too hard). The above extract shows the emotional strain he faced when dealing with his parent's possessions. The possessions not only represented parts of his childhood, but he felt the need to do justice to their historical biography, a biography located within their life collection of 'stuff'. As with the previous extract in which Finlay refers to his mother's possession as stuff, this extract supports the idea that he may have used this word as a rhetorical device to cope with the job he had to do.

The timeframe within which a person has to clear a property is also present in the following extract:

> *"You've only got a short space sometimes to get it. Because either they're in rented accommodation and if they're not going to be able to go back there someone's going to clear it, or umm they lived in home on a their own and then it's going to be packed up and sold, or they lived with someone else, and that's not quite so bad, you know. But yeah it can be difficult because there's like a time-span when you can get these things. And sometimes they might think of it after it's gone" (Elaine, interview, registered manager).*

Elaine suggests that residents have a short space of time to collect their possessions before they are either sold or disposed of. Although she is aware of this, no provisions to enable a person to return home was provided. This extract suggests that the limited time-span does not give adequate time for a person to think about the possessions they might want prior to them being disposed of. This was echoed by another member of staff:

> *"I think people think of things afterwards; well maybe a long time afterwards and as I'm saying, then it's too late to get it, because their home may have been sold and packed up and everything" (Beth, interview, deputy manager).*

The time in which it takes to retrieve objects was also a problem for Karen as she had to rely on her nephew to bring her belongings to the care home:

> "He [nephew] thought he'd bring them to me I think, but time went on and he couldn't seem to get here. And I never saw them again. Well I didn't remember what I had. (Karen, interview, resident)

The timeframe within which a person moves into the care home and time in which their homes are sold, or tenancies relinquished appears inadequate. However, if a person has the right to return home to collect their belongings or opportunities are presented to take a person home to organise their possessions, this situation may be avoided. Karen remarked how she could not organise removals as she no longer had access to her bank account to pay a removal firm. This suggests the timeframe is a contributory factor but perhaps not the main cause of the loss of possessions.

Knowing that some residents had moved directly from hospital to the care home, I asked staff whether residents were given opportunities to return home to sort through their belongings:

> "No, usually it's the families. We have done it for a couple of residents, when we've gone back to their home for them to get some belongings, but usually the family members have taken over and unfortunately some of them dump stuff before even letting the residents look at what's left and things like that."(Abby, interview, AUM)

Abby recalls that staff have been back to a person's home to get belongings, but this did not include the resident returning home with them. Abby suggests that family members 'take over' and that some of them 'dump stuff' before a resident has the chance to decide. Abby's use of words 'dump stuff' might suggest the objects are viewed as not worth keeping. The term 'stuff', similar to Pippa's son suggests that material things are expendable. This shows a lack of understanding of the importance of object-person relations.

There was one occasion recalled by the registered manager of a resident returning home to collect some belongings:

> "I mean a lady went home last Friday. She wanted to get some kitchen bits. So a friend of hers took her back, got the bits she wanted. It's only her that can pick which bits that she actually wants." (Elaine, interview, registered manager)

It later transpired the woman who returned home did not have a dementia. The extract above shows the registered manager has an understanding of the importance of objects as she notes that 'it is only her who can pick which bits her actually wants'. Given the demonstration of understanding that choosing one's own objects is important I asked whether residents with dementia were provided opportunities to return home:

> *"There's always that risk that they won't then, they want to stay and they don't want to come back. But I mean I would do that; that would be me. If I went home and then had to pick bits, I wouldn't want to leave again. That's my home. Rather than putting them through that and the trauma and making them upset." (Elaine, interview, registered manager)*

Elaine introduces the concept of risk, suggesting that returning home might result in the person not wanting to return and that this could cause them distress. Although this might be a plausible assumption, particularly as a person may not have chosen to live in the care home in the first instance, it is an assumption rather than an evidence-based statement. The woman who returned home to collect her belonging did return to the care home bringing back some of her belongings. There were no reports of distress or a refusal to return to the care home demonstrating that people can be supported to return home without causing undue harm or distress. Therefore, it could be argued that residents should be supported to return home to collect their belongings.

None of the participants in this study had an opportunity to return home which suggests that once a person lives in a care home, they are indeed what Pippa's son described as 'stuck'. Once resident in the care home they lack control over their possessions and were not always informed of what had happened to them. This in turn could result in prolonged psychological distress and upset.

6.5   Responsibility

Analysis of the data demonstrated a lack of control afforded to people with a dementia in relation to their personal possession. This included existing personal possession and the purchase of new objects.

6.5.1   Who makes the final decision?

Through comparisons across codes, both within and between participant groups, it was found that there was a lack of coherent practices in relation to resident's personal possessions. Many of

the care home staff believed that the management team at the care home were responsible for saying which objects could or could not come into the care home:

> *"If she said to me, can I bring, then I would go and speak to manager" (Janice, interview, care assistant/domestic).*

Janice states that she would ask a manager whether certain objects could be brought into the home; however, not all staff were as clear:

> *"I suppose ultimately it's someone from the home" (Joe, interview, AUM).*

Joe supposes it should be someone from the home but fails to identify who this person might be. This would suggest a lack of consistent practice. Joe is a member of senior care staff, his responsibilities included showing prospective residents and relatives around the home. and providing them with advice. Therefore, it might be expected that he would be aware of a practice relating to objects.

Michael, a new member of staff, thinks the manager of the care home would have the final say:

> *"The manager would have the last say if there was some sort of controversial, controversy over it. As far as I am aware, no not really, but you know I sort of imagine that registered manager and the deputy manager would have the final say on what was or wasn't allowed really" (Michael, interview, care assistant).*

Michael would ask the manager if it were an item that was controversial, however the type of object considered controversial is not clear. Michael begins the sentence with a confident assertion, but this soon turns vague when he talks of 'imagining' that it would be a member of the management team. Again, this demonstrates a lack of clarity over what can and cannot be brought into the home and who makes the final decision. The lack of consistency between staff is not surprising. The only written advice available in relation to personal possessions were two small paragraphs found in the 'residents guide and information pack'. This informed residents and relatives that the type of objects useful for care home life were everyday items such as clothing, toiletries, books, magazines, ornaments, photographs, small items of furniture (providing these met fire regulations) and a television (providing it was PAT tested).

As shown in Figure 1, a resident will often make a request for an object to either a member of staff or a relative. Once a resident makes a request, the member of care home staff or the relative is responsible for making a decision about the action they will take in relation to that request. Once a request was made many care home staff stated the first step taken was to make contact with a relative to ask them for the object:

"I would ask the family, if it's something from like home, I would ask, I would talk to the family member and say that they've been asking. Yeah, hopefully then they would" (Mandy, interview, care assistant).

Once the request has been made a member of care home staff passes the decision-making responsibility over to a relative. In the extract above the member of care staff may firstly assume the object is an existing possession that can be located at home. This might indicate that the resident believes his or her possessions are still available to them. As discussed previously, the person's possessions may have already been disposed of but they might be unaware of this. Mandy also remarks that she hopes the relative will bring in the object which has been requested. This demonstrates a lack of authority by the member of staff in meeting the request of the resident. Once Mandy has requested the object on behalf of the resident, she has no control of the outcome. Furthermore, the extract demonstrates the lack of control a resident has over their personal possessions once they are resident in the care home. This evident in the following extract in which Karen states that many of her possessions were disposed of by her nephew:

"Well I couldn't bring a lot and David has dispersed, disposed of quite a few, because we couldn't bring them in, but a few things on there are mine; a few bits and pieces" (Karen, interview, resident).

Whilst relatives were often the first step to gaining an object for a resident, not all people residing in care homes have relatives. In the event of a resident not having a contactable relative, care home staff stated they would make contact with either a friend of the resident or social care professional:

"And sometimes the resident wants more things, and we then have to go back to the family and say they're asking for this, or can you bring this in, or if they haven't got direct family or friends who are involved, we go back through the social-worker, and ask them"(Beth, interview, deputy manager).

Although making contact with a relative for the purposes of requesting an object on a resident's behalf may appear straightforward, staff could find conversations about objects difficult:

"And I think it's quite hard, and that's why I will, I will phone up and I will have those difficult conversations for the person" (Beth, interview, deputy manager).

Conversations regarding requests for objects to be brought into the home were difficult for staff as they were aware they may be asking for objects that may no longer be accessible, for example

if family had disposed of the object. It also meant that staff would have to inform a resident that the object was no longer available. Both the resident and the member of staff had little control over the outcome:

> *"Yeah sometimes they do, and we will usually give them a ring, the families a ring and I'll say so-and-sos asked for some of this, if you can bring it in they'd really appreciate it. But I can't tell you you've got to bring it in for them.*
>
> *I can't tell you that's, I can tell you that they've asked, but I can't tell you, or the reason why, because they might not have been able to tell me, but I can tell you that they're asking me for this, so could you bring it in. It's the next of kin who, so yeah, so it's usually the person I'd call" (Joe, interview, AUM).*

This emphasises again a lack of control for the resident, as well as the member of staff. It also suggests that a considerable amount of negotiation is involved. The resident can make a request, the member of staff can direct the message to a relative. This may result in the member of staff either informing the resident they have made the request but are unsure of the outcome, that their request can be granted or that their request was unsuccessful. Members of care staff reported that relatives were responsible for accessing object for residents and reported feeling like a go between.

Other decision-making strategies used by members of staff were to inform the management team of the request, thus handing responsibility over to them or to organise the purchase of the object themselves:

> *"If the families are still not bringing in any belongings, quite a lot of the carers will take them up the High Street, let them pick up some homey stuff. If they haven't got it up the High Street, the carers are quite good, they'll let us know, or they will, they'll go up the shop and see what they can find" (Abby, interview, AUM).*

The ability of care home staff to assist a resident in purchasing an object was complicated by the access to funds. Many of the residents had no direct access to money. Relatives would often provide the care home with an amount of money kept in a 'funds thing' which was to be used should any purchases needed to be made. The funds usually covered items such as toiletries and sundries. The lack of direct access to funds was in line with the handling resident's money and valuables Care Quality Standards (local authority documentary source), the money was held by either relatives or administration staff for 'safekeeping'. A purchase could only be made if relatives or administration staff agreed and the funds were available to cover the request:

"If they ask for something, if they haven't got the funds to buy it, obviously then we, obviously their money is kept, if they've not got family and they've got money, it's kept in a funds thing. And if it was something that they kept oh I want a new television now, I want a new television, if they've got funds in it and got no family, I think it's discussed and I could say right, Elaine, Freya needs a new television, she's got the money, can I go out and buy it. If they've got the access, if they have got funds to be able to go and buy something that they want, they do meet the needs of, they do try and meet, you know they do it" (Carole, interview, care assistant).

This example shows that staff will attempt to fulfil a resident's request by speaking to the care home manager. However, access to funding can prevent this from happening. It is also important to emphasise that the above example provides a simplified version of what is a complicated process of accessing an object. There are often barriers to accessing objects as the next extract illustrates, if a member of staff had access to the funds for an object, the object would need to be small enough for the member of staff to transport from the shop to the care home:

"If it's a small object we've got carers now who go out on a regular basis with residents, and so if it's a smallish object that you can just carry home from a shop, the carers can assist people to buy that" (Elaine, interview, registered manager).

This was not the only a barrier to accessing objects, staffing levels were also a barrier:

"Yeah. Yeah, and it's generally, you know it's generally okay. Like sometimes if there's, if there's a lot of staff come on at two o'clock, sometimes there might be, but it just seems the downstairs residents, one of them might want a new pair of trousers and like I say, if there's a lot of staff coming on at two o'clock, so you can have four people downstairs where normally you only have two, then somebody might say well I don't mind taking Gladys or whoever, up to town and getting them a pair of trousers. So they will go and like, if they're capable of walking, they'll walk, if they're not, they'd take them in a wheelchair and go up and maybe go to Peacock's and buy them, let them pick a pair of trousers or a pair of slippers, which I think is nice for that person" (Janet, interview, care assistant/domestic).

The barriers to accessing objects may prevent a resident from accessing new objects once they become a resident in the care home. The lack of power held by both residents and members of staff, together with a lack of written guidance can make it difficult for requests for objects to be fulfilled. A person with a dementia may make an initial request for an object however, both interview and observational data suggested that this was the extent of their involvement. This

demonstrates a lack of agency and autonomy. A residents lack of power in accessing objects independently passes the responsibility to care home staff. This can lead to more work for care home staff as it means higher levels of dependency from residents. The alternative is that a resident makes the request direct to a relative however, this act of agency is difficult especially as residents do not have easy access to independent use of a telephone.

Care home staff would at times decline a residents request for a functional object. On more than one occasion Karen asked for a pair of curling tongs to make her look like herself. When I asked a member of staff if Karen could have some curling tongs, this request was declined. When I asked why Karen was unable to have this functional object, the member of staff replied, 'she might burn herself'. Care staff did attempt to remedy this situation by buying Karen some plastic hair curlers, shown in Photographic image 5, but Karen did not use them.

Photographic image no. 5 Pink plastic rollers in Karen's bedside drawer

They hair curlers remained in her bedside table drawer as Karen pointed out the plastic hair curlers didn't do the job. She would also need hairpins to secure the curlers, but she was not allowed to have these as that was viewed as a risk so the alternative to the curling tongs was useless.

Requests for existing personal possessions or the purchase of new objects could be directed to a relative providing they visited the care home. When requesting an object from a relative, three decision-making strategies were identified: the visiting relative could either locate the object if it was still in the relative's possession, transfer that object to the home or organise the purchase of

the object. This would mean either taking their relative on a shopping trip to choose the object(s) or purchasing them bring them to the care home. For example, Karen's nephew brought in items of clothing from Karen's home when he visited on one occasion however, Karen complained that he had not brought in all the items she had asked for.

Relatives could also decline a request made by a relative as shown in the next extract in which Charlotte asked her daughter for some different curtains for her bedroom:

> "Oh and curtains at one time she said, could she have different curtains and I suppose,
> well I've been a bit neglectful really on that side, I haven't, I didn't do, because they were
> saying here they were going to get new curtains, and I thought well be silly for me to go
> and get new curtains if she's you know, if she's going to get new curtains anyway. Yeah.
> It's funny isn't it, it makes you look at yourself and what you do and don't do" (May,
> interview, daughter).

This extract shows a conversation took place between May and a member of staff. May was under the impression that the home was 'going to get her new curtains' which in turn resulted in May not fulfilling her mother's request. When I asked May if Charlotte had new curtains in her room, she told me the curtains were the same as when she had moved in. Whilst documentary sources and staff suggest it is important for residents to have opportunities to actively make their bedroom feel homely, this does not necessarily happen in practice.

Conversations about objects did not always take place before an object was brought into the care home. Relatives bring in objects without informing care home staff:

> "Well it can be, because a lot of families just go out and buy things and don't even tell us.
> Yeah, just bring things in, even medications and things like that. And maybe some
> Paracetamol or tablets, and we won't know anything about them until one day someone
> finds them. Either on the floor, a packet or whatever, so yeah" (Beth, interview, deputy
> manager).

However, care staff believed the retrieval of belongings once a person has moved into a care home was generally organised between care staff and relatives:

> "We would contact their family in the first instance, to say is there any way, you know are
> these things still at home, are they talking about things that are still relevant, can you go
> home, can you take that person back, what's happening to their flat, what's happening to
> their house; it all depends whether that flat's theirs or a rented place, but how we get that

person's belongings and who chooses, a lot of it's to do with us communicating with

families and care managers"(Elaine, interview, registered manager).

This suggests that staff feel some responsibility over the retrieval of a person's possessions. Elaine notes it is how they communicate with families and care managers (also known as social workers). The existing practices still maintain the exclusion of the residents. The ability to retrieve possessions is even more important when people can arrive at the care home with no possessions:

> *"the families or whoever's, sometimes we come in and no-one brings nothing for a week*
>
> *or two, especially if someone's coming from hospital, and we're using our spares, and it's*
>
> *horrible having to do it, but I think, again I think it's trying to I'd rather say to someone*
>
> *look, I know they're not like, more to families now, I'd rather say I know it's not their*
>
> *clothes, but they only came in from hospital yesterday and you haven't given us anything,*
>
> *would you rather us leave them naked or in the hospital clothes that are not in good*
>
> *condition"(Joe, interview, AUM).*

This raises concerns surrounding the organisation and transferral of objects for people who do not have living relatives. If a relative is not available to manage a person's possessions and the resident has no opportunity to return home to organise and collect belongings, what happens to their personal possessions? I asked staff who they believed were responsible for bringing in a person's possessions, they believed this was the responsibility of a third party, not the resident:

> *"I can only assume it's the family, or whoever is bringing the person in to care, whether it's*
>
> *a social worker or [pause], or a friend, it's, and I suppose we assume that they bring in*
>
> *what [pause] the person wants, but it might just be they bring in what they think they*
>
> *want" (Joe, interview, AUM).*

Joe was an Assistant Unit Manager (AUM) at the care home. In Joe's position as AUM, he can carry out the eligibility assessments of new residents. Although he can carry out this role, he is not clear who is responsible for bringing in personal possessions. He assumes it would be a relative, friend or social worker. He also goes on to say he assumes they bring in what the person wants but that this may not be the case. This shows that many assumptions are being made surrounding a person's possessions.

Given that care home relocation is a difficult transition, and that personal possessions can make this transition easier, starting life in a care home without any personal possessions is far from ideal. It was reported by care home staff that some people arrived at the care home without clothing, this contrasts with the National Minimum Standards for Care Homes for Older People

(2006) standard 10.3.

6.6   Summary

This study shows that people with a dementia are largely excluded from making decisions about what happens to their personal possessions when they move into a care home. Analysis of the documentary sources found no guidance relating to the importance of transferring objects from home to care home. Once a person moves into a care home, possessions are dealt with often by a family member and within a short timeframe. There was no evidence of opportunities for a person with a dementia to return home to organise and select personal possessions resulting in a lack of control. This is a clear example of how personal possessions can manifest in care home life, the lack of access and control over their belongings becomes the manifestation of a lack of autonomy, independence, and control. The consensus is that management of the care home have the final say over which objects come into the home and which do not. This shows a lack of understanding relating to shared decision-making particularly regarding object-person relations and their importance in maintaining and reconstructing identity. Although Elaine (registered manager) had mentioned that no-one can choose objects for a resident, that only residents would know what they wanted, this was not supported in practice. Care home practices relating to personal possessions were   vague and inconsistent. This was shown where relatives would bring in objects without the care home staff having prior knowledge. The responsibility for accessing objects was often in the hands of relatives and care home staff. Residents were wholly reliant on both parties to retrieve personal possessions and acquire new objects. The restrictions placed on a resident resulted in them lacking control over their existing personal possessions, a lack of access to finances to purchase objects and limited opportunities to go outside of the care home to buy new objects. The manifestation of objects here is shown in higher levels of dependency for residents. Applying a material lens provides an insight into how people with a dementia are malignantly positioned. It elucidates a lack of agency and autonomy and in turn the absence of citizenship.

Chapter 7: Contribution to Knowledge

Access to and use of functional objects

Chapter 7 examines how functional objects are imbued in everyday life in a care home setting. Firstly, the chapter explores the framework category that residents are encouraged to bring in what they like into the care home. This is examined from the perspective of all participant groups, policy and practice documents. This is followed by a discussion relating to safety as it was evident this was a main concern for care home staff and relatives in relation to the access people with a dementia had to functional objects.

7.1   Introduction

Once an understanding of decision-making regarding all personal possessions was established, I then focused on how functional objects are used to perform everyday tasks in care homes. This part of the analysis concentrated on how objects were used rather than the category they were assigned to. The rationale for this was to move away from the passive practices associated with 'cherished' and 'special' objects found in many materiality and ageing studies and focus on the functionality of objects.

The term 'functional objects', as discussed in section 3.6, was developed with an active position in mind. That is, people take action and enact identity with objects. It was important to be clear about what the term functional objects meant and so I developed the following working definition:

> *'Any **inanimate item** which a person can use to perform a task **not necessarily to completion or to any perceived standard**, which maintains or supports cultivation of **his or her identities**.'*

Whilst it is recognised that there may be overlaps between the types of value held for objects, it is the way objects are used and by whom that is key to this study.

Chapter 7 will discuss the framework and sub-categories set out in Table 4 below:

Table 4. Access to and use of functional objects

Overarching categories	Framework categories	Sub-categories
Access to and use of functional objects	Bring what you like in	Objects in the care home
		Objects considered 'risky'
	Safety	Contradictions in words and practice
		Objects go missing
		Someone, somewhere, did something
		Risk as barrier to social citizenship
		The exception

Although this chapter is concerned with the access to and use of functional objects this does of course overlap with decision-making. The way in which decisions are made and the access people have to functional objects in a care home environment is not a linear or straightforward process. However, the usefulness of a material lens is that the access people have to objects and the way people use objects is observable.

7.2   "Bring what you like in"

The idea that new residents could bring what they like into the care home was suggested in an interview with the deputy manager of the home:

> *"Yeah, I go and assess people and I always say bring what you like in, and make your room personalised" (Beth, interview, deputy manager).*

However, once I began to ask questions that were more specific such as: Could a person have a hairdryer or a pair of hair straighteners? it became clear that residents were not able to 'bring what they liked in'. The objects that people were encouraged to bring in were often small in size and to personalise a bedroom. They were not functional objects a person could take action with enabling a person to carry out routines and rituals and enact their identity. The selection of objects recalled by care home staff as commonly brought into the care home when a person moved in were:

"I mean they'll bring pictures, photos, handbags, own bedding and stuff, things like that. If they've got cuddly toys, dolls, things like that. Cushions for their bedroom. It's mainly sort of soft furnishing type things, pictures, photos, family pictures, so if we [staff] put them all on the dressers in their bedrooms or we [staff] can put shelves up for things like that" (Elaine, interview, registered manager).

The objects spoken about by Elaine are mainly items that are considered decorational or comforting. Elaine goes on to suggest that it is *we* (staff) that would organise the objects by putting them on the dressers or putting up shelves to accommodate a person's possessions. Whilst this sounds helpful, it places care home staff as active with a person's possessions, when what might be more important is to allow a resident to organise their own space and their own possessions (Nord, 2013). Placing residents as passive, feeds into the idea that the mere presence of objects is enough. This view continues to overlook the importance of the interactions that take place between human and material worlds. It does not consider the necessary interactions that take place between a person and their objects to make a new space home (Lovatt, 2018). The organisation of a new space can help support the negotiation of a new role (McCracken, 1987) and the satisfaction which can be gained from arranging a new space (Nord, 2013). This is important when considering the cultural changes that will commence when moving from an independent living space to a care home environment. The following extract shows that different members of staff identify different things as being important:

"Their clothes, and possibly if it's a lady, some toiletries and things, you know again like I say, perfume or something, and maybe the odd photograph that they've got in their rooms, but not a lot more" (Janice, interview, domestic/care assistant).

Janice suggests that women might like to bring in toiletries or perfume. She identifies this as being important to a woman, which may suggest she is considering the objects and their use in maintaining a person's identity rather than just objects as 'home comforts' (Csikzentmihalyi & Rochberg-Halton, 1981; Rochberg-Halton, 1984; Rubinstein, 1987; Belk, 1988). Janice points out that a person can bring the 'odd photograph' but not a lot more. This suggests a person moving into care home would need to discard many of their possessions. The amount of space a person has is often limited, a problem identified in previous literature (Kroger & Adair, 2008; Nord, 2013).

Although there were certain objects that were commonly mentioned by care home staff as typical for care home life. Michael identified an object that may be different to those commonly brought in by residents:

"I know Clive, the man I key work, he's got a chair in his room. No idea where it came from, I think it's one of the ones that he had from home, because it's a real old-fashioned type thing, so that's obviously been brought in for him. What else? Photos; people like to bring in photos of their loved ones for them; that's quite common. Other than that it's only really knick-knacks, combs and razors, things for you know washing and things they use like that really" (Michael, interview, care assistant).

Michael describes Clive's chair as a "real old-fashioned type thing", Michael assumes the chair is from Clive's home maybe because it is not in-keeping with the typical care home furniture. From my observations of the care home I found many of the rooms had objects in them which belonged to the resident however, much of the furniture in the bedrooms was identical from room to room. These items of furniture belonged to the care home. The furniture resembling the uniformity of care home life. I asked Elaine, the registered manager, if people were able to bring their own furniture into the care home. Initially Elaine replied that this would not be a problem however, she then stated it would depend on what the object was. Elaine then went on to explain that the care home did not have the space to store its own furniture therefore it would be better just to use the furniture supplied by the home that was already found in the bedrooms. This shows the complexity of dealing with personal possessions. Care home staff initially use encouraging language in relation to what people can have but quickly follow this up by discouraging the object from being brought in to the care home.

Many care home staff provided examples of the objects brought into the home that were in line with the types of objects specified in the Residents' Guide and Information Pack:

"You will need to bring any personal items that you use every day such as clothing, toiletries, soap, shaver/razors, books, magazines etc. We encourage you to bring personal items such as photographs and ornaments, whatever will make your stay more comfortable and homely. For permanent residents it may be possible to bring small items of furniture as long as the furniture meets the fire regulation standards. There are televisions around the home in communal lounges, but you may wish to bring your own for your room if you wish which must be PAT tested or new prior to admission" (Residents Guide and Information Pack, documentary source).

This document produces a list of objects considered suitable for care home life, but it also uses caveats. Caveats were used to restrict the objects that came into the care home such as only small items of furniture and only furniture that meets fire regulation standards. It also states that all electrical appliance that require PAT testing, an electrical test used to identify any fault with electrical appliances. This introduces risk as a factor when considering which objects are

transferred from home to care home. The document also discouraged residents from bringing in anything of monetary value:

> *"It is not advisable to bring large sums of money with you, or excessive jewellery or other valuable items because they are not covered by the Home's Insurance" (Local Authority Care Quality Standard, documentary source).*

This was supported by the care homes local authority policy document Care Quality Standards, relating to handling resident's money and valuables. The aim of the document was to discourage valuable items from being brought into the home in order to minimise the risk of loss or damage. Discouraging valuable items can give an impression that valuable items are not safe here and rather than addressing the problem of security, the organisation removes a person's right to have their possessions. A possible solution could be for residents to obtain their own contents insurance; however, this did not seem to have been considered. The responsibility for a person's valuables and money could then become a shared responsibility rather than that of the care home. Current practices demonstrate the restrictions that are placed upon the access residents have to objects and the way in which they might be used in everyday life. It also shows a lack of upholding the liberties and freedoms of people with a dementia (Baldwin & Greason, 2016).

The Residents' Guide and Information Pack informs residents and relatives that any clothes brought in to the care home should be able to withstand a 60-degree wash cycle, minimising the risk of infection. Furthermore, the document advises residents and relatives to bring clothing that is bigger than the residents' actual size and that any footwear brought in should be 'safe' footwear:

> *"Please ensure that clothing is also easy to get on and off, and if you require help dressing and undressing, that it is easy for care staff to assist you. Often a size larger than normal is easier to wear, cardigans that button up the front are easier than pullovers, and stretchy jogging bottoms are easier than formal trousers. Footwear needs to be supportive and well-fitting to help prevent trips and falls" (Local Authority Quality Standards, documentary source).*

This above extract clearly demonstrates how care practices overlook the importance of object-person relations. The suggestion that a person wears clothing a size bigger or changes the clothing they would normally wear to make it easier for care home staff, shows a lack of understanding of object-person relations for two reasons. The first is that clothing is imbued in everyday care home life as a task-orientated practice. Clothing is not viewed from the perspective of the wearer but

the caregiver and their responsibility to provide clothing. This is a clear example of the usefulness of objects in drawing out practices that place residents and people with a dementia as passive recipients of care. The second is the lack of awareness of objects, in this case, clothing as an extension of the self. The clothing that people keep and the clothing that people wear was shown by Buse and Twigg (2015) as a manifestation of identity. To discard clothing or change it to something different could interrupt and reduce a person's sense of self. It also raises questions about dignity and respect in care practices.

Extracts from care home staff give an account of the objects usually brought into the care home. The objects mentioned by staff are consistent with the objects mentioned in the Residents Guide and Information Pack. Both staff accounts and the documentary sources provide a window into the materiality of care home life and the practices that are in operation. The Residents Guide and Information Pack are intended to advise residents and relatives on what to expect from care home life and the objects a person will 'need'. It also advises the objects that are discouraged and the regulatory standards of health and safety that are to be considered for all electrical appliances and furniture. This introduces the notion of risk relating to objects in care homes.

