A QUALITATIVE STUDY OF SLEEP AND THE NIGHT-TIME IN CARE HOMES FOR OLDER PEOPLE

THERESA ELLMERS

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Department of Sociology
University of Surrey

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ABSTRACT

Sleep is an essential contributor to health, well-being and quality of life. This thesis explores sleep and the night-time in care homes for older people. To date there has been a lack of qualitative research to explore what happens in a care home throughout the night and further our understanding of care home residents' experiences of sleep and the night-time. Forming part of the New Dynamics of Ageing funded Sleep in Ageing project, (www.somnia.surrey.ac.uk) the study aims to explore this previously under-researched area using qualitative methodology including interviews with 38 care home residents and 39 staff, together with observations in each home.

The research findings from this study identify aspects of the social and physical environment of a care home which influence the experience of the night-time and the quality of residents' sleep, as perceived by both staff and residents. In particular, residents expressed difficulties exerting control over their sleep environment and lacked strategies and support to do this. Personal control over sleeping routines and bedroom privacy was found to be related to levels of physical and cognitive ability. The dominance in care homes of a risk-averse culture which focuses on the ageing body as the centre of risk, and organisational routines during the night-time, facilitated an environment where disturbed sleep becomes a normal part of the sleep experience and an accepted consequence of night-time care. This thesis concludes that the current model of 'care' within care homes is unable to provide individualised support to care home residents that makes possible choice and control over the night time sleep environment, and which does not contribute to the promotion of good quality sleep.
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INTRODUCTION

1.1 Background to the study

Sleep is an essential contributor to health, well-being and quality of life. Our sleep patterns are likely to change at different stages of the life course, and be affected by the social context of our lives. This thesis aims to explore the experience of sleep in the later stages of the life course in the setting of a care home for older people. It is the aim of this study to explore the nighttime experiences of people in care homes and contribute to improving practice around the sleep environments for older people living in residential care settings.

The research forms part of a wider project on Sleep in Ageing\(^1\) (SomnIA) funded by a consortium of research councils under the New Dynamics of Ageing programme. Good sleep in later life reduces the risk of falls and depression and is important for maintaining activity and performance levels. The SomnIA project aims to address practice and policy relevant issues arising from the nature, impact and management of the sleep-wake balance in later life in order to understand and improve sleep, and therefore quality of life for people living in the community and in care homes. SomnIA is a large, multi-disciplinary collaborative research project between the universities of Surrey, Bath, Loughborough and Kings College, London. The project brings together the disciplines of sociology, psychology, neuroendocrinology, engineering, nursing, medicine and has consultants in health economics and medical statistics. There are also five non-academic partners in the study, including Phillips Lighting, North Nottinghamshire Healthcare Trust, Healthtalkonline (formerly DiPEx, University of Oxford), The Relatives and Residents Association and Age UK. Within this wider project, the research for this thesis is located in a multi-method work package that researched sleep in care homes for older people.

\(^1\) Funding was received from the New Dynamics of Ageing Initiative, a multidisciplinary research programme supported by AHRC, BBSRC, EPSRC, ESRC and MRC (RES-339-25-0009).
1.2 Context of the study

According to the Office for National Statistics (ONS) (2010), the percentage of the population aged 65 and over has, over the last 25 years, risen slightly from 15 per cent in 1983 to 16 per cent in 2009, an increase of 1.5 million people. The fastest population growth has been in the number of people aged 85 and over, with numbers more than doubling since 1983 to reach 1.3 million in 2008. This is significant as people aged 85 and over are most likely to receive some sort of care, including living in a care home. The growth in the size of the older population has been driven mostly by increases in life expectancy, although the extra years are not necessarily in good health (ONS, 2010). The market survey produced by Lang & Buisson (2007) reported the number of older people living in care homes was 420,000 in 2007, and this is projected to rise to a population of 444,000 by 2017.

While ‘residential care homes’ and ‘nursing homes’ have had a distinct historical development, these titles were brought together under the term ‘care homes’ as a result of the Care Standards Act 2000 (Peace, 2003) which defined ‘care home’ as an establishment which provides accommodation, together with nursing or personal care (Standard 3 Care Standards Act, 2000). There are approximately 15,700 private, voluntary and Local Authority care homes in the United Kingdom (Office of Fair Trading, 2005). Many of these are privately owned however all care homes are subject to government regulation. Government regulations set out the minimum standards for all care homes and determine the level of public funding available for care (Office of Fair Trading, 2005). The minimum standards were previously outlined in the Care Standards Act (2000) and the National Minimum Standards for Care Homes for Older People (Department of Health, 2001b) and were monitored by the Commission for Social Care Inspection. However the Health and Social Care Act 2008 established the Care Quality Commission (CQC) as a single, integrated regulator for health and adult social care services. Currently, care homes in England adhere to

Current health and social care policy prioritises supporting people to remain in their own homes and this has potentially had an impact on the care home population. The resident population in care homes is ageing and becoming increasingly frail (Campbell Stern et al, 1993; Bowman et al, 2004) with many people having complex disabilities and illnesses (Bebbington et al, 2001). As there are increasing disability and health problems within the care home population, residents will have an increased need for support with personal care, such as going to the toilet, dressing and eating, in addition to health care needs. These factors affect experiences in a care home as they influence what an individual resident is able to do and how they interact with their social and physical environment. These factors will also have an impact on the care home resources and organisation structure.

In addition to the health and practical support needs of the care home population, moving into a care home is a significant event in a person’s life which may have emotional and psychological consequences, as well as practical and financial implications.

*For most older people, moving into a care home is usually a lasting decision taken under very difficult circumstances. They may often be in poor physical or mental health, under pressure to make a decision quickly, and typically have little previous experience of choosing a care home. In this situation, even with help from friends and relatives, it can be difficult to make a considered decision on care. Yet entering a care home is a major decision that will have an on-going effect on the older person’s daily quality of life; and for some older people and their families, it will require a large financial commitment.* (Office of Fair Trading, 2005: 1)

The people who live in care homes that took part in this research were often at difficult junctions in their lives, where they may be experiencing ill health or disability and may have recently had to leave family, homes and partners. Although the language of 'dependency' and 'frailty' will be used throughout
this thesis, it should be acknowledged that many of the care home residents that took part in this research were engaged and enthusiastic about the research and hoped to contribute to furthering knowledge through sharing their experiences.

In reviewing figures, legislation and policy, as this introduction and the following two literature review chapters will do, there is the potential to lose sight of a basic fact – care homes are where people live. Care homes are where people spend their days and nights and probably where a significant minority of older people will live for many years. The implications are easily overlooked when considering policy and even practice issues. However care homes have the potential to provide valuable support to older people who have chosen to move into a residential or nursing care setting.

By providing security, company, warmth, regular food and assistance with daily tasks as necessary, a caring and well-run home provides a vital service, both for older people themselves and for their relatives. Such a home offers frail and vulnerable older people a safe and supportive place to live, allowing them to continue their life without being dependent on relatives or friends for their care. (Office of Fair Trading, 2005:2)

The concept of a ‘well-run’ home implicitly includes that most valuable resource in social care, the staff, who are at the front line of service delivery and spend their working days and nights providing support to the older people live there. The research for this thesis involved interviewing staff but also spending time with them as they went about their work. The staff in care homes are a valuable source of knowledge about the residents, work and culture of a care home. Therefore, including their perspectives in this research study will contribute to a broader understanding of the night in care homes and of the sleep of older people who live there.

Reduced sleep quality can be experienced as a normal part of ageing. Additionally, quantitative studies of sleep demonstrate that sleep quality in residential care and nursing settings is reduced. As such, sleep quality may be affected by the environment of a residential care setting, yet there is little
qualitative research that addresses this aspect. Further to this, in most previous qualitative research on care homes, matters relating to the night time or sleep have been paid little attention. This qualitative study of sleep in care homes aims to address this gap. By taking the opportunity to study care homes during the night, this will provide an opportunity to examine hidden aspects of power and interactions between staff and residents in what is ordinarily a closed environment.

1.3 Thesis aims

This thesis is a qualitative study of sleep and the night-time in care homes. The specific aims for this PhD study were as follows:

- to explore the subjective experience of sleep and the night-time in the setting of care homes for older people and to contribute to improving practice in this area;
- to explore the attitudes and perceptions of staff in relation to the sleep of older people in care homes;
- to understand sleep as part of the 24 hour provision of care by not viewing it in isolation, but in its wider social context within the care home;
- to identify features of care home life that are perceived to impact on sleep quality and the sleep environment of the residents.

The research findings are based on interpretation of observations undertaken in the care homes and of interviews with the women and men living and working in care homes for older people.

1.4 Structure of the thesis

Chapters 2 and 3 set out the theoretical, empirical and social policy background to the research. Chapter 2 focuses on the literature relating care homes and sleep, including discussion of the care home as an 'institution' as identified through the history of care home research and the potential impact of the emerging theme of care home routines. The quality
of sleep in residential care and nursing homes is discussed, and the developing sociological literature on sleep. This chapter identifies that residents commonly have reduced sleep quality and establishes the need to recognise sleep in its social context. Chapter 3 considers the recent trends in social care for older people and situated within a policy context and the broader system of adult social care. In considering the implications for those people living and working in care homes, the chapter explores the emerging themes of risk, choice and control, and relates this to the concept of the 'ageing body'. It establishes a key question of whether the principles of choice and control exist within the night-time environment of a care home. Ageing bodies are seen by professionals as central to the risks faced by older people, and therefore identifies the importance of exploring the impact of 'risk' at night in a care home.

Chapter 4 provides an overview of the research aims within the context of the wider research project, Sleep in Ageing (SomnIA). The research methods are set out, including a discussion of ethical aspects such as informed consent, anonymity and confidentiality. The specific challenges of researching in a care home setting are discussed which include aspects of researching with social care staff in their work environment. Particular attention is paid to the issues of researching with older people in care homes who may be physically frail or have cognitive impairments. The value of participant observation in this setting is explored, acknowledging the blurred boundaries of public and private space and the dilemmas this may present for a researcher.

The next four chapters consider analysis from the data collected. While all data sets contributed to the final analysis, and in particular the observations would have contributed to the emergent overall picture, some chapters focus on particular perspectives. Chapter 5 explores sleep in a care home environment from the perspective of the staff using the staff interview data. Rather than focusing exclusively on the night, the aim is to explore sleep across the 24 hour period and examine the general routines and procedures in care homes within which the residents carry out their daily lives and staff carry out their work. The staff perspective of sleep disruption within the
home is explored and the role of staff overnight. The lack of stimulation during the day, and daytime sleeping, is identified by staff as having a potential effect on night-time sleep and the quality of life within the home. Assumptions about sleep in later life may normalise lower expectations by staff of the quality of sleep attainable in later life. Chapter 6 focuses specifically on the perspective of the residents who have been interviewed about their sleep. Despite reporting sleep disruption, residents did not necessarily view their sleep as being 'poor'. The chapter discusses the sleep experience of the residents as a result of the embodied experience of ageing, focusing on the emergent themes of pain/discomfort, continence and disability, and considers the limited methods that residents have to manage wakeful periods during the night.

Chapter 7 explores findings from the research which give an indication of the extent to which residents are able to choose their own routines of daily living, signified by when they go to bed and get up. This was a theme that emerged strongly from interview data with residents, staff and also through observational data collected in the homes. The chapter discusses how residents, rather than experiencing choice and control, have to compromise their sleep preferences and adapt to the unique sleep environment of a care home. This is indicative of a hierarchical relationship with care home staff who were unable, or sometimes unwilling, to meet individual preferences and support residents’ choices which did not fit in with existing care home routines.

Using data from staff interviews, residents interviews and observations, Chapter 8 considers the theme of risk in relation to the night-time and sleep within the care home. The chapter discusses the ageing body as constructed as a potential hazard even before moving into a care home and the tensions created for staff who are employing risk averse practice which may impact on the sleep quality of residents. It is contended that the resulting practices, however, do not always minimise the likelihood of accidents happening, but are a response to the risk that care homes have in protecting themselves against allegations of negligence or poor standards of care. Staff therefore prioritise risk management over sleep quality and the choices of residents.
Building on theoretical developments and empirical sociological research of sleep, Chapter 9 will discuss the status of 'sleep' and 'sleeper' in a care home. It is proposed that the approach to delivering care which runs to timetables, instead of individual choices, does not provide an environment that promotes good quality sleep. It is argued that to improve the experience and quality of 'sleep' in care homes requires more than alterations to night-time practices but a shift in the culture of care within residential settings for older people, with increased focus on maintaining independence and control.

Chapter 10 summarises the main findings of the research, considering the relevance of the study to both an understanding of the nature of sleep and the night-time within a care home, and considers the theoretical and policy implications. Suggestions for improved practice within care homes are considered with the potential to improve care during the night-time which may improve not only sleep but also the quality of life for residents.
Chapter 2
CARE HOMES, SLEEP AND THE NIGHT-TIME

2.1 Introduction

The history of care home research has been shaped by early studies that viewed care homes as institutions which, through their practices, had profound impacts on those that lived and worked in them. It is relevant to review and discuss this body of literature in order to understand its significance to contemporary care home life and research. Care home routines have been shown to have the potential to affect all aspects of a person's life. The previous research studies demonstrate the incursion of organisational structures and routines into the personal routines of the individual care home resident, however the focus of these studies has not been specifically on sleep. Although sleep changes as we get older, quantitative studies of sleep provide evidence that sleep quality in residential care and nursing settings is reduced yet there is little sociological research that explores this area.

2.2 The care home as an 'institution'

Goffman's *Asylums* (1961), and in particular his analysis of the characteristics of 'total institutions', has had a key influence on care home research. 'Total institutions' were described as "a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered way of life" (1961: 11). In proposing the attributes of total institutions, Goffman acknowledged that institutions may possess some or all of these attributes in varying degrees of intensity:

First, all aspects of life are conducted in the same place and under the same single authority. Second, each phase of the member's daily activity is carried on in the immediate company of a large batch of others, all of whom are treated alike and required to do the same thing together. Third, all phases of the day's activities are tightly scheduled, with one activity leading at a prearranged time into the next, the whole..."
sequence of activities being imposed from above by a system of explicit formal rulings and a body of officials. Finally, the various enforced activities are brought together into a single rational plan purportedly designed to fulfill the official aims of the institution.

(Goffman, 1961: 17)

In Asylums, Goffman studied the psychiatric hospital and the prison in his exploration of the effects of institutionalisation as undermining the sense of self and identity. Goffman focused on the situation of those living within the institution and the aspects of institutions that control them or shape their behavior, rather than focusing on those who worked there.

Foucault also considered the impact of institutions in society and on the individual. In Discipline and Punish, as a model for the way institutions function, he utilised the image of the Panopticon as a mechanism which “automatizes and disindividualizes power”, identifying power as pervasive and anonymous (Foucault, 1977:201). The ‘body’, a product of the discourses which constitute it, emerges as a site of control through surveillance, regulation and disciplining, producing ‘docile bodies’ (Foucault, 1977). Twigg has noted that Foucauldian themes of power, knowledge and the body are relevant to the study of social care and that care workers, including those in residential homes, “exercise disciplinary power, ordering and managing bodies” (2000: 180).

Following Goffman’s work, research in care homes and long-term nursing facilities has examined the nature of the total institution approach to care and the impact on the people who work and who live in these places. Townsend’s seminal study The Last Refuge (1962) investigated 173 public, voluntary and private residential institutions for older people, which he felt was a topic that had been neglected for too long. The research included data from surveys and interviews with chief officers, managers and residents as well as observational data in care homes. Framing his analysis as a critique of social policy and values within modern society, Townsend concluded that these institutions did not “adequately meet the physical, psychological and social needs of the elderly people living in them” (1964:222).
Influenced by Goffman, Townsend's study is considered to be "one of the finest critiques of institutions ever written" (Walker, 2009: 1009) and Townsend's findings highlight the potential effects of institutional regimes upon people who live in them, concluding:

_We found that they experience loss of occupation, isolation from family, friends and community, difficulty in forming more than tenuous relationships with members of the staff and other residents, loneliness, loss of privacy and identity and collapse of powers of self-determination. These experiences vary in severity from one type of home to another but seem to exist in some measure everywhere._ (Townsend, 1962: 226)

Townsend, however, was not predominantly concerned with issues of practice but with residential care as an aspect of social policy which contributed to a perpetuation of dependency-creating social structures (Peace et al., 1997). In subsequent work, Townsend questioned society's acceptance of "the existence of contemporary and social institutions as inevitable and necessary" (Townsend, 1981: 8). _The Last Refuge_ also sought to bring out the voice of those people living in residential care, adapting the research methods as the researchers went along so as not to exclude people with physical and cognitive disabilities.

Johnson et al. (2010) revisited Townsend's study, aiming to trace the history of the original 173 homes which took part in the research and undertaking follow up studies in 20 care homes, a sample of the 39 care homes which were still in existence. Overall the authors conclude that quality of care "has improved substantially, particularly in the physical facilities available to staff and residents" (Johnson et al., 2010: 208) although they note that there were still many institutional features in care homes.

The scale of the Townsend study can be contrasted with _Living and Dying at Murray Manor_ (Gubrium, 1975), a classic text analysing one American nursing home as an institution. Gubrium (1975) spent several months as a participant-observer in one large care home and his study highlights the value of in-depth, qualitative research in contributing to understanding the daily life for older people living in a residential care environment and the people who work there. Gubrium (1975) likened the regularity of the routines
in U.S. nursing homes to those in other institutions such as prisons or psychiatric hospitals, but noted how the older people in nursing homes were perceived differently:

The regularity of clientele life in nursing homes is similar to that of clientele in other total institutions such as prisons and mental hospitals. In each, staff is actively involved in scheduling daily living. However scheduling is not the same as accomplishing. In many total institutions with internal clientele and staffs, clientele are believed capable of accomplishing scheduled routines, but this is not so in nursing homes. (Gubrium, 1975: 124).

This comment underlines the nature of some of the work in care homes whereby many residents require the assistance of staff for personal care acts such as eating or going to the toilet. Studies have documented how residents can appear to become “bed-and-body work” to staff (Gubrium, 1975). Lee-Treweek’s (1994, 1996) accounts show how workers try and adhere to tight time constraints in the “back” bedrooms of the home to produce what she termed the “lounge standard” resident. The consequences of “bed-and-body work” (Gubrium, 1975) and “routine work” (Paterniti, 2000) are said to contribute to the erasing of the identities of the residents “so that their separate biographies become the common story of the one-dimensional subject to whom nursing services are provided” (Paterniti, 2003: 58). However Paterniti (2003) argues that this perspective can be altered through prioritising the identity claims of the individual residents in the care home.

Diamond’s (1992) qualitative study of the day-to-day experiences of nursing assistants working in an American nursing home highlighted how the emotional and social aspects of working in a care home were “distilled into measures of productivity, and a responsive job was made over into a prescribed set of tasks” (Diamond, 1992: 166). As such, the activities of everyday life were made countable through regulation by external organizations. He argued that the structures and processes in a nursing home transformed residents from “acting beings into acted upon beings” (1992: 127). According to Henderson (1995) the rapid, task-oriented nature of staff work is derived from the medical values of care which focuses on
physical tasks and the principle of time efficiency. The nursing staff supervisors are trained in a medical model and consequently “the style of caregiving is one in which physical care is emphasized to the neglect of psychosocial care” (Henderson, 1995: 53).

Drawing on a four month participant observation study of one U.S. nursing home, Paterniti (2003) suggests that residents were categorized by staff and that this information was used to schedule their working day. Staff related to residents through specific categories of perceived resident ‘deficiency’. For example, some residents were labeled by staff as ‘time consumers’ because they were thought to be very demanding of staff time. Other residents who needed help with eating were categorized as ‘feeders’. Residents were viewed as ‘bed and body’ information which was a form of constantly updating knowledge that passed between members of staff and across shifts. The home was also required to keep documentation on the residents’ health status and care tasks undertaken and which focused on physical rather than psychosocial aspects of care. The flow of ‘bed and body’ information and the documentation on task assignments and completion, in effect, became pieces of work-relevant information. However, the research also noted that residents did not define themselves in institutional terms, but rather brought identity claims of their own to nursing home life through, for example, telling stories and playing music and so exerting their individuality. As such, Paterniti describes residents as active agents in establishing their own identities within the home.

Being a nursing home resident was not merely a subjective reproduction of staff timetables and institutional charts, but was also shaped by staff members’ recognition of residents’ identity claims. (Paterniti, 2003: 70)

In this sense, residents narratives are understood to challenge the “organizationally familiar categories of persons and the taken for granted institutional order” (Paterniti, 2000:96). Paterniti argues that residents show resistance to the routines of the home by exercising their individuality and they disrupt the routines by refusing to have showers at the prescribed time,
by refusing to be hurried over their meals or to conform to the general 'stereotype' of a nursing home resident.

More recently, research in the UK and USA on care homes has focused on emotional and social aspects of care that are primarily aimed at improving the well-being and quality of life of people who live in care homes, but which also encourage the staff to engage with residents as individuals rather than view them as a set of tasks. The Eden Alternative, for example, is a philosophy of care developed in the United States which aims to change the culture and environment of care homes and to address what they perceived as the 'loneliness, helplessness and boredom' of care home residents (Thomas, 1996). However, the effectiveness of such philosophies has been questioned because they do not effectively impact upon structural problems such as inadequate staffing, and therefore it has been argued that it can even become part of the problem by not focusing on the structural aspects (Lopez, 2006).

In the UK, the role and nature of relationships is popular and significant in current care philosophies (Kitwood, 1997; McCormack 2004, Nolan et al 2006). Instead of understanding care homes as institutions which may depersonalize care, this body of work prioritises the importance of nurturing and positive relationships within care environments. Current trends in care home research also explore the notion of care homes as communities (Davies, 2003; Brown Wilson 2009a). These perspectives offer alternative ways of conceptualizing care and provide an alternative to understanding care homes as inevitably 'institutional'. However it could be argued that a focus on relationships also ignores structural and organizational factors, and the limitations placed by these on both staff and residents.

Stanley and Reed (1999) argued that Goffman's characterization of the total institution has been uncritically applied to institutions in a number of settings with diverse populations which has resulted in pervasive negative and stereotypical images of residential settings. Baldwin et al (1993) also argue that Goffman's influence has been pervasive and that influential studies in the 1980's focused too much on the internal mechanisms of care homes and
the limiting range of actions and roles of people in residential care. They suggested that much of the existing care home research at that time neglected to account for wider structural factors in society that create dependency for all older people. Rather than adopting approaches that 'blame' the institution, Baldwin et al (1993) argue that older people have an induced dependency because of social and economic factors in society and regardless of whether they enter a residential care setting.

In responding to this, Peace et al (1997) note that it is certain groups of older people (women, people with cognitive impairments, people living alone and those who have spent time in hospital), who may be more likely to be residents of care homes and as such the care home population may not be representative of all older people. Whilst acknowledging that moving to a care home may be a positive choice for some, Peace et al (1997) also argue that the transition into a care home may involve serious dislocation from familiar people, routines and surroundings and therefore may be an undermining experience for the older person (Peace et al, 1997). The authors suggest that the

"complex factors which determine the shape and style of residential living are distinct from those which influence life for older people in the community and exert an additional set of influences which devalue older people still further as they become residents" (1997:59-60).

Baldwin et al (1993) contend that much of the care home research has ignored the structured dependency thesis (Townsend, 1981) which locates 'dependency' in the context of wider inequalities experienced by older people. They suggest that this approach is an essential element in any consideration of institutional processes, although they acknowledge that structured dependency theory's lack of attention to individual agency (Dant, 1988) prevents it from being a suitable alternative on its own. However, they argue that the structured dependency thesis would facilitate analysis of

"How far processes within residential establishments can be separated from processes affecting the lives of all older people, the economic and
social opportunities available to them, other peoples' expectations of them and their own expectations.” (Baldwin et al, 1993:77).

This underlines their argument that research on older people’s services had traditionally focused on the negative aspects of residential care and the positive aspects of community care, which they believe may present a skewed picture of the nature of social care for older people as a whole, not just those living in communal residential settings.

The influence of Goffman and in particular his analysis of total institutions is prevalent in care home research and how the institutional approach to care requires that systems are in place which manage a group of individuals as a mass and do not take into account individual identity and behaviour. Relationships between staff and residents have been highlighted as task-oriented rather than focusing on psychosocial or emotional support. It is argued that task-oriented perspectives are encouraged by external regulatory procedures (Diamond, 1992) and values of care derived from a medical model (Henderson, 1995). More recent care home research focusing on cultures of care and relationships in care can be critical of research which focuses on the total institution approach to providing care. However it is argued that a focus on relationships can ignore the potential for organizational structures and other attributes of the ‘institution’ to negatively impact on experiences of care in a residential setting.

2.3 Care home routines

A theme that threads through much of the care home research is the care homes ‘routine’. These care home routines are well documented (Kerr et al., 2008, Eyers, 2007; Valins, 2002; Willcocks et al, 1987) and mostly follow set patterns around key events in the daily life of a care home (for example, meal times) and the routine work of the staff, in particular undertaking personal care, shift patterns and hand over meetings. Any programmed activities provided for the residents by the care home tend to fit around these timetabled aspects of the day.
Much of the research, particularly the ethnographic work, indicates that these routines of the care homes will relate to, or significantly influence, the personal routines of the residents, as many of the residents will be reliant on the staff to help them. Further to this, personal autonomy may be reduced by the rigid timetables in care homes which determine when residents will have meals, drinks and undertake leisure activity. In considering the specific issue of sleep, there is some evidence that this effects the night time and sleep routines of the individual residents.

Gubrium (1975) links the 'bed and body' work of the staff to residents' sleep routines, noting that breakfast necessitated the majority of bed and body work to ensure that all residents were up and dressed before the allotted time for breakfast. As such, the time for 'awakening' became part of the night shift work and the night shift finished at 07.30am. Similarly, McColgan's more recent study (2005) in a U.K. care home for people with dementia noted that residents' daily lives were structured around the staff routines:

Night staff going off duty at 7 a.m. were instructed by managers to get at least five of the twelve residents on their wing out of bed, washed, dressed and waiting in the lounge before the end of their shift. Day staff would then get the remaining residents ready, before breakfast at 9 a.m. Similarly in the evening, most residents were in bed before the day staff went off duty at 7 p.m. This required the first residents' being put to bed just after 5pm. The amount of choice for residents in this routine was restricted. The result was a routine for residents not necessarily of their own choosing. (McColgan, 2005: 417-418)

The group of older people in the McColgan (2005) study had dementia but it raises a key question of how older people respond to such routines. The need for the assistance of staff for personal care and daily activities may result in the necessity for older people to compromise their personal need, choice and preference in order to fit in with the staff routines. In residential settings, the staff will also have to consider the needs of other residents as well as there being limitations on the availability of time and resources.
The notions of ‘privacy’ and ‘place’ were important to a large research study in England by Willcocks et al (1987). Using a representative stratified sample of 100 local authority homes, the research methods included statistical information from the government Department of Health and Social Services, questionnaires to local authorities and the individual homes, structured interviews with 1000 residents, questionnaires completed by staff and a more detailed qualitative aspect in three homes. The authors argue that residential care at this time was burdened by negative images of Victorian workhouses and the institutional traditions of social control. They argue that organisational goals were prioritised over the individual, making it hard to achieve aspects of privacy within the care home. Organisational goals also influenced risk taking within the care home and the extent of participation in the wider community. The study also examined the physical environment of residential care settings and found that certain design features may facilitate or inhibit behaviours in an institutional setting. One pertinent aspect of this topic was the bedrooms and at the time of the study only half of the residents in the 100 homes had single bedrooms. The authors argue that resident autonomy may be improved with single bedrooms:

*While we have noted that the single bedroom offers the resident the potential for privacy, it also offers the potential for an expression of self-identity in the form of personal territory or as a power base from which the resident may engage in some form of exchange relationship with the staff.* (Willcocks et al, 1987)

The authors found that residents attached significant importance to having control of their immediate (physical) environment, especially if they already had their own room, however scope for such personal control was said to be very limited. Although moving to a care home may potentially provide an improved physical environment for some residents who have been unhappy with their previous living conditions or may alleviate a person’s anxiety about living alone, it is noted that a problematic aspect of care home life is the inflexible routines.

*Thus, the uncertainty of life in a community environment which made excessive demands on an old person is exchanged for an environment*
which is routinized and predictable, often to the point that hardly any demands are made upon residents. (Willcocks et al, 1987: 50)

In adapting to life in the care home, a common approach by residents was to take the 'course of least resistance' by adopting residential routines which the authors argue further encourages the block treatment of residents in a perpetuating cycle. Communication is key to expressing preferences and many older people in residential care settings may have difficulties with communication through sensory impairments or cognitive impairments. However, even where residents do have the ability to clearly express preferences, they may not have the physical ability to freely carry out their choices and therefore may be more susceptible to care home routines. Collopy (1988) has sought to understand the concept of autonomy as

A cluster of notions including self determination, freedom, independence, liberty of choice and action. In it's most general terms, autonomy signifies control or decision making and other activity by the individual. (Collopy, 1988:10).

Collopy also draws distinctions between different dimensions of autonomy, for example 'decisional' and 'executional' autonomy relating to the ability to express choices and make decisions, as distinct from being able to implement them. Older people in residential care may be disadvantaged by health problems that can impact on their participation in decision making. Peace et al (1997) highlight the importance for providers of residential care to recognize the distinction between different dimensions of autonomy so that staff can provide support to older people to exercise control within their (changing) capacities. The My Home Life report (Owen et al, 2006) also argues that residents with any degree of cognitive impairment may find it difficult to express their wishes and may particularly be at risk if care home routines become inflexible and unable to respond to the preferences and needs of the individual resident. This argument should also be extended to those with communication difficulties.

Brown Wilson et al stated that "routine care frequently prompts pejorative reactions from researchers, who see much of it as impersonal and of poor
quality" (2009b:1056) and argue that “valuing everyday routines is a useful starting point” in developing relationships between residents, family members and staff working in care homes. Brown Wilson’s study found that “care routines were described by many residents and their family members as providing markers in the residents’ day that gave a sense of coherence to what was happening” (2009b: 1056) and also required input from the resident to enable staff to personalise their care routines. However, the criticism of routines by care home researchers has been when they have found evidence of routines which appeared to be inflexible and therefore were unable to suit the preferences and needs of the individual. In support of their argument, Brown Wilson et al (2009b) cite a research study (Bouisson and Swendsen, 2003) as supporting a positive view of ‘routine’ however the main focus of the study was the capacity of ‘routinization’ (Reich and Zautra, 1991), as a personality trait in older people, to predict behavioural routines in daily life, as well as the relationship of routines to mood states. Following an initial questionnaire to establish ‘routinization’ preferences, 47 participants (living both in care homes and in their own homes) were assessed four times per day over four days concerning their location, activity and mood. The authors state that although they “observed no effect for anxious or depression moods”, positive mood was seen to decrease with repetition of activities and environments. In the research design and conclusions, the authors do not address how the potential effect of some of the participants living in a care home may have influenced their results.