7.2.1   Objects considered 'risky'

From the comments of staff and documentary sources, it was evident that not all objects were welcome in the home. However, when care home staff were asked whether any objects were not permitted in the care home, their responses were often mixed. Some care home staff could not recall any objects that were not permitted:

> *"I can't think of anything that I know is like prohibited, like can't come anywhere near the grounds. There might well be some items, but I've just not come across them" (Joe, interview, AUM).*

Although Joe could not identify any objects that are not permitted in the care home, he admits that he cannot be sure. Another member of staff also reports she is not aware of any objects that are not permitted in the care home:

> *"No not really that I can, not to my knowledge. I don't think there's any restriction" (Carole, interview, care assistant).*

Whilst Carole does not think any restrictions exist in relation to the objects taken into the care home, this is contrary to the objects recommended in the policy documents. As previously mentioned, caveats exist regarding the objects that *are* encouraged in the care home.

When asked whether any objects should not be permitted into the care home, relatives and care home staff gave varying responses. Whilst some members of staff suggested restrictions did not exist, other members of staff identified objects they believed should not be in the care home:

> *"The only things I can really, you know I don't really know, but the sort of thing that I would have thought that wouldn't be allowed into the home, end of, would be things like weapons if someone wanted to bring in like a sword or something, huh, yeah you know that would probably be sticking out of someone by the end of the week. Drug paraphernalia, you know if someone was a big pot smoker or something, and they wanted to bring in a bong or something, that probably wouldn't be allowed. Yeah as for things that just aren't flat out allowed in the home, I don't think people are allowed to bring in their own medication with them, I think it has to be stuff that's prescribed only" (Michael, interview, care assistant).*

This member of staff considers objects that carry an age restriction are unsuitable for care home life. He also goes on to say that he believes if a sword was brought into the care home it 'would probably be sticking out of someone by the end of the week'. This promotes the idea that objects in the care home are viewed as dangerous. This provides a mixed message concerning how residents are viewed. On one hand, people in care homes are viewed as passive recipients of care but if given an object, residents are viewed as potentially dangerous. Another member of staff in the following extract echoes the idea that if a resident has access to certain objects this may result in them causing harm to another person. In this extract it is was surprising that samurai swords were brought into the conversation when considering the objects a person may want to take into a care home:

> *"I would assume that anything of sharp objects, someone might have a Samurai sword given by a family member, and they would like to be hung up on the wall, as at home, we would not be able to allow that to happen, the same thing, because the bedrooms are open, they're not locked, and so residents wandering around, someone might have a funny idea of getting things off the wall, use it maybe against somebody else…...sharp objects, cigarettes; you mean in their bedrooms? Anything flammable, guns, but of course I'm just joking now. Let me think. Yeah, so grenades and stuff! Anything that gives harm to the resident and others" (Max, interview, AUM).*

Max does not think that sharp objects should be given to residents in the care home; again, the reason given is that a person may use an object to harm another person. He also introduces the idea of risk in relation to a safety of a person's possessions. He reports the lack of privacy residents have and that their possessions may not be secure even when in their own bedrooms.

Family members also mentioned swords as being an object that should not be permitted to a care home:

> *"Yeah, Samurai swords. My wife's got a whole collection of those, but I wouldn't want to bring them in here; someone might use them. Yeah, obviously there are objects that would be not only a hazard to themselves, but a hazard to other people if they decided to use them, for example, Samurai swords, chain saws, they might find that a gentleman has been a tree surgeon all his life and he's got a whole collection of chain saws he wants to bring in; I could see them being quite dangerous. So yeah there has to be a limit of what you can and can't bring in, but who makes that decision" (Finlay, interview, son).*

Another relative also mentioned sharp objects such as samurai swords:

> *"I guess anything health and safety wise, you know sharp objects, all the rest of it, but Samurai swords maybe or [laughs] yeah I guess, you know that are offensive things to other people, you know maybe not to you, but maybe to other people I guess" (Oliver, interview, son).*

Of the relatives and care home staff who mentioned samurai swords it is only Finlay who provides a rationale for thinking about swords. It was evident that care home staff and relatives believed certain objects were dangerous in a care home context. To focus on objects used in everyday life, I used the example of a hairdryer. I explained that if I were to move into a care home, I would need to have my hairdryer and I asked if that would be possible. The responses I received from care home staff were mixed:

> *"No I don't think so, because it's electrical" (Janet, interview, domestic staff).*

Janet did not think it would be possible for me to have my hairdryer in the care home as it is an electrical appliance. I asked care home staff whether my hair straighteners would be permitted to gain a fuller idea of the functional objects available for use in the care home:

> *"[hair straighteners] Well you know like I say, burn with the hot, leaving them on the hair like that, people have left them on a bit of fabric and they haven't cut out. And that risk of fire. So it would assessing those sort of risks, and obviously the risk of the burning yourself or hopefully not others…..[hairdryer] Well as soon as I said that, because I thought the hairdryer would be alright, but then as I was saying that, I was thinking actually the same, some of the same things apply to the hairdryer, but I think because I, I suppose because I know what a hairdryer, and I've used hairdryers, I understand it more, but I wouldn't have a clue how to switch on or off a hair straighter things and how to tell if it was, so I think that's, yes. Again I'd have to say no to it, but if I did that same as for the, or have*

someone, have it kept like in the hairdresser's room and bring it up. No, hang on, tell a lie, hairdryers can be in the rooms, because they've been in someone's room before; someone has had their own hairdryer, and it's been alright. Hairdryers are alright, yeah. I just remembered that. I did remember there was this one, one lady that did have a hairdryer. Yeah, I do remember her. Now we've been talking about it, I do remember one lady did have a hairdryer. I should have remembered that, I used to key work her. Why did I forget that? Well that was about four or five years ago. So I'd like to be able to say yes, but I think it would be, providing just someone was around to sort of just keep on eye and make sure it was safe" (Joe, interview, AUM).

The above extract shows Joe is attempting to work through this question. He begins by arguing the hair straighteners would not be suitable as *he* does not know how to use them. Joe then considers the risk of harm, contemplating that a person might burn himself or herself or it could be a fire hazard if not supervised properly. Whilst some people may not be able to use this appliance, Joe assumes that *no residents would* be able to use the appliance. This provides further insight into the way in which objects are generalised in care home life. Joe demonstrates an uncertainty over access to a hairdryer, he verbalises his dilemma over whether it should be permitted or not. Joe concludes by recalling that five years ago, one woman did have a hairdryer therefore from that piece of evidence he was then able to say yes. This was quickly followed by the use of a caveat that someone would need to supervise the use of the appliance. Basing a decision on an example of another resident (or previous resident) was found to be the basis for many of the decisions about objects in the home. The perception of many staff was that objects were hazardous and in order to keep people safe it was likely that access to functional objects would be denied. The lack of a formal assessment shows how care home staff can create barriers for residents' access to and use of functional objects.

 The responses given by care home staff relating to what could and could not be brought into the care home varied. Care home staff also contradicted themselves at times, which would indicate the lack of guidance relating to this topic. The only clear practice articulated was of PAT testing electrical appliances. All care home staff were aware that unless an electrical appliance was new (less than a year old), they were required to undergo a Portable Appliance Test (PAT) to ensure the appliances are safe to use.

The idea that you can 'bring what you like in' and that objects are encouraged is not accurate. The data shows that only certain objects are encouraged, and these often come with caveats. The extracts taken from both care home staff and relatives indicate that decisions about objects are often based upon anecdotal information rather than a formal assessment. Safety was an

important issue for both care home staff and relatives. When asked what objects were not permitted (care home staff) or should not be permitted (relatives) both care home staff and relatives tended to err towards objects that were on the extreme end of harmful. These objects had sharp edges and could potentially be used as a weapon. This was followed by the idea that should a resident have access to certain objects, this would increase the risk of harm to himself, herself, or another person.

The data shows that both care home staff and relatives view the safety of residents as of paramount importance. The extracts of data show that objects in a care home context were viewed as hazardous and dangerous, particularly if in the hands of a resident. Whilst some risks are more tangible, it appeared the element of risk was somewhat exaggerated in its individual and collective social construction.

Several residents in the care home smoked cigarettes. All residents were required to relinquish their cigarettes and lighters to care home staff and these were kept in the registered manager's office. They were placed in a desk drawer and only members of staff had access:

> *"Like the cigarettes are a risk, and for everybody, we made the decision cigarettes*
>
> *have to be kept in the office and the lighters" (Abby, interview, AUM).*

The management of lighters and cigarettes seems reasonable in line with health and safety. For example, both residents and care home staff have the right to live and work in a safe and healthy environment, which includes the right not to be exposed to second-hand smoke. However, the smoking at work law states that residential care homes can offer individual smoking rooms for the use of residents (hse.gov.uk 2019). Therefore, it could be argued that both cigarettes and lighters could be kept in a smoking room rather than in the desk drawer of the registered manager's office. Other objects did not carry such reasonable or explicit concerns. As previously mentioned, hair appliances such as hairdryers, hair straighteners and curling tongs were also viewed as carrying a potential risk:

> *"yeah there could be a problem (with you having hair straighteners); people would look at*
>
> *that as a health and safety risk if it's not for you, the person, it could be someone going in*
>
> *your room. Could be a risk couldn't it? A burns risk or a fire risk, if they were left*
>
> *smouldering; I don't know" (Abby, interview, AUM).*

Similar to Joe's extract, Abby articulates an element of risk in a person having a pair of hair straighteners. The perceived risk was anecdotal; there was no evidence to support a resident using a pair of hair straighteners that resulted in harm being caused. When asked whether documentation existed for risk assessments relating to residents use of functional objects, I was

informed that risk assessments were not carried out for that purpose. Therefore, the everyday objects that may support a person to carry out everyday activities, which maintain or cultivate identity, are often denied based upon an idea of risk rather than a formal risk assessment.

Oliver, the son of a resident in the home identified golf clubs as a meaningful object to his father. Oliver believed that golf clubs would not be allowed in the home due to health and safety:

> *"You'd see one or two, one, there's one photograph of his pals up in Scotland, on a golfing trip, but that's about it. You wouldn't see much evidence really. I mean obviously he had golf clubs, but I don't expect they'd have a set of golf clubs in his room, well probably health and safety" (Oliver, interview, son).*

This extract demonstrates that whilst the literature does not suggest golf clubs are prohibited, the idea that these would not be suitable for care home life is still present.

> *"Yeah, because, yeah I suppose it would be up to you as a carer and with the family, to make that decision to either remove the object or keep" (Carole, interview, care assistant).*

Another object considered a risk was a telephone. This was not viewed as a health and safety concern or a risk of harm to a resident, but it was considered problematic for care home staff and relatives:

> *"Well yeah, because they could be phoning the Police, which we've had before, with a resident; that she used to phone the Police [laughs]" (Janice, interview, domestic/care assistant).*

Whilst it may be conceivable that a resident may telephone the police, this suggests a resident does not have the right to call the police. Removing the telephone from a resident in a care home context could be considered a form of marginalisation. It removes power and maintains powerlessness; it suggests they are unimportant or less significant than those outside of the care home context are. It denies social citizenship through the loss of power, reduction in agency and a practice that systemically disempowers individuals living in a care home. It prevents a person from having opportunities to connect with life outside of the care home and in doing so, fully denies a person the right to participate in life possible (Bartlett & O'Connor, 2010).

The lack of access to an object, which can maintain a connection to the world outside of the care home, denies a resident the ability to advocate for themselves, to raise questions relating to their situation. The lack of access to use certain objects may be indicative of why people may feel incarcerated, a term used by some of the residents. Applying a material lens can provide a concrete example of why people feel this way. Although care home staff often spoke about

residents being able to have access to a private telephone, the following extract shows it is the relatives who are given the choice:

> *"So we give them the choice, we the families, if you want them to have a landline that's fine, we have a phone that we can take round to them, which I was doing yesterday, I was taking round to some residents so they could phone their families, but a lot of the families they say don't always to get phone calls and that from them. Sometimes it makes them worried or [pause] if they've got a landline they would then phone in the middle of the night, so they don't want to be disturbed if there's no need to be disturbed" (Abby, interview, AUM).*

The extract shows the relative's needs are being met above the needs of a person resident in the home. It also shows that a resident could be denied access to a telephone. Finlay was the only relative who explained why he did not want his mother to have access to a telephone:

> *"Ten past two, twelve minutes past two, fourteen minutes past two, and it would go on and so it was at a point where my phone, my own personal phone would be on night-time mode come ten o'clock at night, which is completely silent until seven o'clock in the morning. So if mum, if I had a problem with my wife or my wife's family, I wouldn't know of it until seven o'clock in the morning. So I took the decision to remove the phone. Like I say as far as I'm aware she hasn't noticed the loss of it, because she can still get hold of me anyway, through asking the staff" (Finlay, interview, son).*

Pippa's access to a telephone caused problems for her son; however, there could have been ways to reduce the usage of calls, which would still enable Pippa to retain her connection with the world outside of the care home. Finlay suggested his mother could get hold of him anyway through care home staff however, as reported in Chapter 6, gaining access to telephone was not as easy as he might have imagined.

It is conceivable that objects such as lighters and cigarettes hold a legitimate health and safety risk, whilst objects such as a hairdryer and a telephone pose a less conceivable risk.

7.3   Safety

From the data, it was easily identifiable that care home staff and relatives viewed functional objects as dangerous and hazardous in a care home setting. Care home staff expressed feeling a strong sense of protection over the residents. Whilst safety appeared to underpin much of the decision-making that took place relating to the access to and use of objects, the management of risk was not carried out in a formal way. When comparing interview data, observation data and

photographic evidence inconsistencies were found. It also highlighted that there were multiple perceptions of risk in relation to objects; there was the risk of harm regarding certain objects and the risk of objects being broken, lost or stolen. What was notably absent was an understanding of the risk to a person's identity and citizenship if they were denied functional objects.

7.3.1 Contradictions in words and practice

The analysis of data sources provided a confusing picture of care practices relating to the access residents have to objects. Although care home staff initially believed people could bring in the items they wanted, the more objects were discussed the more apparent it became that only certain objects were encouraged, and these had caveats. It was evident from the interview data that the idea of residents using functional objects was viewed as dangerous resulting in many residents being denied access to certain objects. When I asked about the use of a hairdryer many of the staff would remark that there was a hairdresser downstairs. This response seemed to be an acceptable justification for the denial of a hairdryer. What they failed to recognise is that most of the residents only saw the hairdresser every other week at best and this was only if had adequate funds. The mere presence of certain objects was viewed by care home staff as carrying a risk without a formal risk assessment.

For example, from my observations and informal conversations with Karen she enjoyed taking care of herself. She enjoyed clothing, make-up, hair colouring and hair styling, and appeared capable of looking after her appearance. In Karen's room there were two canisters of hair mousse, these were placed on top of her wardrobe were out of her reach:

Photographic image no. 6 Karen's hair mousse in her room
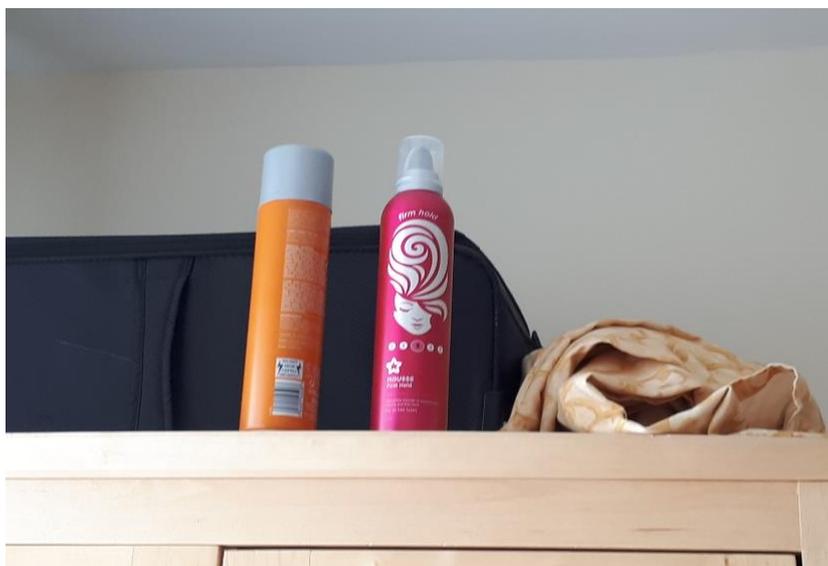
The placement of the hair mousse suggests that these objects are viewed as carrying a potential risk to Karen. There was no evidence of a risk assessment to explain the potential risk the hair mousse posed to Karen, yet it could be argued that the placement of the hair mousse posed at least two potential risks. The first risk is the potential psychological risk, the act of placing her own objects in view of the resident whilst denying her access. This could produce feelings of marginalisation, frustration, inadequacy and a lack of control. The second risk was a physical risk; the placement of the functional objects being in view of Karen has the potential for Karen to attempt to gain access the functional objects. There was the potential for her to move her commode over to the wardrobe to climb up to get the mousse or to use her walking stick to knock the mousse down. Both of which could pose more of risk to Karen than her having access to the hair mousse to style her hair.

From my observations of the objects in resident's rooms, it became apparent that the rules on safety were not consistent. In the absence of a formal assessment, the association between functional objects and safety were subjective rather than guided by policy and practice or an evidence-based objective assessment. The functional objects residents had access to often depended upon the views members of staff held about the resident, the object, and their perception of safety. Whist many members of staff considered objects as dangerous or hazardous, one member of staff considered himself a maverick. This was because he believed residents should take part in everyday chores and that it was wrong when they were not encouraged to do so. Bill remarked in one of my observations that he did not care what other people (care home staff) thought, he did not agree that people (residents) were not supported to do things and that he believed that residents should be able to take part in everyday chores. This again evidences the subjective nature of object-person relations in care home care. The lack of coherent practice was also evident when comparing the objects different residents had in their rooms. For example, Rosie had a trolley in her bedroom that contained hairspray, mousse, nail varnish remover and non-edible creams all within reach:

Photographic image no.7 Rosie's trolley in her room
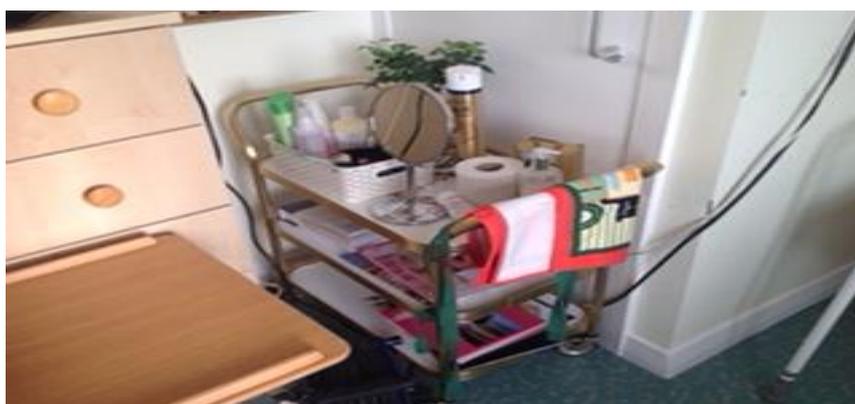
This contradicts Abby's assertion:

"But that's probably it, or just mainly like if they brought nail varnish remover or nail polish and things like that, we would probably take them away, but then brought out and supervised anyway, but they're probably the only things that we have taken away" (Abby, interview, AUM).

The photographic images taken show that the interview data and observational data are inconsistent. Whilst some objects were accessible to some residents, others were not. It could be argued that this is evidence of person-centred care however, without a formal risk assessment or the inclusion of objects in care planning this may be a generous conclusion to make. Rosie had access to hair mousse and many other objects, her trolley suggested she actively used many objects. Although Karen talked about wanting objects and verbalised her desire to interact with objects, she did not have access to the objects she wanted. Furthermore, having spent time with both Karen and Rosie, I could find no logical explanation for the disparity the women had to functional objects.

When entering Steve's bedroom there were many books next to his television, a panama hat on the top of his wardrobe and family photographs on the walls. On Steve's windowsill was an ornamental frog that held a pair of nail scissors:

Photographic image no.8 Steve's nail scissors in his room

This contradicts many of the care home staff who stated scissors would not be permitted in residents' rooms and residents would not have access to use nail scissors as they are viewed as dangerous:

"Nail, well nail scissors, erm you know that person, you know might not be safe to use them. Erm [pause] you know that they could theirself harm with, we would give them back to the family or you know, yeah" (Mandy, interview, care assistant).

Freya had objects such as a hairbrush and books on the bedside table:

Photographic image no. 9 Freya's hairbrush and books in her room

She also had a set of knitting needles that were placed sharp ends downwards in a large fish shaped vase on a chest of drawers:

Photographic image no. 10 Freya's knitting needles in her room

The knitting needles in Freya's room were surprising for two reasons. The first, based upon the interview data in which staff noted that anything sharp would be considered dangerous, I did not expect to find knitting needles in a bedroom. Secondly, Freya lived upstairs in the care home and sat in the lounge referred to by care staff as where 'those with very advanced dementia' sat. The impression given by several care home staff was that the people occupying this space were not capable or competent to take part in daily life. When I asked a member of staff if he ever engaged in activities with residents he replied:

> *"To be honest people in here are too far gone just downstairs really as people upstairs don't really engage so it doesn't really warrant getting anything out" (Michael, observations, care assistant).*

After finding the knitting needles, I enquired about them and found that Freya was known to be a 'proficient knitter'. I later found when I engaged in activities with her, that she was also proficient at word searches, jigsaw puzzles and playing Spyder Solitaire on my iPad. This demonstrates that a person cannot be assessed adequately without considering various aspects of a person's environment (Kondrat, 2013). The objects in Freya's room maintained Freya's identity as a person who was active with objects, who was interested in hobbies and who enjoyed mental stimulation. The lounge in which she was encouraged to sit each day and the label the lounge had been given placed her at a disadvantage of engaging with objects that could enhance her quality of life by supporting her identity.

Whilst collecting data, staff mentioned that care home practices were very risk averse and that they were aware this was not very helpful for residents. The care home would receive notifications from the local authority requesting the removal of functional objects as 'someone, somewhere, did something' and that this had caused a problem. An example of this was when a resident had eaten some non-edible cream. This had resulted in an email being sent ordering all care homes to remove non-edible creams and place them in lockable cupboards. Residents would only be able to access their non-edible cream if supervised by a member of staff. Whilst this was clear guidance, staff deviated from this and allowed non-edible creams to be present in the bedrooms of *some* of the residents:

Photographic image no.11   James' creams in his room

Again, this shows the complexity of care home practice. The photographs presented show that some objects are accessible to some residents whilst not to others. Some objects reported by care home staff as dangerous were found in bedrooms, direct orders from the organisation, such

as locking away all non-edible creams were not adhered to; care home staff made subjective decisions, and removed objects from resident's rooms without prior agreement, discussion or notice.

7.3.2   Objects going missing

The practice of removing objects from a person's 'private' room is a cause for concern. It is particularly poignant as it shows a disregard for a person's private space and the lack of control a person with a dementia has over their personal possessions. Care home staff would often use the concept of risk when justifying the removal of a person's objects from their bedroom:

> *"we've never actually had anyone that has brought something in that we need to take away, apart from probably scissors, yeah scissors I've had to take away recently, because erm [pause] the resident was cutting up all her clothes, doing alterations and then she was wondering why she had no clothes left" (Abby, fieldnotes, AUM).*

Abby justifies the act of removing the scissors from Karen's room by stating she 'had to take them away' as Karen was cutting up her clothing. This assertion suggests she had no choice but to remove the functional object. The extract shows Abby attempting to keep Karen's belongings safe. It emerged from my conversation with Abby that she had not engaged in a discussion with Karen about the scissors and her clothing before removing the scissors. When I asked what Karen had done to her clothing Abby replied that she had cut the neck off her jumper as it was too tight. Abby had viewed this as an act of Karen destroying her clothing. I asked Abby whether Karen's act might have been an act of altering her clothing to make it fit better. Abby remarked that she had not thought of it in that way. This again shows the complexity of decision-making surrounding the use of functional objects and a tendency to malignantly position people with a dementia when they take action. It also shows that residents lack control over what they do with their own belongings.

Care home staff often commented how valuable items were discouraged in the care home as 'things go missing'. Care home staff would describe how residents walk into each other's rooms and take objects that do not belong to them. Care home staff typically viewed people with a dementia as responsible for moving, removing and losing objects. The idea that the loss of an object is a result of people with a dementia taking objects that belong to another person is concurrent with findings from other studies (Innes et al., 2011; Powers, 2003). Whilst it is wholly conceivable a person with a dementia may pick up an object that does not belong to them, use an object that is not their own, or walk into a bedroom which is not theirs, what goes unnoticed are the systematic practices of care home staff removing a person's objects without discussion,

agreement or informing the person with whom the object belongs. Instead, care home staff advise relatives that objects in the care home are not safe:

> *"I mean I brought in a little vase and things like that, and not only that, but they told me things go missing. So if you had anything that was really valuable or something, that you don't bring it in, because, they don't mean to, but they walk into each other's rooms and pick things up and put them down. And I know I sometimes see my mum in something, she's wearing something and that's not hers. Or you know, and then I'd bring her slippers in and then I never see them again. You know things do go walkabout here" (Nerys, interview, daughter).*

The above extract shows how residents are told by care home staff that objects will go missing in the home. The matter that her mother was wearing clothing that was not hers and her slippers had gone missing may be a result of ineffective care home practices rather than one resident taking the property of another resident. It was evident from my observations that when clothing went to the laundry there was a chance it might not be returned to its rightful owner. This was not the only time care home practices did not take appropriate care of a person's possessions. Nicola explained how Peter had been moved from the bottom floor of the care home to the top floor of the care home. As a result of the move, a picture that his daughter had bought him had gone missing:

> *"And then in, they moved him [pause], you know he was downstairs and they moved him upstairs, and from then it disappeared, but I mean that was his way of having conversations with us. My daughter got cross over it, really, really cross because she goes on these courses, because she's a carer, she goes on these courses, and they were saying like the pictures and memories, like he's got a blanket in there and that keeps going missing as well"*

I enquired what the response was from the care home in relation to the missing picture:

> *"Well they don't know what happened to it. They've searched, they've said, and they don't know what happened to it. I think somebody had it" (Nicola, interview, wife).*

This demonstrates a lack of regard for a person's possessions. It also shows a lack of control of both residents and relatives in relation to the objects a person has. The loss of clothing was also a cause for concern within the care home. Although care staff would request all clothing had a nametag attached, Judy talked of her clothing going to the laundry and never returning. Judy also mentioned having two coats in her wardrobe but now only having one. She had no idea where it had gone or who had taken it but was clear she had two coats. James would also often ask where

various items of clothing were. The regard given to a person's clothing was at best sympathetic and at worst lacked any regard for its importance. The importance of clothing was overlooked on three levels. The first was lack of support given to a person to buy his or her own clothes. Judy had mentioned she needed some new bras, one that did up at the front, as she could not manage the ones that did up at the back anymore. She also wanted new tights and underwear as she was running low. Judy did not want anyone else buying these for her she wanted to choose them herself.

The second was the lack of understanding the importance of a person's clothing for maintaining independence and control. Clothing was imbued in care practices, the importance of laundry often focusing on a person having clean clothes. This carries the perception that a person who looks clean and tidy is receiving good quality care (Buse, Twigg, Nettleton, & Martin, 2018) rather than viewing clothing from an object-person perspective. This is emphasised in the National Minimum Standards which recognises the importance of maintaining residents' personal clothing (National Minimum Standards, Department of Health, 2006) but tends to focus on the management of infection control (Health Technical Memoranda, Department of Health, 2016; National Minimim Standards, Department of Health, 2006). Whilst this provides guidance on the decontamination of soiled clothing, it does not provide guidance on the importance of ensuring a resident is included in the management of their clothing.

Thirdly, the data demonstrated that the laundry practices often led to a person's clothing going missing. If a resident's clothing disappeared, care home staff would attempt to find it however, it was widely accepted that 'clothes just goes missing'. Care home staff again remarked that residents go into each other's rooms, this seemingly providing a suitable explanation for the missing clothing. When I began hanging out in the care home Karen was often preoccupied with her clothes. She would tell me that her pink jumper was missing, and her tights had not come back from the laundry. She would also argue that her clothing did not need washing after only one day of being worn and informed me that 'certain fabrics do not cope well with the amount of washing done here'. Although Karen often complained that her clothing was going missing, from my observations, care staff often dismissed this and suggested it was Karen's dementia. She was just making a fuss because she had forgotten it had gone to the laundry. During my observations, I saw that her clothing was going missing as it was taken without her permission and that this was not symptomatic of Karen's dementia. Karen would routinely lay her clothing out in the evening ready for the next day however upon waking her clothing would be gone:

> "I am grumpy because I put my velvet black skirt and white sweater on my chair to wear this
> morning but they have gone" (Karen, fieldnotes, resident).