Zisberg et al (2007) reviewed the literature to explore the concept of routine and its relevance to nursing. Whilst noting some positive consequences of ‘routines’, the authors also note that

*Hospitals and other institutional settings limit patients’ ability to practice personal routines, and instead establish new passive inactive activity patterns that later do not serve patients in their readjustment to the home environment.* (Zisberg et al, 2007:447).
Aspects relating to disease and disability and their effects on routines were also discussed, noting that these health conditions may challenge existing routines and invoke a higher need for routine in daily life.

Brown Wilson et al (2009b) argue that routines should not necessarily be viewed as a negative and suggest that researchers should adopt a more open interpretation of routines. However, when discussing routines, clarity is required to establish whether authors are considering personal and individual routines or institutional practices. Institutional routines have been criticised for their potentially damaging effect on the individual. Goffman’s Asylums (1961) identified the ability of a large institution to deconstruct the personal characteristics of the individual inmates of the psychiatric hospital to facilitate the smooth running of the organisation. This is not achieved through single events, but through the gradual erosion of personhood through the use of processes and routines. Whilst 21st century care homes are more humane environments that are able to value individuals, the potentially damaging effect of institutional routines and practices remain.

There is little research that explores how residents respond to and feel about care home routines. De Veer and Kerkstra (2001) interviewed 686 residents and family members in 36 nursing homes in the Netherlands. They found that residents who did not feel ‘at home’ wanted more flexible routines. Residents with ‘mental illness’ and residents who had lived longer in the home generally felt more comfortable than those with physical disabilities and residents who had only recently entered the care setting.

2.4 Care homes and sleep

The history of care home research, for the most part, does not include a qualitative focus on sleep. However, a number of qualitative studies of care homes will be discussed here to establish what insights into sleep can be gleaned from these studies. The Last Refuge (Townsend, 1964), while not explicitly addressing sleep matters, did highlight some relevant issues to be considered. Some of the problems highlighted in the study related to what
are now considered outmoded practices, such as the dormitory style sleeping arrangements of the old workhouse buildings, of which over 300 of these were still in use as local authority residential facilities in 1960:

_M ward consisted of 42 beds in two big dormitories. Each dormitory had been roughly divided into two, by the simple exercise of placing seven wardrobes (shared by each group of 21 women) across the centre._ (Townsend, 1964:31)

However other homes available at the time such as post-war local authority homes, voluntary and private homes usually offered single or shared (up to four people) accommodation. After 2001, the Care Home National Minimum Standards and The Care Homes Regulations (Department of Health, 2001b) specified that all newly built or extended homes or first time registrations of care homes must provide single room accommodation and that sharing in other rooms could only be by no more than two people who had chosen to do so.

Gubrium (1975) noted the 'floor routines' performed by staff and, in particular, the work that had to be done in the morning helping residents to get up and get ready for breakfast in the dining room. This brings to light a link between the work of the staff, the bed and body work and the sleep routines of the residents. Routine work is described as 'bed and body work' because:

_In practice, floor staff believes that once beds have been made and the highly visible bodily needs of clientele have been attended to, it has accomplished a day's work._ (Gubrium, 1975: 124).

As noted earlier, the timing of the majority of 'bed and body work' is said to vary between shifts with the most bed and body work being needed before breakfast. Gubrium's research briefly outlines the bedtime routines of residents and the work routines of the staff overnight. A short discussion of sleep emerges, but only through the finding that, for the residents, sleeping is one way of passing time during the day. He also noted a moral dimension to sleep for residents and staff of the care home relating to when and where sleeping takes place.
Where one sleeps to pass time makes a difference in how the sleeping is evaluated by others. Sleeping in bed most of the day is judged negatively, but spending nearly as much time sleeping in the Manor’s lobby or lounges is considered just a matter of dozing off. The former is believed to be a deliberate plan to just sleep, whereas the latter is treated as one of those things that ‘happens’ when it gets warm and quiet. (Gubrium, 1975:179-180)

Gubrium found that those sleeping in the more public areas of the Manor were considered ‘available’ to be woken at any time, unlike someone sleeping in their own room who was likely only to be woken for a specific reason, such as meal times. He concluded that sleep in public areas signified only a momentary inattention to social interaction and that the sleeper was therefore available for visits or conversation. It was noted that

(W)hen someone is discovered to be sleeping in his own room, he is not disturbed unless time is close for some event such as meals or bingo, which others believe he should attend. (Gubrium, 1975:180)

McColgan (2005) argues that people with dementia endeavour to create home-like privacy as a strategic resistance to nursing home culture. One of these strategies was to feign sleep with the intention of avoiding interaction or requests from staff. McColgan argues that residents used sleep in public areas of the home to create a distance from the group and therefore sleep in public areas was associated with making choices about privacy. Other resistance strategies observed were regular attempts to leave the home and physical and verbal opposition to requests from staff. However, this research was carried out with people with dementia and it was not clear whether these behaviours were solely in response to being in the care home or were exacerbated as a result of the symptoms of dementia.

Although these studies were not directly focused on sleep, and only addressed sleep in passing, they do contain important insights into the nature of care in a care home and point to the potential effects of living in a care home on sleep. Until relatively recently, sleep in residential settings occurred primarily in a communal environment however a shift has occurred
in policy and regulations whereby the privacy of the sleeping area is recognised as important. This points to a general construction of sleep as having a spatial significance and that the physical environment is linked to what is considered acceptable practice around sleep and the night-time. A temporal dimension is identified which links staff routines and care home timetables with the sleeping patterns of residents. Further to this, moral values and social meanings have been attached to sleep within care homes, in particular relating to when and where an individual sleeps.

2.5 Care homes at night

In previous research there has been little focus on the night time in care homes. This may reflect assumptions of a dormant night time period where the provision of health and social care is minimal due to all residents being asleep. However, two studies in particular have considered aspects of care at night and it can be argued that they demonstrate how the night time in residential and nursing settings should not be overlooked and may contribute to the further understanding of care home life.

Lee-Treweek carried out night observations and the author felt that the staff were, as a time saving method, more likely to treat residents as 'objects' at night during the "ritual of rounds" (1994:3). Extracts from her fieldnotes are used to illustrate this point:

_The same ritual is observed in each room entered: the auxiliaries go alone or in pairs, the toilet light is switched on, a jug is collected from the toilet, the patients’ bed sheets are pulled back exposing them to the air, their night clothes are pulled up to allow the leg bag to be emptied. They might need to be rolled over to allow access. [...] If two auxiliaries are in the same room on the round they very often chat over the patients while they deal with them. Should a patient stir or open their eyes during this ritual they are told to go back to sleep. Any patient awake at night is considered an inconvenience to this two hourly ritual. Many patients lie motionless with their eyes open and staring blankly as this ritual is performed._ (Lee-Treweek, 1994: 3)

In this way, it is argued that the physical work is prioritised by the staff over the emotional side of their work. The study by Lee-Treweek starkly brings
out many negative aspects of social care in a residential environment which the author argues should be classed as mistreatment and abuse. She notes that staff enter bedrooms, often without a greeting to the occupant, and often immediately commence ‘invasive’ actions to find out if the person or the bed had been ‘soiled’.

The notion of bedroom privacy is explored in Lee-Treweek’s (1994) research in a nursing home. Lee-Treweek acknowledges the ambiguous status of the bedroom in a care home as a place of privacy for the resident and a place of work for the staff. Drawing on Goffman (1959), the bedroom is conceptualised as a ‘backstage’ area where time is spent by the residents and is the main site of work for staff to produce residents suitable (i.e. clean, dressed tidily) for ‘frontstage’ areas of the home. Lee-Treweek’s study also highlighted how the work of the staff may affect the sleep routines of the residents, as “it was customary to present the patients to the new shift intact, clean and quiet in their rooms for 8am” (Lee-Treweek: 1994: 2) and this was perceived as symbolic for staff of having done the job properly.

A recent Joseph Rowntree Foundation action research study into the night time in care homes (Kerr et al, 2008) undertook qualitative research in three care homes in Scotland including observations and interviews with residents, staff, relatives and care home inspectors and highlighted a number of factors in relation to night time care. Noting that the majority of care home studies focused on the daytime, it was recognised that there was a need to explore night time practices. This study has formed the basis of the Care Quality Commission (CQC) guidance for care home inspectors which provides night time care prompts to help inspectors evaluate the provision of night time care. The study by Kerr et al identified a number of issues relating to night time care, however particularly pertinent here are the perspectives of the staff and residents. Perspectives of the staff related largely to their own personal circumstances that led them to undertake night work, their reasons for and effects of working at night. The study also found that there were problems with staffing the night time and low levels of staff available to deal with unexpected occurrences or the peak pressure times, such as first thing in the morning. The use of agency staff at night was highlighted as
increasing pressure for other staff, and low levels of staff at night caused difficulties for residents who expressed a preference for male or female staff. The study also identified ‘what if’ anxiety about the night which was experienced by staff, but also by relatives.

Kerr et al’s study has a very small sample of eight residents who were interviewed (4 without dementia and 4 with a diagnosed dementia). A number of issues were identified including their general views on the staff and their experiences of the overnight checking regimes, where care staff may perform regular checks on each resident. Night time noise from the staff, physical environment and other residents was another aspect raised by residents. It was also found that despite some good practice, the participants reported some incidents of practice which they found unacceptable. Examples of this included ‘insensitive behaviour’ such as turning the television off in a resident’s room without asking them or entering unannounced during the night time, looking for something and leaving again without acknowledging the resident. This underlines how routine night-time work for the staff can be perceived differently by residents and may cause them distress. As previously noted, this was an action research study and the care homes taking part agreed and implemented certain changes to practice which the authors state subsequently reduced sleep disturbance for residents, although how this finding was established or measured is not stated.

2.6 Sleep problems in care homes

Bahr has described sleep as a ‘natural occurrence having a psychological or physiological function that activates the restorative repair process of the body’ (1983: 535). Sleep problems may occur at any point during the life course however it has been argued that they do increase with age (Morgan, 1987). In a study comparing community dwelling poor sleepers with care home residents using actigraphy (Meadows et al, 2010), it was found that older people living in care settings experienced more fragmented rest/wake patterns than people living in the community (after controlling for variables
such as age and dependency level) therefore suggesting that the care home setting has a negative association with an individual's rest/wake pattern. Importantly, this is a study undertaken in the U.K. as much of the relevant sleep research in care homes has been in the U.S.A. and The Netherlands.

Alessi and Schnelle (2000) argue that there is evidence to suggest that sleep problems are extremely common among care home residents and that the characteristics of care home residents should be taken into account; for example that care home residents have ongoing and complex health status and needs. A national census undertaken in 2006 across 751 care homes in the UK stated that 72% of residents were immobile or needed assistance to mobilise, 89% of residents required care as a result of the disabilities arising from long-term medical conditions, 62% were confused or forgetful, and 24% were confused, immobile and incontinent (CCC, 2006).

Bebbington et al (2001) identified that in the UK, 71% of admissions to care homes were women. They also identified a range of illnesses associated with admission to a care home, including dementia (38%), arthritis (32%), cardiovascular disease and stroke (20%), respiratory disease, deafness, depression, fractures and visual impairment. Lack of motivation and mental health needs were more likely to be associated with residential home admissions, whereas physical and functional needs were more likely to be associated with nursing home admissions. Carer-related factors were also identified in 40% of admissions. As an example of this, Pollack and Perlick (1991) in the U.S.A. found that 70% of carers cited night time problems and the subsequent effect on their own sleep as contributing to their decision to move the older person into a care home.

For people living in residential care settings, age-related changes to sleep patterns may be exacerbated by environmental factors such as increased light and noise, as well as general disruption from other residents or staff (Ancoli-Israel et al, 1989, Middelkoop et al, 1994, Ersser et al 1999). Middelkoop et al (1994) undertook a comparative study in the Netherlands between people in residential care settings and living at home in the community. Nocturia, the need to wake and pass urine during the night, was reported to be the most frequent cause of waking up at night across all
groups, but people living in residential care settings reported nervousness and pain most frequently as causes of disturbed sleep. Additionally, disturbance due to environmental factors was almost exclusively reported by older people in residential care settings. In a UK study, Ersser et al (1999) also found that nocturia, pain and discomfort were the most commonly reported causes of sleep disturbance, with noise being the most commonly reported external factor.

Care home residents therefore may experience high levels of sleep disturbance at night, yet the evidence suggests they also spend a long time in bed. Residents spending a long time in bed and frequent night-time disturbances have been reported in U.S. studies by Ancoli-Israel et al (1989) and Ancoli-Israel (1997) who found that residents spent up to 17 hours per day in bed (with only 8 hours actual sleep time) and were awake for at least 14 minutes each hour of the night. Examining the amount of time that residents spent in bed during the day time, in another U.S. study, Schnelle et al (1998) found that in daytime observations conducted in 8 nursing homes between 8am and 4pm, residents were in bed for an average of 36 per cent of observations. Ice (2002) observed residents in one nursing home to be in bed for 29 per cent of observations between 8am and bedtime (approximately 13 hours). These authors argue that the time spent in bed indicates residents being alone and lacking stimulation or social interaction which they argue therefore exemplifies poor 'sleep hygiene', and that minimal daytime activity was associated with disturbed night time sleep.

A randomized controlled trial on non-pharmacological intervention in four USA nursing homes (Alessi et al, 2005) found that the only effect on night time sleep was a fairly small decrease in the mean duration of night time awakenings, however there was a significant decrease in daytime sleeping. The participants receiving the non-pharmacological treatment spent less time in bed during the day, had more daytime light exposure, more physical activity and a structured bed time routine. Other outcomes noted in the study were an increase in social interaction and physical activities. However, this was a small study over a five day period. The actual intervention provided at night intended to reduce night care episodes was
unclear as night care was “timed to occur while participants were awake, with limits placed to prevent excessive intervals without care being provided” (2005:806). The research team also made hourly rounds at night to each participant to identify whether participants were awake or asleep and the potential effect on sleep of these hourly rounds was not discussed.

As well as the potential sleep problems discussed above, other practices within health and social care settings may impact on sleep. For example, Cruise et al (1998) in the U.S.A. found that 76% of resident direct care episodes undertaken by staff at night resulted in the resident being woken up. Schnelle et al (1993) reported that 85% of resident awakenings at night were related to environmental changes associated with nursing care, concluding that individualized night time care would improve sleep quality.

Further understanding of and the improvement of sleep among older people in care homes therefore may have particular implications for nurses and carers in care homes. Haelser (2004) reported on a systematic review of literature to explore the assessment and diagnosis of sleep problems in the population of nursing home residents and included a review of the effectiveness of sleep management strategies in nursing homes. Despite widespread use of sleeping medication in care homes, there was little evidence of a substantial effect in improving sleep of residents and other strategies in combination, such as reduction in environmental noise, light and incidents of being woken by staff giving night care seem to be the most effective strategies for the promotion of sleep. There was no conclusive evidence about the effects of physical activity upon sleep at night and the small number of studies exploring the effects of changing daily routines and activities had only been conducted in facilities for people with dementia. The review also found that subjective reports of sleep quality are largely absent from the literature and are an important consideration in sleep assessment.

The potential reduced sleep quality experienced with normal ageing therefore may be exacerbated by the social and physical environment of a residential care setting. This may also be compounded by other factors as discussed above, as well as individual factors such as physical and mental
health status and pre-existing sleep problems. The literature discussed in this section highlights many of the issues relating to sleep in a care home, however, there is little qualitative literature which explores these dimensions subjectively or from the point of view of the care home residents. Another important factor is that while care home staff assisted with data collection in many of these studies, there is no information in the literature that specifically addresses the views and opinions of staff, both nursing and social care professionals.

2.7 Sleep as a topic of sociological inquiry

The development in recent years of a sociological approach to the study of sleep may offer the possibility to build upon the findings of the studies outlined in the previous section which principally involve a biomedical approach. A sociological approach to researching sleep acknowledges that it is important to understand sleep as socially patterned, embodying an individual's social roles and socio-structural factors. The first published work that focused on the sociological aspects of sleep was by Aubert and White (1959a & 1959b). Drawing heavily on previous anthropological accounts of diverse sleeping arrangements in different cultures, Aubert and White highlighted the socio-cultural variation of meanings attached to sleep and the related rituals and rules of sleep related behaviour. This work highlighted the plethora of cultural variation possible around sleep as well as acknowledging both the influence of physiological need and environmental constraints. Following a functionalist perspective, Schwartz (1970) focused on how society must protect sleep and therefore institutionalises it through the co-ordination of timing (and the behavioural rules around this) and by categorising the role of the sleeper in order to elicit certain behaviour from those who are awake. Schwartz argued that the sleep role established the rights of the sleeper to sleep within a specific time period that is respected by others. Sleep may generate identity through social and spatial variation and thus social status is linked to the control of sleep. Schwartz is particularly relevant when considering sleep in the context of a care home as he refers
to the difference of sleep in total institutions where the 'private' (ward, cell or bedroom) becomes 'public'.

Taylor (1993) notes that the majority of sleep research focuses on the physiological, biological and medical including the often researched relationship between age and sleep. He also notes the lack of sociological inquiry into the topic and introduces relevant concepts from interactionist sociologies, for example the concept of observed sleep. Using the example of total institutions, he notes how the notion of observed sleep can be understood by interactionist sociology to infantilise the residents of the institution or reduce them to the status of children due to the lack of sleep privacy. This develops the notion that privacy is a key element to sleep status in contemporary Western society.

More recent work on the sociology of sleep has sought to expand upon "this most important of topics and neglected of domains" (Williams and Bendelow, 1998a: 186). Drawing on the work of Schwarz and Taylor, they explore the social significance of sleep. Acknowledging both the biological and cultural aspects of sleep leads to the requirement of a more subtle and complex understanding of the nature/culture interaction, with sleep being a product of "physiological need, environmental constraint and socio-cultural elaboration" (1998a: 185). Williams and Bendelow (1998a) draw on the Parsonian 'sick role' to propose the rights and responsibilities of the sleeper. The right to freedom from disturbance, to be exempt from normal social role responsibilities and to retain waking role status while asleep is balanced with a social obligation to sleep in private and to conform as much as possible to the general pattern of sleep time. Williams and Bendelow discuss one example of the social significance of sleep though the case of a hospital. Factors such as the spatial and temporal organisation of sleep, the public monitoring of sleep, cultural and ethical aspects relating to death, issues of power, surveillance and control are all considered particularly relevant to the study of institutional sleep. Williams (2005) discusses sleep in nursing homes, reiterating a number of sociological issues and raising some new ones including the concept of bed/bodywork and the occurrence of hidden 'backstage' abuse in residential settings.
It has also been suggested that sleep is a social act that is negotiated with self and others (Meadows, 2005). For empirical support of this argument, Meadows draws upon the work of Hislop and Arber (2003a, 2003b, 2003c) whose research into sleep patterns of women aged over 40 highlights how women negotiate their own expectations of sleep, their social roles and the social environment of their lives. Meadows (2005) argues that the extent to which women ‘allowed’ their sleep to be affected and whether they viewed their sleep as problematic indicates a negotiation with the ‘self’ relating to how they prioritise their own sleep within the household. Hislop and Arber (2003a) demonstrate how gendered roles such as worrying about their family and well-being impacts on sleep and that the sleep environment was shaped by women’s various roles and responsibilities. Women in their study felt that disturbed sleep was something that they had little control over and it is argued that in relation to “a situation which is largely outside women’s control, to accept the reality of sleep disruption is a pragmatic response.” (Hislop and Arber, 2003a:703). In addition to actual sleep disturbance that is generally accepted by the women in the study as ‘par for the course’, the behavioural strategies adopted to mitigate against sleep disruption may also be limited by their roles and responsibilities and by prioritising the needs of others in the household. The sociocultural ‘rights’ of a sleeper as set out by Williams and Bendelow (1998a) are challenged by this research which presents women at an apparent disadvantage due to the sleep role being structured by existing gendered divisions of labour that already exist in the household (Hislop and Arber, 2003b).

Martin and Bartlett (2007) specifically addressed issues of sleep for older people in the context of care. They reviewed their previous data from research investigating empowerment for people with dementia with a view to exploring the social significance of sleep for people with dementia. The results demonstrate differences in the narratives of the participants, with residents’ perspectives connecting the themes of sleep with health and vulnerability, and the staff discourse of the ‘organisation of sleep’ through temporal and spatial management within a care setting. The analysis also considered issues of personal safety, surveillance and privacy.
The meanings and perceptions of sleep in later life, and the personal significance of sleep disruptions, are influenced by the social context in which they arise (Williams, 2002). A sociological approach to sleep should identify that as other people and the social context and relationships may impact on an individual’s sleep, so the sleep environment has a dialectical relationship between your own sleep requirements, your identity and social role in addition to the sleep requirements and social roles of others around you. In the context of a care home setting, which is a communal sleep environment, sleep ‘negotiation’ will not just be with partners, family or others within a household. Negotiation will occur with not only other ‘sleepers’, but also with staff (who are awake) and with the policies and practices within the individual home.

2.8 Conclusion

While it is suggested that sleep problems can increase with age, quantitative research by sleep scientists has shown that people living in care homes commonly have reduced sleep quality and that this is not only an effect of health or disability status. The qualitative study of sleep in care homes, which forms the basis of this thesis, recognizes and prioritises the social context of sleep, acknowledging that sleep is more than a physiological process. Sociological theoretical and empirical work on sleep highlights the need for individuals to negotiate their sleep with those around them and their environment. It is acknowledged that these negotiations will change throughout the life course and a key question for this research is to explore what negotiations and compromises may be required of older people resident in care homes. When combined with what sociology can tell us about the impacts of care home routines and the imbalances that exist in the relationships between residents and their carers, there is clearly a need to examine the effects of this imbalance on the ability of individuals to successfully manage their own sleep environment.
3.1 Introduction

This chapter considers existing national policy in the UK which prioritises the empowerment, choices and control of people who use social care services, including those who live in care homes. In understanding the practical application of the concepts of choice and control it is necessary to examine the notion of risk applied to older people in care homes. Where service users are encouraged to have choice and control, they may choose to take what others perceive as risks, leading to a tension between choice (risk taking) and perceived professional accountability. Older people living in care homes, in particular, may be subject to 'over protectiveness' by staff and managers wishing, and being expected by wider society, to create a 'safe' environment for those people who live there. Ageing bodies may be viewed by professionals as sites of risk, a view that is not necessarily shared by older people. Ageing bodies are seen as central to risks faced by older people and managing risk is central to work in a care home. Through this process managing ageing bodies becomes central to the work of risk reduction, as well as a primary focus of care home life. These practices can exclude other factors such as assessing the physical environment or considering the impact of loss of control and choice on individual residents.

3.2 Empowerment, choice and control in health and social care policy

The experience of ageing is often homogenized, with older people characterised as dependent and ignoring the fact that many live independently and do not rely on support from agencies or others (Phillipson et al, 1986). However, many older people who are living in residential and nursing homes do require some physical assistance or support in carrying out everyday tasks. While a medical discourse has dominated much of
social care provision for older people, focusing on the ‘illness’ of the person, alternative approaches have been highlighted. The disabled people’s movement provided a major impetus towards focusing on rights rather than care (Oliver, 1990; Barton 1996; Campbell and Oliver, 1996) arguing that a care-focused model places individuals in a position of dependency. ‘Care’ is characterised as fostering conceptions of people who receive care as ‘dependent’ and who are also silent in research and policy analysis (Shakespeare, 2000). Further to this Oldman (2002) argues that the social model of disability can make an intellectual contribution to how later life is conceptualised through focusing on the disabling aspects of society rather than the individual. In discussing social care practice, Thompson and Thompson (2001) discuss an ‘empowerment’ model to move away from traditional social care practice and the ‘care of the elderly’ model which, like the medical model, emphasises the knowledge and dominance of the professional. Fine and Glendinning (2005) have argued that more recently, the traditional and hierarchical carer-dependent paradigm is being replaced with a more active and engaged notion of the care relationship in which both parties have rights as individuals.

Service user empowerment, choice and control is currently at the heart of UK national policy initiatives within health and social care. However, the voices of older people are rarely found in academic analyses of policies and consulting older people as consumers of services is a relatively new occurrence in policy making (Leeson et al., 2003: 22). The more recent focus on consulting with older people to contribute to policy development can be seen in such programmes as the Cabinet Office Better Government for Older People and the publication of Making Choices: taking risks - a discussion paper (Commission for Social Care Inspection, 2006). It is argued that there is a culture of representation of the voices of user groups which is a required element of contemporary health and social care services. Such consultation and representation unifies the ‘voice’ of the service users to follow “predetermined agendas and already decided strategies” of those who are doing the consulting (Gilleard and Higgs, 1998a: 246). However, as Scourfield (2007) notes, people in residential care have not been adequately
represented in the 'participation agenda' and that "of the many difficulties that older people in residential care face, 'consultation fatigue' is not one of them" (2007: 1138). The culture of consultation and the language of consumerism in welfare services may also have created the "possibility of a third age voice being used for a fourth age constituency" (Gilleard and Higgs, 1998a: 247). This may lead to those in the fourth age, whose needs may be more complex and challenging, being overlooked in favour of those in the third age whose aspirations and needs may be easier to meet and therefore more attractive to policy makers. There is therefore a need to understand more fully the views and experiences of people in what can be described as the fourth age whose 'voices' have not necessarily been included in consultation initiatives.

Consultation and inclusion at a policy or strategy level dealing with broader issues can be distinguished from aspects of personal choice and empowerment in daily living. The Green Paper Independence, Well-being and Choice (Department of Health, 2005) states that independence, empowerment and choice were key themes to emerge from a nationwide dialogue on the future of adult social care. The White Paper Our Health, Our Care, Our Say (Department of Health, 2006) set out the vision for "high quality support meeting people's aspirations for independence and greater control over their lives, making services flexible and responsive to individual needs" (2006: 5) although the reference to 'control' is generally linked to the commissioning stage and people being able to choose appropriate services. In the White Paper there is little reference to residential care, however it states for those in residential care that "the principles of retaining independence and opportunities for interaction and involvement with the wider community will remain fundamental." (2006:139). The White Paper also recognises that people in residential care are not always able to access health and social care services available to those living in the community. Legislation and national policy explicitly attempts to integrate both health and social care services in order to overcome financial, cultural and practical boundaries and to provide some cohesion for people who use these services (Alaszewski et al, 2003). Such integration between health and care services
is particularly important in service provision for older people who are more likely to require both health and care services over a long period of time or to access different services at different times (Leichsenring, 2004). However, the effect of the integration of services may also reinforce the traditional dominance of a medical paradigm within older people’s services.

Ensuring service user choice and control is one of the six founding principles of the development proposals for a National Care Service (Department of Health, 2010). In addition to general social care ideology, policy relating specifically to older people also reflects the principles of retaining choice and control. One of the four themes of the National Service Framework for Older People (Department of Health, 2001a) is ‘person centred care’ which argues that older people should be treated as individuals and enabled to make choices about their own care. The Framework acknowledged that older people have not always received person centred care which requires services and staff to:

- listen to older people
- respect their dignity and privacy
- recognise individual differences and specific needs including cultural and religious differences
- enable older people to make informed choices, involving them in all decisions about their needs and care
- provide co-ordinated and integrated service responses
- involve and support carers whenever necessary.

(Department of Health, 2001a:23)

The home page of the Department of Health website relating to ‘older people’ states:

_The Department’s policy for older people and their carers seeks to promote social inclusion and control over their lives, ensuring respect and choice. This enables older people to live independently for as long as possible, benefit from tailored care and support, and experience an enhanced quality of life._


The general shift away from institutional to community-based care is implicit in this statement, alongside the development of services which provide people with choice and opportunities to have control over their own lives.
Further to policy initiatives moving towards supporting people in their own homes rather than residential care, it has been argued that the approach of organisations providing social care services has also been influenced by wider social changes relating to the legal rights, quality of life and empowerment of individuals who use care and health services (Thomas, 2000).

Social policies based on the principles of service user choice, control and empowerment may need further investigation where older people have been excluded from consultation on the formation of these policies. Drawing on the discussions in the previous chapter, it is acknowledged that care homes may have practices which impact on the ability of individuals to exercise choice and control and it is therefore a key question of this research to explore this in relation to the night-time environment of a care home.

3.3 Empowerment, Choice and Control in Care Homes

Legislation and national policy generally encompass adult social care as a whole, rather than focusing specifically on certain groups or services. However, the requirement for care homes to be registered and monitored as service providers generated the publication of standards and guidance which related specifically to residential care services. Since the fieldwork for this research was completed, the regulations governing the registration and standards of care homes have changed and are now governed by the Health and Social Care Act 2008 which established the Care Quality Commission (in place of the Commission for Social Care Inspection) to regulate the new system. In line with the strategic initiatives to integrate health and social care services, the Care Quality Commission is the independent regulator of all adult health and social care in England. The previous star rating system of inspecting care homes has been replaced by a new registration system and new standards, which came into force on 1 October 2010.

During the fieldwork period of the research upon which this thesis is based, the regulations and guidance specifically for residential and nursing care
homes were provided by the Care Home National Minimum Standards and The Care Homes Regulations 2001 (Department of Health, 2001b). The Standards were the basis for inspection by the Commission for Social Care Inspection (CSCI) and reflected the general principles in social care, pertaining to choice, control and empowerment. Standard 12 required that:

12.1 The routines of daily living and activities made available are flexible and varied to suit service users’ expectations, preferences and capacities.
12.2 Service users have the opportunity to exercise their choice in relation to:
   - leisure and social activities and cultural interests;
   - food, meals and mealtimes;
   - routines of daily living;
   - personal and social relationships;
   - religious observance.

(Department of Health, 2001b:14)

In relation to autonomy and choice, Standard 14 required that:

14.1 The registered person conducts the home so as to maximise service users’ capacity to exercise personal autonomy and choice.
14.2 Service users handle their own financial affairs for as long as they wish to and as long as they are able to and have the capacity to do so.
14.3 Service users and their relatives and friends are informed of how to contact external agents (e.g. advocates), who will act in their interests.
14.4 Service users are entitled to bring personal possessions with them, the extent of which will be agreed prior to admission.
14.5 Access to personal records, in accordance with the Data Protection Act 1998, is facilitated for service users.

(Department of Health, 2001b:15)

It is clear from this guidance that policy makers intend for residents of care homes to retain autonomy and choice within the care home environment. It is the implication that care homes would take steps to meet these needs and attempt to understand and support people’s choices. The My Home Life report (Owen et al, 2006) also notes the importance for residents of care homes to have choice and control and to feel that they have a say in running the home. However, it has been argued that the notion of ‘empowerment’ in
services for older people, including care homes, has trailed behind the progress of other groups within social care (Nusberg, 1995).