The task-orientated behaviour of collecting laundry was causing problems for Karen. She felt that the home was not a safe place for her possessions. Karen told me that:

"My nephew brought me something but at night my clothes walk out of my wardrobe!" (Karen, fieldnotes, resident).

The practice of task-orientated behaviour appeared to continue even though residents made verbal complaints. Rather than addressing the problems these practices caused they are viewed as a problem with the resident:

"Karen is obsessed by her clothes. You know whenever they go out to the wash, it's like today; she's throwing a big er, making quite a big deal about it"(Michael, interview, care assistant).

Michael's language shows a disregard for the importance of Karen's clothing and what it means to the management of her identity. His remark also undermines the importance Karen's clothes hold to her and dismisses the negative impact the laundry practices had on her psychological wellbeing. The lack of understanding of the importance of object-person relations is concerning for two reason (1) this practice is likely to continue, and (2) this will continue to have a negative impact on her psychological wellbeing and quality of life. I observed Karen walking around the care home with a portable radio under her arm. Care home staff concluded this was a result of her dementia, commenting 'oh bless her'. I would argue that this action could be a result of her clothing go missing. Karen remarked that her possessions were not safe in the care home; she may have been carrying her radio to prevent it from going missing. The practice of removing residents' items from their room seemed to feed into a negative view of the capabilities and capacity of people living in the care home. Care home staff viewed the response of residents to their items disappearing as a symptom of dementia, a fuss over something unimportant or often blamed the loss of items on other residents (Powers, 2003). Care home staff had not identified that the systematic practice of care home staff removing objects from a person's room without discussion with residents could also be a cause of psychological distress to residents.

The lack of discussion surrounding the removal of a person's objects is shown in the extract below in which a resident named Steve requested his binoculars:

"he's asked me for, while he's just been sat in the lounge, he's asked me for a pair of binoculars. I have got no idea why, and like I say to him, you know what do you want them for? He says oh you know just, just to look" (Michael, interview, care staff).

Steve lives on the ground floor of the care home. The lounge chair that Steve often occupies faces the dining room and out onto the back garden. It may be that Steve can 'look' out to the garden with his binoculars. I asked Michael whether Steve had his binoculars:

"Not any more, they seem to have gone. He had two pairs, but I think his daughter took them away. But he does still ask for them. But that's like, we didn't actually know they were gone. So when he asked for them, I knew they were there and I went to look for them and they weren't there, so I had to report them as missing, until you know the whole situation was resolved."

I then asked Michael whether the situation had been resolved:

"Well they had to erm find out whether his daughter had taken them or not. But it caused Steve quite a lot of stress. He was, you know he really wanted those binoculars, and it causes a fair amount of confusion for us, because we sort of want to know where they've gone, you know there are people here who have potential to steal things. I think it was resolved as that his daughter would keep them and we just remind him that his daughter has them whenever he asks for them. I'm not sure whether he has them, and I don't think he has them at the moment" (Michael, interview, care assistant).

This was not the only object of Steve's that was missing. Whilst interviewing Steve in his room about his belongings he wanted to show me a favoured blanket. Steve could not find the blanket in his room which led to negative feelings:

''Isn't that annoying; just when you want to show off something'' *(Steve, interview, resident).*

This provides evidence that a person's belongings can be taken from a resident's room without the owner's knowledge or agreement. It shows that it is not only care home staff who remove objects from a person's room, but relatives. This again shows the complexities of managing objects in a care home environment and is concurrent with Powers (2003) assertion that care staff face difficulties in the management of personal possessions such as how to keep possessions safe. Although this situation caused Steve a considerable amount of stress, the situation had not been clarified and Steve is still without his binoculars. What is also interesting within this extract is the predisposition of staff to assume that another resident has stolen the object. At best these practices display a tendency to unwittingly proportion blame onto another as a quick and neat

way of relinquishing responsibility and at worst it blames a group who are vulnerable due to the cognitive impairment, compromised memory and lack of a strong voice. The practices deny a person access to the objects they use in everyday life can have a detrimental psychological impact on mood, as was seen with Karen and Steve and systematically removes any control a person has over the access to and use of functional objects.

The findings highlight the usefulness of objects as a topic of enquiry but also as a way of exploring care home life. Exploring the access people have to functional objects, and how functional objects are used, provides evidence of the involuntary passivity of some care home residents who have a dementia. Applying a material lens illuminates certain care practices which may have a detrimental impact on those living in the home such as; removing objects from a person's room without consent, unsatisfactory answers to questions about objects, a lack of control over one's possessions and the lack of support in using functional objects to carry out everyday tasks. All of which may contribute to higher levels of dependency and negative affect.

7.3.3   Someone, somewhere, did something

Taking part in everyday life often consists of using functional objects. For instance, to make a cup of tea requires several objects such as a kettle, cup and spoon. The ability to prepare for the day may contain appliances such as a hairdryer, curling tongs, a razor, beard trimmer and access to clothing. Without access to these objects, a person may lack the ability to demonstrate agency and autonomy. A sub category that was presented in Table 4, was titled someone, somewhere, did something. Analysis of the data demonstrated that staff felt a strong need to protect residents from harm, the premise of which was based upon anecdotal evidence that someone, somewhere, had done something. There was no evidence of formal risk assessments taking place to assess the potential risk certain objects may pose to individual residents. That being said, staff did report attempting to support people to participate in everyday life:

> *"We do try to, [pause] we try to get them, if they're capable, so they can make themselves a cup of tea, we would let them do it anyway, if they want a biscuit they can help themselves and that, we would never stop them doing that here anyway, but obviously there's some with dementia that wouldn't be able to say that's a cup of tea, wouldn't know that's a hot cup of tea, to be careful and that, so we do have to be careful with the kettle and that here" (Abby, interview, AUM).*

Abby emphasises that care home staff try to and allow people to participate in life, but only if a person is viewed as 'capable'. The use of caveats is prominent around the speech used relating to

a resident's use of objects and participation. Abby states that some people with a dementia are not capable of making a cup of tea, from my observations Pippa found it difficult to make a cup of coffee however; with support from a member of care staff, this was achieved. Whilst in the care home most of my time was spent observing residents sat in chairs as care home staff hurried around completing their list of 'jobs'. I observed residents attempting to help with the household chores but being discouraged by care home staff who suggested they sit down until the next meal or organised activity took place.

The following extract shows how the need to be careful impacts on residents who want to participate in everyday activities:

> *"But yeah, it's, it's really hard sometimes to get carers to allow people to do things. Because they want to do everything and they think, look at everything as being a risk. They do; there are some people who really look at it as being a risk. We had a resident who used to make their cup of tea, and then they'd make tea for other people, and then that become almost stressful because then carers would be going well they fill it up too much or they don't put enough milk in, so it all became, it can become quite stressful"* (Beth, Interview, deputy manager).

The complexities of managing a care home is evident from the above extract. Beth suggests that care home staff find it difficult to support residents to take part in everyday activities such as making a cup of tea. It is interesting that Beth, who is part of the management team, did not step in to support care staff, offering another way of approaching this particularly as she recognises that the resident enjoyed making tea for other residents. The action of supporting residents to take action such as making other residents a cup of tea would provide evidence that care home staff are supporting agency and participation, in doing so it also shows social citizenship in practice. By offering this kind of support to residents, it shows how micro-citizenship could work in care home practice. The member of care staff could facilitate higher levels of participation, showing a willingness to support residents in taking part in everyday tasks (Baldwin & Greason, 2016). However, it would appear that care home staff are not supported in providing this type of care. They were reported as feeling increased levels of stress when a resident attempted to take everyday household activities. Beth explains that care home staff want to do everything rather than allowing residents to take part. This is not surprising as a care home is a place of work for care home staff. Whilst observing handover sessions, staff were given lists of the residents they were responsible for and tasks to be completed associated with each resident. Beth believed that care home staff saw potential risks with residents using objects to carry out household activities

but gave no indication that care staff were supported in positive risk-taking practices. Beth also remarked that care homes staff believed that the resident who wanted to make tea for other residents could not perform the task to the same standard as care home staff. This demonstrates the undermining of residents. If an activity is not performed to a certain standard, opportunities to use functional objects to take part in everyday activities, can be removed.

The following extract shows how a member of staff processes the idea of supporting a resident to take part in using a dishwasher:

> "Again if their hands were clean, but they could maybe. Mind you they're not, you know they use them, so they're not that sharp. So they could potentially, you know they could empty the dishwasher, and not necessarily load it because things are quite, you know you have to obviously make sure they're quite stacked and not too close to one another, so you know it cleans them properly. But you know unloading the dishwasher. I mean one of the other residents that's here, she does that, so a younger a resident that's here, she does do that sometimes, and put things away, you know she will have a little tidy around and that. but yeah I mean you know, yeah that's laying the table and folding the serviettes and that kind of thing, or clearing the tables away, you know stacking them up ready to go in the dishwasher" (Janice, interview, care assistant).

Janice provides, albeit not fully, many reasons why a person may not be able to use a dishwasher. She begins with the health and safety protocol such as having clean hands when handling objects that be used for food purposes. This then turns to an issue around the safety of residents as some objects may be sharp, even though residents may have handled these sharp objects to eat their meal. Janice then switches her attention to the perceived capabilities of residents in performing a task. Like Beth in the previous extract this highlights that care home staff are judging the capability of a person by their own subjective standards of how well a task is performed. If the resident does not meet the subjective standard, it is likely this will reduce or prevent a resident having opportunities to use object to take part in everyday life, thus leading to marginalisation and the denial of social citizenship.

Janice points out that a 'younger resident' sometimes puts the objects away and has a tidy around which suggests that the perception of ability may not be just about a person having a dementia but also their age. Janice finishes by giving examples of the type of tasks people may be supported in completing. In doing so, she identifies the objects that a person would be supported with; objects such as folding serviettes and laying tables and stacking crockery ready to go in the dishwasher. This extract identifies that residents can only have objects that are agreeable by a

member of staff. A resident is supported to complete task, but only the tasks a member of staff has decided are suitable. The material lens demonstrates the multitude of restrictions in operation preventing a person from taking action with objects, having control over their objects and demonstrating their identity through the use objects. In turn, this demonstrates an imbalance in the protection and empowerment (MCA, 2005) afforded to people with a dementia living in a care home. The following extract shows how people are not encouraged to do things for themselves:

> *"Tea and coffee making facilities and things like that are always communal, they're always found in the lounges, but again people aren't really encouraged to make their own to be honest. I think it's because of the nature of the some of the clients, they're too likely to hurt themselves doing it and you know if we are seen there, helping them make a cup of tea and they pour boiling water all over their hands, we're equally as liable, so we don't really like to" (Michael, interview, care assistant).*

Michael reports that supporting a person to participate in a daily activity could result in a negative outcome for the resident and the member of staff. He goes on to say that if a resident hurt themselves as a result of being supported to take part in an everyday activity that he or the care home are equally as liable. This indicates that he believes there is a risk to him or the organisation if he supports a resident to make a cup of tea. The fear of being blamed for a resident being injured is likely to act as a barrier to positive risk-taking practices.

Very few residents were observed participating in the routines and rituals of care home life. Care home staff carried out household chores and served residents meals and drinks (both hot and cold). It was evident staff did things for residents, if a resident got up to take a cup to the sink, typically a member of staff would intervene by politely taking the cup from the resident. They would affirm the resident did not need to do that and that the member of staff would do it for them. If a resident got up from their chair, staff would often ask what they were doing or where they were going, generally suggesting they sit back down. If a resident attempted to help a member of staff with chores, their help was generally politely declined:

> *"We have had residents go up to the domestics, they'll pick up a bottle and then say oh no that's mine, you can't have it, that's mine, and obviously we see what they're going to do with it and they don't look like they're going to do cleaning, so we need to take it away from them"(Abby, interview, AUM).*

This extract shows that residents do make attempts to take part in daily activities but that this is viewed as a risk. There appears to be a tendency to presume a person's incompetence rather

than competence. Whilst some residents may use an object for its intended purpose and others may not, Abby seems to be looking for potential risk rather than carrying out an objective risk assessment. The idea that someone, somewhere, did something appeared to be an influential undercurrent in care practice. The analysis of interview data showed that safety was at the forefront for care staff, the need to keep people safe by reducing the functional objects people had access to. The need to keep residents safe was also present in the fieldnote data, which on analysis showed few interactions taking place with residents and functional objects, and staff often preventing residents from taking action with objects. The Care Quality Standards – Control of Substances Hazardous to Health (documentary source) provides guidance for staff relating to the safe practice of dangerous substance. The guidance refers to the safe keeping of cleaning products, where they should be stored, how they should be rotated and disposed of and the that dilution measures should be adhered to. The guidance does not include residents as a risk factor.

The complexities of managing physical risk tended to result in discouraging residents in this care home from taking part in the routines and rituals of care home life. The management of risk and autonomy was difficult for care staff to balance. The next extract shows that the management of risk is not well understood and is inconsistent amongst members of staff:

> *"I mean we do have residents that fold up washing, lay the tables, can dust their own bedrooms, but yeah I do agree that it is a case of staff do say oh you don't have to do that, that's all done for you, the cleaners will do that, rather than thinking it is a a meaningful activity for that person. And we have had a resident, Wayne, and he said about doing some ironing, and our Activities Coordinator's like oh no you can't do that, burn and all the rest of it. Well I burn myself doing the ironing; it doesn't stop me doing it. So I said that's, you know he'd be quite capable and if he wants to iron some, whatever he wants to iron that's absolutely fine. But it is because I think the Council has been so risk-averse and everything is risk assessments and risk assessments. People see a risk assessment means you can't do it; it's not, it's just assessing that risk and seeing what we can do you know ensure that it's carried out absolutely fine, it works wonderful and nobody gets hurt. A risk assessment doesn't mean we can't do it" (Elaine, interview, registered manager).*

Elaine provides examples of certain household chores that residents are supported in completing but recognises that staff can be a barrier to residents achieving agency and autonomy. Elaine is empathetic to the position of residents and suggests the organisational practices are too risk averse. She also suggests that risk assessments need not result in a negative outcome but can produce a positive outcome for those involved, however this was not carried out in practice.

What is clear is that the management of risk and autonomy is difficult for staff to manage (Evans et al., 2018).

7.3.4   Risk as a barrier to social citizenship

Applying a material lens to care home practices illuminated the perception of risk amongst care home staff in relation to what they enabled residents to do. Care home staff were preoccupied with keeping residents safe. Psychological risk and quality of life were overlooked and more tangible physical risks such as a resident burning himself or herself was at the forefront of care practices. The management of risk acted as a barrier to care practices that supported autonomy, self-determination and opportunities to use functional objects:

> *"Yes. But like you say, those scenarios come in, we do have cake-making, biscuit-making, so the people that do like to do that sort of thing, can get involved. And like cutting up fruit, you do give them a knife to cut it up, but you wouldn't give it to someone who could stab someone. If that person was able to lift that pot up to make a cup of tea, I would allow them to do it. But it would be risk-assessed. I think risk assessment, risk protects the resident and it protects the carer. But they could say, why did you let Pippa have that pot of coffee, she's dropped it on. But I'm not, I wouldn't let her, you would think of the situation, I've got a trolley with a teapot on. She's not walking around the home with it, she's pouring it into a cup on a trolley. The risk assessment would be an, it would be classed as an accident. Pippa dropped the pot of coffee and it burnt her foot. You would document that she was helping. It's all explained, she was helping the carer serve teas and she dropped the teapot on her foot. Yeah. But they, we don't stop, if I Pippa wanted to make herself a cup of coffee and the access, the milk's in the fridge, the kettle's there, we are aware that she is able to do that and if she did have an accident, once again it's just all documented of what Pippa was doing"(Carole, interview, care assistant).*

Carole describes a scenario in which residents may be supported in cake or biscuit making. Carole suggests that she would not give a knife to a person who could stab another person. The very mention of a knife here and in previous extracts conjures up ideas of objects being used to cause harm. Given that the term risk assessment is used often by care home staff, this appears to be a tokenistic term as again, there was no evidence of a risk assessment being completed relating the use of functional objects. Whilst some care home staff were more confident in supporting residents' use of functional objects other members of staff are not:

> *"Upstairs we had a lady who would always do the washing up and drying up, and people get up and just do it. Then obviously you get people who get extremely worried about the*

health and safety of it, and I always say well that's fine, let them do it, and then just put it
through the dishwasher, because we have to, for health and safety. It's little things like
that. We've given people dusters, they get people folding up napkins or folding up the
washing, so little things people can do, and sometimes that's enough, just to be able to do
little things" (Beth, interview, deputy manager).

Beth describes how people are supported to do 'little things' this provides insight into how people are thought about. Whilst care home staff frequently used language that suggested residents had access to functional objects and could take action with these objects, by applying a material lens to explore how functional objects were imbued in everyday life this illuminated a number of the restrictions. The next extract is the response from an assistant unit manager when I asked him if a person could have access to a duster and furniture polish to polish their bedroom:

"Well this is a rare situation I believe it would be. If such a thing is indicated on
assessment, if the family made us aware of this person really is so keen, craving to polish
almost all the time, and he or she would like to have a cloth and a spray can, I wouldn't
have a problem for her not to be doing that all the time when she wants to. Well I'm just
thinking from the manager perspective, if I would be a manager here, I would take into
consideration the condition of the person, her mental state kind of situations with
aggressiveness and things like that, and any kind of history of it, and if we think that the
person might be safe with using that, and really need it, I think I'll allow that to happen,
and the close monitoring of the staff and constant reassessment if needed" (Max,
interview, AUM).

Max emphasises the importance of managing risk and the possible problems that may result from allowing a resident to polish some furniture. Although he has not carried out a formal risk assessment, he appears to be carrying out his own risk assessment explaining the factors he would consider when deciding whether a resident could undertake the task of polishing. Max takes responsibility for allowing this activity to take place and adds that that 'close monitoring' and 'constant' assessment might be needed. The extract shows that the power dynamic is largely on the side of the member of staff. In the absence of care practices, which follow a formal risk assessment for the purposes of using functional objects a resident, is wholly reliant on the subjective opinions and views of members of staff.

7.3.5   The exception

It is argued that residents are unlikely to be involved in everyday tasks carried out in the care home due to functional object being viewed as hazardous and dangerous. Whilst care home staff

describe how residents are supported to complete 'little tasks' with certain objects this was rarely observed in the care home. Care home staff often talked of risk assessments taking place to assess whether a person could participate in everyday life however; the reality was that the risk assessment for these purposes was a myth. However, there was an exception in this study.

One resident was observed to be encouraged to take part in household chores and was supported in tasks that care home staff had described as being problematic. Pippa was aged 69 years and had moved into the care home in May 2017. The symptoms of Pippa dementia suggested she struggled with executive functioning. Pippa found it difficult to work out what object did what and how to use certain objects. However, I observed Pippa to be determined and driven when taking part in carrying out domestic chores. It was visible that she enjoyed wiping down tables, stacking the dishwasher, washing up crockery and cutlery and washing down the kitchen sides. Pippa would also display signs of anger, frustration and annoyance if a member of staff carried out the chore or prevented her from doing it. Pippa told me that she was completing the chores as she was hoping to get a job in the care home. This suggested that Pippa was not simply carrying out the domestic chores as a result of her biographical history but that she had an intention in mind. Pippa's actions, carrying out everyday tasks with household objects showed her demonstrating her identity. Pippa did not see herself as a resident in a care home, but as a capable woman helping out care home staff with the aim of gaining employment.

Whilst staff did not seem to be aware that Pippa saw this as a way of gaining employment, she was supported in accessing objects to carry out domestic tasks:

> *"Scenario this morning, you've got Pippa, she likes to, after the breakfast things, she's got a routine now where she sees cups and saucers where someone's finished she will automatically remove them from the table and wash them up. We don't stop her from doing that. We encourage her to do it. Also there are where she, she likes to fold, she will fold a whole packet of serviettes into triangles, because that's a task we've given her to do. And she enjoys doing it. We try and promote, if they like doing it, we do try and find things they can do. Like today she had a duster. She does the serviettes, she'll clear down. But sometimes we might have to step in. Because there's an activity coming, but you don't exclude her, you just make the task quicker" (Carole, interview, care assistant).*

This demonstrates amidst the talk of risk assessments, dangerous objects, hazardous situations and barriers to supporting a person to use functional objects in everyday life, it can be achieved. That although it may take longer to complete the task this should not prevent a person from taking action. Although Pippa struggled with the chores, she was still encouraged to take part:

"I'm okay with it, but in most situations, well we've had a lady come in called Pippa, who's not that old, she's probably in her sixties, maybe seventy, and she's got dementia, and when she came in she was fully encouraged to help lay the tables in the evening, but she really struggles with it. She, you know you can lay a place and say this is how you know I'd like you to do it, and give her all the tools to do so, but she seems to really struggle with, yeah struggle with it. I mean yeah it's okay to have people do it, as long as they're you know not going to hurt themselves in any way. If they have very poor mobility and they're trying to move from place to place and they're going to fall over it's not really the best idea. But you know Pippa still helps lay the table from time to time, although she does find it a challenge we still try and encourage her to do it" (Michael, interview, care assistant).

Michael mentions that Pippa is in her 60's or 70's, this could suggest that this may be an important influencing factor of why she was encouraged to take part in the household chores. When I first met Pippa, I assumed she was visiting a relative in the care home, as she looked younger. Her appearance may have been a factor in staff believing Pippa *should* be more active and take part in everyday activities. On many occasions, I observed her looking at a jug of milk and a cup, picking one up and then putting it back down, her expression suggesting she was not sure of their function. Whilst some of Pippa's symptoms of dementia appeared advanced, she was afforded social citizenship. Pippa was the only resident who was enabled to take action, supported in her use of functional objects and exhibited behaviour that demonstrated agency. Pippa was treated as more competent than those who displayed milder symptoms. This suggests that discrimination may not simply be a result of the perceived incapabilities of people with a dementia, but a result of ageism. It is widely understood that ageism is highly prevalent and unlike other forms of discrimination is socially accepted, and often unchallenged due to its largely subconscious and implicit nature (World Health Organisation, n.d.). However, by applying a material lens it is possible to draw out and challenge ageism in discriminatory practices.

7.4   Summary

This chapter has examined whether residents have access to functional objects, how functional objects are used and by whom. The data has demonstrated that the idea that a person moving into a care home can bring with them what they like is misleading. The findings also study show that only certain objects are encouraged in a care home, and even they may have caveats attached. Care home staff viewed objects as hazardous and dangerous in care home setting and tend to remove or refuse objects based upon anecdotal evidence that somewhere, somewhere, did something. There was a lack of consistent practice or objective evidence available to explain

the inconsistencies in residents' access to objects and decisions were made by staff on an ad hoc basis, supported by anecdotal evidence. Although management had noted that residents could use the new kitchenette areas in the building, most of the residents were encouraged not to use the objects in the kitchen area. The observation data showed that if attempts were made by residents to make a drink or help with chores these were discouraged. Staff would often intervene to prevent a person from participating in the running of the home due to a perceived risk of harm to the resident, due to the time it might take the resident to complete the task or perceived competence.

Existing literature and the findings of this study argue that objects play an important part in everyday life. The ability to maintain and cultivate identity through interactions with objects is evident. The way in which people use their objects to carry out tasks supports autonomy, agency and social citizenship. The way in which residents use objects to carry out tasks for another person can demonstrate micro-citizenship. The lack of access to functional objects limits the ability for people with a dementia to enact identity and actualize citizenship. It also demonstrates that care home staff and relatives require support and guidance to better understand the importance of functional objects in the enactment of identity through everyday routines developed over a lifetime. It is crucial for organisations to address how the current management of risk is in opposition with a rights-based approach to care.

Current care practices operate discriminatory practices that deny people with a dementia the right to be include in decision-making and the right to take part in everyday life. Whilst risk management is a priority for both care home providers and regulatory and governance authorities there is a distinct lack of appropriate risk assessments taking place. Most residents were restricted in their access to and use of functional objects, this concurs with findings from Popham and Orrell (2012). This study reports an exception that shows that people with a dementia can be supported to use functional objects to carry out everyday tasks when supported by care home staff. It also places objects and people as relational, by concentrating on the interactions between the human and material worlds the practice of social citizenship has the potential to be actualised.

Chapter 8: Contribution to Knowledge

Material citizenship framework

Chapter 8 introduces and describes a new framework: Material citizenship. Material citizenship was developed during analysis of the three data sources. It provides four important elements in advancing dementia care practice; (1) an educational tool which elevates the importance of personal possessions and functional objects upon relocation to a care home (2) an educational tool which can support the inclusion of residents in everyday activities through the use of functional objects, (3) a mechanism for locating and evaluating social citizenship in dementia care, and (4) a way of highlighting institutional policies and procedures that are designed to meet physical care needs rather than promote rights and citizenship. Material citizenship may provide support and guidance for all members of the triad; residents, relatives, and care home staff by addressing the overlooked area of object-person relations in dementia care. Material citizenship employs functional objects to mediate between the perception of risk and supporting social citizenship.

Material citizenship provides three specific contributions to current literature. It contributes to object-person literature by extending the psychological theory that 'you are what you have' by applying it to sociological ideas of care home life. It contributes to citizenship theory by providing a practical framework to locate the presence or absence of social citizenship in a care home environment through a material lens. Finally, it contributes to dementia care literature by focusing on the functionality of objects in enabling a person with a dementia to remain active in their own lives. Material citizenship contributes to existing literature by taking what we already know about the importance of balancing rights, responsibilities and risk, and applies a material lens to systematically consider functional objects as relational in dementia care practice.

8.1   Introduction

This study sought to address whether a material lens could be a useful way of locating social citizenship for people with a dementia living in a care home. This chapter contributes to citizenship theory by introducing a new framework: material citizenship. The concept of material citizenship represents a framework that integrates citizenship theory and object-person theory and the findings of this study. Whilst there is growing literature on the subject of citizenship regarding people living with a dementia there is a lack of applied practice. The material citizenship framework can support care home staff by assessing risk through a material lens and encouraging

practices that support people with a dementia to enact social citizenship through their interactions with functional objects. As defined in the overview at the beginning of this thesis my working definition of material citizenship is:

>*'the right to be included in decision-making relating to personal possessions and the right to have opportunities to use functional objects to perform everyday tasks'.*

This chapter begins by introducing a visual representation of the domains that conceptualise the material citizenship framework. A full description of the five domains that form material citizenship framework are explained. The chapter concludes by discussing the potential usefulness of the material citizenship framework to locate either the presence or absence of social citizenship for people with a dementia. Material citizenship offers the fundamental elements for developing a practical tool to actively support the enactment of social citizenship by applying a material lens to a care home context.

8.2   The conceptualisation of material citizenship

The conceptualisation of material citizenship is a rights-based approach to care practice. It supports the right to be included in decision-making regarding personal possessions and the ability to remain active. In doing so, it supports the maintenance and reconstruction of a person's identities through the subjective and material worlds in which life is performed with functional objects. Material citizenship is highly relevant to people living with a dementia in care homes, particularly as institutional policies and procedures are designed primarily to meet care needs rather than promote rights and citizenship.

The concept of material citizenship represents a framework that draws on the perspectives of all three participants groups included in this study: residents with a dementia, relatives/spouses, and care home staff. The framework has five domains that will be discussed drawing on the literature reviewed in chapters 1, 2 and 3 and the findings presented in chapters 6 and 7. The framework was developed as a result of research question number 2 which asked "Can the location of social citizenship be examined by exploring how functional objects were imbued in everyday activities?"

I have created a visual representation of the domains contained within material citizenship (Figure 2 overleaf). This illustrates that five domains were identified as important in practicing material citizenship in a care home environment.

Figure 2. Conceptualisation of Material Citizenship
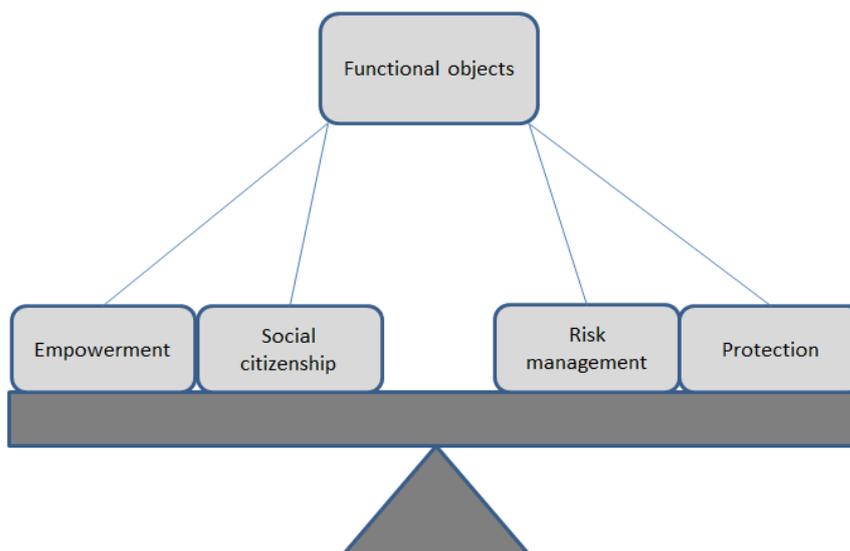
The visual representation above shows a set of weighing scales. The representation of weighing scales is an important analogy as it shows the balance of one set of ideas with another. There are five domains in total, four of the domains are placed on the weighing scales and one domain is placed above. The fifth domain above the weighing scales: functional objects, acts as an enabler in balancing the four domain types: empowerment, social citizenship, risk management and protection. Empowerment and social citizenship are placed on the left-hand side of the weighing scales; these represent the importance of self-determination, feelings of control and opportunities for residents to take part in their own care in an institutional setting. Risk management and protection are placed on the right-hand side of the weighing scales; these represent the importance of the management of risk in a care home context. The weighing scales show that both sides have equal importance; however, if the scales tip too far towards risk management/protection, this can result in overly protective care practices.

The domain of functional objects is identified as being an influential factor on all four domains on the weighing scales. Functional objects provide a mechanism to enable the balance of relationships between the domains.

The domains of risk management and protection in the context of dementia care

The domains of risk management and protection are combined as they are inextricably entwined within the context of care practices. The management of risk in contemporary health and social care practice can be problematic. Clarke, Gibb, Keady et al, (2009) argue that there are few areas of practice that are more complex and contended than managing risk in dementia care. Whilst some risks are very tangible, such as being scolded with hot water when using a kettle, others are less visible, for example, the psychological harm when being excluded from decision-making. What constitutes as an acceptable risk to care home staff can differ to that of relatives and that of residents. Health and social care tend to operate a safety-first approach and according to Titterton (2005) this approach, while aimed at achieving a safe physical environment, can have negative consequences (See page 22).

Chapter 7 demonstrated how care home staff were preoccupied with operating a safety-first approach by the way they removed objects from a person's room or placed them out of reach. It was also clear that risk was an underlying feature of decision-making when discussing the objects that were accessible. When interviewing care home staff, they often talked of objects being potentially dangerous or hazardous in the hands of a person living in the care home. However, the perception of risk varied, and this was demonstrated when care home staff deviated from an email sent out to local authority care homes to remove all resident's access to non-edible creams because someone, somewhere had eaten some. The study findings demonstrated that care home staff were focused on keeping people safe and this attitude was reflected in government, local authority and inspectorate policies that prioritise physical safety. Whilst safety is an important priority, the way in which risk is managed shows little consideration for a person's human rights. This may be because care practices are dominated by the bio-medical model (Ursin & Lotherington, 2018) rather than following a rights based approach to care.

The current lack of balance between the protection and empowerment (MCA, 2005) of people with a dementia was prevalent throughout Chapter 7. Applying a material lens to the everyday lives of people with dementia living in care homes demonstrated how the manifestation of objects in care practices can draw out the safety concerns of care home staff and policy makers. Viewing functional objects as hazardous and dangerous, and imposing restrictions without an objective assessment, can lead to the denial of social citizenship. The material citizenship framework offers an opportunity to readdress this balance by viewing functional objects as a way in which people can take action and enact their identities as community members. The

implementation of a material citizenship framework in a care home environment may prevent contraventions in a person's human right to enjoy their possessions (Human Rights Act, 1998, amendment Dec 2018).

The domains of social citizenship and empowerment

In Chapter 3, I outlined the conceptualisation of social citizenship and put forward Bartlett's (2015) assertion that a focus on the importance of the private domestic sphere for dementia studies is required. This study explored the private spheres of people living within an institutional setting and therefore it was important to place citizenship in the context of organisational practices.

Baldwin and Greason (2016) considered citizenship in dementia care by adapting the four types of citizenship for the purposes of applying it to people with a dementia in a long-term care setting. Micro-citizenship was of interest to this study as it considered the activities in which people engage, the meanings attributed to this and how this affects identity and a person's sense of self. Action, meaning and identity established a meaningful narrative of identity experienced through a person's life story, the ability to participate in life encompassing individual agency and collective decision-making about being in the world. Baldwin and Greason (2016) suggest the relationship between participation/engagement and identity/meaning in micro-citizenship is the clearest. The two concepts come together in decision-making relating to how a person wishes to be cared for. A person's biographical history and values often become a focus for the realisation of micro-citizenship, bringing together a person's wishes and sense of self. The material citizenship framework can ensure that joint decision-making takes place in relation to personal possessions, enabling people to continue their biographical narrative in the present.

Social citizenship is active. The location of social citizenship was largely absent in the findings presented in Chapter 7. People with a dementia were not free from discrimination as they were not provided opportunities to grow or opportunities to participate in life to the fullest extent possible (Bartlett & O'Connor, 2010). For example, Karen was unable to have access to blonde hair dye, her curling tongs or control over when and if her clothing went to the laundry. Steve had his binoculars removed, possibly by his daughter however, there was a lack of reliable information to provide reasons for this. Pippa was the only person with a dementia who was actively encouraged to take part in everyday household activities. This demonstrates it requires 'care collectives' (Ursin & Lotherington, 2018) to support social citizenship. To date there has not been a practical framework that provides guidance and support encouraging a collectivist

conceptualisation of citizenship in dementia care. Material citizenship provides a practical knowledge transfer between academia and practice with the ability to work across groups by focusing on the functionality of objects in dementia care.

The domain of functional objects

The domain of functional objects places people with a dementia as active citizens by focusing on the functionality of objects. To view people with a dementia as active and therefore able to use objects to carry out everyday tasks, calls into question the domains of risk management and protection. Whilst risk management and protection may be necessary and can be positive, this study demonstrates that the way in which both domains are currently operationalised in care practices can disempower and restrict people with a dementia. The study findings demonstrate how care home staff often deny a person access to functional objects without conducting a formal risk assessment. It also showed how functional objects are often removed from a person's room without negotiation or explanation and often without the person knowing. This contrasts with the conceptualisation of social citizenship.

The domain of functional objects can be useful as an enabler between the concepts of risk management and protection and social citizenship and empowerment. By understanding the importance of functional objects in the maintenance and enactment of identity, and by applying a material lens to care home practices, material citizenship can balance the domains to ensure people with a dementia are treated as active individuals rather than passive recipients of care (Bartlett & O'Connor, 2010).

Functional objects may be used for conventional reasons such as Karen's desire for curling tongs to curl her hair but may be used for unconventional purposes. An example of this was Judy using her handbag as a portable filing cabinet. The documents Judy carried around in her handbag provided her the ability to prove that what she said was accurate and her mental capacity was intact.

Functional objects are a powerful tool in advancing dementia care practice for two reasons; (1) the way in which decisions are made about objects elucidate discriminatory practices and inequalities, (2) the way functional objects are imbued in daily activities illuminates how a person with a dementia living in a care home is positioned.

By approaching dementia care with a material lens, certain questions can be asked of dementia care practices. Questions such as:

1) What objects can a person have and why?

The answer to which can provide valuable information about care provision in care homes and an understanding of the importance of object-person relations.

2) Who was involved in decision-making in relation to objects?

The answer to which can provide information about whether reasonable steps are being taken to include a person in decision-making balancing protection and empowerment (MCA, 2005).

3) Which functional objects do people with a dementia have access to use?

The answer to which can provide information about how a person is being positioned by raising questions about capability and capacity.

In asking these questions, the balance between risk and social citizenship can be objectively assessed and evaluated. Material citizenship provides a practical framework for social citizenship for people with a dementia in a care home setting. It works towards upholding the human rights of a person to access and enjoy objects and supports the intentions of the MCA (2005) in providing a practical framework to balance protection and empowerment (Boyle, 2008).

The material citizenship framework contributes to the theoretical literature of citizenship and social citizenship for people with a dementia by offering a practical application for locating either the absence or presence of social citizenship in care practices.

8.3   Objects as a human rights issue

Human rights and citizenship are widely discussed concepts in health and nursing literature. The British Institute of Human Rights (2010a) declare that human rights are basic rights to which all human beings are entitled. However, documentation deriving from the media, regulatory bodies (Brimelow & Lyons, 2009), Government (House of Commons, 2007) and independent organisations (Mental Welfare Commission, 2011) continued to report unacceptably high levels of mistreatment and neglect of people with a dementia in the care system. Although there is still much to do in the provision of care home care, a 2012 report by The Centre for Policy and Ageing gave a more encouraging picture. They noted that amidst the challenges faced by care homes, in general a positive view was present which provided an overall picture of successful effort in providing resident-centred care (Center for Policy on Ageing, 2012). Many organisational reports make assertions relating to getting the basics right and the importance of delivering care of a high quality. However, the importance of access to personal possessions and the use of objects in everyday activities continues to go unnoticed.

On the 6th December 2018, there was a change in the Human Rights Act (1998) which states the protection of property as human right:

Part II The first Protocol Article 1

> *"Every natural or legal person is entitled to the peaceful enjoyment of his possessions. No one shall be deprived of his possessions except in the public interest and subject to the conditions provided for by law and by the general principles of international law.*
>
> *The preceding provisions shall not, however, in any way impair the right of a State to enforce such laws as it deems necessary to control the use of property in accordance with the general interest or to secure the payment of taxes or other contributions or penalties."*

Article 1 not only recognises that people are entitled to enjoy their possessions but that they should not be deprived of their possessions. The placement of a person's possessions as a human right elevates the status and importance of objects. I will now address the amendment of the Human Rights Act (1998) alongside the findings of this study.

8.3.1   The right to have property

Whilst the change to the Human Rights Act 1998 in relation to objects came into force after the data collection had taken place, I met with the local authority Adult Services Service Manager in February 2019 to provide him with a progress report. He was unaware of the change in legislation relating to personal possessions. This suggests that although legislation exists it may not have an impact on the daily lives of people with a dementia living in a care home. This is important particularly as in section 6.3, I reported that of the 15 people with a dementia who took part in this study, 11 were not included in decision-making relating to their personal possessions and of the remaining four residents, reliable information was not available. In addition, people with a dementia did not have opportunities to return home to organise their belongings, have access to their personal possessions or the use of functional objects. These practices could now contravene the recent amendment to the Human Rights Act (1998).

The ideals of human rights are closely linked to the concept of citizenship. Citizenship involves a person having rights but also responsibilities. As reported in section 6.5 there was a lack of understanding over who was responsible for a person's possessions and what this responsibility entailed. It became apparent that care home staff did not feel they were responsible if a person's

belonging went missing however, they did take responsibility for a person's possessions when making the decision to remove a person's possessions from their room without informing the resident. It could be argued that the act of removing a person's possessions from their room by care home staff, without the resident's knowledge, is also removing the resident's responsibility for their possessions resulting in the denial of social citizenship. An example of this is demonstrated in the following extract:

> "the other day a resident was asking me for some of her Veet hair removal cream, and she just wanted to put some on her chin, but erm I saw it in the room there, it was on top of the chest of drawers, it was very reachable, but you know I had to grab it and put in my pocket, because I thought you know this is possibly something that she shouldn't have, because it is meant to be on top of the wardrobe, so it's well out of reach, but it wasn't. So erm I said to her, she didn't realise I'd put in my pocket, so I said to her oh I'll just, I'll go down to the office and see if they've got it there. So I went down to the office and said to Elaine , look like she's got this Veet, I don't know whether to give it to her, because it's got a label on it that says 'out of reach', and Elaine says, no, no don't give her that, like just leave it down here in the office, and we'll sort it. So I just ended up having to go back to her room and say yeah, look it's not here, I can't find it, I think they've taken down to the office, and you know for safety reasons" (Michael, interview, care assistant).

This extract shows how the resident not only had her property removed by the member of staff, but that the member of staff also lied to the resident about the object. The registered manager made the decision to keep the object in her office, the member of staff then returned to the residents and rather than explaining what had happened and the decision that had been made, he chose to avoid the possible conflict and use a deceptive strategy. At no point was the resident offered assistance in using the hair removal cream, the object was simply removed. The removal of this object and the lack of support to assist the resident in using her hair removal cream demonstrates the absence of social citizenship in current care home practices but is now also a human rights issue. In this example, reasonable access to the Veet cream would now be protected as a right. Understanding the importance of object-person relations can provide care home staff with an objective tool with which to mediate between the four domains: risk management and protection, and empowerment and social citizenship. To prioritise functional objects in care plans and on-going care decisions could enable care home staff to think about the resident as an active being. This could ensure the management of risk and protection is proportionately balanced (as shown in figure 2) and decisions are made by taking an evidence-based approach rather than a subjective approach. In doing so, it could ensure that social citizenship and empowerment is

supported wherever possible. The reported incident reveals that current practices do not follow a risk assessment process. At no point was a formal risk assessment carried out to measure potential risk an object posed. Furthermore, the registered manager confiscated the person's object without negotiation or explanation. It is therefore argued that this practice demonstrates an absence of social citizenship.

It was not uncommon for resident's possessions to be removed from their room with their knowledge or agreement. Objects were removed based on the belief of either a member of care home staff or a relative or spouse that the object was a potential risk to the resident. This was demonstrated in section 7.3.2 whereby Steve's binoculars were removed, possibly by his daughter, without his authority or knowledge. It was unclear what had happened to the binoculars, which suggests the missing object was not viewed as a priority even though it had caused Steve distress. Care home staff also removed objects as a result of care home practices such as laundry duties without checking with the resident that their item needed to be laundered. In section 7.3.2, Karen's clothing was routinely removed from her room by care home staff as they took them to the laundry. Although the act of removing Karen's clothing from her room caused her considerable and ongoing distress, the act of removing her clothing was justified as a care home duty. Thus, the practice of removing Karen's clothing to be laundered superseded Karen's psychological wellbeing, denied her the ability to take responsibility for her possessions, to make decisions about her possessions and her entitlement to social citizenship.

8.4   The use of functional objects in locating social citizenship in care practice

This thesis examines whether social citizenship can be located in the context of a care home. It explores the everyday activities that help maintain and reconstruct a person's identities by focusing on the interactive nature of object-person relations. Whilst dementia research has explored the use of objects, it has tended to take a more therapeutic view (Loboprabhu et al., 2007) which continues to pathologise people with a dementia. Other uses of objects within dementia research has focused on the development of interventions *for* people with a dementia or activities involving objects delivered *to* people with a dementia. Whilst activities such as music, art and reminiscence groups are valuable (Brooker & Duce, 2000; Vink et al., 2003; Woods et al., 2009; Zeilig et al., 2014) they have a tendency to focus on the life stories of people with a dementia, often focussing on the past. Whilst it is clearly important to understand a person's historical biography there has been a lack of focus on the present and future. This position also fails to address that older people and people with a dementia may wish to participate in the

present by continuing routines and rituals developed over a lifetime, taking part in meaningful tasks.

The tendency to view people with a dementia as passive recipients of care (Bartlett & O'Connor, 2010) has meant that the use of functional objects and how they are imbued in everyday life has been overlooked. The term functional objects as introduced in Chapter 1 is defined as:

> *'A functional object - an inanimate item which a person can use to*
>
> *perform a task (not necessarily to completion or to any perceived*
>
> *standard) which maintains and supports his/her identities'.*

This places a person as active. The use of functional objects enables a person to take action, perform tasks and in doing so actualise social citizenship. A pen portrait of Judy was presented in section 6.2.3. As previously mentioned, Judy had not been involved in decision-making relating to her relocation nor had she been involved in the transferral, organisation or management of her personal possessions. Judy strived for social citizenship in the way she used her handbag. The handbag was not an existing personal possession transferred from home, a member of staff whom she became friendly with whilst participating in this study gave it to her. Judy liked the handbag for its size and referred to it as her 'portable filing cabinet'. She liked how it was big enough to fit lots of paperwork and important documents such as her and her deceased husband's passport. Judy also kept paper cuttings that provided insight to her historical biography, the paper cuttings told the story of how her parents moved from London to the South Coast setting up new businesses in the hospitality trade. Judy had also set up a business in the local area and was clearly proud of her achievement; Judy as evidence used the paperwork she kept in her 'portable filing cabinet' as It was proof that she had achieved in her life, that she had a good brain and that her words were accurate:

> *"Well I mean going by that, a little while ago when we've been talking, I said to you I had*
>
> *these things that proves what I was saying. Now you've got the proof that I think I was*
>
> *saying about, and it's there" (Judy, Interview, resident).*

Judy used the handbag as a filing cabinet not only to hold important documentation but also as a way of 'proving' her narrative was accurate when talking with others:

> *"Well if you were arguing, when I was sort of saying you know I can't be doing little odds*
>
> *and ends that I remember, and that if I've got proof that I did it, then I've got these to*
>
> *prove it" (Judy, Interview, resident).*

This is a poignant narrative of an older woman with a diagnosis of a dementia who lives in a care home, not of her choosing, and feels unheard. In section 8.4, it is reported that activities for people with a dementia tend to focus on historical biographies. Judy's handbag appears to help keep her grounded to her life story. It was important to Judy that those around her have some understanding of her life story and the things she has done. It also helps her to take action in the present, providing proof that the narrative she tells is accurate. It was important to Judy for people to respect her and treat her with dignity; she often rolled her eyes when a member of staff or a visitor spoke to her with a paternalistic tone. The handbag and its contents had multiple functions, firstly it enabled her to reminisce and provided a biographical history of who she was and who she is. It supported her identity as a business woman and demonstrated how capable she is. Secondly the objects in the handbag could be used as evidence to show that her words were accurate, that she could engage in meaningful dialogue and could articulate who she was and what she wanted. The objects enabled her to influence how others viewed her and in doing so maintain her identity as a woman who was capable.   The way in which Judy used the handbag as a portable filing cabinet may also suggest that the handbag enabled her to keep her objects safe.

The ability to access objects and take action was important to residents. Many residents talked of wanting to go out. Karen wanted to see the new season's clothing and touch the different fabrics, even if she did not buy anything. Judy wanted to choose her own underwear and hosiery rather than other people buying things for her. Karen talked of being able to get out of the care home, to have control over her resources, to buy new objects such as blonde hair dye and an eyebrow pencil, the objects she wanted for everyday use. Karen talked about having everything she wanted when she was young and how she lost everything when she came out of hospital. Karen seemed to feel a great sense of loss from having limited access to resources. Karen often talked about the everyday objects she did not have access to. The lack of control Karen had over her personal possessions and the lack of access she had to purchasing new objects highlighted the importance of object-person relations for psychological wellbeing. It also demonstrated the usefulness of objects as a practical framework to support social citizenship. The lack of access to resources to buy objects and the lack of opportunities to choose the items she wanted suggests social citizenship was absent.

For Karen participation in life was constrained by a lack of access to material resources. Karen had no access to the belongings that remained in her flat and could only request her nephew brought them the next time he visited. She had no direct access to money to buy new objects; this too was in the hands of her nephew. It was clear that Karen felt restricted and had limited access to

the world outside of the care home. On one occasion Karen mentioned that she had a sore eye and that *she* wanted to contact the GP to make an appointment however, she did not have access to a telephone. Whilst care staff were happy to contact the GP on her behalf, they did not support her to use a telephone, thus removing her ability to take responsibility for herself. The lack of citizenship arose in different ways for different residents however, the denial of citizenship often came in the form of discrimination (age), perceived capacity (a diagnosis of a cognitive impairment), environmental affordances (care home design and access to objects) and cultural identification (care home resident). Current care home practices that overlook the importance of functional objects create environments that are overly restrictive and constrain residents rather than enabling choice and free will (Craig, 2004). Care home staff stated that they attempted to provide an environment that offered choice to residents:

> *"we try to give them choices at times, but sometimes you put two outfits up in front of them" (Abby, interview, AUM).*

The above extract shows that the choices people are given are still restricted. The resident can only make a decision based upon the choices offered by others. It can also be argued that care home staff are in a difficult position as they can only offer more choice if they have permission to do so. Care home staff may also be restricted in what they can and cannot do.

Whilst this study found that many of the residents were denied social citizenship Pippa was encouraged to use functional objects. Pippa was supported in helping out in the care home and encouraged to take part in household chores, something important to women in older age (Hellström et al., 2014). Although Pippa's dementia effected her executive functioning and she visibly struggled with comprehending the intended functionality of objects, she was provided access to functional objects and supported in using functional objects. It became apparent that the reason for encouraging Pippa to take part in activities, which were viewed as hazardous by many members of staff, was not due to an evidence-based risk assessment but because of her age. She was a 'younger resident'. In Pippa's case, because she was a younger resident she was considered by members of staff as being more active than the older residents are. This highlighted an age-related inequality. This also demonstrates the importance of material citizenship in dementia care. By applying material lens, it is possible to draw out underlying assumptions, which affect the unintended discriminations that take place.

To ensure care practices are developed that uphold a person's human rights and that social citizenship is recognised for all people in a care home setting, a straightforward and practical framework is required.

8.5   Summary

Material citizenship in relation to people with a dementia is 'the right to be included in decision making relating to personal possessions, the right to access their belongings and opportunities to use functional objects'. Until now citizenship theory has lacked a material lens. Material citizenship advances citizenship theory in terms of introducing a way of locating social citizenship in practice. Material citizenship provides a framework with which to educate, implement and evaluate the presence or absence of social citizenship in a care home environment. Five domains were identified as crucial to the introduction of the material citizenship framework and a visual representation was provided in section 8.2. This demonstrated the four domains placed on a set of weighing scales to provide the analogy of balance. The domains were risk management, protection, social citizenship and empowerment. Above the weighing scales was the fifth domain of functional objects. The domain functional objects act as an enabler which can provide a mechanism for assessing whether the other four domains are reasonably balanced. It can also provide a practical framework for a rights-based approach, ensuring the rights of people living in care homes are upheld.

Chapter 9: Conclusion

9.1   Introduction

In this thesis, I have explored the relevance of object-person relations for people with a dementia living in a care home. I have addressed the research questions by exploring how decisions are made about personal possessions, how functional objects are used and by whom, and whether a material lens was useful in locating social citizenship.

The first research question asked how object-person relations manifest in care homes for people with a dementia. To answer this question, I explored who was involved in decision-making relating to personal possessions, how functional objects were used in a care home setting, and by whom. The study has discovered that object-person relations manifest in care homes for people with a dementia in the lack of control they have over their existing belongings and the acquisition of future items. The study found that although care home staff initially suggested that residents could bring what they liked into the care home, this was quickly followed with caveats discouraging certain objects, often justified by anecdotal evidence based upon keeping residents safe. Relatives and care home staff were involved in making decisions about the objects a person could have in the care home, and people with a dementia were often excluded. Relatives were often left to deal with a person's household possessions and people with a dementia were not provided opportunities to return home to collect their belongings.

The study discovered that the practice of keeping people safe resulted in care home staff having access to use functional objects to carry out household tasks however, residents' access was restricted. This study found that functional objects such as hair straighteners, hair dryers and nail scissors were not permitted in resident's rooms and that residents regularly had their possessions removed from their rooms without their agreement or knowledge. The manifestation of object-person relations in care homes for people with a dementia shows that opportunities to advocate agency, independence, or control are replaced by practices that create dependency, a lack of control, and an interruption in the routines and rituals a person has developed over a lifetime.

The second research question asked whether social citizenship was a useful lens to examine object-person relations and if it was, how. The study discovered social citizenship is a useful lens to examine such relations, as objects could provide a mechanism to show whether a person with a dementia has autonomy, agency and choice. The choice to have objects and the choice to use

objects to carry out everyday tasks which support identity, thus reflecting that people with a dementia are provided the same opportunities as everyone else (Bartlett & O'Connor, 2010).

The study found that by combining a material and citizenship lens I was able to develop the material citizenship framework. The framework employs functional objects as a mediator to provide a balance between protection and risk management, and empowerment and social citizenship. This has the potential to support dementia care in care homes by providing a practical application for the inclusion of social citizenship in dementia care.

9.2   Research Implications

This thesis makes a number of original contributions to knowledge in the fields of dementia, materiality and citizenship studies. These are outlined below.

9.2.1   Highlighting exclusionary decision-making practices for people with a dementia

In Chapters 6 and 7, it was demonstrated through the exploration of object-person relations that people with a dementia were often excluded from decision-making in relation to the personal possessions that were moved into the care home, and the objects they had access to whilst residing in the care home. Exploring object-person relations provided a basis to examine how decisions were made about a person's possessions and who was involved in decision-making regarding a person's belongings. Initially, I had only considered examining the decision-making practices that took place once a person was resident in the care home however; it became clear that this would only provide a partial story. The circumstances surrounding a person's relocation could influence whether or not they were included in decision-making. Therefore, the details pertaining to a person's relocation to a care home were included and analysed. This provided a full and comprehensive picture of how decisions were made about a person's possessions and who was involved in decision-making.

A number of discriminatory practices were identified in relation to decision-making. The first was that people with a dementia who had been admitted to hospital, would often find themselves 'moved' to a care home following a best interests decision. This was a decision that was made by a team of health care professionals and/or relative, which resulted in the person not being able to return to their own home. Whilst this decision was made in the best interests of the person with a dementia, the people with a dementia were not always included in or informed of this decision. The findings of this study demonstrate that once a decision was made for a person to move to a care home, this could start a trajectory for further exclusions. People with a dementia were often not included in decision-making relating to which care home they moved to and were not included in deciding which personal possessions they would take with them. The implications for a person

not knowing they have relocated to a different residence may reduce their ability to psychologically adapt to this transition. Whilst it is not appropriate to generalise that all hospital transferrals follow this practice it is important to highlight that it was common in this study. Only one participant in this study had made an advanced decision to move to a care home.

The relocation to a care home is often a result of a crisis or hospital admission resulting in an urgency to find a care home that has an available space (Lindley & Wallace, 2015). Opportunities to visit care homes, to test out their suitability, may not be realistic nor viable for people with a dementia. Furthermore, it is conceivable that the individuals who have had a best interests decision made may not agree with this decision and therefore visiting various care homes may not prove useful. Therefore, the 'ideal' as set out in policy documents and reported in section 6.2.6 of this thesis, of a person visiting the care home to assess its suitability is impractical and unrealistic for many. This highlights the importance of planning and making decisions about how a person wants to live well in older age. It also highlights the importance of developing policies that consider the complexities of a person with a dementia moving to a care home as a result of a crisis or hospital admission.

9.2.2   The responsibility for objects

The second discriminatory practice was a lack of opportunities for a person with a dementia who were resident in a care home, to return home to organise and/or collect their personal possessions. The study findings demonstrate that residents lacked control over their existing possessions and that relatives were often left to deal with an entire household of possessions. The person with a dementia was often excluded in making decisions about their possessions and often unaware of what had happened to their belongings. Several people in this study had experienced a hospital to care home transition and interviews with relatives and care home staff highlighted the extent of the practical and emotional difficulties this situation entails. Whilst difficulties exist, opportunities to include people in deciding which objects they would like to have were missed.

Residents were wholly reliant on others to retrieve or purchase objects for them. As demonstrated in Chapter 6, it was common practice for people with a dementia residing in the care home to ask care home staff and/or relatives for objects. Once the request was made the resident had no control over the outcome. The responsibility for either retrieving existing objects or purchasing new objects was often passed between care home staff and relatives. Care home staff often felt they were the go between, the messenger relaying a request to the relative, placing the responsibility for getting the objects onto the relative. However, this position was

precarious and liable to shift. If a relative did not bring in the requested object, care home staff at times took the initiative and bought the object for the resident outside of work hours. There were also occasions when a member of staff was given permission to go to the shops in work time to purchase the object, but the resident was rarely included in this shopping trip.

The study found a lack of consistent practice relating to objects in the care home. Whilst some care staff recorded the objects brought in on arrival, others did not. Furthermore, objects brought in after the day of arrival where not documented. Relatives would often bring in objects whilst visiting residents without notifying the management team and care home staff often removed objects from a person's room if they deemed them to be a potential risk. Although risk assessments already exist in care homes, these were not being used for the purposes of the access to and use of functional objects. Instead, care home staff made subjective decisions. At the time of conducting this study the only guidance available to care home staff in relation to personal possessions and future objects was found in the Local Authority Quality Standards documentation regarding insurance related cover for valuable objects, the requirement to PAT test electrical equipment and that items of furniture should hold a safety retardant certification.