Older people are one of the last groups with which the notion of empowerment has become associated. Yet the privileges it represents—the ability to make informed choices, exercise influence, continue to make contributions in a variety of settings, and take advantage of services—are critically important to the well-being of the elders. These are choices often taken for granted by working-age adults, but they have eluded older persons for a variety of reasons, including poverty, poor health, low educational levels, lack of transportation and access to services, negative stereotypes about aging, and overt and subtle age discrimination. (Nusberg, 1995: ix)

Bowers et al (2009) conducted research in care homes focusing on older people’s experiences of choice and control in their lives and the support they needed when experiencing high support needs. The research was conducted in four study sites in the U.K. as well as workshops with care home residents, families, staff and commissioners. The aims of the research were to engage with older people with high support needs to understand their vision for long term care within the potential range of future services. A key finding from the scoping literature review “highlighted the lack of a clear voice and low levels of engagement and empowerment among older people with high support needs” (2009: 16). This qualitative research found that older people wanted to be involved in decisions that affected them, but that for care home residents ‘choice’ is most often equated with food, when to get up, when to go to bed and so on. The key finding is that a deeper understanding of and focus on voice, choice and control—on self-determination and independent living—is missing for older people with high support needs.” Bowers et al (2009) also highlighted how aspects of the research process itself also contributed to the findings in that older people were ‘spoken for’ by staff, implying an imbalance in the relationship:

There is a related need to recognise much more clearly the impact of disempowering relationships, which have wide-reaching consequences for older people who live in situations where their voices are effectively ‘managed’ by others. Often this arises as a result of other people’s concerns and anxieties for them. For example, some staff felt that older people would not want to come to a meeting, or attend an interview or
small-group discussion because 'they are too tired', 'it is too taxing for them', or 'they really wouldn't be interested'. We found that such comments were always refuted by the older people concerned, who expressed a keen desire to be included and involved. (Bowers et al, 2009: 32)

The research concludes with a summary of what they have termed the 'keys to a good life' consisting of personal identity and self esteem, meaningful relationships, personal control and autonomy, home and personal surroundings, meaningful daily and community life, personalised support and care. (Bowers et al, 2009:38).

In accordance with the principles of adult social care policy, regulations and guidance relating to care homes for older people promote the concepts of choice, control and empowerment. However, there is little research on how these principles are applied in practice or experienced by residents of care homes. The recent research by Bowers et al (2009) which aimed to conduct a policy-level consultation on vision for long term care highlighted that there is a lack of control around basic aspects of life for people with high support needs and that without these being met, it was difficult for participants to engage in the research about more strategic policy development. This links to the discussion in the previous chapter around the potential impact of organisational routines which can be inflexible and take precedence over individual choices and autonomy. The literature therefore suggests that a lack of choice and control is an aspect of care home life which will be explored in this study.

3.3 Risk in Health and Social Care

There has been an increased policy interest in risk assessing and risk management which should be viewed in the context of the themes discussed in the previous section on service user choice and control. In recent policy guidance and discussion on the subject of risk, there has been a focus on choice, control and empowerment and this highlights tensions in the policy

A tension exists where service users having the opportunity to make choices, including what may be perceived as ‘risk taking’, is balanced against professional responsibilities and duties of staff to protect ‘vulnerable’ people. Balancing empowerment, autonomy and risk taking for service users and the professional duties of protection is complex in the context of limited resources and professional fear of litigation and public scrutiny (Kemshall, 2002). A recent discussion on these tensions is the Department of Health *Independence, Choice and Risk* framework (2007) which in itself, it is argued, may lead to the greater formalization of risk practice and may add to the existing fears of professionals through an emphasis on the legal basis of care and the ‘duty’ of care for service providers (Manthorpe, 2007). It is noted that “the key for practitioners will be to see if broad support for taking risks will translate into specific support when things go wrong” (Manthorpe, 2007: 239) as policies to regulate risks rarely meet the complexities of the roles and tasks of health and social care professionals (Taylor, 2006), even if they do acknowledge tensions relating to risk management between the different stakeholders of health and social care services. Although the guidance seeks to move towards a common approach for practitioners, this may not adequately address areas of diversity and subjectivity around perceptions of risk (Mitchell and Glendinning, 2008).

Parton (1996) notes that the development of social care (or social work) in the post-war period was based on ideas of improvement and rehabilitation and contributed to the growth of welfarism. However notions of risk have taken prominence since the collapse of ‘welfarism’ and the rise of neo-liberal beliefs (Culpitt, 1999). Drawing upon ideas from Giddens (1991), Beck (1992) and Douglas (1986, 1992), Parton (1996) argues that the rising concern with risk in social care is a reflection of and response to wider social
and economic transformations. Risk is argued to be a "way of thinking" rather than a measurable, external reality and a notion which has been recast with the emergence of the neoliberal individualised notion of citizenship emphasising personal fulfilment and individual responsibility and the impact of global market forces which has "hastened dislocation in most areas of economic and social life, reinforcing a whole variety of insecurities, uncertainties and fears" (Parton, 1996:99). The growing preoccupation with risk in social care practice, therefore can be understood as both reflecting these increased insecurities and as providing a rationale for responding to the new situation. Parton argues that

> while there is growing concern that certain sections of the population are increasingly marginalised and vulnerable, there is also a greater emphasis on professional responsibility and accountability for the safety and well-being of those they come into contact with (Parton, 1996: 99-100).

Kemshall (2002a) argues that risk is replacing 'need' in health and welfare policy and that this is manifest through the increased accountability procedures for staff, performance management and risk management strategies. 'Risk management' in social care refers to the processes which organisations develop to minimise any negative outcomes which may occur in the delivery of services and the term implies that risk can be 'managed' (Gurney, 2008). The definition of risk management referred to above also positions responsibility for managing the risks with the organisations, however users of services may also have responsibility for managing risk (Stalker, 1999). In social care, it is generally understood that risk management is not an assurance to preventing risk but can only endeavour to reduce the likelihood of occurrence of risky events or reduce their impact (Kemshall, 2002b). It is also generally acknowledged that risk assessment and risk management is largely associated with 'bad risks' (Kemshall, 2002b).

Drawing on Hood et al (2001) who argue that there are seven distinctive dimensions of organisations' response to risk, and drawing upon a number
of classic welfare organisation studies, Alaszewski and Manthorpe (1998) state that traditional bureaucracies and staff-centred welfare organisations are likely to rely on expert advice in relation to risk, punish mistakes and endeavour to control the environment through the anticipation of risk. More user-centred organisations are likely to involve clients and wider participation in decision making, adopt a ‘learning from mistakes’ culture and focus on rapid response to potentially harmful incidents rather than on prevention of incidents.

Carson (1996) argues that as risk decisions are extremely complicated then ‘errors’ will occur and consequently individuals and agencies will potentially be subject to public scrutiny and potentially litigation. Gurney (2008) sets out risk management in social care as a continuum between control, legitimate authority and empowerment, highlighting the varying perspectives that may interpret and manage risk in different ways. By acknowledging the different perspectives and agendas between staff, agencies and service users, conflicting issues may be more adequately addressed. Issues underpinning responses to risk management include:

- the degree to which there is acceptance that risk exists in any society and that a degree of risk taking is normal.
- the extent to which responsibility for risk is seen to be shared collectively as a consequence of social structures.
- the extent to which society seeks to apportion individual blame for bad outcomes in relation to risk.
- the location of the power to make decisions about what are bad outcomes.

(Gurney, 2008:300-1)

In response to risk, organisations may be more controlling or empowering for service users, and may move along this continuum in different aspects of their work (Alaszewski and Manthorpe, 1998). Alaszewski and Manthorpe (1998) conducted a survey of 42 agencies providing care for vulnerable children or adults with learning disabilities and examined their policy documentation. It was found that different agencies’ responses to risk may
vary considerably and, drawing on Douglas (1992), the authors hypothesise that this variation may relate to the sense of security in the organisation. If an organisation sees itself as under attack, it may create and reinforce boundaries by establishing systems which externalise blame or ‘scapegoat’ individuals within the organisation. Fear of being held accountable for a particular negative outcome may act as a discouragement to risk-taking (Tanner, 1998). The NHS and Community Care Act 1990 established a ‘duty of care’ towards adults by both health authorities and local authorities (Kemshall and Pritchard, 1997) although the concept of ‘duty of care’ remains largely underdeveloped in theory and practice (Manthorpe, 2007). In addition, there are a number of other legislative and policy drivers for risk management including health and safety legislation and fear of litigation (Taylor, 2006). Recent research with a range of health and social care professionals also identified the use of complaints systems and attention by the media and politicians as contributing to an “uneasy blame culture that could inhibit practice by making practitioners overly cautious in the interests of being ‘seen to do the right thing’” (Taylor, 2006: 1423).

Perceptions of risk are also contextual, being socially and culturally produced, and influenced by factors such as gender and age (Douglas, 1992; Lupton, 1999; Lupton and Tulloch, 2002). The ‘tensions’ acknowledged within national health and social care policy reflect complex ‘everyday’ experience of risk for service users and staff. Stalker (1999) notes that risk in social care is an under researched area, particularly from the perspective of service users. Significantly, any empirical evidence which exists suggests that lay knowledges of risk are complex and contradictory (Gabe, 1995; Lupton, 1999).

A scoping review of UK research evidence on risk and adult social care (Mitchell and Glendinning, 2008) investigated how different groups of service users and providers perceived and managed the everyday risks that they faced. The review identified diversity within perceptions of risk and its management in adult social care. Managing risk took different forms, including controlling personal behaviour, controlling information and controlling the physical and/or social environment. Much of the available
empirical evidence took a practitioner perspective, which highlighted three areas of conflict:

- the rights of service users to take risks or make the choice to undertake ‘risky’ behaviour and learn from experience versus the responsibility of practitioners (or others) with a duty of care to protect users from harm and/or potential danger

- the rights of service users to take risks versus the responsibility of practitioners to protect others (including the wider community) from harm and/or potential danger

- the rights of service users to take risks in their own home (or other informal settings) versus the rights of paid carers to have a safe working environment.

(Mitchell and Glendinning, 2008:310)

Risk has been identified as an important theme within social care policy and practice and as a point of tension with the aims of service user empowerment, choice and control. Perceptions of risk and notions of risk management are contextual and subjective. As a result, responses to perceived risks within social care are not standardised and will vary between individuals and organisations.

3.4 Risk and older people in social care

What is identified as risky and what is considered an acceptable risk may be judged in various ways by different stakeholders (Douglas, 1992). A study of older people entering residential homes by Neill et al (1998) highlighted how understandings and perspectives of risk can vary. Of those entering residential care only 40% mentioned risk as a reason, compared with 90% of their social workers and 75% of their carers. Norman (1990) highlights the inconsistencies that are present in the ways that certain groups in society are free to take risks compared to the over protectiveness to which older people are often subjected. Historically, older people are subject to a paternalistic approach which frequently denies them opportunities to take positive risks (Bytheway, 1995). Ageist assumptions may neglect that the
later stages of life can be considered a period of development where people develop skills to manage many changes in their life (Pritchard, 1997). Older people may be discouraged from taking risks, the emphasis being on highlighting their perceived limitations and downplaying their abilities (Littlechild and Blakeney, 1996).

The majority of the studies reviewed by Mitchell and Glendinning (2008) that related to older people focused on the physical risks of everyday life for older people wanting to remain in their own homes and the risk assessment process relating to hospital discharge. Research by the Commission for Social Care Inspection found that older people recognised that achieving their aims and wishes may entail a degree of risk, and that older people should be considered as having significant experience in managing change and risk (Commission for Social Care Inspection, 2006). The research also noted that anxiety about risk by other people and organisations can have a negative impact on the choices made by older people and the control they have over their everyday lives. Some older people may utilise risk avoidance as a strategy for negotiating everyday activities (Wilson, 1994). Other research has highlighted that older people sometimes engaged covertly in 'risky' behaviour, concealing this from family and paid carers, in order to maintain independence (Clarke, 1996). Lupton and Tulloch (2002) have argued that an individual's position in the life course may be related to the degree of risk taking and risk avoidance that a person is likely to engage in. Whilst participants constructed youth as a time of risk-taking which lessened with age and responsibilities, some older participants noted a change in their approach to risk-taking in later life when they felt less need to be cautious as their responsibilities to other people lessened (Lupton and Tulloch, 2002).

In residential and nursing care homes for older people, the issue of risk is 'ever present' for staff and managers to create a 'safe' environment for those who enter residential care, with failure to do so potentially resulting in blame and accusations of negligence (Stevenson, 1999). In residential care and nursing homes, risk management is an ideology that limits residents' autonomy (Lidz et al, 1992). Within these environments, "staff believe that
they need to restrict patients and their actions in order to protect their safety and keep them in good medical condition. Such restrictions are a central feature of institutional life in nursing homes" (Lidz et al, 1992:87). However, risk aversion also emanates from other places and perspectives, not just staff, institutions or systems but also from relatives and friends. Bowers et al (2009) noted that in relation to older people with high support needs that this has a "very limiting effect on personal control, and ultimately how you and others see your life and future life chances" (Bowers et al, 2009: 35).

In addition to the social environment of a care home, providing a ‘safe’ physical environment, for example the installation of heavy fire resisting doors, can impact on the ability of older people to easily exercise their freedom and choices (Stevenson, 1999). Using this example, Stevenson demonstrates how a seemingly benign act such as installing protective fire safety doors can have an unforeseen consequence for particularly frail people who subsequently cannot move through their living environment without assistance with opening these heavy safety doors. As well as being a useful practical example of limiting an individual’s freedom of movement, it also demonstrates the potential for risk averse practices to impact on an individual through the creation of a disabling environment. It is argued that the concepts of ‘risk’ and ‘harm’ in health and social care should be viewed in broader terms including not only physical, but emotional and social factors which, for example, may include the effects of loss of personhood in a residential care environment (Stevenson, 1999).

The theme of risk has emerged as prominent in practice issues and policy guidance. Despite discussion in the literature, the idea of risk in relation to policy and practice within adult social care is lacking in clear definition. The literature highlights that approaches to risk are subjective, being understood, experienced and managed differently by service users and professionals. It also suggests that risk related to social care practice is open to interpretation and can vary greatly between organizations and people. What does emerge is that social care practice relating to older people can often be dominated by risk management even though, as a notion, it is not always clearly defined or understood. What also emerges from the literature is that risk is closely
associated with aspects of choice and control for service users, underlining a tension between service user autonomy and professional accountability. This draws attention to the importance of further understanding the practices linked to risk management in care homes and how this relates to sleep and the sleep environment.

3.6 Sociological perspectives on the ageing body

The previous section has highlighted the prominence of risk management in social care and its potential effects on users of services. In relation to older people, notions of risk are linked to perceptions of physical decline, frailty and the ageing body. It is only recently that the ‘body’ has been addressed in ageing studies (Oberg, 1996; Harper, 1997; Gilleard and Higgs, 1998; Tulle-Winton, 2000; Twigg, 2000, 2004). In part, this previous absence emanated from a desire to move away from medical accounts of old age (Tulle-Winton, 2000; Twigg, 2006) that are dominant in intellectual and popular conceptions. Ageing bodies, subject to a medical gaze, are conceptualised as distinct biological entities that are objects of medical expertise (Tulle-Winton, 2000). The dominance of medical accounts was challenged by a political economy approach which highlighted how the experiences of older people were not determined by biology but by structural social processes such as class and gender (Phillipson and Walker, 1986; Estes, 1991; Arber and Ginn, 1991, 1995; Estes et al, 2003). These perspectives aimed to separate ageing from discourses of decline and illness which created the body as a topic to be avoided rather than focused upon, avoiding what was seen as an unwelcome return to biological determinism and discourses of decline (Twigg, 2006). An intellectual shift away from structural perspectives towards cultural approaches has opened up possibilities for more reflexive accounts that focus on identities and lived experience of ageing (Gilleard and Higgs, 1998). The emergence of consumer culture, postmodern and cultural perspectives and masking theories has brought the body, ageing and self into analytic focus (Gullette,
Woodward, 1991; Featherstone and Hepworth, 1991; Gubrium and Holstein, 1999; Gillear and Higgs, 2000) and:

(a)s such it is part of the wider Cultural Turn. This literature drives forward the earlier agenda of social constructionist, but in a more radical way, showing how the body itself is socially constituted. Essentializing discourses, in relation to the body need to be replaced by ones that recognise its nature as a social text, something that is both formed and given meaning within culture. The aging body is thus not natural, is not prediscursive, but fashioned within and by culture. (Twigg, 2004:60)

Poststructuralist accounts are significant for health and social care analysis in reconceptualising power at the level of frontline service delivery and, more specifically, the body (Watson, 2000; Twigg, 2000) and for Foucauldian influenced work that questions the nature of expert knowledge (Twigg, 2006) and how social policy subjects are constructed (Watson, 2000).