The findings of this study showed different types of responsibility regarding objects existed. The first type of responsibility was that of keeping the residents safe. This manifest in the way care home staff removed functional objects from a resident's room and restricted access to functional objects. The second type of responsibility was being accountable for the objects in the care home. If objects went missing care home staff would often assume that a resident was to blame, thus giving them the responsibility. Care home staff would comment that residents often walked into other resident's rooms and were responsible for stealing their belongings, removing objects, hiding objects or forgetting where they had put things. It could be argued that by proportioning this type of responsibility on residents, care home staff are absolved of all responsibility for a resident's belongings. It could also reduce the likelihood of an investigation taking place. This fits with the typical pathological approach to dementia care which frequently assumes that the actions of a person with a dementia are symptomatic of dementia. Whilst it is reasonable to consider that people with a cognitive impairment may not recall where they have placed certain objects or may use an object that does not belong to them, placing them at fault allows for the systematic practices of care home staff removing and moving objects to go unaddressed. Care home staff would routinely remove objects without the owner's knowledge or permission and hide objects from residents if they were believed to be a risk. An example of this was the way in which care home staff would remove the clothing Karen had laid out ready for use the following day and take them to the laundry. Although the act of taking Karen's clothing from her room caused her some distress care home staff continued to carry out this action. This suggests that

care home staff lacked an understanding of the importance of Karen's interactions with her objects.

The practice of systematically removing a person's possessions from their room demonstrates an absence of social citizenship, Karen was not afforded the right to take responsibility and make decisions about when her clothing was taken to the laundry. The care home environment did not allow her to have agency or control. A material citizenship framework may alleviate the problems caused by removing Karen's clothing as it focuses on the importance of objects and how they are used. The material citizenship framework has the potential to help staff understand that Karen enjoyed organising her clothing for the next day. It also has the potential to provide an opportunity for care home staff to understand Karen did not want her clothing laundered each day, as she believed this ruined the fabric. A material citizenship framework could also encourage practices that respected Karen's needs and encourage conversations relating to how her clothing was managed.

9.2.3   Functional objects are 'dangerous'

The study findings show the manifestation of objects in care homes by the way that care home staff and relatives prioritised safety over the importance of access to functional objects. This is not surprising when care homes are regulated care providers who have a legal requirement to provide care that is safe. The study findings show that the management of risk features within both the informative documentation for residents and relatives and policy documents for care home practice.

The management of risk is a complex aspect of care practice and the ability to maintain the physical safety often leads to risk averse practices (Clarke et al., 2011). Whilst it is recognised that risk averse practices reduce independence and autonomy, care providers are caught between providing care entrenched with paternalistic and regulatory concern for residents, and a growing emphasis to not lose sight of individuals as free agents (Evans et al., 2018). This is mainly due to social construction of care provision that is profoundly influenced by the perception of risk, in particular the management of care which aims to minimise risk (Clarke, 2000). Although the construction of risk may differ between relatives, health care professionals and people with a dementia (Clarke & Heyman, 1998), this study found that care home staff and relatives seemed to agree over the types of objects viewed as hazardous. What was surprising was the type of objects that care home staff and relatives considered dangerous. On several occasions' relatives and staff mentioned 'samurai swords' as being dangerous. One member of staff elaborated on this idea by suggesting to say it could be found 'sticking out of someone by the end of the week'. The surprise

was the extreme of linking samurai swords to people in care homes and viewing people with a dementia as dangerous with objects. Although it is reasonable to view a sword as a dangerous object there was a lack of risk assessments carried out for all objects, not just those considered dangerous.

The study found both similarities and variation across participant groups in relation to perception of risk associated with objects. For relatives, objects were a risk due to the burden they placed upon the relative. Finlay mentioned that if his mother had a telephone there was risk, she could call him multiple times of the day or night. For care home staff objects were considered dangerous and hazardous, the responsibility of care home staff was to ensure the safety of residents therefore the removal or denial of objects was common practice. For residents, the risk was that their possessions could go missing, and the risk of being restricted by care home staff and relatives in the access they had to functional objects. All of which posed a risk to the maintenance and cultivation of the person with a dementia's identity (Belk, 1988; Mihalyi Csikszentmihalyi & Rochberg-Halton, 1981; Dittmar, 1992; Rochberg-Halton, 1984a; Rubenstein, 1987).

It could be argued that the although the introduction of the Mental Capacity Act (2005) intended to balance empowerment and protection for people considered vulnerable due to a cognitive impairment (Boyle, 2008) the Act lacks a practical framework. The material citizenship framework has the potential to address this by using functional objects as a mediator with which to explore and evidence assessments carried out which ensure empowerment and protection are reasonably balanced.

9.2.4 Applying a material lens in dementia care

This study found that the phenomenon of object-person relations was helpful in drawing out and providing an understanding of the term 'passive recipients of care' (Bartlett & O'Connor, 2010). Applying a material lens and asking the question 'what does social citizenship look like in a care home', enabled the material citizenship framework to be developed. The material citizenship framework can provide a tangible mechanism with which to understand object-person relations in dementia care. It also has the potential to provide a practical application for locating the presence or absence of social citizenship in care practices. This section reflects on the material lens in more detail and considers its implications on policy and practice.

The study found that functional objects could provide a window into understanding how care home staff, relatives, policy makers, regulators of care and governing bodies, think about people with a dementia. Recall that 11 out of the 15 people with a dementia who took part in this study

were not involved in decision-making relating to their personal possessions. Reliable information for the remaining four participants was unavailable. This suggests that care home staff and policy makers are not giving much thought to the importance of deciding which objects are transferred from a domestic home to a care home. The lack of focus on objects within policy and practice documents suggest that dementia care practices do not take object-person relations seriously.

By applying a material lens to care home practices this study has elucidated the lack of opportunities for people with a dementia to use functional objects crucial to performing routines and rituals developed over a lifetime. Although evidence suggests that interactions with objects have the ability to support the maintenance, cultivation and demonstration of identity (Belk, 1988; Mihalyi Csikszentmihalyi & Rochberg-Halton, 1981; Dittmar, 1992; Rubenstein, 1987, Dittmar, 1992) the tendency to view functional objects as dangerous reduces self-determination and in turn denies agency and social citizenship. The way in which people with a dementia talked about their objects highlights that the material lens can provide insight into what people with dementia are striving for in a care home environment. The notion that 'we are what we have', (Dittmar, 1992) was made explicit by Karen. She was not herself without her clothing and did not look like herself without access to blonde hair dye and curling tongs to curl her hair. The paperwork which Judy kept in her 'portable filing cabinet' provided her with her historical biography, kept her grounded in her past but importantly gave her confidence in present conversations. Judy believed the objects helped demonstrate her identity and the proof it provided could be used to influence how others (care home staff) viewed her. The actions taken with the objects may support the enhancement of relationships with others (Miller, 2010). This study has demonstrated that a material lens has the potential to support social citizenship taking a rights-based approach, ensuring that people can take action with objects that are important to them. This study has also demonstrated how a material lens can elucidate the passivity of dementia care in practice, thus contributing knowledge to both citizenship and dementia research.

9.3   Implications for practice and policy

The findings of this study demonstrate many implications for practice and policy. From a practical perspective the following factors could make a significant difference to the care practices currently in place: (1) including an assessment and transferral of personal possessions, treating objects as a priority prior to and during induction to the care home, (2) including information in the induction and ongoing care plans regarding how a person lives their everyday life and the functional objects they use to carry out tasks, (3) using risk assessments to focus systematically on the use of functional objects, (4) revisiting laundry policies to ensure that clothes are not taken

without consent and are returned to their owner, and (5) ensuring the removal of a person's objects are only permitted when a risk assessment has been carried out evidencing a reasonable and proportionate risk of harm to the resident or someone else.

9.3.1   Implications for practice

Care home staff and care home organisations could address the lack of inclusion in decision-making about a person's possessions by treating objects as a priority, prior to and during a person's induction to the care home. This could ensure that residents feel that they have at least a certain amount of control when moving. This could prevent barriers to conversations taking place relating to personal possessions, as this would have been discussed at the outset. It brings to the fore the importance of object-person relations and could support the choices people have rather than the idea that they can 'bring what they like in'.

The implementation of material citizenship framework could be trialled by care homes as an induction tool with which to understand how a person lives their day. In essence, members of staff could walk a day in the resident's life using the functional objects they would have used at home. This would require the systematic use of current risk assessments and if included in care plans this may not result in the need for extra resources. Risk assessments could be used to assess what a person can do and ensure they have opportunities to do so. This could prevent situations in which care home staff remove objects as a result of subjective risk taking. Care home staff and organisations could revisit current laundry practices, whilst ensuring health and safety regulations are maintained, care home staff make certain that clothing is not arbitrarily removed without the owner's consent. Viewing clothing from an object-person relations perspective could make sure that care home staff and residents negotiate how clothing is managed, giving residents some responsibility and feelings of control.

9.3.2   Implications for policy

An implication for care staff, policy makers and regulators is the lack of guidance in policy documents relating to care practices regarding personal possessions and functional objects. The lack of guidance can result in inequalities in care practices. Whilst some residents had access to use and enjoy certain objects, other residents did not. An example of this was Karen's mousse being placed on top of her wardrobe out of reach, while Rosie's were placed on a trolley in her room within reach. The lack of guidance in policy and practice documents and the way in which objects are systematically overlooked appears to result in care home staff making on the spot decisions without an assessment taking place. Policy documents such as National Minimum

Standards for Care Homes for Older People (DoH, 2006) and initiatives such as My Home life could consider the importance of object-person relations and use the functionality of objects to ensure that the quality of care home care continues to improve. Applying a material lens can draw out stigma often found associated with people with a dementia, older people and people who live in care homes. It can support policy makers to address current practices that keep people physically safe but at risk of psychological harm. Whilst it is argued that the psychological effects of risk-averse practices are not as tangible as the physical aspect of risk (Clarke et al., 2009), the material citizenship framework offers an approach that can elucidate the less tangible.

By applying a material lens to policy and practice documents, it is evident that object-person relations have been systematically overlooked. At a time when decision-making can often become a grey area for care home staff and relatives and conflicts can arise, it is important to have practical guidance to support care home staff provide care which maintains a residents autonomy whilst ensuring health and wellbeing are not compromised (Evans et al., 2018; Whitlatch & Menne, 2009). To this end, a material citizenship framework may be useful. Furthermore, current policy statements produce guidance which fits with the 'ideal' scenario, but this study has highlighted this is rarely realistic or practical for people with a dementia or moving from hospital. The policy documents would be more useful if they reflected the needs of an ageing population with health complexities such as dementia, multimorbidity's and frailty.

9.4   Contribution to citizenship studies for people with a dementia

To understand object-person relations for a person living in a care home, this study intersected psychological understandings of object-person relations with sociological ideas of materiality in care homes, examining both through a citizenship lens. By drawing on the existing knowledge from both disciplines, this study was able to examine whether social citizenship could be located within a care home environment for people with a dementia. This was carried out by exploring how decisions were made, who was involved in decision-making relating to personal possessions and the purchase of future objects. It also explored how objects were imbued in the everyday lives of people with a dementia, who used functional objects and how they were used.

Along with Bartlett and O'Connor (2010), Baldwin and Greason (2016) and Brannelly (2011b) this study maintains the need to broaden the dementia debate by applying a citizenship lens. People with a dementia as a group face stigmatisation and discrimination particularly in institutional settings that are organised to meet care needs rather than promoting the rights and citizenship of those living there. Until now, citizenship has remained under theorised and lacked a practical application. Whilst citizenship is an ideal to strive for (Bartlett, 2016), it is difficult to

operationalise in everyday life for those with a dementia in the absence of a practical supportive framework. The lack of a practical framework may also make it difficult for researchers and practitioners to locate social citizenship in dementia care practice. This study set out to explore whether object-person relations could be a useful tool for locating the presence or absence of social citizenship in dementia studies. This was achieved by examining how decisions were made about the objects a person with a dementia takes into a care home, how they are transferred, organised and managed on relocation. It also positioned residents as active in their own care by understanding that objects could be used as a mechanism with which activities could be performed, thus supporting a person's identities. By combining object-person relations and a citizenship approach, this study was able to address the gap of applied social citizenship and contribute to citizenship studies.

The findings reported in chapters 6 and 7 provide two main reasons given by care home staff as to why people with a dementia were usually denied opportunities to return home to collect their belongings. The first problem was short timeframes and the second was the concept of risk. In section 6.4 relatives and staff suggested time constraints were a problem when retrieving a person's possessions. The responsibility and control of a person's property and the personal possessions inside it were taken over by a third party, often a relative (Innes et al., 2011; Lindley & Wallace, 2015). The person with a dementia was denied control over what happened to their property and personal possessions, this shows the absence of social citizenship as agency is removed. It appeared that the person with a dementia was not informed of what was happening and what was done with their belongings. The second reason for denying a person with a dementia access to their personal possessions was that of risk. In section 6.4, the registered manager of the care home reported that once a person had relocated to a care home, they were unlikely to be provided as opportunity to return home. The reason given was that this might cause distress and they might refuse to return to the care home. This again demonstrates the usefulness of objects for citizenship practice.

The material citizenship framework offers a practical application to support social citizenship in care homes. It has the potential to identify and question inequalities elucidated by the possessions people have and the objects that people have access to use. Material citizenship offers a way of enabling risk to be managed through an evidence-based practice. By applying a material lens, material citizenship concentrates on the use of objects to enable people to think about the care that is being provided and brings the organisational structures into focus. Material citizenship considers citizenship in dementia care from both an organisational and individual perspective. However, to fully integrate a citizenship approach to care, policy and practice

documents are required to support this practice. The decisions care home staff were making about objects were influenced by the social structures of the organisation and regulatory bodies who focus on keeping people safe. An example of this was the tendency to view objects as risky. The underlying mechanism for the practice of risk averse behaviour was a result of organisational policy and regulatory expectations.

The contribution material citizenship provides for policy makers and care home providers is that it enables services to take object-person relations seriously. It provides a framework within which to support object-person relations by carrying out assessments that include functional objects in care planning. This also has the potential to reduce practices that may unwittingly contravene the Human Rights Act (1998) Part II The first Protocol Article 1 that states no one should be deprived of their possessions.

To advance dementia care practices policymakers and regulators of older person care need to find ways to rethink the traditional cultural view of residential care homes. Health care professionals have a duty to ensure that reasonable steps are taken to include people with a dementia in decision-making. It is particularly important to consider object-person relations rather than just human-human relations. This study shows that by applying a material lens, the access to and use of functional objects can ensure that people with a dementia are viewed as active agents, rather than passive recipients of care. By including functional objects in key documents such as the National Minimum Standards for Adult Care (DoH, 2003) and quality standards documents, this would ensure that people with a dementia are viewed as active agents.

It is also important to educate older people of their rights as many people in the care home were not empowered and were unaware they could question the decisions being made about them. Residents seemed to feel a sense of overwhelming disempowerment often talking of having their choices removed. Residents should be advised of their rights by informing them of the access they have to advocacy services, their entitlement to a trial in the care home to test out its suitability and that they can contest a DoLS application made against them. Currently this information is not forthcoming for people with a dementia.

9.5 Limitations of the study

The first limitation of the study was the sample size and profile of those who took part. This was a doctoral study and due to the amount of resources available, only a limited number of care homes could be included in the research. The study involved two residential homes in South East England and for this reason I cannot claim that the care homes are representative of all those in the UK. The profile of the participant groups was also a limitation of this study as there was little diversity between participants. Each participant involved in the study was of white British origin except for Max, the assistant unit manager, who was Romanian.

A second limitation was the data collected in the object-elicitation interviews with people with a dementia. The topic of objects was a sensitive topic particularly when many participants were not included in decision-making relating to their personal possessions. I was acutely aware that my questioning had the potential to cause distress or create tension between residents, relatives and care home staff. This may have created a barrier within the interview process.

As reported in Chapter 4, a number of limitations resulted from the caveats attached by the HRA Social Care REC. The first caveat was that any data collected at the pilot site could not be included in used for analysis or discussed within this thesis. This resulted in a significant amount of data being excluded from the analysis. It also prevented a comparative element between care homes, which may have been useful.

The second caveat was the exclusion of people who had been assessed as lacking mental capacity from taking part in interviews about their objects. This prevented me from carrying out object-elicitation interviews with this group, discussing the possessions they had in the care home. The exclusion of people assessed as lacking mental capacity from opportunities to take part in interviews is not uncommon (Brannelly, 2011b). By conducting object-elicitation interviews with people with a dementia I now know more about the method and have experience of working with people with a dementia in this way. As a result, it may be possible to make a stronger case for including people assessed as lacking mental capacity in this type of interview process in the future.

The third and final caveat and the one I believe was the biggest limitations of this study was the restricted access in observing interactions that took place between residents and care home staff when personal care was taking place. Whilst this has sound ethical and reasons relating to dignity and privacy, given that residents possessions were in their rooms and it is likely they would use objects whilst receiving personal care, this resulted in a gap in knowledge. It was not possible to observe who used the functional objects or how functional objects were used. Neither was it

observed how interactions with objects unfolded and whether residents made any requests for functional objects during personal care. This caveat also made it difficult to explore identity and object-person relations. Whilst it was apparent that the clothing people wore, the grooming accessories they had access to, newspapers, handbags and walking aids that were observable in communal spaces could enable people to demonstrate identity, it was the private spaces of the home in which a person's belongings were situated. The private spaces in the home were only available to me if I was invited in which was unlikely as many of the residents were encouraged to spend their time in the communal areas. To really explore identity and object-person relations it would be helpful to spend time observing people with a dementia in their private spaces with their belongings rather than carrying out a single interview with those who were assessed as having capacity to consent. This data could have added to the richness of this study.

9.6   Future research

This doctoral study has challenged assumptions that are made about what personal possessions a person with a dementia can take into a care home. It examined the idea that people can 'bring what they like in' by understanding how decisions are made and by whom. It also explored whether citizenship could be located through a material lens by asking what social citizenship would look like in a care home environment. These contributions to knowledge and dementia studies can be taken forward into further research.

Firstly, given that many small-scale qualitative research studies are criticised for their lack of generalisability, the obvious next step is to examine the findings on a larger scale. A comparative study could gleam findings demonstrating that current exclusionary practices relating to personal possessions are wide spread or not.

Secondly, the findings of this study could be used to develop an intervention to introduce material citizenship in a care home setting. This could include the development of an assessment that includes questions relating to the objects a person with a dementia may need or indeed want to have in a care home. This could run parallel to the development of an educational programme that supports care home staff provide dementia care from a rights-based approach through the introduction of material citizenship.

Thirdly, future research could develop an evaluative tool to support a rights-based approach to dementia care. The Quality of Interactions Schedule (QuIS) which provides a systematic approach

for independent observers to measure the number of staff-patient interactions within a healthcare context, and rate the interactions as either 'positive social'; 'positive care'; 'neutral'; 'negative protective'; or 'negative restrictive'(McLean, Griffiths, Eguiagaray, Pickering, & Bridges, 2017) has the potential to measure and support a rights based approach. With the addition of object-person interactions QuIS could provide a tool to ensure the sustainability of a rights-based approach by focusing on dyadic and triadic interaction including care home staff, residents and functional objects.

Finally, the focus of objects as a topic of enquiry can provide insight into practices that can bring about positive change. Using objects as method with which to enquire provides information and knowledge that ventures beneath the superficial and produces findings that can (1) provide insight into care practices, (2) illuminate discriminatory practices, and (3) identify areas for educational and training.   It is a softer approach in comparison to the traditional formal interview. The use of objects as a method with which to enquire such as wardrobe interviews (Buse & Twigg, 2015a) offers a way to include people with a dementia assessed as lacking mental capacity in interview, a method which until remains a contentious issue (Brannelly, 2011b).

9.7   Concluding thoughts

To conclude, this thesis has demonstrated the importance of object-person relations in older age and dementia care, building on the recent materiality research (Buse & Twigg, 2015; Kroger & Adair, 2008; Lovatt, 2018; Nord, 2013). A material citizenship framework can add to care home studies research, which have emphasised the need for a social revolution in care home practice (Theurer et al., 2015). The material citizenship framework offers a practical application to support social citizenship in care homes. By combining material and human worlds, material citizenship has the potential to ensure that people with a dementia are included in decision-making relating to their personal possessions. Material citizenship can also ensure that people with a dementia have access to the use of functional objects, unless reasonable evidence is provided to the contrary. It has also contributed to citizenship theory by offering a practical application for locating social citizenship for people with a dementia in care homes, which until now has been absent. Finally, in many ways this thesis has raised more questions than it has been able to answer. Most notably the role of external policy makers and regulations who unwittingly support discriminatory practices and are at risk of contravening the human rights of people with a dementia. The preoccupation for keeping people safe, which in turn denies people with a dementia access to functional objects, coming at the cost of a person with a dementia's dignity,

respect, agency, and psychological well-being and ultimately the very essence of who they were, are and who they want to be.

Bibliography

Alzheimer's Disease International. (2010). *World Alzheimer Report 2010 The Global Economic Impact of Dementia*. https://doi.org/10.1007/BF01276902

Alzheimer's Society. (2013). *Low expectations: attitudes on choice, care and community for people with dementia in care homes*. Retrieved from http://alzheimers.org.uk/site/scripts/download.php?fileID=1628

Authority, C. and M. (2017). *Care home market study*. Retrieved from http://www.oscar-research.co.uk/datasheets/carehomes

Baldwin, C. (2008). Narrative citizenship and dementia: The personal and the political. *Journal of Aging Studies*, *22*(3), 222–228. https://doi.org/10.1016/j.jaging.2007.04.002

Baldwin, C., & Greason, M. (2016). Micro-citizenship, dementia and long-term care. *Dementia*, *15*(3), 289–303. https://doi.org/10.1177/1471301216638762

Banks, M. (2001). *Visual method in social research*. Thousand Oaks: Sage.

Barnes, M. (2006). *Caring and Social Justice*. Routledge: London.

Barnes, R., Auburn, T., & Lea, S. (2004). Citizenship in practice. *British Journal of Social Psychology*, *43*(2), 187–206. https://doi.org/10.1348/0144666041501705

Bartlett, H., & Martin, W. (2002). Ethical issues in dementia care research. In H. WILKINSON (Ed.), *The Perspectives of People with Dementia: Research Methods and Motivations*. Jessica Kingsley Publishers Ltd.

Bartlett, R. (2014). Citizenship in action: the lived experiences of citizens with dementia who campaign for social change. *Disability and Society*, *29*(8), 1291–1304.

Bartlett, R. (2016). Scanning the conceptual horizons of citizenship. *Dementia*, *15*(3), 453–461.

Bartlett, R., & O'Connor, D. (2007). From personhood to citizenship: Broadening the lens for dementia practice and research. *Journal of Aging Studies*, *21*(2), 107–118.

Bartlett, R., & O'Connor, D. L. (2010). *Broadening the Dementia Debate Towards Social Citizenship*. Policy Press Bristol.

Belk, R. W. (1988a). Possessions and the Extended Self. *Journal of Consumer Research*, *15*(2), 139–

Belk, R. W. (1988b). Possessions and the extended self.

Bernard, H. R. (1995). *Research Methods In Anthropology Qualitative and Quantitative Approaches* (2nd Ed.). London: AltaMira Press.

Bigby, C., Bowers, B., & Webber, R. (2011). Planning and decision making about the future care of older group home residents and transition to residential aged care. *Journal of Intellectual Disability Research*, *55*(8), 777–789.

Birt, L., Poland, F., Csipke, E., & Charlesworth, G. (2017). Shifting dementia discourses from deficit to active citizenship. *Sociology of Health and Illness*, *39*(2), 199–211.

Blackman, T., Mitchell, L., Burton, E., Jenks, M., Parsons, M., Raman, S., & Williams, K. (2003). The accessibility of public spaces for people with dementia: A new priority for the "open city." *Disability and Society*, *18*(3), 357–371.

Bond, J., & Corner, L. (2001). Researching dementia: Are there unique methodological challenges for health services research? *Ageing and Society*, *21*(1), 95–116.

Bowling, A. (2009). *Research Methods In Health Investigating health and health services*. England: McGraw-Hill Education.

Boyle, G. (2008). The Mental Capacity Act 2005: Promoting the citizenship of people with dementia? *Health and Social Care in the Community*, *16*(5), 529–537.

Brannelly, T. (2011a). Sustaining citizenship: People with dementia and the phenomenon of social death. *Nursing Ethics*, *18*(5), 662–671.

Brannelly, T. (2011b). That Others Matter: The Moral Achievement—Care Ethics and Citizenship in Practice with People with Dementia. *Ethics and Social Welfare*, *5*(2), 210–216.

Brannelly, T. (2016). Citizenship and people living with dementia: A case for the ethics of care. *Dementia*, *15*(3), 304–314.

Brimelow, S., & Lyons, D. (2009). *Remember, I'm still me: Care Commission and Mental Welfare Commission joint report on the quality of care for people with dementia living in care homes in Scotland*. Retrieved from http://www.mwcscot.org.uk/media/53179/CC__MWC_joint_report Remember Still Me.pdf

Brooker, D., & Duce, L. (2000). Wellbeing and activity in dementia: A comparison of group reminiscence therapy, structured goal-directed group activity and unstructured time. *Aging and Mental Health*, *4*(4), 354–358.

Bruner, J. (2004). Life as narrative. Social Research, 71(3), 691–710.

Buch, E. D., & Staller, K. (2007). The feminist practice of ethnography. In *Feminist research practice: a primer* (pp. 187–222). London: Thousand Oaks.

Buse, C., & Twigg, J. (2014). Looking 'out of place': Analysing the spatial and symbolic meanings of dementia care settings through dress. *International Journal of Ageing and Later Life*, *9*(1), 69–95.

Buse, C., & Twigg, J. (2015a). Materialising memories: exploring the stories of people with dementia and dress. *Ageing and Society*.

Buse, C., & Twigg, J. (2015b). Materiality and dress. *Ageing and Society Society*.

Buse, C., Twigg, J., Nettleton, S., & Martin, D. (2018). Dirty Linen, Liminal Spaces, and Later Life: Meanings of Laundry in Care Home Design and Practice. *Sociological Research Online*, 136078041878003.

Cahill, S. (2018). *Dementia and Human Rights*. Bristol: University Press.

Center for Policy on Ageing. (2012). *How can the care experience of older people in care homes be improved: findings from five Preventing the Abuse and Neglect in Institutional Care of Older Adults studies. Preventing the Abuse and Neglect in Institutional Care of Older Adults*. Retrieved from http://www.panicoa.org.uk/studies

Chapman, S. A. (2006). A "new materialist" lens on aging well: Special things in later life. *Journal of Aging Studies*, *20*(3), 207–216.

Chaudhury, H., Cooke, H. (2014). Design matters in dementia care: the dementia care settings. *Excellence in Dementia Care*, 144–158.

Chaudhury, H., Cooke, H. A., Cowie, H., & Razaghi, L. (2018). The Influence of the Physical Environment on Residents with Dementia in Long-Term Care Settings: A Review of the Empirical Literature. *Gerontologist*, *58*(5), e325–e337.

Cipriani, J., Kreider, M., Sapulak, K., Jacobson, M., Skrypski, M., & Sprau, K. (2009). Understanding object attachment and meaning for nursing home residents: An exploratory study, including implications for occupational therapy. *Physical and Occupational Therapy in Geriatrics*, *27*(6), 405–422.

Clare, L., & Woods, B. (2001). A role for cognitive rehabilitation in dementia care. *Neuropsychological Rehabilitation*, *11*(3–4), 193–196.

Clarke, C. L. (2000). Risk: constructing care and care environments in dementia. *Health, Risk & Society*, *2*(1), 83–93.

Clarke, C. L., & Heyman, B. (1998). Risk management for people with dementia. In B. Heyman (Ed.), *Risk, Health and Healthcare: A Qualitative Approach* (Ed, pp. 228–240). London: Chapman and Hall.

Clarke, C. L., Keady, J., Cook, A., Wilkinson, H., Williams, L., Gibb, C. E., & Luce, A. (2009). Risk management dilemmas in dementia care: an organizational survey in three UK countries. *International Journal of Older People Nursing*, *4*(2), 89–96.