However, there are limitations to both biologically determined and social constructionist approaches. Biomedical accounts do not incorporate subjectivity or lived experience, overlooking broader cultural and sociological aspects of ageing and the impact of structures or organisations. Radical cultural accounts construct the body as discursively produced and question any corporeality or physiology of the body, or our capacity to know it (Twigg, 2004, 2006). However, it has been argued that the privileging of discourse and denial of the body in these accounts has reproduced the traditional dualism between the body and the mind (Kontos, 1999).

Featherstone and Hepworth’s (1991) account of the mask of ageing suggests that we experience tensions between the ageing body as a mask which obscures a young person within. This has been criticised for neglecting the significance of bodily ageing and for conceptualising a ‘self’ that is distinct and separate from the body, therefore excluding any account of how the body and self could be entwined (Oberg, 1996; Kontos, 1999). Andrews (1999) also argues that the ‘seductiveness of agelessness’, conceptualising age as socially constructed and fluid, is false. To assert agelessness is not to challenge ageism, but to internalise the values of an
ageist culture (Andrews, 1999). Ageism, however, goes beyond cultural representation and can directly influence the process of ageing itself for example through socioeconomic disadvantage of older people, through institutional ageism limited access to healthcare resources and through low expectations of functioning (Gilleard and Higgs, 2000). Older people are said to internalise these negative messages in ways that undermine confidence and physical and cognitive performance (Gilleard and Higgs, 2000).

It is argued that post-modernism in its most radical form is “an attractive option only for the healthy” and that the physical manifestations of ageing make the corporeality of bodies difficult to evade (Twigg, 2006). In particular, conceptual distinctions between ‘third age’ and ‘fourth age’ stages of later life tend to equate the ‘fourth age’ with physical and cognitive decline and the arrival of ‘dependency’ (Laslett, 1994). Reconstructing old age in the positive image of the ‘third age’, potentially further stigmatises older people who do not possess the characteristics of the third age (Laslett, 1994). It is argued that the new literature on the body largely relates to the ‘third’ age and that the challenge lies in trying to recover the subjective experiences of people in the ‘fourth age’ when cultural barriers and structures that may inhibit this (Twigg, 2006).

Recent research has argued that pain, ill health and emotion require analytic engagement with the materiality of the body (Bendelow and Williams, 1995; Williams and Bendelow, 1998b; Bendelow, 2009). The dual nature of human beings are conceptualised in a way in which we are a body and we have a body (Williams and Bendelow, 1998b). Bodily presence has been described as fundamentally paradoxical:

While in one sense the body is the most abiding and inescapable presence in our lives, it is also essentially characterized by absence. That is, one’s own body is rarely the thematic object of experience. When reading a book or lost in thought, my own bodily state may be the farthest thing from my awareness. (Leder, 1990:1).
Our knowledge of our world is mediated through our bodily senses and experiences (Leder, 1990) therefore acknowledging interaction between the bodily processes experienced with ageing and the cultural and social worlds in which they exist. In contrast to the disappearance of the body in everyday experience referred to above, Leder argues that during times of vital functioning, pain, disease and physical manifestations of emotion the body comes into focus, it ‘dys-appears’ (Leder, 1990: 83). For Gubrium and Holstein (2003), the ageing body is not an everyday constant presence, but may at times be evident or appear through intruding into daily routines (the objective body) and at other times fades from view as a body of everyday lived experience. For older people the increasing visibility of an ageing body needs to be managed and given new meanings (Gubrium and Holstein, 2003). Nursing homes, in particular, are where the body comes into focus as sick or close to death (Gubrium and Holstein, 1999). Although it is acknowledged that this is not the situation for every resident, the care home is an environment where these conditions are discursively centred.

3.7 The ageing body in social care

The body and its management are central to health and social care policy but often overlooked (Twigg, 2002). In the case of social care, Twigg argues that the ‘gaze’ of social work, with it’s traditional juxtaposition to health services through focusing on relationships, has obscured the body, in addition to the existence of wider social assumptions of privacy, bodily boundaries and dignity. Norms, taboos and “traditions of decorum in public discourse” (2002: 429) all contribute to an absence of the body in related policy and research accounts. Certain aspects of social care and in particular, personal care, is largely focused on the body and is about helping people with functions that an adult would normally do themselves such as getting in or out of bed, washing, dressing and using the toilet. As such, social care engages directly with the body and is a primary focus of care services, and in doing so defends the status of the people using the services through helping older people maintain their dignity (Twigg, 2002). Lawton
(1998) argued that bodywork is overlooked because it deals primarily with the negativities of the body. Similarly, Twigg (2006) argues that the absence of the body in social care is due to an attempt at positivism by the agencies delivering social care. The purpose of this is to downplay the emphasis of bodily needs and functions thereby seeking to view those in receipt of care as a person and not simply to reduce them to a failing body. It is argued that the body is further removed from the ideology of social care which is increasingly characterised by managerialist interventions and discourse that focus on quantification and abstraction which permeate the sector with a discourse far removed from the complex and messy reality of front line services (Twigg, 2006). Care homes, and in particular nursing homes, therefore may be subject to two established ideological influences around the body; the biomedical gaze of healthcare and the absent body of social care.

Through empirical research on bathing provided by home care services, Twigg (2003) demonstrates how a detailed focus on an everyday experience of daily life can elicit important insights into the meanings of growing older. The study explores the bounded intimacy of care and body work, but also explores the power dynamics of care that are brought into sharp focus through the nakedness of service user's bodies. Twigg argues that the power dynamics in the bodywork of care services has an unstable dynamic, either reducing care workers to the status of 'servant' or destabilising the service users' already fragile sense of self (Twigg, 2003). It is noted that these power dynamics are influenced by the environment, and the setting of the service user's home as the site for care however the body plays a direct part in these relations. It is argued that the balance usually tips in favour of the care staff and these dynamics are said to be stronger in residential care, where the environment is completely under the control of staff (Lee-Treweeek, 1994, 1996).
3.7 Conclusion

Service user empowerment, choice and control are guiding principles underpinning current policy relating to social care in the UK. It is acknowledged that older people, particularly those in care homes, have not been widely involved in the development and critique of policies that attempt to give them choice and control over the services they receive. Therefore a key question for this research study is to examine the extent to which the principles that underpin these policies exist within the night time environment within the care home. In understanding the everyday relevance of the concepts of choice and control, it is also necessary to examine whether concepts of risk and risk management are relevant to the sleep environment of older people in care homes. The literature demonstrates that ageing bodies may be viewed by professionals as failing and therefore as sites of risk. Ageing bodies are seen as central to risks faced by older people and therefore managing risk is central to work in a care home environment. Through this process managing ageing bodies becomes central to the work of risk reduction and a primary focus of care home life. These practices can exclude other factors such as assessing the physical environment or considering the impact of loss of control and choice which may be experienced by individual residents. The subjectivity and diversity of the perception of risk means that this view may not necessarily be shared by older people themselves.
Chapter 4
THE RESEARCH METHODS AND METHODOLOGY

4.1 Introduction

This research forms part of a wider multi-disciplinary project, SomnIA (Sleep in Ageing), within the New Dynamics of Ageing programme investigating sleep in ageing through a number of linked research work packages. In particular, my PhD research forms part of a work package (WP3) investigating sleep specifically with older people living in residential care or nursing homes. The work package included research with 10 care homes in which 15-20 resident participants wore actiwatches to monitor their sleep/wake patterns and kept activity diaries for a two week period. There were also monitors placed around the home to record noise, light and temperature. The aims of the overall work package were to identify the determinants of poor sleep in care homes to inform how organisational structures and policies can be adapted to improve the quality of sleep experienced by older people living in care homes.

My research specifically was a more in-depth qualitative study which took place in four of the ten care homes. To summarise, in each of the four homes the aim was to undertake interviews about sleep with ten residents and ten care staff, as well as conducting observations over different periods of the day. These parts of the methodology will be the focus of this chapter which discusses each of these aspects in detail and also provides a critical discussion on the reality of fieldwork in care homes and suitability of the chosen methods.

This thesis focuses on the subjective experience of sleep and the meanings attached to sleep for the older people who live in care homes. A fundamental aspect of life in a care home is the presence of care and nursing staff. Many residents are physically dependent on staff for many aspects of living and the staff may play an essential emotional and social role in the lives of all residents. No previous research has focused on the
views of residents about sleep in care home settings. Little previous research about sleep has been conducted which has included the opinions and perspectives of care home staff who provide the hands on care and who significantly impact on the lives of the residents. In addition to understanding the experiences of the residents, it is also important to explore the views of the staff on sleep in the care home as their opinions, assumptions and practices will impact on the general sleep environment of the residents as part of the culture of the home.

4.2 Research aims

The specific aims for this PhD study were as follows:

- to explore the subjective experience of sleep and the night-time in the setting of care homes for older people and to contribute to improving practice in this area;
- to explore the attitudes and perceptions of staff in relation to the sleep of older people in care homes;
- to understand sleep as part of the 24 hour provision of care by not viewing it in isolation, but in its wider social context within the care home;
- to identify features of care home life that are perceived to impact on sleep quality and the sleep environment of the residents.

4.3 Methodological considerations

The focus of the study is to capture the meanings of sleep and the sleep experiences of residents in care homes and how this relates to the social context of the care home environment. This is the first qualitative study of sleep in care homes and therefore is exploratory in nature. This approach was considered appropriate as the focus was to broaden understanding of the lived experience of sleep in care homes.

Within sociology, qualitative research is strongly associated with the interpretivist tradition and also draws on other disciplines such as
anthropology, linguistics and psychology (Mason, 2002). Bryman (1998) states that fundamental characteristics of qualitative research are contextualism and exploring the perspectives of the research participants. Qualitative approaches are usually used when "the object of study is some form of social process or meaning or experience which needs to be understood and explained in a rounded way" (Mason, 2002: 134). This study therefore is exploratory in nature, inductive and is located within a broadly interpretive sociological framework.

The research uses both interviews and observations, and as such utilises a combination of methods and sources to explore sleep in a care home. These methods are sometimes brought together under a broad heading of 'ethnographic' research however the limited time spent in the field in this study I feel prohibits the use of the term 'ethnography' in method or product (Agar, 1980). However, my undergraduate degree in Anthropology will undoubtedly have influenced my approach. The data collection techniques are typical of ethnographic research and are useful for exploring social issues and gaining the participants' own perspectives (Angrosino, 2007). The use of these two methods of data collection was employed to explore different aspects of care home life in relation to sleep and it is important to acknowledge the implications of the distinct research methods and how these work together.

Interviews are said to enable the researcher to 'hear the voices' of the participants, in this case the residents of the care homes and the staff that work there, providing first-hand accounts of the members of the setting and allowing for complexity, subjectivity and lived experience (Byrne, 2004). Formal interview situations are also a purposefully organised meeting to discuss whatever the interviewer is interested in, therefore accounts could be considered problematic "because of the activity of the interviewer in producing them" (Dingwall, 1997:60). Byrne (2004) states that "what an interview produces is a particular representation or account of an individual's views or opinions" (2004:182). As the study aims to broaden understanding of the potentially complex nature of private activities in the context of a care home, it was considered appropriate to also undertake observations.
Different methods may be utilised to explore different parts of a phenomenon (Mason, 2006) or to allow different or new aspects of problems to be investigated and encourage further analysis (Bloor, 1997). The use of observations in this study is not as a validation technique although, as will be discussed later, it raised questions about the status of interview data when participants' statements in interviews were contradicted by their actions. Weinberg (2002) notes the distinct value of observations in that they allow a researcher to witness practices without relying on the opinion of respondents as to whether it should be brought up in an interview (Weinberg, 2002). Observation enables a researcher to view members in the research setting, record their interactions with each other and the social environment (Dingwall, 1997). In addition to enabling a researcher to view a range of dimensions including routines, behaviour, language and conversations, observations are also useful for non-verbal interaction or where retrospective accounts may be lacking (Mason, 2002). As Goffman noted, "that you are close to them while they are responding to what life does to them" (1989:149).

The status of the interview and observation data was considered equal. The interview and observation data were integrated at the point of data collection in that they were conducted simultaneously throughout the fieldwork period in each care home. They also influenced each other whereby occurrences witnessed during observation could be explored in interviews and issues raised in interviews could be kept in mind during observations. At a technical level, the data sets of interviews and observational field notes are incompatible as the units of analysis are different (Mason, 2002), either being individuals or care homes. At the analytical level, it is possible to integrate the data through a 'following a thread' approach (Moran-Ellis et al, 2006), taking an analytical theme and following it across the other data sets to "create a constellation of findings which can be used to generate a multifaceted picture of the phenomenon" (2006:54).
4.4 Recruitment and Sample Selection

The research took the form of interviews and observations in four residential and nursing care homes for older people. Overall the design included 10 interviews with residents and 10 interviews with staff in each care home. There were also a number of observations in each home during the period of study which lasted between two to three weeks in each of the four care homes. Specific aspects of the research design are discussed later in more detail.

4.4.1 Selection of care homes

The SomnIA project, on which this thesis is based, stipulated that the work package on sleep in care homes would be undertaken in ten purposively selected care homes in South East England registered to meet the needs of older people. The research design was not appropriate for people with dementia and therefore research was not undertaken in care homes registered only to meet the needs of older people with dementia. All homes were within a 50 mile radius of Guildford to facilitate fieldwork.

Access to the 10 selected care homes was sought by approaching providers and individual care homes and the original selection criteria was based on:

- dependency level of residents; number of residents cared for
- organisational structure (corporate/small business; profit/not for profit)
- geographical location (urban, suburban)
- type of build (new build, conversion)

For the work package as a whole, it was considered that a home with a larger number of residents would be more likely to achieve the desired number (15-20) of resident participants. It was also hoped to achieve a cross section of homes with regard to organisational structure, geographical location and type of build.

My part of the research took place within four of the care homes and I was able to choose which homes would be my preferred research sites.
Residential and nursing home care is characterised by a mixed economy of providers and therefore I tried to achieve a range of different types of homes. The final four selected research homes consisted of two that were operated by a London Borough local authority (one residential care, one nursing), one private sector home (nursing) and one operated by a charity (nursing). The size of the care homes was limited to medium and larger care homes due to the number of participants required for the work package as a whole. In this thesis, each home has been made anonymous by the removal of their names and any identifying features. The care homes have been given a pseudonym and a brief profile and description of each home is at Appendix A.

4.4.2 Selection of Participants: Residents

For the overall work package, all eligible residents in each home were given an introductory letter and information sheet (Appendices B and C) and were able to volunteer to participate in the study. Care home residents aged over 60 years and those able to give consent were eligible for the study. Those with severe ill health (as determined by the care home manager), severe dementia (as determined by the care home manager) and those unable to give informed consent were excluded from the study. For interview recruitment, I worked with the SomnIA researcher at the beginning of the data collection process in each of the selected four homes and was involved in the recruitment of participants to the overall project. During this recruitment process, I was able to ask if people were willing to participate in a recorded interview about their sleep. Potential participants were asked at this stage to sign a consent form which included information about interviews (see section 4.5 for a discussion of issues associated with consent).

My aim was to recruit 10 residents in each home for an audio recorded interview. Some participants who were recruited for the overall work package at this stage were not selected for interview. As discussed later in this chapter, some older people with cognitive impairment may, at an initial meeting, appear suitable for interview. However, as I got to know them over
the research period, it sometimes became apparent that their cognitive impairment was such that an interview would not be an appropriate research method. It may be, for example, if a person had trouble with recall or was confused, that the format of an interview was not appropriate. If the required number of 10 interviewees was not achieved from the recruitment to the overall work package, I talked to other residents in the home as some had indicated they did not want to take part daily in a two week research project, however they were prepared to participate in an interview as a one-off occurrence. In these cases, I would give them the written information and consent form for the overall project (Appendices B and C), but in practice participants generally preferred discussing it with me and asking any questions that they might have.

Despite trying to gain a balance of male and female participants, the majority of the participants were female which reflects the general population of care home residents. In residential homes, 78% of residents are women, and in nursing homes 72% (Help the Aged, 2008). Participating residents were aged between 69 and 99 years old. Table 4.1 sets out the number of resident participants in each home by gender, age group and dependency. The categories of low, medium and high 'dependency' were allocated informally by the researcher based upon observation and information received from the resident and staff, rather than being based upon an existing index or score used in health or social care services, such as the Barthel index. 'High' dependency was allocated where the resident had limited or no mobility and did not walk even with the use of aids. These residents used wheelchairs and would also require the support of two members of staff to transfer between a chair and bed. 'Medium' dependency was allocated where some assistance with personal care was required from one member of staff, and usually the resident would walk with the assistance of an aid, such as a frame. 'Low' dependency was allocated where little or minimum assistance with personal care was required and the resident did not require support with walking. It is important to note that any person funded by a local authority to be in a care home would be deemed to have a substantial or critical level of need in order to qualify for a placement within a residential or nursing care home. It is also
important to note that care homes are not physically demanding places in relation to tasks that people need to carry out for themselves.

<table>
<thead>
<tr>
<th>Care Home</th>
<th>Female</th>
<th>Male</th>
<th>Age group</th>
<th>Dependency</th>
<th>Total Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Windley Lodge</td>
<td>5</td>
<td>1</td>
<td>66-75 - 1</td>
<td>Low - 0</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>76-85 - 4</td>
<td>Med - 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>86-95 - 1</td>
<td>High - 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Over 96-1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bascombe House</td>
<td>8</td>
<td>2</td>
<td>66-75 - 1</td>
<td>Low - 2</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>76-85 - 3</td>
<td>Med - 6</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>86-95 - 5</td>
<td>High - 2</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Over 96-1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kimble House</td>
<td>8</td>
<td>2</td>
<td>66-75 - 3</td>
<td>Low - 5</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>76-85 - 3</td>
<td>Med - 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>86-95 - 4</td>
<td>High - 1</td>
<td></td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>Over 96-1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Longford Manor</td>
<td>12</td>
<td>-</td>
<td>66-75 - 1</td>
<td>Low - 1</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>76-85 - 3</td>
<td>Med - 8</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>86-95 - 8</td>
<td>High - 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Over 96-0</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>33</td>
<td>5</td>
<td></td>
<td></td>
<td>38</td>
</tr>
</tbody>
</table>

*Table 4.1 Resident participants by care home, gender, age group and dependency*

4.4.3 Selection of participants: Staff

The overall work package provided letters and information leaflets for each member of staff, explaining the research process and this included asking for volunteers to be interviewed (Appendices D and E). The intention was for me to select a representative sample of 10 care staff to reflect as closely as possible the overall mix of staff in each of the 4 care homes. However, in reality it was not always possible to achieve the desired number of interviews in each home.
The managers of the care homes had consented to staff being interviewed as part of the data collection and staff had permission to be interviewed during their work time. This was useful in recruitment of participants as it would have been difficult to find staff willing to be interviewed during their lunch break or at the end of a busy shift. In three of the four homes, senior members of staff assisted me by arranging times for staff to be interviewed. This made the process easier for them as managers because they were able to plan for the staff to be absent for a while and also reassured them that I would not be asking staff to 'leave the floor' at inappropriate times. I also feel this gave the staff explicit permission to participate in the interview process which they knew had been legitimately sanctioned by the senior member of staff on duty at the time.

Despite this support from the management team, some staff interviews felt rushed or cut short as staff felt obliged to get back to work. They were aware that residents may be needing assistance or that other staff may be under pressure. Although staff had permission to stop working to be interviewed, there was no extra cover arranged to replace the staff member being interviewed.

When arranging staff interviews through a senior member of staff, I explained that I would like to obtain a range of interviews with both male and female workers, full and part-time, care staff and qualified nursing staff. Where interviews had been arranged with a senior member of staff, it was important for me to emphasise to the potential participant that the process was entirely voluntary. Where I felt the person may have met me for an interview because it was expected of them, I clearly stated that I would not be reporting back about people who had not wanted to be interviewed and that it was entirely their decision whether or not they took part and whether the interview was recorded. I explained that the study was exploratory and that I was interested in their views, opinions and experiences as health or care workers in this field. I checked that they had received the written information provided by the SomnIA research project (Appendices D and E) and answered any questions about the background, method and outcomes.
of the study. Table 4.2 sets out staff participants by gender and care home.

<table>
<thead>
<tr>
<th>Care Home</th>
<th>Female</th>
<th>Male</th>
<th>Total Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Windley Lodge</td>
<td>5</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>Bascombe House</td>
<td>13</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>Kimble House</td>
<td>9</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Longford Manor</td>
<td>10</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>37</strong></td>
<td><strong>2</strong></td>
<td><strong>39</strong></td>
</tr>
</tbody>
</table>

Table 4.2  **Staff participants by care home and gender**

Table 4.3 sets out the characteristics of staff interviewed in relation to gender, night and day shift workers and whether English was not the participant's identified first language. In the following chapters, certain characteristics of staff participants will be included with their pseudonym and their care home pseudonym. This will be whether they are a nurse or care staff, and their predominant current care home shift work. This will be identified as 'days', 'nights' or 'both days and nights'. Most staff working at Longford Manor worked on a rolling rota and worked both days and nights. A number of staff who worked mainly day shifts also worked nights occasionally as overtime or had previous experience of working nights in care homes. Although currently working day shifts, some staff had considerable experience of night shifts either in their current or previous places of work. For example Stephen, a residential care officer at Kimble House, was at the time of the research working only day shifts, however he had two and a half years previous experience of working solely on night shifts.
### Table 4.3 Staff participants by gender, day or night shift worker and whether English was a first language.

<table>
<thead>
<tr>
<th></th>
<th>Day Shift Work Only</th>
<th>Night Shift Work Only</th>
<th>Currently works both days and nights</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female staff</td>
<td>16</td>
<td>11</td>
<td>10</td>
<td>37</td>
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<tr>
<td>Male staff</td>
<td>2</td>
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<tr>
<td>Sub-totals for shift pattern</td>
<td>18</td>
<td>11</td>
<td>10</td>
<td>39</td>
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<tr>
<td>English as first language</td>
<td>10</td>
<td>6</td>
<td>1</td>
<td>17</td>
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<td>English not first language</td>
<td>8</td>
<td>5</td>
<td>9</td>
<td>22</td>
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4.5 Ethical Issues

The research was designed and conducted in accordance with the British Sociological Association’s Statement of Ethical Practice (2002) and the Department of Health’s Research Governance Framework for Health and Social Care published in 2005. The overall work package submitted a detailed protocol which was given a favourable opinion by the Ethics Committee of the University of Surrey (Appendix L). Additional research governance approval was received from the relevant local authority for the research conducted in the two local authority owned care homes. All members of the research team obtained enhanced Criminal Records Bureau (CRB) checks prior to entering the field, in line with the Protection of Vulnerable Adults Scheme published by the Department of Health (2004). Although the research protocol benefited from the scrutiny of the Ethics Committee, the researcher is aware that ethical practice extends further than this and is also down to the integrity of the researcher (Ali and Kelly, 2004).
4.5.1 Obtaining informed consent

As determined by the care home manager, those residents with severe dementia were not included in the research as the wider research project was not designed for people with more severe cognitive impairment.

The research protocol stated that written informed consent would be gained from each participant in the study. The care homes were provided with written information about the project and had consulted residents and relatives before agreeing to the research. As previously discussed all staff, residents and relatives (Appendices B - G) were provided with their own written information providing details of the study, how participants could be involved and providing contact details for people to obtain further information. In order to recruit participants within the home, the researchers were available to discuss details of the research, the methods that would be used and also to answer any questions. At all times, emphasis was given to the rights of residents not to participate, or to opt out of any or all the research. Consent for the observations in the homes was given at the outset by the care home manager who had consulted with residents and their families.

A care home is a unique and challenging research environment. The population of residents is very old and, by virtue of being resident in a care home, are very likely to have physical or cognitive impairment. Even though the research was conducted in homes that were not registered as specialist homes for people with dementia, the reality was that there were a number of residents with various stages of dementia, diagnosed or undiagnosed. This meant that consent was a key issue, and obviously an ongoing process rather than just a signature. Even if a participant said they were willing to participate, judgement had to be made that they had the capacity to consent. A judgement also had to be made that they genuinely did want to participate in the research and were not just being obliging because they did not want to offend the ‘friendly people’ who had come to talk to them. This meant being acutely sensitive to the smallest of cues, verbal and non-verbal, that the person did not want to take part or continue to take part. Continuously
throughout the research, I was prepared to explain the study again to ensure that the resident remembered what the study was about and was still in agreement to continue being a participant.

At the first stage of recruitment staff were introducing the researchers to people they thought were 'suitable' to be involved in the research. It was common for staff to introduce the researchers to people with dementia who had wakefulness at night because they had misunderstood and thought the research was studying poor sleepers. However, the study was not designed for people with more advanced dementia and we had not included this group of people in the research protocol which was submitted for consideration by the Ethics Committee. There are times when 'dementia' is not so clear cut. Where people had a 'confusion' which was undiagnosed or potentially early stage dementia, it felt wrong to make potentially discriminatory assumptions that the person automatically did not have the capacity to consent.

I was involved in the resident recruitment process to the wider work package and therefore I was able to talk to the residents about whether they would also be willing to participate in an interview as well. The consent forms for the wider project for both residents and staff included information about interviews (see Appendices H and I). If I was not able to recruit enough participants from this initial process then I tried, with the assistance of staff, to recruit people who had not wanted to participate in the overall two week study, but who were prepared to participate in a one-off interview. The same consent form was used for these participants.

It was not uncommon when recruiting residents to the wider study for them to respond "well if you think it's a good idea, I'll do it" or "if you like". In addition, they may have asked a member of staff what they thought about it. Many care home residents become used to having health and social care professionals tell them what to do; encouraging them in some way to take action and telling them what the staff think is best. If residents are not really differentiating the researcher from that type of role, it is essential to ensure the residents are genuinely willing to participate and not just agreeing because the staff encouraged them to. Residents may also have been
motivated to take part in the study because of the additional social interaction it would bring.

There were occasions when relatives of potential participants became involved in consent issues. The care home staff would inform the researcher where families had expressed that they did not wish their relative in the care home to participate. One of the key principles of the Mental Capacity Act 2005 is the presumption of capacity in that every adult is assumed to have the capacity to make their own decisions unless it is proved otherwise and a designated decision maker is appointed. Even where families did not have this designation, the care home would not agree to the resident being recruited to the study if the family raised objections. Although this was not in accordance with the Mental Capacity Act 2005 we needed to be mindful of maintaining a good relationship with the home. Furthermore, care homes and the relatives of the residents who live there sometimes have complex and delicate relationships and it was not considered appropriate that the research would interfere with or undermine these existing relationships. Conversely, Donald, one male resident in the first care home had agreed to participate in the research against the wishes of his wife, who did not live in the care home. The head nurse reported to us that she had received a strong complaint from his wife that he was wearing an actiwatch when she did not want him to. Donald had Parkinsons disease and had hand tremors and slow speech. I asked the head nurse if, in her opinion, Donald had the capacity to consent and she replied that he did. The nurse also told us that staff had heard Donald telling his wife that he wanted to take part in the research because it was something he could do to help and he hoped that, in the future, someone would benefit from it. It was agreed with the nurse that he would continue to participate in the research and I went ahead with the interview. This is an example of the complex relationships that had to be managed during the research process as the staff wanted to maintain good relationships with the families. It was also important for the researcher to maintain good relationships with everyone involved in the study including the families of residents, so any potential discontent needed to be managed carefully and dealt with appropriately.
One issue for this type of research in a care home is that participants may forget that the research is taking place. This is a real dilemma for researchers with certain groups of people and it was a matter of balance and judgement as to how often and when I felt people needed reminding that they were taking part in a research study (Lawton, 2001). The information and consent literature given to potential participants stated that participants could withdraw at any time and I emphasised this in recruitment discussions. However certain groups of people may be reluctant to tell you that they do not want to continue participating in the research project or may be unaware that they can change their mind about something they had formerly agreed to and therefore it was important to be sensitive to non-verbal cues about unwillingness and to continuously monitor this throughout the research (Wiles, 2007).

In each care home there were a number of residents who were not taking part in the study. However, because of the public nature of care homes during the day with different people coming and going, residents not taking part in the study would interact with me, ask who I was, and also talk about their sleep when they found out what I was doing. Additionally, observations included the whole home and did not exclude people who were not taking part in the study. Observations were only conducted in the public areas of the home such as the corridors, lounges, reception and dining areas, unless I was invited into a resident's room. However observations often felt intrusive, if for example a toilet door had been left ajar revealing someone making use of the facilities; or a bedroom door was left open with a naked or half-dressed resident in view. These were a clear reminder that I was in someone's home despite the blurred public/private boundaries that are characteristic of this type of environment. However, I reminded myself that relatives and other visitors were also able to walk freely around these parts of the home, and that residents' bedroom doors were typically left open, so it would not have been a totally new experience for the residents.
I am confident that all participants understood the purpose of the interviews. Even if some residents may have lost the theme of the discussion and may have asked again what I was interested in talking to them about, they understood that I was a researcher from a university. Consent was continuously monitored to ensure the residents understood and were happy to continue. However, I am unsure about how much participants, both staff and residents, understood about the analysis process and how their narratives may be deconstructed and interpreted in other ways. As this was an exploratory study, the researcher did not initially have a clear understanding of the themes that would emerge. Despite having confidence in the analytical process, I cannot be certain how individual participants or homes would respond to some of the conclusions drawn in this thesis.

### 4.5.2 Anonymity and Confidentiality

The names of care homes and participants referred to in this thesis have all been changed to protect anonymity. Documents such as participants’ signed consent forms are maintained by the researcher securely and in strict confidence.

Anonymity of who was taking part within the home was not possible as staff members were able to discuss with each other who had agreed to an interview and they also made suggestions about residents who would like to take part. Additionally some interviews were conducted in visible (but private) areas around the home. As research was being conducted within the home, members of staff assumed that many residents would be involved. The main concern of staff was the anonymity of the care home and that their individual identity was preserved to outsiders and the general public. However emphasis was placed on maintaining confidentiality of what was said by all participants during interviews and observations. As some residents did talk about their dislikes of particular staff or certain home practices, it was especially important to safeguard their anonymity. It was common for staff to engage the researcher in a discussion about particular residents and their sleep, however it was still essential for the researcher to
keep private the matters disclosed by residents during interviews. As part of their daily work, staff were used to sharing information about residents between themselves and with other health and social care professionals, therefore it would have been a normal process for them to talk about specific residents. Not only did this provide useful information for the research, it also helped to develop relationships with staff as it placed them in the position of teacher to the researchers.

4.6 Interviews with staff

The interview guide for care staff was semi-structured, intending to be exploratory in nature and to encourage a coherent analytic framework and open ended questions were used to encourage and allow the participant some freedom to talk about issues they wanted to raise. The topic guide (Appendix J) included questions about the staff member's role in the preparation for night time and morning time, physical environment, what the care home was like overnight, disruptions to residents' sleep, interventions for sleeping problems, daytime napping and medication. Care staff were also asked to describe a good and bad night's sleep for residents. All except one interview was audio recorded.