Clarke, C. L., Wilcockson, J., Gibb, C. E., Keady, J., Wilkinson, H., & Luce, A. (2011). Reframing risk management in dementia care through collaborative learning. *Health and Social Care in the Community*, *19*(1), 23–32.

Commons, H. of. (2007). *The Human Rights of Older People in Healthcare*. *Human Rights*. Retrieved from http://www.publications.parliament.uk/pa/jt200607/jtselect/jtrights/156/156i.pdf

Cooney, A. (2012). "Finding home": A grounded theory on how older people "find home" in Long-term care settings. *International Journal of Older People Nursing*, *7*(3), 188–199.

Costall, A. (1995). Socializing Affordances. *Theory and Psychology*, *5*(4), 467–481.

Craig, G. (2004). Citizenship, Exclusion and Older People. *Jounral of Social Policy, 33*(1), 95-114.

Cram, F., & Paton, H. (1993). Personal Possessions and Self-Identity: the Experiences of Elderly Women in Three Residential Settings. *Australian Journal on Ageing*, 19–24.

Csikszentmihalyi, M., & Rochberg-Halton, E. (1981). *The meaning of things Domestic symbols and the self*. Cambridge University Press.

Dankl, K. (2012). Material Immaterialized: Mature Living Beyond Smart Housing. *Space and Culture*, *15*(3), 198–209.

Day, K., Carreon, D., & Stump, C. (2000). The therapeutic design of environments for people with dementia: A review of the empirical research. *Gerontologist*, *40*(4), 397–416.

Department of Health. (2006). *Care Homes for Older People National Minimum Standards*.

Department of Health. (2016). Health Technical Memorandum 01-04: Decontamination of linen for health and social care, (March).

Deprivation of Liberty Safeguards. Accessed 11April 2016. https://www.gov.uk/government/publications/deprivation-of-liberty-safeguards-forms-and-guidance

Dewing, J. (2007). Participatory research: A method for process consent with persons who have dementia. *Dementia*, *6*(1), 11–25. https://doi.org/10.1177/1471301207075625

Dittmar, H. (1992). *The Social Psychology Of Material Possessions To Have Is To Be*. Hertfordshire: Harvester Wheatsheaf.

Dobson, C. (2008). *Conducting research with people not having the capacity to consent to their participation: A practical guide for researchers* (Vol. 7).

Ekerdt, D. J., Sergeant, J. F., Dingel, M., & Bowen, M. E. (2004). Household disbandment in later life. *The Journals of Gerontology. Series B, Psychological Sciences and Social Sciences*, *59*(5), S265–S273.

Emerson, R. M., Fretz, R. I., & Shaw, L. L. (1995). *Writing Ethnographic Fieldnotes*. London: The University Chicago Press Ltd.

Epp, A., & Price, L. (2008). Family Identity: A Framework of Identity Interplay in Consumption Practices. *Journal of Consumer Research*, *35*, 50–70.

European convention on human rights. (1971). *International and Comparative Law Quarterly*, *20*(4), 766–768.

Evans, E. A., Perkins, E., Clarke, P., Haines, A., Baldwin, A., & Whittington, R. (2018). Care home manager attitudes to balancing risk and autonomy for residents with dementia. *Aging and Mental Health*, *22*(2), 261–269.

Fetherstonhaugh, D., Tarzia, L., & Nay, R. (2013). Being central to decision making means I am still here!: The essence of decision making for people with dementia. *Journal of Aging Studies*, *27*(2), 143–150.

Fletcher, J. R., Lee, K., & Snowden, S. (2019). Uncertainties When Applying the Mental Capacity Act in Dementia Research: A Call for Researcher Experiences. *Ethics and Social Welfare*, *0*(0), 1–15.

Forchammer, H. B. (2006). The woman who used her walking stick as telephone: The use of utilities in praxis. In A. Costall & O. Dreier (Eds.), *Doing things with things: The design and Use of Everyday Objects*.

Gibson, J. J. (1986). *The Ecological Approach to Visual Perception*. New Jerssy: Lawrence Erlbaum Associates, Publishers.

Gilleard, C., & Higgs, P. (2010). Aging without agency: Theorizing the fourth age. *Aging and Mental Health*, *14*(2), 121–128.

Graham, R. (2004). Cognitive citizenship: Access to hip surgery for people with dementia. *Health*, *8*(3), 295–310.

Guba, E. G., & Lincoln, Y. S. (1994). Competing Paradigms in Qualitative Research. In N. K. Denzin & S. Lincoln (Eds.), *Handbook of qualitative research* (Eds, pp. 105–117). Thousand Oaks, CA:Sage.

Gubrium, J., & Holstein, J. (1997). "Active interviewing." In D. Silverman (Ed.), *Qualitative Research: theory, method and practice* (ed.). London: Sage Publications.

Gubrium, J., & Holstein, J. (2000). "Analysing Interpretitive Practice." In N. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed.). California: Sage Publications.

Hammersley, M., & Atkinson, P. (2007). *Ethnography principles in practice* (3rd ed.). London: Routledge.

Harper, D. (2002). Talking about pictures: A case for photo elicitation. *Visual Studies*, *17*(1), 13–26.

Health and Safety Executive. Accessed 20 February 2019. http://www.hse.gov.uk/contact/faqs/smoking.htm

Hellström, I., Eriksson, H., & Sandberg, J. (2014). Chores and sense of self: Gendered understandings of voices of older married women with dementia. *International Journal of Older People Nursing*, *10*(2), 127–135.

Hocking, C. (1997). Person-object interaction model: Understanding the use of everyday objects. *Journal of Occupational Science*, *4*(1), 27–35.

Holloway, I., & Wheeler, S. (2002). *Qualitative Research in Nursing* (2nd ed.) Wiley Blackwell Publishing.

Howitt, D. (2016). *Introduction to Qualitative Research Methods in Psychology* (2nd Ed.). Pearson Education Limited.

Iltanen, S., & Topo, P. (2015). Object-elicitation in interviews about clothing design, ageing and dementia. *J. of Design Research*, *13*(2), 167.

Innes, A., Kelly, F., & Dincarslan, O. (2011). Care home design for people with dementia: What do people with dementia and their family carers value? *Aging and Mental Health*, *15*(5), 548–556.

Jones, J., & Smith, J. (2017). Ethnography : challenges and opportunities, *20*(4), 98–100.

Jones, S. J. (2003). What is an affordance. *Ecological Psychology*, *15*(2), 107–114.

Kay, A. C., Wheeler, S. C., Bargh, J. A., & Ross, L. (2004). Material priming: The influence of mundane physical objects on situational construal and competitive behavioral choice. *Organizational Behavior and Human Decision Processes*, *95*(1), 83–96.

Kelly, F., & Innes, A. (2013). Human rights, citizenship and dementia care nursing. *International Journal of Older People Nursing*, *8*(1), 61–70.

Killett, A., Burns, D., Kelly, F., Brooker, D., Bowes, A., La Fontaine, J., & O'Neill, M. (2016). Digging deep : how organisational culture affects care home residents ' experiences. *Ageing and Society*, *36*, 160–188.

Kitchin, R. (1998). "Out of place", "knowing one's place": Space, power and the exclusion of disabled people. *Disability and Society*, *13*(3), 343–356.

Kitwood, T. (1997). *Dementia Reconsidered: The Person Comes First*. Buckingham: MsGraw-Hill Education.

Kroger, J., & Adair, V. (2008). Symbolic Meanings of Valued Personal Objects in Identity Transitions of Late Adulthood. *Identity: An International Journal of Theory and Research*, *8*(1984), 5–24.

Larsson Ranada, Å., & Hagberg, J. E. (2014). All the things I have - Handling one's material room in old age. *Journal of Aging Studies*, *31*, 110–118.

Lewins, A., & Silver, C. (2014). *Using Software in Qualitative Research a step by step guide* (2nd ed.). Thousand Oaks: Sage.

Lindley, S., & Wallace, J. (2015). Placing in Age : Transitioning to a New Home in Later Life. *ACM Transactions on Computer-Human Interaction*, *22*(4), 1–40.

Link, B. G., & Phelan, J. C. (2006). Stigma and its public health implications. *Lancet*, *367*(9509), 528–529.

Lister, R. (2007). Inclusive citizenship: Realizing the potential. *Citizenship Studies*, *11*(1), 49–61.

Loboprabhu, S., Molinari, V., & Lomax, J. (2007). The Transitional Object in Dementia: Clinical Implications. *International Journal of Applied Psychoanaltic Studies*, *4*(2), 144–169.

Lovatt, M. (2018). Becoming at home in residential care for older people: a material culture perspective. *Sociology of Health and Illness*, *40*(2), 366–378.

Luff, R., Ellmers, T., Eyers, I., Young, E., & Arber, S. (2011). Time spent in bed at night by care-home residents: choice or compromise? *Ageing and Society*, *31*(07), 1229–1250.

Luff, R., Ferreira, Z., & Meyer, J. (2011). *Care Homes*. *School for Social Care Research*. Retrieved from http://www.sscr.nihr.ac.uk/PDF/ScopingReviews/SR10.pdf

Lune, H., & Berg, B. L. (2017). *Qualitative Research Methods for Social Sciences* (9th Ed.). Essex: Pearson Education Limited.

Marshall, T. H. (1987). *Citizenship and Social Class*. Pluto Press.

Mccracken, G. (1987). Culture and Consumption among the Elderly: Three Research Objectives in an Emerging Field. *Ageing & Society*, *7*(02), 203–224.

McCurdy, P., & Uldam, J. (2014). Connecting Participant Observation Positions: Toward a Reflexive Framework for Studying Social Movements. *Field Methods*, *26*(1), 40–55.

McLean, C., Griffiths, P., Eguiagaray, I. M., Pickering, R. M., & Bridges, J. (2017). Reliability , feasibility , and validity of the quality of interactions schedule (QuIS) in acute hospital care : an observational study. *BMC Health Services Research*, *17*(380), 1–10.

Mental Capacity Act. 2005. Accessed 11 April 2016. http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf

Mental Welfare Commission. (2011). *Starved of care*. Retrieved from http://www.mwcscot.org.uk/media/52047/Starved of Care Mrs V.pdf

Miller, D. (2008a). *The Comfort of Things*. Cambridge: Policy Press.

Miller, D. (2010). *Stuff*. Cambridge: Polity Press.

Müller, C., Lautenschläger, S., Meyer, G., & Stephan, A. (2017). Interventions to support people with dementia and their caregivers during the transition from home care to nursing home care: A systematic review. *International Journal of Nursing Studies*, *71*(July 2016), 139–152.

Myhomelife.org.uk. Accessed 10 June 2016. https://myhomelife.org.uk/

Nedlund, A. C., & Nordh, J. (2015). Crafting citizen(ship) for people with dementia: How policy narratives at national level in Sweden informed politics of time from 1975 to 2013. *Journal of Aging Studies*, *34*, 123–133.

Nedlund, A. C., & Larsson, A. (2016). To protect and to support: How citizenship and self-determination are legally constructed and managed in practice for people living with dementia in Sweden. *Dementia*, *15*(3), 343–357.

Nettleton, S., Buse, C., & Martin, D. (2018). 'Essentially it's just a lot of bedrooms': architectural design, prescribed personalisation and the construction of care homes for later life. *Sociology of Health and Illness*, *40*(7), 1156–1171.

NHS Health Research Authority. Accessed 7 February 2016. https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/mental-capacity-act/

Nord, C. (2013). A day to be lived. Elderly peoples' possessions for everyday life in assisted living. *Journal of Aging Studies*, *27*(2), 135–142.

O'Connor, D., & Nedlund, A.-C. (2016). Editorial introduction: Special issue on Citizenship and Dementia. *Dementia*, *15*(3), 285–288.

O'Toole, P., & Were, P. (2008). Observing places: Using space and material culture in qualitative research. *Qualitative Research*, *8*(5), 616–634.

Österholm, J. H., & Hydén, L. C. (2014). Citizenship as practice: Handling communication problems in encounters between persons with dementia and social workers. *Dementia*, *15*(6), 1457–1473.

Österholm, J. H., & Hydén, L. C. (2016). Citizenship as practice: Handling communication problems in encounters between persons with dementia and social workers. *Dementia*, *15*(6), 1457–1473.

Parkinson, S., Eatough, V., Holmes, J., Stapley, E., & Midgley, N. (2016). Framework analysis: a worked example of a study exploring young people's experiences of depression. *Qualitative Research in Psychology*, *13*(2), 109–129.

Pastalan, L. A., & Barnes, J. . (1999). Personal rituals: Identity, attachment to place, and community solidarity. In S. Benyamin & B. Ruth (Eds.), *Aging, autonomy, and architecture: Advances in assisted liviing* (pp. 81–89). Baltimore: The Johns Hopkins University Press.

Phenice, L. A. G. R. J. (2013). The Importance of Object Memories for Older Adults. *Educational Gerontology*, *39*(10), 741–749. htt

Popham, C., & Orrell, M. (2012). What matters for people with dementia in care homes ? Aging and mental health. *Aging & Mental Health*, *16* (2), 181–188.

Porksen, U. (1995). Plastic words: The tyranny of a modular language. University Park: Pennsylvania University Press

Powers, B. A. N. N. (2003). The Significance of Losing Things For Nursing Home Residents With Dementia And Their Families. *Journal of Gerontological Nursing*, 43–52.

Price, L. L., Arnould, E. J., & Folkman Curasi, C. (2000). Older Consumers' Disposition of Special Possessions. *Journal of Consumer Research*, *27*(2), 179–201.

RCN Research Society. (2011). Informed consent in health and social care research. *The Royal College of Nursing*, (January), 17.

Richards, L. (2015). *Handling Qualitative Data A Practical Guide* (3rd Ed.). Thousand Oaks: Sage.

Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman & R. G. Burgess (Eds.), *Analysing qualitative data* (pp. 173–194). London: Routledge.

Rochberg-Halton, E. (1984a). Object Relations, Role, Models, and Cultivation of the Self. *Environment and Behavior*, *16*(3), 335–368.

Rochberg-Halton, E. (1984b). Object Relations, Role Models, and the Cultivation of the Self. *Environment and Behavior*, (16), 335–368.

Rubenstein, R. L. (1987). The significance of personal objects to older people. *Journal of Aging Studies*, *7*, 225–238.

Sabat, R. S. (2001). *The Experience of Alzheimer's Disease Life Through a Tangled Veil*. Oxford: Blackwell Publishers.

Salkind, N. J. (2010). *Encyclopedia Of Research Design*. Sage Publications.

Samsi, K., & Manthorpe, J. (2011). "I live for today": A qualitative study investigating older people's attitudes to advance planning. *Health and Social Care in the Community*, *19*(1), 52–59.

Sherman, E; Newman, E. S. (1978). The Meaning of Cherished Personal Possessions for the Elderly. *The International Journal of Aging and Human Development*.

Smith, J. A., & Osborn, M. (2008). *Qualitative Psychology: a practical guide to research methods*. London: Sage.

Srivastava, A., & Thomson, S. B. (2009). Framework Analysis: A Qualitative Methodology for. *Applied Policy Research. JOAAG*, *4*(2), 72–79.

Sweeting, H., & Gilhooly, M. (1997). Dementia and the phenomenon of social death. *Sociology of Health and Illness, 19*, 93-117

Taylor, H. (2015). Is the Mental Capacity Act fulfilling its aims? *Nursing Times*, *111*(26), 14–17.

Theurer, K., Mortsenson, W. B., Stone, R., Suto, M., Timonen, V., & Rozanova, J. (2015). The need for a social revolution in residential care. *Journal of Aging Studies*, *35*, 201–210.

Titterton, M. (2005). *Risk and risk taking in health and social welfare*. London: Jessica Kingsley Publishers Ltd.

Topo, P., Kotilainen, H., & Eloniemi-Sulkava, U. (2012). Affordances of the care environment for people with dementia - An assessment study. *Health Environments Research and Design Journal*, *5*(4), 118–138.

Tuckett, A. G. (2012). The experience of lying in dementia care: A qualitative study. *Nursing Ethics*, *19*(1), 7–20.

Ursin, G., & Lotherington, A. T. (2018). Citizenship as Distributed Achievement: Shaping New Conditions for an Everyday Life with Dementia. *Scandinavian Journal of Disability Research*, *20*(1), 62–71.

Van't Leven, N., & Jonsson, H. (2002). Doing and being in the atmospher of the doing: Environmental influences on occupational performance in a nursing home. *Scandinavian Journal of Occupational Therapy*, *9*(4), 148–155.

van Hoof, J., Janssen, M. L., Heesakkers, C. M. C., van Kersbergen, W., Severijns, L. E. J., Willems, L. A. G., … Nieboer, M. E. (2016). The Importance of Personal Possessions for the Development of a Sense of Home of Nursing Home Residents. *Journal of Housing for the Elderly*, *30*(1), 35–51.

Vigoda-Gadot, E., & Golembiewski, R. T. (2004). Citizenship behavior and the new managerialism:A theoretical framework and challenge for governance. In E. Vigoda-Gadot, & A. Cohen (Eds.),

Citizenship and management in public administration: Integrating behavioral theories and managerial thinking (pp. 7–25). Cheltenham: Edward Elgar.

Vink, A. C., Bruinsma, M. S., & Scholten, R, J. (2003). Music therapy for people with dementia. *Cochrane Library*.

Wapner, S., Demick, J., & ReDondo, J. . (1990). Wapner, S Demick, J ReDondo, J.R. *International Journal of Ageing and Human Development*, *31*, 219–235.

Weir, K., & Costall, A. (2015). A personal approach: An empirical study of the process of studying my son's problem with computer games. *International Journal of Qualitative Methods*, *14*(5), 1–10.

Whitlatch, C., & Menne, H. (2009). Don't Forget About Me! Decison Making by People with Dementia. *American Society on Aging*, *XX*(X), 66–73.

Woods, B., Spencer, A. E., Jones, C. A., Orrell, M., & Davies, S. P. (2009). Cochrane Database of Systematic Reviews Reminiscence therapy for dementia (Review) www.cochranelibrary.com, (2).

World Health Organisation. (n.d.). Retrieved from https://www.who.int/ageing/ageism/en/

World Health Organisation and Alzheimer's Disease International. (2012). *Dementia A Public Health Priority*.

Zeilig, H., Killick, J., & Fox, C. (2014). The participative arts for people living with a dementia: a critical review. *International Journal of Ageing and Later Life*, *9*(1), 7–34.

Appendix 1 Participant information sheet - care staff

UNIVERSITY OF
Southampton

Leading the fight
against dementia
**Alzheimer's
Society**

Exploring objects, people with memory problems and the perception of risk in care homes

Information for care staff

Your invitation to take part

You are invited to take part in a research project which will look at the type of belongings people with memory problems bring into care homes. As a member of care staff your thoughts and opinions are important. You have been given this participant information either by the adult services service manager or the registered manager. Please take time to read through or listen to the following information to understand more about it. Talk to your work colleagues and family about the project if you wish. Feel free to contact me if anything is not clear or if you have any questions or concerns about taking part. Alternatively the adult services service manager or registered manager will contact you in seven days time to ask you if you would like more information. If you do, they will pass your details to me and I will make contact with you.

What is this project about?

This project aims to explore the belongings people with memory problems bring into care homes and the meaning these belongings have. It also aims to understand how decisions are made about what can and can not be brought into the care home and any risks associated with people with memory problems both having and using these belongings.

Who is organising the project?

The project is being organised by me, Kellyn Lee. I am a PhD student at the University of Southampton. I have a BSc (Hons) in Psychology and a Masters in Research Science. My Masters project looked at how informal carers of people with memory problems access information. I have also worked on two projects exploring creative arts for people with memory problems and the usefulness of carer groups for informal carers.

This research project is part of a Doctorate studentship at the Doctoral Training Centre – Dementia Care based within the Health Sciences department at the University of Southampton. The studentship is funded by the Alzheimer's Society.

Why do we need you?

You are being asked to take part in this project because you are a member of care staff at Southcote Manor Care Home. I will spend four hours per day, three days per week for one month at the care home on various shifts. I would like to observe the general day to day activities in the care home and this will include observing you carrying out some of your daily tasks. This will not include tasks of giving personal care to a resident such as washing or dressing. I would like to ask you questions about what I see and make notes about this. I would also like to look at the 'this is

me' file and the care records that you write about residents but only in relation to their belongings.

Are there any benefits of taking part?

This is an opportunity for you to give your views, opinions and experiences which are often overlooked. It is hoped that the information gathered may help to provide training materials for care homes and recommendations for the Care Quality Commission which may have an impact on future practice. A report will be written giving overall findings from the research and I will present this to you at an event at the end of this research project.

What if something goes wrong?

I do not anticipate any risks to you for participating in the project. The interviews will be undertaken at work during your usual work hours. I will visit the care home and take part in daily activities and I may observe you. This can feel a little strange to start with, therefore every effort will be made to make sure you feel comfortable when carrying out your daily tasks. You might want to discuss your suitability with your manager or a relative and this is fine. You can also withdraw at anytime throughout the project. If you decide to withdraw from the research this will have no effect on your employment.

Do I have to take part?

No, it is up to you. It is a personal choice and you should only agree to take part if it is something you want to do. If you do decide to take part but then change your mind that is okay too. You are free to withdraw from the project at any time without giving a reason.

What will happen next?

If you indicate to the adult services service manager or registered manager that you would like to take part your details will be passed to me and I will contact you. I will invite you to take part in the project, talk through the project and answer any questions you may have. If you are then willing to take part an informed consent form will be given to you to sign. This confirms that you understand the project, have had the ability to ask any questions, and are willing to take part.

What will I need to do?

I would like to interview you about the topic of people with memory problems and their belongings. An interview time will be arranged within your working hours. This will be the most convenient time for you and will be in agreement with your manager. The interview will last

approximately one hour. You can stop the interview whenever you like or take a break if needed. I will ask questions in relation to people with memory problems having belongings in the home, their use and and any risks you see in relation to them having these everyday objects. I would also like to observe you at times whilst working at Southcote Manor. I will spend four months in the home participating in daily activities to carry out observations. I will be observing the people who live, visit and work in the home and have given consent for me to do so. This does not mean that I will follow you around the care home. What this means is that I will be around the home and sometimes I may be in the same place as you. I may ask questions about what I see and I may make notes about this

It is your choice whether you would like to take part in both the interview and observations. If you agree to take part in one that does not mean you are required to take part in the other.

How will information be recorded?

The interviews will be recorded on a dictaphone, this is so that I can give you my full attention instead of trying to write down everything we have said. You can stop the recording at anytime. The recorded interview will not be played to anyone else other than my supervisory team if necessary. The recording will be typed word for word and a copy of the transcript will be sent to you to make sure you are happy that it has been written correctly.

The observations will be written down in note form and I may ask questions about what I see at the time I see it. I will ask if I can record these conversations. My role is not to assess your daily care practices but to observe how people interact with belongings.

Will my data be kept confidential?

Yes. Everything discussed during the interview, your personal details and all notes taken whilst carrying out observations will be kept confidential. You will be given a pseudonym at the beginning of the project to give you as much anonymity as possible. All paperwork will include this pseudonym and will not include your real name or other identifying details. Whilst measures are taken to remove any personal identifiable information, when reading through the report there is a chance that you may be able to recognise yourself from what you have said.

It is also important to mention that, if during any conversations or observations it is felt that a person is being harmed, physically or psychologically, or exploited in anyway, confidentiality cannot be maintained. I have a duty of care to pass on this information to a relevant person/organisation giving full details.

Your contact details will be kept in order to get in touch with you but these will not be shared or passed on to anyone else. They will be kept in a locked cabinet in a locked office at the University and on a university computer. Details kept on the university computer will be protected by passwords so that only I can access them. The data will be kept for ten years in accordance with University of Southampton policy.

Thank you for taking the time to read this invitation to take part in this research project, and I hope to work with you soon!

This document is also available in large print and video.

Contact Information

If you have any questions feel free to contact me

Ms Kellyn Lee

PhD Research Student

Doctoral Training Centre – Dementia Care

Health Sciences – University of Southampton

Kw1g15@soton.ac.uk

Tel: 079 404241 98

If you have any concerns in relation to this invitation now or in the future, or are unhappy with the research conduct of any member of staff/student from the Faculty of Health Sciences and would like to discuss the matter, please contact the Research Goverance Office in the first instance.

Their contact details are as follows:

Address: University of Southampton, Building 37, Highfield, Southampton, SO17 1BJ

Tel: +44 (0)23 8059 5058

Fax: +44 (0)23 8059 5781

Email: rgoinfo@soton.ac.uk

Exploring objects, people with memory problems and the perception of risk in care homes

Information for family members of Southcote Manor Care Home

Your invitation to take part

You are invited to take part in a research project which will look at the type of belongings people with memory problems bring into care homes. As a visiting family member of a person living in a care home your thoughts and opinions are important. You have been sent or given this participant information by either the adult services service manager or the registered manager. Please take time to read through or listen to the following information to understand more about it. Talk to friends or family about the project if you wish. Feel free to contact me if anything is not clear or if you have any questions or concerns about taking part.   Alternatively the adult services service manager or registered manager will contact you in ten days time to ask you if you would like more information. If you do, they will pass on your details to me and I will make contact with you.

What is this project about?

This project aims to explore the belongings people with memory problems bring into care homes and the meaning these belongings have. It also aims to understand how decisions are made about what can and can not be brought into the care home and any risks associated with people with memory problems both having and using these belongings.

Who is organising the project?

The project is being organised by me, Kellyn Lee. I am a PhD student at the University of Southampton. I have a BSc (Hons) in Psychology and a Masters in Research Science. My Masters project looked at how informal carers of people with memory problems access information. I have also worked on two projects exploring creative arts for people with memory problems and the usefulness of carer groups for informal carers.

This research project is part of a Doctorate studentship at the Doctoral Training Centre – Dementia Care based within the Health Sciences department at the University of Southampton. The studentship is funded by the Alzheimer's Society.

Why do we need you?

You are being asked to take part in this project because you are a visiting family member of person living at Southcote Manor Care Home Care Home.   I would like you to take part in an interview which will explore the aims of the project which I mentioned earlier. I will request to audio-record the interviews. Following the interview I will spend time at Southcote Manor Care Home. I will spend four months in the care home, four hours each day, three days per week on

various shifts taking part in daily activities. I may ask questions about what I see and I may make notes.

I will be asking many people to take part in the project however family members must visit their family member to be eligible to take part.

Are there any benefits of taking part?

This is an opportunity for you to give your views, opinions and experiences which are often overlooked. It is hoped that the information gathered may help to provide training materials for care homes and recommendations for the Care Quality Commission which may have an impact on future practice. A report will be written giving overall findings from the research and I will present this to you at an event at the end of this research project.

What if something goes wrong?

I do not anticipate any risks to you for participating in the project. The interviews will be undertaken at a pre-arranged time convenient for you and will take place either at Southcote Manor Care Home or a place of your choosing. I will visit the care home and take part in daily activities and I may observe you.This can feel a little strange to start with. Therefore every effort will be made to make sure you feel comfortable when visiting. You can also withdraw at anytime throughout the project. If you choose to withdraw this will have no effect on a residents care or employment of staff.

Do I have to take part?

No, it is up to you. It is a personal choice and you should only agree to take part if it is something you want to do. If you do decide to take part but then change your mind that is okay too. You are free to withdraw from the project at any time without giving a reason.

What will happen next?

 If you indicate to the adult services service manager or registered manager that you would like to take part your details will be passed to me and I will contact you. I will invite you to take part in the project, talk through the project and answer any questions you may have. If you are then willing to take part an informed consent form will be given to you to sign. This confirms that you understand the project, have had the ability to ask any questions, and are willing to take part.

What will I need to do?

An interview will be arranged at a time that is convenient for you, in a place of your choosing. The interview will last approximately one hour depending on what you want to say. You can stop the interview whenever you like or take a break if needed. I will ask questions in relation to the belongings that were taken into the care home, belongings your relative would have liked to have taken and why. Also how the decisions were made about what could be taken. I will also ask you questions about any risk you see in having certain belongings in the care home.

I will spend four months in the home participating in daily activities to carry out observations. I will be observing the people who live, visit and work in the home and have given consent for me to do so. This does not mean that I will follow you around the care home. What this means is that I will be around the home and sometimes I may be in the same place as you. I may also ask you questions about what I see.

It is your choice whether you would like to take part in both the interview and observations. If you agree to take part in one that does not mean you are required to take part in the other.

How will information be recorded?

The interviews will be recorded on a dictaphone, this is so that I can give you my full attention instead of trying to write down everything we have said. You can stop the recording at anytime. The recorded interview will not be played to anyone else other than the supervisory team if necessary. The recording will be typed word for word and a copy of the transcript will be sent to you to make sure you are happy that it has been written correctly.

The observations will be written down in note form and I may ask questions about what I see at the time I see it.

Will my data be kept confidential?

Yes. Everything discussed during the interview, your personal details and all notes taken whilst carrying out observations will be kept confidential. You will be given a pseudonym at the beginning of the project to give you as much anonymity as possible. All paperwork will include this pseudonym and will not include your real name or other identifying details. Whilst measures are taken to remove any personal identifiable information, when reading through the report there is a chance that you may be able to recognise yourself from what you have said.

It is also important to mention that, if during any conversations or observations it is felt that a person is being harmed, physically or psychologically, or exploited in anyway, confidentiality

cannot be maintained. I have a duty of care to pass on this information to a relevant person/organisation giving full details.

Your contact details will be kept in order to get in touch with you but these will not be shared or passed on to anyone else. They will be kept in a locked cabinet in a locked office at the University and on a computer. Details kept on the university computer will be protected by a password so that only I can access them. The data will be kept for ten years in accordance with University of Southampton policy.

Thank you for taking the time to read this invitation to take part in this research project, and I hope to work with you soon!

This document is also available in large print and video.

Contact Information

If you have any questions feel free to contact:

Ms Kellyn Lee

PhD Research Student

Doctoral Training Centre – Dementia Care

Health Sciences – University of Southampton

Kw1g15@soton.ac.uk

Tel: 079 404241 98

If you have any concerns in relation to this invitation now or in the future, or are unhappy with the research conduct of any member of staff/student from the Faculty of Health Sciences and would like to discuss the matter, please contact the Research Goverance Office in the first instance.

Their contact details are as follows:

Address: University of Southampton, Building 37, Highfield, Southampton, SO17 1BJ

Tel: +44 (0)23 8059 5058

Fax: +44 (0)23 8059 5781

Email: rgoinfo@soton.ac.uk

Organisations you may find useful

Age Concern Hampshire

St Georges House

Winchester

SO23 8AH

Tel: 01962 868545

Alzheimer's Society New Forest Branch

Sea Road

Milford on Sea

Lymington

SO41 0PG

Tel: 01590 644649

Care Quality Commission

National Customer Service Centre
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Tel: 03000 616161

Carers UK – Carers advice

Tel: 0808 808 7777

Cognitive Stimulation Therapy for people with dementia

http://www.cstdementia.com/

Memory problems UK – Helping families face dementia

Our Dementia Helpline: 0800 888 6678

Exploring objects, people with memory problems and the perception of risk in care homes

Information for residents of Southcote Manor Care Home

Your invitation to take part

You are invited to take part in a study for a research project which will look at the type of belongings people bring into care homes from home. As a person living in a care home your thoughts and opinions are important. You have been given this participant information by either the adult services service manager or the registered manager. Please take time to read through or listen to the following information to understand more about it. Talk to your family or friends about the project if you wish. Feel free to contact me if anything is not clear or if you have any questions or concerns about taking part. Alternatively the adult services service manager or registered manager will contact you in seven days time to ask you if you would like more information. If you do, they will pass on your details to me and I will make contact with you. Family members may also be invited to take part in this research project as their thought and opinions are important too. They may have helped you move into the care home and in doing so may have helped to make decisions about what to take.

What is this project about?

This project aims to explore the belongings people bring into care homes and the meaning these belongings have. It also aims to understand how decisions are made about what can and can not be brought into the care home and any risks associated with people having and using these belongings.

Who is organising the project?

The project is being organised by me, Kellyn Lee. I am a PhD student at the University of Southampton. I have a BSc (Hons) in Psychology and a Masters in Research Science. My Masters project looked at how informal carers of people with memory problems access information. I have also worked on two projects exploring creative arts for people with memory problems and the usefulness of carer groups for informal carers.

This research project is part of a Doctorate studentship at the Doctoral Training Centre based within the Health Sciences department at the University of Southampton.

Why do we need you?

You are being asked to take part in this project because you live at Southcote Manor Care Home. I would like you to take part in some interviews exploring the objects you brought into the care home with you. I will request to audio-record the interviews. I will also spend some time atSolent Mead. This means I will spend four hours each day, three days per week, for four months, taking

part in daily activities, making notes and asking questions about what I see. I would like for us to take some photographs of the belongings you have brought into the care home for us to discuss but again, only if you comfortable with this. I would like to look through the 'this is me' file to look at which belongings you brought into the care home and things that are important to you. I would also like to look at the daily care records the care staff write. This is to see whether anything is reported in relation to objects and how you use them.

Are there any benefits of taking part?

This is an opportunity for you to give your views, opinions and experiences which are often overlooked. It is also an opportunity for you to influence the design of the main research project as this pilot study will test the processes being considered. It is hoped that the information gathered project may help to provide materials for care homes and recommendations for the Care Quality Commission which may have an impact on future practice. A report will be written giving overall findings from the research and I will present this to you at an event at the end of this research project.

What if something goes wrong?

I do not anticipate any risks to you for participating in the project. The interviews will be undertaken at a pre-arranged time convenient for you and will take place at Solent Mead. I will visit the care home and take part in daily activities and I may observe you. This can feel a little strange to start with, therefore every effort will be made to make sure you feel comfortable. You can also withdraw at anytime throughout the project.

Do I have to take part?

No, it is up to you. It is a personal choice and you should only agree to take part if it is something you want to do. If you do decide to take part but then change your mind that is okay too. You are free to withdraw from the project at any time without giving a reason. If you decide to withdraw from the research this will have no effect on your care.

What will happen next?

If you indicate to the adult services service manager or registered manager that you would like to take part your details will be passed to me and I will contact you. I will invite you to take part in the project, talk through the project and answer any questions you may have. If you are then willing to take part an informed consent form will be given to you to sign. This confirms that you understand the project, have had the ability to ask any questions, and are willing to take part.

You may also have a family member with you at the time of consent to sign the consent form too.

What will I need to do?

I would like to carry out some interviews with you about what belongings you brought into the care home and how the decision about what to bring and what to leave were made. I would like to look through your care records to see what belongings you brought into the care home and how you use objects in your daily life. I would also like to observe you at times at Solent Mead. Interview times will be arranged with you and this will be the most convenient time for you. The interviews will last approximately thirty minutes to one hour depending on what you want to say. You can stop the interview whenever you like or take a break if needed. I will ask questions in relation to you having belongings in the home, how you use them and whether you see any risks in relation to them having these belongings. I will spend one month in the home participating in daily activities to carry out observations. I will be observing the people who live, visit and work in the home and have given consent for me to do so. This does not mean that I will follow you around the care home. What this means is that I will be around the home and sometimes I may be in the same place as you.

It is your choice whether you would like to take part in both the interview and the observations. If you agree to take part in one that does not mean you are required to take part in the other.

How will information be recorded?

The interviews will be recorded on a dictaphone, this is so that I can give you my full attention instead of trying to write down everything we have said. You can stop the recording at anytime. The recorded interview will not be played to anyone else other than the supervisory team if necessary. The recording will be typed word for word and a copy of the transcript will be sent to you to make sure you are happy that it has been written correctly.

The observations will be written down in note form and I may ask questions about what I see at the time I see it.

I will make my own notes about the care notes I read.

Will my data be kept confidential?

Yes. Everything discussed during the interview, your personal details and all notes taken whilst carrying out observations will be kept confidential. You will be given a pseudonym at the beginning of the project to give you as much anonymity as possible. All paperwork will include this pseudondym and will not include your real name or other identifying details. Whilst measures are

taken to remove any personal identifiable information, when reading through the report there is a chance that you may be able to recognise yourself from what you have said. I may also include some of the photographs taken.

It is also important to mention that, if during any conversations or observations it is felt that a person is being harmed, physically or psychologically, or exploited in anyway, confidentiality cannot be maintained. I have a duty of care to pass on this information to a relevant person/organisation giving full details.

Your contact details will be kept in order to get in touch with you but these will not be shared or passed on to anyone else. They will be kept in a locked cabinet at the University and on a university computer. Details kept on the university computer will be protected by a password so that only the researcher working on the project can access them. The data will be kept for 10 years in accordance with University of Southampton policy.

Thank you for taking the time to read this invitation to take part in this research project, and I hope to work with you soon!

This document is also available in large print and video.

Contact Information

If you have any questions feel free to contact me:

Ms Kellyn Lee

PhD Research Student

Doctoral Training Centre – Dementia Care

Health Sciences – University of Southampton

Kw1g15@soton.ac.uk

Tel: 079 404241 98

If you have any concerns in relation to this invitation now or in the future, or are unhappy with the research conduct of any member of staff/student from the Faculty of Health Sciences and would like to discuss the matter, please contact the Research Goverance Office in the first instance.

Their contact details are as follows:

Address: University of Southampton, Building 37, Highfield, Southampton, SO17 1BJ

Tel: +44 (0)23 8059 5058

Fax: +44 (0)23 8059 5781

Email: rgoinfo@soton.ac.uk

Appendix 4 Interview guide - residents

UNIVERSITY OF
Southampton

Participant number: ....

Verbal explanation of project & process: YES ☐   NO   ☐

Written information given/video watched: YES ☐   NO   ☐

Consent Form signed: YES ☐   NO   ☐

Briefly describe the project again before starting the interview:

"I would just like to go over the project and what we will be doing today before we start the interview. This project is looking at the belongings you brought into the care home from home. I will ask questions about the belongings you have and also any belongings you might like to have. We will also look at how decisions were made surrounding what belongings were brought into the home. I would also like to ask you whether the belongings you brought have any special meaning to you and how you use these belongings. We will also look at whether you think there are any benefits or problems associated with having certain belongings.

I am really interested in your thoughts and opinions. If there are any questions you do not want to answer, you do not have to. I would like to stress that there are no right or wrong answers and I am interested to hear about your thoughts and opinions. I will tape record the interview so that I can remember all that has been said.

If at any time you wish to stop or take a break I will stop the tape immediately. You are also free to withdraw at any time. The contents of your interview will be kept confidential but I cannot promise anonymity as you

may recognise yourself in text if any of your words are quoted. I will use a pseudonym in any quote I use in order to respect your privacy.

Do you have any questions before we begin?"

Check interviewee ready to start interview.

Test recording equipment.

The following is a brief guide of the topic areas to be considered. It is likely that the content of the interview schedule will be adapted for individual participants who will have varying degrees of memory problems. It may also incorporate other areas as the researcher reflects upon each interview as it takes place. It is also likely that the order in which the topics are addressed may change according to the flow of the interview.

The prompts/explore sections in italics will be raised only if not covered spontaneously by participants. The warm up questions will start the interview process, the main questions are here purely as a guide around the topic being discussed. The warm down will finish off the interview process. The questions will often differ with each individual conversation as the conversation will be led by the person being interviewed.

Warm up questions

Thank you for agreeing to take part in this interview, I hope I won't take up too much of your time. Would you like to tell me about the person who lives here, your relationship to that person?

Interview guide

Warm up questions

Thank you for agreeing to take part in this interview, I hope I won't take up too much of your time.

How are you today?

How do you like to spend your days?

Are there many hobbies you enjoy?

What sort of things do you do on an average day?

Main topic

I've brought something from home to show you, it's only a photo as the object is too big to bring in. (Talk about the object, and what it means)

Do you have many belongings here that you brought from home?

Would it be okay to show me them?

> *Talk through the belongings, the meaning they hold where they are from etc, led by the person being interviewed.*

Would it be okay to take a photograph of some of your belongings?

Would you like to take the photograph?

So these belongings were brought in from home?

> *How do you use these objects? (one by one)*

Are there any belongings you wanted to bring but didn't?

> *Why didn't you bring them with you?*

> *Who decided what to bring from home?*

If you had brought them how would you use them?

> *How would that feel?*

Can you think of any reasons people might not want you to have some belongings?

> *Explore who and the possible reasons given*

Who would you say is responsible for your belongings?

> *What would happen if something went missing?*

Do other people ever touch or use your belongings?

Can you tell me how you might feel i*f they did?*

Warm down

I mentioned earlier that I will use a pseudonym in order to respect your privacy, would you like to provide me with a name you would like to be known as?

I've enjoyed listening to you, how did you find that interview?

That is all of my questions, do you have any for me?

Thank individual for participating in the interview. Inform participant of what will happen next. Arrange next interview slot (if applicable). Assure him/her of confidentiality of responses.

SWITCH OFF TAPE RECORDER

Appendix 5 Interview guide - relatives

UNIVERSITY OF Southampton

<u>**Interview guide (family member)**</u>

Participant number: ....

Verbal explanation of project & process:	YES ☐	NO ☐
Written information given/video watched:	YES ☐	NO ☐
Consent Form signed:	YES ☐	NO ☐

Briefly describe the project again before starting the interview:

"I would just like to go over the project and what we will be doing today before we start the interview. This project is looking at the belongings your relative brought into the care home with them. I will ask questions about the belongings they have and also any belongings you think they might want to have, how decisions were made surrounding what belongings were brought into the home. We will explore whether you think there are any meanings attached to the belongings brought in and how you believe these belongings are used. We will also look at whether there is any risk associated with your relative having certain belongings.

I am really interested in your thoughts and opinions. If there are any questions you do not want to answer, you do not have to. I would like to stress that there are no right or wrong answers and I am interested to hear about your thoughts and opinions. I will tape record the interview so that I can remember all that has been said.

If at any time you wish to stop or take a break I will stop the tape immediately. You are also free to withdraw at any time. The contents of your interview will be kept confidential but I cannot promise anonymity as you

may recognise yourself in text if any of your words are quoted. I will use a pseudonym in any quote I use in order to respect your privacy.

Do you have any questions before we begin?"

Check interviewee ready to start interview.

Test recording equipment.

Interview Guide

The following is a brief overview of the topic areas to be considered. It is likely that the content of the interview schedule will develop and may incorporate other areas as the researcher reflects upon each interview as it takes place. It is also likely that the order in which the topics are addressed may change according to the flow of the interview.

The prompts/explore sections in italics will be raised only if not covered spontaneously by participants. The warm up questions will start the interview process, the main questions are here purely as a guide around the topic being discussed. The warm down will finish off the interview process. The questions will often differ with each individual conversation as the conversation will be led by the person being interviewed.

Warm up questions

Thank you for agreeing to take part in this interview, I hope I won't take up too much of your time. Would you like to tell me about the person who lives here, your relationship to that person?

How long have they lived here?

How often are you able to visit?

Can you tell me about the circumstances behind the move from home to care home?

Main topic

When moving into the care home were they able to bring many belongings with them from home?

What did they bring initially?

Have any other items been brought in or purchased in the time they have lived here?

Can you talk me through how decisions were made about what to take into the care home and what to leave behind?

Who was involved in making the decisions?
Who had the final say on what was brought in?
Was this a difficult process to go through?
If so can you think of any ways this could have been made easier?

Are you aware of there being any belongings they may have liked to have brought with them but didn't?

Can you tell me what these were?
Can you tell me why they weren't taken into the care home?

What do you think it would mean to them to have those belongings here?

Do you think that having those objects would have any impact on their everyday life?

If so how?
If not why not?

Can you think of any belongings your relative might like to use here, things they can take action with?

Do you think using these objects can have an impact on everyday life?

Can you think of any reasons why certain belongings should not permitted?

Can you tell me which objects you think should not be permitted?

Can you tell me why these objects should not be permitted?

Can you see and benefits or problems with have certain objects?

In relation to the personal belongings people have in the care home, who would you suggest has overall responsibility for a person's belongings?

Could you explain why?

What if something went missing or was broken, who would be responsible?

If we think about objects in that they can enable us to do things, what sort of objects do you find useful in your everyday life?

Do you think your relative might find this useful too?

If not why?

From your experience of a loved one moving into a care home is there any advice you could give regarding which belongings to take?

Warm down

If you were to move into a care home, what objects/belongings would you want to take with you?

I mentioned earlier that I will use a pseudonym, in order to respect your privacy, would you like to provide me with a name you would like to be known as?

I enjoyed listening to you, how did you find that interview?

That is all of my questions, do you have any for me?

Thank individual for participating in the interview. Inform participant of what will happen next. Arrange next interview slot (if applicable). Assure him/her of confidentiality of responses.

SWITCH OFF TAPE RECORDER

Appendix 6 Interview guide - care homes staff

UNIVERSITY OF Southampton

Interview guide (Care Staff)

Participant number: ....

Verbal explanation of project & process:	YES ☐	NO ☐
Written information given:	YES ☐	NO ☐
Consent Form signed:	YES ☐	NO ☐

1. Briefly describe the project again before starting the interview:

"I would just like to go over the project and what we will be doing today before we start the interview. I am interested in the belongings people with dementia bring in with them when they first move here. I will ask questions about the belongings they have and also any belongings you think they might like to have. I will ask how decisions were made surrounding what belongings were brought into the home. We will explore whether you think there are any meanings attached to the belongings brought in and how you believe these belongings are used by the person with dementia living in the care home. We will also look at whether there is any risk associated with people with dementia living in a care home having certain belongings.

I am really interested in your thoughts and opinions. If there are any questions you do not want to answer, you do not have to. I would like to

stress that there are no right or wrong answers and I am interested to hear about your thoughts and opinions. I will tape record the interview so that I can remember all that has been said.

If at any time you wish to stop or take a break I will stop the tape immediately. You are also free to withdraw at any time. The contents of your interview will be kept confidential but I cannot promise anonymity as you may recognise yourself in text if any of your words are quoted. I will use a pseudonym in any quote I use in order to respect your privacy.

Do you have any questions before we begin?"

2. Check interviewee ready to start interview.

3. Test recording equipment.

Interview guide (care staff)

The following is a brief overview of the topic areas to be considered. It is likely that the content of the interview schedule will develop and may incorporate other areas as the researcher reflects upon each interview as it takes place. It is also likely that the order in which the topics are addressed may change according to the flow of the interview.

The prompts/explore sections in italics will be raised only if not covered spontaneously by participants.

Warm up questions

Can you tell me how long have you worked in the care profession?

What was it that attracted you to this type of work?

How long have you been working in this care home?

Do you work a set number of hours per week?

What combination of hours, days and shifts do you usually work?

If you were to move into a care home, what objects/belongings would you want to take with you?

Main questions

Can you tell me about any processes you are aware of involving what objects, personal belongings can be brought into the care home?

>*Who is involved?*
>*Who has the final say?*

Are you aware of people with dementia or family members requesting to bring in more belongings once they have moved in?

>*Can you tell me what items these are?*

>*Does the person with dementia now have these items?*

>*If not care you aware of the reasons they were not?*

What would you say are the most common belongings brought into the care home?

>*Can you recall anybody requesting to bring in an unusual belonging?*

>*What was this?*

When person with dementia brings their belongings in the care home are you aware of any policies in place which determine who is responsible for them?

>*What if something were to go missing or was broken?*

I am interested in the whether a person's belongings are a part of their ongoing care planning. Are you involved in this process?

>*Who would be involved in this process?*

Would you be able to talk me through this process?

If a resident asks for a new object or an existing object not in the care home what happens?

Who makes the decision as to whether they can have the object?

Are there any belongings you can think of that you know are not allowed in the care home?

Are you aware of the reasons as to why?

Has something happened previously which has prompted this?

Are you aware of this being written in a care home policy?

Do you think that by having or not being able to have belongings may impact on a person with dementia's everyday life in a care home?

Can you explain your reasons?

Can you think of any times in which a person with dementia has had access to a certain object and this has either made a positive difference to their lives or caused problems?

Can we discuss the idea of a person with dementia using object to carry out chores is they wanted to?

What are your thoughts on a person with dementia living in a care home completing chores such as ironing?

What if a person wanted to offer refreshments to their guests by making drinks or cooking lunch?

Do you think objects can help people maintain some supported independence?

Can you thinks of any benefits this may have?

Who would it benefit?

Can you think of any problems this may cause?

Who would it cause the biggest problem for?

Warm down

Is there anything else you would like to tell me about this topic that we have not covered?

I mentioned earlier that I will use a pseudonym, in order to respect your privacy, would you like to provide me with a name you would like to be known as?

I have enjoyed listening to you, how did you find that interview?

That is all of my questions, do you have any for me?

Thank individual for participating in the interview. Inform participant of what will happen next. Arrange next interview slot (if applicable). Assure him/her of confidentiality of responses.

SWITCH OFF TAPE RECORDER

UNIVERSITY OF
Southampton

Consent form - Interview

Study: Exploring objects, people with memory problems and the perception of risk in care homes.

Researcher name: Kellyn Lee

If you are willing to participate in the interviews being conducted in this project after reading the information sheet or watching the video, please initial the boxes then sign and date the bottom of this form. There are two copies to be signed, one is for my records and one is for you to keep for future reference.

I confirm that I have read the information sheet or watched the information video and understand the information given to me about this project. I have had the opportunity to ask questions and am happy to proceed with the interview (s).

I agree to take part in the interviews and understand that the data collected will be used for the purpose of this project.

I agree to the use of anonymised quotations being used for publications or care home materials and under that a

I understand my participation is voluntary and I may withdraw at any time without my legal rights being affected.

Data Protection

I understand that information collected about me during my participation in this study will be stored on a password protected computer and that this information will only be used for the purpose of this study. All files containing any personal data will be made anonymous.

I agree to take part in this study

Name of participant (print name)………………………………………………….

Signature of participant………………………………….

Date……………………………………….

Representative of the participant (print name)…………………………………….

Signature of the representative of participant……………………………………..

Date…………………………………….

Researcher (print name)……………………………………………………………….

Signature of researcher………………………………………………………………..

Date…………………………………………..

Appendix 8 Observation consent form

Consent form - Observations

Project: Exploring objects, people with memory problems and the perception of risk in care homes.

Researcher name: Kellyn Lee

If you are willing to participate by being observed in the care home environment for the purposes of this project, after reading the information sheet or watching the video, please initial the boxes then sign and date the bottom of this form. There are two copies to be signed, one is for my records and one is for you to keep for future reference.

I confirm that I have read the information sheet or watched the information video and understand the information given to me about this project. I have had the opportunity to ask questions and am happy to be observed whilst in

I am aware and agree to notes being taken whilst I am being observed. I am also aware and agree to being asked questions in relation to those notes. I understand that the data collected will be used for the purpose of this project.

I agree to the use of anonymised quotations being used for publications or care home materials and that a pseudonym will be used instead of my name.

I understand my participation is voluntary and I may withdraw at any time without my legal rights being affected.

Data Protection

I understand that information collected about me during my participation in this project will be stored on a password protected computer and that this information will only be used for the purpose of this project. All files containing any personal data will be made anonymous.

I agree to take part in this project

Name of participant (print name)……………………………………………………

Signature of participant…………………………………

Date……………………………………

Representative of the participant (print name)………………………………………

Signature of the representative of participant………………………………………

Date……………………………………

Researcher (print name)……………………………………………………………

Signature of researcher……………………………………………………………

Date……………………………………

Appendix 9 Photography consent form

UNIVERSITY OF Southampton

Photography

Consent Form

Exploring objects, people with memory problems and the perception of risk in care homes

I am aware that I am the legal owner of photographic images that are taken for the purposes of this study.

I give permission in advance for the photographic images taken for the purposes of this study to be used by the University of Southampton in the following situations:

The public event, due to take place at the end of the study	☐
Conference presentations, teaching and training sessions	☐
Academic articles and publications	☐
For use in press releases and articles for the media	☐

☐
The University website ☐

I am aware that the University takes no responsibility for any information or photographs that are 'exported' when placed on its website. ☐

I give permission for the photographs to used alongside quotes given under my pseudonym ☐

I am aware that I can withdraw from the research project at any time I am also aware that I can withdraw permission for the use of my photographs by contacting Ms Kellyn Weir ☐

Name	
Pseudonym (if required)	
Signed	

Exploring objects, people with memory problems and the perception of risk in care homes

Information for a Personal Consultee

An invitation to take part

A friend or relative whom you act on behalf of as a personal consultee has been invited to take part in a pilot study for a research project which will look at the type of belongings people bring into care homes from home. As a person living in a care home their thoughts and opinions are important. You have been given this participant information by either the adult services service manager or the registered manager because you are the personal consultee of a friend or relative invited to take part in the research. Please take time to read through or listen to the following information to understand more about it. Talk to the friend or relative you act as a personal consultee for and anyone else about the project if you wish. Feel free to contact me if anything is not clear or if you have any questions or concerns about the friend or relative with memory problems taking part. Alternatively the adult services service manager or registered manager will contact you in ten days time to ask you if you would like more information. If you do, they will pass on your details to me and I will make contact with you.

What is a personal consultee?

A personal consultee is a friend or relative who acts on behalf of a person who has been assessed as lacking capacity.

Who can be a personal consultee?

A personal consultee can be a family member, friend or carer. They may also be an attorney acting under a Lasting Power of Attorney or a court appointed deputy providing they have had a relationship with, or personal knowledge of the person assessed as lacking capacity before the appointment as duty. A personal consultee is able to make decisions on behalf of a friend or relative who has been assessed as lacking capacity.

Whilst a number of people may be capable of acting as a personal consultee, you will be someone whom the person assessed as lacking capacity would trust with important decisions about their welfare.

Who cannot be a personal consultee?

A personal consultee must not be someone who is caring for the person assessed as lacking capacity or is interested in their welfare in a professional capacity or for remuneration.

Why am I being asked to be a personal consultee?

The researcher would like to observe people who have been assessed as lacking capacity in this research project. This is to establish whether they have different objects or use objects differently to those who have capacity. You are being asked to act as a personal consultee to give your opinion as to whether you believe they would like to take part in this research project.

What do I have to do?

For the purposes of this study you will be asked to read this participant information sheet on behalf of the friend or relative you are acting for. You will have the opportunity to ask the researcher any questions in relation to the research project. You will then be asked to take into account the wishes and feelings of the friend or relative you are acting for before giving your opinion as to whether you think they would like to take part in the research project. If in your opinion you believe they would like to take part in the research you will be asked to sign the personal consultee declaration form. It is also important to understand that you can change this opinion at any time and the person will be removed from the study.   Equally if the friend or relative assessed as lacking capacity show signs of distress whilst taking part in this research they will be removed for the study and not re-enrolled.

What is this project about?

This project aims to explore the belongings people bring into care homes and the meaning these belongings have. It also aims to understand how decisions are made about what can and can not be brought into the care home and any risks associated with people having and using these belongings.

Who is organising the project?

The project is being organised by me, Kellyn Lee. I am a PhD student at the University of Southampton. I have a BSc (Hons) in Psychology and a Masters in Research Science. My Masters project looked at how informal carers of people with memory problems access information. I have also worked on two projects exploring creative arts for people with memory problems and the usefulness of carer groups for informal carers.

This research project is part of a Doctorate studentship at the Doctoral Training Centre based within the Health Sciences department at the University of Southampton.

Why do we need you?

We need you because you are willing to act as a personal consultee for the friend or relative with memory problems. They are being asked to take part in this project because they live at Bickerley Green Care Home. I will spend some time at Bickerley Green. This means I will spend four hours each day, three days per week, for one month, taking part in daily activities, making notes and asking questions about what I see. I would like for us to take some photographs of the belongings that were brought into the care home. I would also like to look through the 'this is me' file which relates to the objects brought into the care home and things that are important to the friend or relative. I would also like to look at the daily care records the care staff write. This is to see whether anything is reported in relation to objects and how they are used.

Are there any benefits of taking part?

This is an opportunity to observe people assessed as lacking capacity who are often overlooked in research. It is also an opportunity for the friend or relative to influence the design of the main research project as this pilot study will test the processes being considered. It is hoped that the information gathered project may help to provide materials for care homes and recommendations for the Care Quality Commission which may have an impact on future practice. A report will be written giving overall findings from the research and I will present this to you at an event at the end of this research project.

What if something goes wrong?

I do not anticipate any risks to anyone participating in the project. I will visit the care home and take part in daily activities and I may observe the friend or relative you are personal consultee for. This can feel a little strange to start with, therefore every effort will be made to make sure they

feel comfortable. If any uncomfort or distress is identified the friend or relative will be withdrawn with immediate effect and not re-enrolled.

Do they have to take part?

No, it is up to you. It is a personal choice and you should only agree if you believe the friend or relative you are acting as personal consultee for would like to take part. If you give an agreeable opinion for the friend or relative to take part but then change your mind that is okay too. You are free to withdraw the friend or relative from the project at any time without giving a reason. If you decide to withdraw them from the research this will have no effect on their care.

What will happen next?

If you indicate to the adult services service manager or registered manager that you believe the friend or relative would like to take part your details will be passed to me and I will contact you. I will invite you to take part in the project, talk through the project and answer any questions you may have. If you still believe the friend or relative would like to take I will give you a personal consultee declaration to sign. This confirms you understand the project, have had the ability to ask any questions, and are willing to give your opinion as a personal consultee.

What will they need to do?

I would like to look through the friend or relatives' 'this is me' file and the care records which the staff write up daily. This is to see what objects were brought in and whether objects are mentioned by staff. I would also like to observe them at times at Bickerley GreenI will spend one month in the home participating in daily activities to carry out observations. I will be observing the people who live, visit and work in the home and have given consent for me to do so. This does not mean that I will follow people around the care home. What this means is that I will be around the home and sometimes I may be in the same place as the friend or relative you act as personal consultee for.

How will information be recorded?

The observations will be written down in note form and I may ask questions about what I see at the time I see it.

I will make my own notes about the care notes I read.

Will their data be kept confidential?

Yes all personal details and all notes taken whilst carrying out observations will be kept confidential. A pseudonym will be given at the beginning of the project to give you as much anonymity as possible. All paperwork will include this pseudondym and will not include the friend or relatives' real name or other identifying details. Whilst measures are taken to remove any personal identifiable information, when reading through the report there is a chance that you may be able to recognise the friend or relative you are personal consultee for

It is also important to mention that, if during observations it is felt that a person is being harmed, physically or psychologically, or exploited in anyway, confidentiality cannot be maintained. I have a duty of care to pass on this information to a relevant person/organisation giving full details.

Your contact details will be kept in order to get in touch with you but these will not be shared or passed on to anyone else. They will be kept in a locked cabinet at the University and on a university computer. Details kept on the university computer will be protected by a password so that only the researcher working on the project can access them. The data will be kept for 10 years in accordance with University of Southampton policy.

Thank you for taking the time to read this invitation to take part in this research project, and I hope to work with you soon!

This document is also available in large print and video.

Contact Information

If you have any questions feel free to contact me:

Ms Kellyn Lee

PhD Research Student

Doctoral Training Centre – Dementia Care

Health Sciences – University of Southampton

Kw1g15@soton.ac.uk

Tel: 079 404241 98

If you have any concerns in relation to this invitation now or in the future, or are unhappy with the research conduct of any member of staff/student from the Faculty of Health Sciences and would like to discuss the matter, please contact the Research Goverance Office in the first instance.

Their contact details are as follows:

Address: University of Southampton, Building 37, Highfield, Southampton, SO17 1BJ

Tel: +44 (0)23 8059 5058

Fax: +44 (0)23 8059 5781

Email: rgoinfo@soton.ac.uk

Exploring objects, people with memory problems and the perception of risk in care homes

Information for Nominated Consultee

An invitation to take part

A person whom you act on behalf as a nominated consultee has been invited to take part in a pilot study for a research project which will look at the type of belongings people bring into care homes from home. As a person living in a care home their thoughts and opinions are important. You have been given this participant information by either the adult services service manager or the registered manager because you are the nominated consultee of a person invited to take part in their research. Please take time to read through or listen to the following information to understand more about it. Talk to the person you act as a nominated consultee for and anyone else   about the project if you wish. Feel free to contact me if anything is not clear or if you have any questions or concerns about the person with memory problems taking part. Alternatively the adult services service manager or registered manager will contact you in seven days time to ask you if you would like more information. If you do, they will pass on your details to me and I will make contact with you.

What is a nominated consultee?

A nominated consultee is a person who is nominated by the researcher.

Who can be a nominated consultee?

A person who is a member of a care team or GP may be identified as nominated consultee providing there is no connection to the research project. The nominated consultee can also belong to a research-active trust, social care organisation. Local authorities or patient groups.

Who cannot be a nominated consultee?

The nominated consultee must have no connection to the project but must be willing to be consulted about the participation of a person assessed as lacking capacity in an approved research project.

Why am I being asked to be a nominated consultee?

The researcher would like to observe people who have been assessed as lacking capacity in this research project. This is to establish whether they have different objects or use objects differently to those who have capacity. You are being asked to give your opinion on behalf of the person you act for as a nominated consultee for in relation to whether you believe they would like to take part in this research project.

What do I have to do?

 For the purposes this study you will be asked to read this participant information sheet on behalf of the person you are acting for. You will have the opportunity to ask the researcher any questions in relation to the research project. You will then be asked to take into account the wishes and feelings of the person you are acting for before making giving your opinion as to whether you think they would like to take part in the research project. If you believe they would like to take part in the research you will be asked to sign the nominated consultee declaration form. It is also important to understand that you can change this opinion at any time and the person will be removed from the study. Equally if the person assessed as lacking capacity show signs of distress whilst taking part in this research they will be removed for the study and not re-enrolled.

What is this project about?

This project aims to explore the belongings people bring into care homes and the meaning these belongings have. It also aims to understand how decisions are made about what can and can not be brought into the care home and any risks associated with people having and using these belongings.

Who is organising the project?

The project is being organised by me, Kellyn Lee. I am a PhD student at the University of Southampton. I have a BSc (Hons) in Psychology and a Masters in Research Science. My Masters project looked at how informal carers of people with memory problems access information. I have also worked on two projects exploring creative arts for people with memory problems and the usefulness of carer groups for informal carers.

This research project is part of a Doctorate studentship at the Doctoral Training Centre based within the Health Sciences department at the University of Southampton.

Why do we need you?

We need you because you are willing to act as a nominated consultee for the person with memory problems. They are being asked to take part in this project because they live at Bickerley Green Care Home. I will spend some time at Bickerley Green. This means I will spend four hours each day, three days per week, for one month, taking part in daily activities, making notes and asking questions about what I see. I would like for us to take some photographs of the belongings that were brought into the care home. I would also like to look through the 'this is me' file which relates to the objects brought into the care home and things that are important to the person. I would also like to look at the daily care records the care staff write. This is to see whether anything is reported in relation to objects and how they are used.

Are there any benefits of taking part?

This is an opportunity to observe people assessed as lacking capacity who are often overlooked in research It is also an opportunity for the person to influence the design of the main research project as this pilot study will test the processes being considered. It is hoped that the information gathered project may help to provide materials for care homes and recommendations for the Care Quality Commission which may have an impact on future practice. A report will be written giving overall findings from the research and I will present this to you at an event at the end of this research project.

What if something goes wrong?

I do not anticipate any risks to anyone participating in the project. I will visit the care home and take part in daily activities and I may observe the person you are nominated consultee for. This can feel a little strange to start with, therefore every effort will be made to make sure they feel comfortable. If any uncomfort or distress is identified the person will be withdrawn with immediate effect and not re-enrolled.

Do they have to take part?

No, it is up to you. It is a personal choice and you should only agree if you believe the person you are acting as nominated consultee for would like to take part. If you agree for the person to take part but then change your mind that is okay too. You are free to withdraw that person from the

project at any time without giving a reason. If you decide to withdraw them from the research this will have no effect on their care.

What will happen next?

If you indicate to the adult services service manager or registered manager that you believe the person would like to take part your details will be passed to me and I will contact you. I will invite you to take part in the project, talk through the project and answer any questions you may have. If you still believe the person would like to take I will give you a nominated consultee declaration to sign. This confirms you understand the project, have had the ability to ask any questions, and are willing to give an opinion as a nominated consultee.

What will they need to do?

I would like to look through the persons' 'this is me' file and the care records which the staff write up daily. This is see what objects were brought in and whether objects are mentioned by staff. I would also like to observe them at times at Bickerley Green. I will spend one month in the home participating in daily activities to carry out observations. I will be observing the people who live, visit and work in the home and have given consent for me to do so. This does not mean that I will follow people around the care home. What this means is that I will be around the home and sometimes I may be in the same place as the person you act as nominated consultee for.

How will information be recorded?

The observations will be written down in note form and I may ask questions about what I see at the time I see it. I will make my own notes about the care notes I read.

Will their data be kept confidential?

Yes all personal details and all notes taken whilst carrying out observations will be kept confidential. A pseudonym will be given at the beginning of the project to give you as much anonymity as possible. All paperwork will include this pseudondym and will not include the persons' real name or other identifying details. Whilst measures are taken to remove any personal identifiable information, when reading through the report there is a chance that you may be able to recognise yourself the person you are nominated consultee for

It is also important to mention that, if during observations it is felt that a person is being harmed, physically or psychologically, or exploited in anyway, confidentiality cannot be maintained. I have a duty of care to pass on this information to a relevant person/organisation giving full details.

Your contact details will be kept in order to get in touch with you but these will not be shared or passed on to anyone else. They will be kept in a locked cabinet at the University and on a university computer. Details kept on the university computer will be protected by a password so that only the researcher working on the project can access them. The data will be kept for 10 years in accordance with University of Southampton policy.

Thank you for taking the time to read this invitation to take part in this research project, and I hope to work with you soon!

This document is also available in large print and video.

Contact Information

If you have any questions feel free to contact me:

Ms Kellyn Lee

PhD Research Student

Doctoral Training Centre – Dementia Care

Health Sciences – University of Southampton

Kw1g15@soton.ac.uk

Tel: 079 404241 98

If you have any concerns in relation to this invitation now or in the future, or are unhappy with the research conduct of any member of staff/student from the Faculty of Health Sciences and would like to discuss the matter, please contact the Research Goverance Office in the first instance.

Their contact details are as follows:

Address: University of Southampton, Building 37, Highfield, Southampton, SO17 1BJ

Tel: +44 (0)23 8059 5058

Fax: +44 (0)23 8059 5781

Email: rgoinfo@soton.ac.uk

Appendix 12 Framework matrix

A : Interviews	B : Safety	C : Decision Making	D : Taking action	E : Control
	we've had a resident here who's got hair removal cream, as long as we stay with her. For them, that they wouldn't know where it was, but if they said they wanted to do their hair, the carers are quite happy here to let them, they would stay there, supervising them while they did their hair anyway. I: Okay. P: So they do get that option anyway. I: Yeah, but they can't just. P: They can't just take it down. I: They can't do it at their own leisure, it has to be assisted. P: No, it has to be, yeah. We've had erm chairs that they've brought in and that are	we try to give them choices at times, but sometimes you put two outfits up in front of them, sometimes they don't even want to choose, so you do try to give choices and that, So do the residents ever get to go back to their property and choose the things that they want to choose? P: No, usually it's the families. I: Is there any reason why that doesn't ever happen? P: Erm we have done it for a couple of residents, when we've gone back to their home for them to get erm some belongings, but [pause] usually the family members have taken over and unfortunately some of them dump stuff before even letting the residents look at what's left and things like that. But I wouldn't say,	We try to say to them it would make it, that adjustment to their lives would be, it's a lot easier process if they can walk in a bedroom and see familiar surroundings, it's easier for them to feel like right, this feels quite homey, but when they come into a bedroom that there's not much, there's not much there, it's, it just feels like an empty, cold room, and they, it, unfortunately to me, a person feels like oh they've just left a hospital bed to come into another room that is like a hospital room. And you try to	For them, that they wouldn't know where it was, but if they said they wanted to do their hair, the carers are quite happy here to let them, they would stay there, supervising them while they did their hair anyway. I: Okay. P: So they do get that option anyway. I: Yeah, but they can't just. P: They can't just take it down. I: They can't do it at their own leisure, it has to be assisted. P: No, it has to be, yeah. we've never actually had anyone that has brought something in that we need to take away, apart from probably

quite not great and things like that, [pause] but then we try to make it, this lady has just brought in a new chair, erm but it's so unsafe for the resident, so she couldn't sit on it, so we've made it, so we've put all her teddies and her cuddly toys on it. Sometimes it makes them worried or [pause] if they've got a landline they would then phone in the middle of the night, so they don't want to be disturbed if there's no need to be disturbed. Nothing wrong with that; that is what the care is set up for. But, so for you, it was important to you to be able to do the polishing, to be able to do the Hoovering, to be able to for a walk, to do these things, so you're not just	no, not really, they never get erm, some, like we've got a couple upstairs that will say what they want being brought back and the family members have been really good and gone and brought them straight back, but [pause] we've had residents which we've just had come in, who I've asked the families numerous of times to please bring in some stuff, some belongings, so we can sit down, if that resident's feeling low, we can look at them photos with her and she can tell us her life history, and it's they still haven't brought the stuff in, so we've tried to make it feel homely with some pictures that we have brought in, so it feels more like a home than just a bedroom, but yeah, or they bring in a few bits of clothes, but not have their favourite tops, so it is quite erm upsetting when they don't get what they want.	explain that to the families, but they don't understand that for what those, what benefits with photos around the room would make for that resident and that. Because they think even though they've got dementia they feel oh they won't, they don't need that, they won't sit and look at them pictures. What they, what they like, erm what's their favourite stuff and things like that, if they like butterflies we find them some butterfly stuff, to make it feel, but unfortunately not the photos or their favourite	scissors, yeah scissors I've had to take away recently, because erm [pause] the resident was cutting up all her clothes, doing alterations and then she was wondering why she had no clothes left. But that's probably it, or just mainly like if they brought nail varnish remover or nail polish and things like that, we would probably take them away, but then brought out and supervised anyway, but they're probably the only things that we have taken away. I know some have come in with mobile phones, so if they wanted to phone their families, but a lot of the families don't want them to have

sat there passively accepting care, actually you want to do stuff for yourself. So you also mentioned a kettle, so somebody picking up a kettle, so you have to get them to put it down because there's potentially the risk of.
P: Yeah, burning themselves or, yeah.

We do try. There's a few residents down here, erm who do want to do more stuff for themselves, so we try to erm, we get them to set the tables, erm if we're, if we're making the teas in the afternoon, then we get them to hand the cakes out, so they feel part of it. Erm we get them to put the menus out so they're doing stuff. Erm if they want to, if we're cleaning up after lunch, then we get them to wipe

And when they bring in families, lovely they do, they'll bring in flowers and you think that's not what they want. Like erm sometimes we do get asked by residents family's on their birthdays and that, what do they bring, and some of them do do it, we're like, we say photo albums, they don't need flowers or chocolates, we can get that if, because sometimes they're just sat on the side for months and they don't really want it anyway, they've lost the appetite for chocolate, so we're like bring them things that remind them of their old memories, maybe their old school they went to, maybe you could find like some information on the internet, and we can make a scrap book for them. Some have done it, but some families, no.

Who has the final say about what comes in, so say

teddy's or things that is them.
I: Yeah.
P: Sometimes we don't get that, it is a bit.
I: And it's not something that you can.
P: No, you can't replace them.

And when they bring in families, lovely they do, they'll bring in flowers and you think that's not what they want. Like erm sometimes we do get asked by residents family's on their birthdays and that, what do they bring, and some of them do do it, we're like, we say photo albums, they don't need flowers or chocolates, we can get that if, because sometimes they're just

telephones.
I can't, obviously animals, we like animals to visit, we'll never stop, if they have a pet or anything, them to visit, erm [pause] but majority of it, we wouldn't erm, we wouldn't necessarily say no to, we might say, like I said to you, like scissors or [pause] things that could cause them harm, we would then probably put them higher up anyway so they can't just get to them unsupervised, but we would never really stop them bringing anything in that they want; that wouldn't benefit them at all.

maybe like in the kitchen, when they've been in our kitchenettes

	the mats down and they can put it away and everything. I think it would be a good idea for more to do it, but then you also have the other residents that [pause] you have stop and because they see someone else doing it and then they think they can do it, but then some incidents happen were they've burnt themselves by trying to do it or [pause] then they start fighting over the job, because they both want to do it, so I think it's beneficial to get residents to do more for themselves, out of their bedrooms and everything, and it makes it feel more home, because at the minute it is like a hotel for them, they get up, they have their breakfast, their tea and then they go off again.	somebody wants to bring something in, who decides? P: It depends what it is.

Erm say if it's erm electrical or anything, then obviously Elaine, we will have to ask Elaine, but usually, generally the families', it's whatever, but usually ourselves would say, yes or not, but.

We are quite happy anyway, whenever they bring something in, because it's not just that resident that enjoys it, it's all the residents that erm like to look at it as well.

So we give them the choice, we the families, if you want them to have a landline that's fine, we have a phone that we can take round to them, which I was doing yesterday, I was taking round to some residents so they could phone their families, but a lot of the families they say don't always to get phone calls and that from them. | sat on the side for months and they don't really want it anyway, they've lost the appetite for chocolate, so we're like bring them things that remind them of their old memories, maybe their old school they went to, maybe you could find like some information on the internet, and we can make a scrap book for them. Some have done it, but some families, no.

If she's feeling unwell or stuff, we bring pictures out, like photos so they're surrounding her and that.

It would be, we just do like a list. Erm obviously we do their | where they've maybe picked up the kettle and we're like right that's, it's got hot water in that we've had to be like calm them down to take it off

We do try. There's a few residents down here, erm who do want to do more stuff for themselves, so we try to erm, we get them to set the tables, erm if we're, if we're making the teas in the afternoon, then we get them to hand the cakes out, so they feel part of it. Erm we get them to put the menus out so they're doing stuff. Erm if they want to, if we're cleaning up after lunch, then we get them to wipe the mats down and they can put it away and everything. I |

Yeah, yeah, they do, but the families, we do talk to the families, and we do let the residents know, and none of them seem to be bothered anyway, they are quite happy, erm it's not upsetting the family, that it's not upsetting the resident anyway, that they're losing chocolate, or we tend to, a lot of us staff anyway, if we're at the shop, we bring in chocolate anyway, we're not really bothered if, how much it costs. I: So you say staff would actually go out and buy stuff for residents? P: Yeah, we all do personal, I know we shouldn't, but it's just if it's their last bit of chocolate and that, if that's what they want and they haven't got the money, we're not going to be. I: No.	I usually phone the family. If a resident has ever asked for something and the carers come and say oh she's asking for this, I phone the family, erm I document I've asked the family for this specific item. Sometimes, the majority of time we don't get it. Erm if they are really getting, if they are adamant they want this object, we do try and get it for them, we'll just go up the shop and grab them one. Erm and the family wouldn't buy her one because they think it's a stupid idea, so that's probably the only time that we've really had any concerns I personally don't think we are, no. I was just looking at objects like to make their bedroom nice and everything like that, but now you've said that, [pause] no we don't, we don't	history, about their children and what jobs they had, how long they've been married, where they met their husband, if they had any pets, where they lived; their like unit before they came here. And then we do like a thing of what they enjoy doing, to say here, like what's important, so he loves to listen to music and then what sort of music do they like to listen to, and then what they like watching on telly, the activities they like doing, if they like writing letters, if that's important to them, then we would make sure they've got the paper, the	think it would be a good idea for more to do it, but then you also have the other residents that [pause] you have stop and because they see someone else doing it and then they think they can do it, but then some incidents happen were they've burnt themselves by trying to do it or [pause] then they start fighting over the job, because they both want to do it, so I think it's beneficial to get residents to do more for themselves, out of their bedrooms and everything, and it makes it feel more home, because at the minute it is like a hotel for them, they get up, they have their breakfast, their tea and then they go off again.

251

P: And some of the family aren't supportive.
I: Yeah.
P: So it's only like a pound, it's not going to break the bank balance, so.

Erm if the families are still not bringing in any belongings, quite a lot of the carers will take them up the High Street, let them pick up some homey stuff. If they haven't got it up the High Street, the carers are quite good, they'll let us know, or they will, they'll go up the shop and see what they can find.

Yeah, what they have brought in and everything. Erm because they're not labelled the majority of the time. IF they do go missing while they're here, then we're obviously liable, that it's gone missing for them, we will try and find it and if the

erm, we don't give them the options of being able to, but then I would say we don't get told that bit either.

You have made me look at it different, and especially when I'd go out and do assessments and things like that. Maybe I will look more round the house to see what they enjoy, to see what they do and everything, because like you say I ask the family members, but they might not always know what they get up to and everything and.

we try to see that and we, some families are really hard to talk to, like we try to communicate and see, to get, like whenever we have a resident who is coming in for admission, when we go out and do an assessment, we try and say ideally please could you bring in photos, erm tell us a bit of what that resident, what she's like or he's like, so we know, so we can

envelopes, and then we'd make sure we go and post the letters for them. If they like to speak to their family, we always make sure they can keep in contact with them.

If they didn't, and then we'd do it like erm [pause], say if she didn't like, if it was me, if I had a personal care, it would there, it would be highlighted do not put her in a dress or a skirt, as it does make her upset, it's not what she enjoys, likes to wear. We would put it in there, as we have live, we have residents that have dentures, we have it highlighted in there, they're always saying that they

Like here they're a bit higher stage. So there we had, we had a kitchen that we tried to get the residents to go and do stuff for themselves, like we had a kettle, erm cups and everything, with the tea, coffee, sugar, all placed out for them, so they could do it themselves. And we had like little baskets where they could pick up crisps, biscuits. But then they wouldn't do it themselves, they were like, a lot of them were like no, I'm paying your wages so you can make it for us, so.

I personally, the dementia isn't as high down here, so a lot of the times [pause] we can something to them, like if they say oh we're hungry,

families, or she loses, or she's not got any family, we would then replace it.

We will, no, the care home would replace it.

If that's broken, say if I, if I put, if I have broken a photo frame I wouldn't say to the home, I would just go and get one anyway, because you can buy them so cheap anyway, and I would, if I do, if anyone has broken anything, we do let the family know, unfortunately we've broken it, apologies, and we will try and replace it. Some of the, a lot of the families are like oh no, don't worry, it's fine, but we do, we do try to replace it for them, because I know the families might think oh it's just an old windmill, but it could mean something to

give the staff what they need to know about that resident and everything, but half the time a lot of the family don't, they sort of, we know it's difficult at home, they're having their own challenges and everything, so for them, they might only see it as a little issue, so they're not really bothered

So are you aware, so when someone moves into a care home, are you aware of the process of by which belongings come in or?
P: Yeah, it varies.
I: It varies.
P: It, with different families it varies. Some families are really good; they'll get the bedroom setup before the resident even arrives.

AUMs, well the care staff would ask you and we'd either be yeah that's fine, or not really a great idea.
I: Okay.
P: Or yeah we would bring it in but we would have to take it out of the

don't like them, so why make them wear them, if they don't feel comfortable, erm if they've got lovely long hair, some carers would love to play with it and put them up, but if they don't want to have their hair up, we have that, we will put it in there, this is the way they like to look, she likes red nails, she likes to have red put on her nails. We try to make it, that it is that person-centred and everything.

I do think it's important that they have their belongings here. I think it's important that it's here before they come here as well. A lot is happening, a lot of changes, and

we could say oh go and help yourself you know, you know where everything is, but up there, yeah there is a few that would be able to understand what we're saying that they can do, but there is others that they know then or [pause] the ones up there, we've got residents that don't stop eating; they will just eat and eat and don't think they've eaten, so then we do have to restrict them.

So yeah I suppose we are restricting them from what they would do at home.

the resident anyway, so we do try to [pause] set something and replace it for them.

we try to ask family members and that if, what do they feel comfortable and that, and it is, sometimes we have residents here that have been here for a few months before the family say, we'll say oh she looks really pretty today, and they go, oh that's, she never wore skirts at home, and you feel like oh well, we've just taken that bit from them that was them, and put them how we think they should look, which yeah, really isn't person-centred, it is just, unfortunately we all see them as wear a nice cardigan, and they have the skirts that flow out and that, and that is majority of what they all wear

bedroom and just bring it out when it's supervised or something, but generally everything is fine to bring in anyway.

Yeah, we have erm, there's quite a few residents families that still do that.
I: Yeah.
P: They bring bits, odd bits here and there where they've just found up in the loft and that and thought I'll bring it in.
I: Yeah.
P: Which are quite nice

Yeah, we are happy whenever they bring anything in for them.

Obviously photos, quite a lot do bring in photos, but you'd be surprised some don't ever. Unfortunately yeah, obviously clothing is, they always bring clothing in. Some bring in chairs, but [pause] a lot of the family don't bring in that much really.

A lot of the ladies, they get teddies brought in, from their childhood,

to come here, to walk into here you feel, as much as you try to like you say make it feel like home, it is like a prison, and lot of them see care homes on telly, and they relate to it as that's it, this is it, this is where my last days are going to be, so for them to walk up to a bedroom that is just empty, with nothing that belongs to them, and it just is an empty room, you've got all these staff saying hello to you, oh I'm this and that, it's scary.
And you want home comforts. It's like if you go on holiday, when your holiday's done you are looking forward to going home and having your home

	and we all put them in that category that that's what they should look like, but yeah. We do try to, [pause] we try to get them, if they're capable, so they can make themselves a cup of tea, we would let them do it anyway, if they want a biscuit they can help themselves and that, we would never stop them doing that here anyway, but obviously there's some with dementia that wouldn't be able to say that's a cup of tea, wouldn't know that's a hot cup of tea, to be careful and that, so we do have to be careful with the kettle and that here, but if there was the jobs I could do, I'd be happy.	erm [pause] favourite perfumes. Obviously there's usually picture of the husband or the wife that always get brought in. But that's probably mostly it. They don't usually bring much more in that that, even though we do ask. We do, obviously we do have bedrooms here that they have made it look lovely, where they've brought in a rug, made it feel like home, but a lot of the family don't [pause] bring anything in. Yeah, no, see erm [pause], no there's one, actually there was one lady, she's in hospital at the minute, she brought in like a bicycle, the electrical bike, but just the foot one. And I was like oh okay we've never actually been asked for anyone to bring, no-one's ever brought that in, but she does it, she does it every day, she'll sit there doing her little bike ride and that in the mornings to keep	comforts, your own bed. Because you walk into your room and you feel you've got home comforts, you can feel like you can get into your own quilt and you've got your familiar smells. You don't feel so alone; you know someone has put that there for you so you don't feel like oh no-one cares, like if you walk into a room that's empty, you feel no-one's bothered, they just, my family have just dumped me here, they're not bothered what I want, but if you walk into a bedroom that's go erm your home, you're pictures of your family, you think oh	

		her legs going and that, so that's probably the most. When I started care, it used to be when people would say to bring dolls in and I was like why are they bringing in dolls, and then they'd obviously cradle it like it is a baby, but now it's just normal, so I don't [pause] think anything of it, but that's probably it.	they are thinking of me, they know that's what I would have wanted. I feel personally if erm I, say I went into the dining room and I'd think ah, I feel a little bit low, I could do with someone bringing out maybe one of my old knitted jumpers or something, or a picture, I personally would hope that a carer would listen to me, and then go and grab that item for me, so I could look at it or cuddle it. But then I could always walk back to my room. Like quite a lot of them say oh where's my room, and then they go to their bedrooms, they get their stuff and they put	

			some stuff on their trolley and they can take it up to the lounge. So I think I would be alright with that, if I had a safe place to go. As long as I know that if I am coming to the dining room I can go back and I know I've got my safe place, so I've got my home comforts, it's only down the corridor, I don't have to worry. I think that's, that is the key, that is important to the residents. So you're very much seeing objects as being comforters. P: Yeah. I: As being something that you know keeps you calm, makes you feel safe, I don't know, is that some of them?	

| | | | P: That's the way they feel, that is how residents feel, it's their home comforts, and it makes them know that their family still care.

It has erm, photo albums, where we can, we can sit there and have half an hour with that resident and we can go through all their pictures and let them talk. We don't really have to say much, but you can see the smile on their face, for us actually taking that time to hear about their life history and everything.

a necklace has been important to a resident, where it stays on their, like a little locket | |
|---|---|---|---|---|
| | | 258 | | |

| | | | | and it's got pictures of her children in there; that's important. And a lot of it is jewellery that we know is important. It could be erm just a cheap watch, we see it, we know it's a cheap watch, but to them, it means everything has the husband brought it in the war or something and it might not even work, but they don't take it off.

I personally don't think we are, no. I was just looking at objects like to make their bedroom nice and everything like that, but now you've said that, [pause] no we don't, we don't erm, we don't give them the options of | |
|---|---|---|---|---|---|

			being able to, but then I would say we don't get told that bit either. We do try to, [pause] we try to get them, if they're capable, so they can make themselves a cup of tea, we would let them do it anyway, if they want a biscuit they can help themselves and that, we would never stop them doing that here anyway, but obviously there's some with dementia that wouldn't be able to say that's a cup of tea, wouldn't know that's a hot cup of tea, to be careful and that, so we do have to be careful with the kettle and that here, but if there was the	

			jobs I could do, I'd be happy.	
		261	We have had residents go up to the domestics, they'll pick up a bottle and then say oh no that's mine, you can't have it, that's mine, and obviously we see what they're going to do with it and	