In the first care home, I only achieved 5 care staff interviews and therefore did not achieve the desired number of 10. Although staff had been given permission by the home manager to be interviewed, they were very busy during the day and therefore early in the research period it was difficult to get to know them well enough to establish a rapport in which they felt comfortable agreeing to an interview. I felt they were sceptical of what we were doing there and the other researchers on the wider project reported seeing staff look at us suspiciously. As the nurses and care staff were usually busy with residents or in the staff room on their break, there were not that many opportunities to approach them. The first member of staff I interviewed was the most senior nurse, who was also invaluable as a 'gatekeeper' to the home. The only other staff interviews achieved were on the two night shifts I observed. One nurse did not want to be recorded, so I
had to take notes, which may have been an indication of the level of mistrust of the research. I found the process of interviewing and simultaneously taking notes difficult, as this section of my observation fieldnotes illustrates:

For a start, there is much less eye contact as I kept having to look at what I was writing. You are constantly thinking about what you are writing so this leaves much less brain capacity available for probing etc. And thinking about the next questions. She also spoke very fast (and quietly) so it was difficult to keep up and I know that I did not get everything down, although I tried to get the key points. During the interview the buzzer was going and Aziza said that the carers would see to it. Aziza rushed the end of the interview as she said she wanted to get on with her medicine round.” (Field notes, Windley Lodge)

The ‘gate keeper’ in the other 3 homes was usually a nurse or senior carer. In each case, these gatekeepers organised interviews with staff during the day time, which was a great help and I was able to specify that I would like a mix of staff. It is expected that gatekeepers will be concerned with the reputation of the organisation, having an interest in themselves and their colleagues being presented in a positive way (Hammersley and Atkinson, 1983) and therefore they may have influenced, consciously or subconsciously, which particular members of staff were interviewed.

However, in the first home it had proved difficult recruiting staff participants directly and this partly was because they needed management approval to leave the ‘floor’. Bearing this in mind, I welcomed the assistance from the gatekeepers in organising interviews and in hindsight do not feel that I only spoke to those who would have been considered ‘good’ carers. Although this was convenient for the research process, I was also apprehensive that staff may have felt that they had no choice over whether they took part in the interview. I always emphasised in the beginning that it was not compulsory and that they did not have to take part, whatever their manager had said. Some may have seemed hesitant to begin with but visibly relaxed throughout the interview. I tried to conduct the interviews early on in the 2 week research process in each home, as staff seemed to feel more comfortable with the research once they had been interviewed and realised that they were not being judged or criticised, but simply asked for their opinions and experiences relating to residents’ sleep. Interviews also helped to build
rapport and trust which I felt made staff less self-conscious in observations because they had got to know me and were more used to my presence.

Although there are peak busy times during the day, care staff are generally very busy around the home and it was difficult for them to find the time to be interviewed. This problem did not occur as much for interviews that took place during the night shifts as there were more likely to be periods of quiet when most residents were asleep or in their rooms. The length of interviews overall varied between 20 minutes and one hour. The longest interviews were from night staff with English as a first language. This variation partly reflects the pressure staff felt during the day being taken ‘off the floor’ for an interview. This may also reflect the confidence of night staff in talking about sleep. For the night staff, sleep is seen as their business whereas the day staff sometimes did not have a detailed understanding of what the night was like in the care home and therefore did not feel they knew enough to talk knowledgeably about the subject.

Interviews generally were held in empty offices or dining rooms. However, it was always possible to hear (and sometimes see through windows) what was going on in other parts of the home so staff were not always able to completely detach themselves from their work. During the day, interviews were sometimes interrupted by other staff or residents wanting to speak to that particular member of staff or needing to get something from the room that we were using. Many of the nurses and carers were from overseas and many did not have English as a first language. Although much of the time, the level of English was good, there may have been some difficulty in my full understanding due to particularly strong accents. Many of these interviews were shorter and this may have been a reflection of their lack of confidence in their language skills. Additionally, it was important not to exclude carers who did not have English as a first language as they represent a significant proportion of the workforce in care homes. In all homes it would not have been possible to recruit 10 care and nursing staff members who spoke English as a first language.
Another aspect to consider about the staff interviews may be their own perceived low status as care workers in our society. Additionally "most informants lack assurance that they know enough, that the ethnographer is really interested" (Spradley, 1979:68). I endeavoured to mitigate against this by taking opportunities, both in informal conversations and in the interviews, to acknowledge the expert knowledge of care staff in their field, by expressing interest in what they do and expressing ignorance about what they do, to reinforce their 'expert' status as participants in the research. The ‘expressing ignorance’ aspect of this is a balancing act, as I wanted to encourage participants to talk in detail, however I also needed to establish positive relationships with them through indicating that I was "informed enough to make the conversation worthwhile" (Rubin and Rubin, 2004:86) and would have some understanding of what they were talking about. I also did not want to be ascribed the role of 'untrustworthy outsider' (Rubin and Rubin, 2004: 86) by the staff as they may not have felt able to be open in discussing sensitive issues.

Nursing and care staff were wary of research generally as they were conscious of negative media reports about care homes and also aware of the negative perceptions of care homes in society generally. In addition to this, they had experience of the interviews and observations conducted by the Commission for Social Care Inspection (now Care Quality Commission) after which their care home would be given a public rating, and I felt that this had an effect on the dynamic of the interview. For example, some staff members tended to answer questions in terms of how the home adhered to policy guidelines, rather than talking about personal experience and opinions. Interviews with these staff members also tended to be shorter and take place during the day. However, many care staff who were interviewed found it to be a positive experience and encouraged others to take part. Some reflected how it had been interesting to take time out from their daily routine and talk about a topic which they did not normally think about in such detail.
4.7 Interviews with residents

Overall there were interviews with 39 care home residents (5 male, 34 female, see table 4.1) and all participants consented to the interview being recorded. I had made an assumption that I would not encounter too much difficulty in obtaining the desired number of resident interviews, due to being introduced to potential participants by staff. However the care home setting as a research site offered a number of challenges on a practical level. From the 40 or 50 people who live in each home however, it was sometimes difficult to reach the 10 desired interviews. Especially in a nursing home, some people were just too ill to want to take part or simply did not wish to take part and many people were cognitively impaired to the extent that it ruled them out of the study.

The interview guide was semi-structured to allow for the participant to raise their own issues. The topic guide (see Appendix K) included questions about personal routines around sleep, what the night was like in the care home, disturbance to sleep (causes and responses), strategies for coping with poor sleep, napping, medication, daytime activities and what sleep was like before they moved into the care home.

4.7.1 The right time and place for an interview with a resident

Finding the right time for an interview can be quite difficult. I did not want to make assumptions that residents would be necessarily available at any time for interviews so I endeavoured to make appointments with them. However, this strategy was not often successful in that appointments would often not be kept.

Today I went to interview Maud as arranged at 11am. As I came out of the lift, she was being pushed in a wheelchair into the lift. Apparently she was going to chapel so I agreed to see her this afternoon at 2pm. When I arrived at 2pm she said she was just going to an activity......! (Field notes, Windley Lodge)
This example from my field notes is an example of the problems that can occur when an appointment has been made with a resident. This highlighted for me that the dependence of residents upon staff creates a kind of ‘permanent present’ for many residents who are physically reliant on others and seem therefore to no longer be managing their own time and routines. Nevertheless I continued to pursue this strategy throughout the fieldwork, even if appointments were not kept, because I felt it was disempowering for residents to have other people make assumptions about their time and a few residents were able to make and keep or change appointments for interviews which gave them more control over the situation.

Despite popular conceptions of care home life, and the indications from our research, that many residents are not that busy, it was surprisingly difficult to find the right time for interviews. When I started in the morning I might have an idea of who would be interviewed that day however a number of factors often occurred. Residents may have still been in bed, either lying in or waiting for staff to assist them; they may have been being assisted to wash and dress or having breakfast. Then they might not want to spend time being interviewed in case they missed getting their preferred spot in the lounge or the dining room for lunch, or they may have been waiting in the dining room for lunch and sometimes this could be for a fairly long time. They may have been dozing after lunch, participating in an activity or sitting having afternoon tea. They might not be feeling well that day, have had appointments with the doctor or hospital or hairdresser, having visitors and so on. The window of opportunity for an interview was small and I had to be ready to grab it with both hands when it came along. Even when I did manage to secure an interview, some cut short the interview so they could get to a particular activity or watch a television programme.

Finding a place for an interview could be difficult. Many were happy for me to come to their rooms, however I would always wait for it to be suggested first by the participant. Although I was in their private space, their room might have been a more empowering space for them to engage in an
interview. Sometimes I had to sit on their bed which could feel a bit strange and intimate. Depending on the circumstances and gender dynamics, this may be a help or a hindrance as one male participant wanted a cuddle and asked for a kiss. Another factor was that not all rooms are laid out to accommodate visitors and this sometimes appeared to make residents feel awkward when asking me to sit down, although in this situation most encouraged me to sit on their bed. This highlighted the changing nature of the meaning of the bed from a place of privacy and intimacy to a piece of furniture that could receive a relative stranger as a guest (van Dongen, 2007). There was sometimes an available chair, however in one case realising halfway through an interview that I was sitting on a commode chair was a little disconcerting.

If I was not invited to their room for an interview, we sometimes wandered around the home trying to find somewhere suitable in the more public areas. I conducted interviews in the dining room, lounge, activity rooms or corridors, as necessary. This was not considered problematic as the noise and activity of a public area can protect the privacy of a conversation as opposed to a quiet room where a carer could hear from outside the door (Savishinsky, 1995). Participants interviewed in 'public' areas did not appear obviously hindered or guarded in their talk and the main problem with such interviews was the ambient noise interfering with the quality of the digital recording.

4.7.2 Health status and interviews

Most residents of nursing homes are physically frail and/or cognitively impaired to some degree. Although residential homes do not have the same intensive nursing input, residents could still be in poor health, frail or dependent upon staff. In this discussion of the physiological aspects of interviewing, it is not my intention to homogenise all older people (or the biological ageing process) but to address some issues that may arise when researching in the unique situation of a care home and with “fourth age” participants.
The comfort of participants is important and this, in turn, is likely to effect the length and quality of an interview. It was important to be aware of non-verbal signs and to ensure the participant was happy to continue with the interview at that time. For example, it is actually quite tiring sitting and talking for any length of time in a focused way and one participant actually fell asleep while she was talking during the interview. Sitting in the same position for any length of time might cause discomfort or pain and this was noticeable with some residents who shifted their position constantly during the interview. Hearing is another aspect to consider and reading back one transcript it was clear that the participant was making up for not fully hearing the question and was not always answering the question that had been asked. Having a dry mouth and reduced saliva flow are common problems in older people. This can be caused by disease and medication, and may also affect the ability to pronounce words and be the cause of some embarrassment (Gerdin et al, 2005). Where this appeared to be the case, I would always offer to get a drink for the participant if they wanted to continue. Another aspect affecting verbal communication was badly fitting dentures and this was seen to affect some participants. In extreme cases, the dentures move and drop when the person is speaking and again this may cause them communication difficulties or embarrassment. Some or all of these individual physiological aspects may have been present in any one interview and should not be overlooked in the research process due to the potential effect on quality and length of interviews. However there are also research factors to be considered relating to the wider social environment of the care home.

4.7.3 Interviewing in the environment of a care home

People living in care homes can be disempowered by that environment. For many people, the act of moving in to a residential home can undermine their identity (Peace et al, 1997). It is a fundamental life transition that may be associated with a series of losses and declining health (Help the Aged, 2007) which may have a negative effect on their sense of autonomy.
potentially leading to stoicism and passivity (Reed and Morgan, 1999). The social environment of a care home is such that, for many residents, the main source of interaction is with health and social care professionals. The combined effect of this disempowerment and a general lack of conversation in the homes leads to a task-based discourse with staff who are in control of the communication (Eyers, 2003), whereby residents are mostly giving short answers in response to questions from staff. Therefore some residents do not talk at length and in some interviews I had to try and find different ways of encouraging more active participation in the interview and encouraging people to talk for longer. This may have been hindered by the fact that sleep is an unusual topic of conversation and many people, not just older people, are not used to talking about it at length. One female resident I was attempting to recruit for an interview told me "I go to bed, I sleep, I get up – there's nothing more to it." (Field notes, Kimble House Nursing Home). As the research process progressed, I became more experienced and would talk about anything that helped to get the conversation flowing and the participant more actively involved.

4.7.4 Recall and cognition

In some interviews, it became apparent that the participant was talking about their night time routines as if they were still living in their own home. This could have been due to a number of factors and some judgement was required as to whether this was force of habit, early dementia or confusion, or a personal strategy for dealing with the trauma of leaving their previous home and familiar environment behind. If it was felt to be the latter, then this demanded careful negotiation of the interview, as I did not want to force someone into a "present" that was emotionally difficult for them or one that they did not want to discuss. This required quick thinking and careful monitoring of their responses. For example, consideration may have been given to whether it would be appropriate to try and continue the discussion by asking them "when you stay here sometimes, what is that like?"

However, it did not always feel appropriate to do that, so I had to rely on my
judgement and prior knowledge of the participant. If someone was having difficulty recalling things, then this could also be a disempowering situation for them and if I started to feel that a participant was becoming uncomfortable or upset by that, it needed to be addressed in an appropriate way. Depending on the situation, it may have been necessary to change the subject, talk about today or ask about a photo immediately visible in their room in order to find a way of guiding the conversation to a point that the participant could comfortably connect with again.

Some older people with cognitive impairment may be able to participate in an interview: they are articulate, talkative, have good social skills and can respond appropriately to questions. However, as discussed in section 4.8 on observations, they may provide inaccurate answers about factual aspects of their daily life. However assumptions cannot be made about the cognitive ability of a person if they contradict themselves or they give seemingly incongruous answers to questions and this is one of the challenges of researching with older people (Wenger, 2002). There may be inconsistencies or contradictions which appear in discussions with participants, but this may not be due to age related factors. In addition to talking to staff, the observations (as discussed in more detail in section 4.8) were useful for establishing the degrees to which participants had cognitive impairment.

4.7.5 Managing Emotion

Historically the concept of emotion has largely been neglected in social research, however recent sociological interest in the body has generated debates around emotion and well-being (Williams and Bendelow, 1998). 'Sleep' may seem a fairly innocuous topic, however in our society it is characterised as an intimate and private activity. Due to the individual and personal nature of the topic it was not possible to predict how residents would respond to questions. Occasionally during the interviews some participants raised very emotive topics or became emotional themselves. Through talking about their sleep, participants sometimes talked about their
personal lives and occasionally this prompted painful memories. For example, in one case a seemingly harmless question about watching television before bed elicited an emotional response whereby the participant associated watching television with his family house and with the family life he no longer had. This, understandably, made him emotional. He was also having problems with recall and it was making him frustrated, however he did keep saying, without prompting by me, that he wanted to carry on with the interview and that he wanted to answer my questions. However when talking about his previous family life, and about his present situation in the care home, this became very upsetting for him.

Another aspect of emotion during an interview was where a participant deviated slightly from the research topic and started talking about something to do with their life that was upsetting them. Many residents in care homes are socially isolated and the interview may become an opportunity to discuss strong feelings. For example, one female participant had Motor Neurone Disease and spoke through a type-talk machine. We had got to know each other quite well during the course of the research. Her mind was active and alert but she felt that her body was failing her. The disease was fairly advanced and she was getting to the stage where she would need liquid thickeners in her drinks as her swallowing mechanism was deteriorating. One of her few pleasures was a cup of tea and the time was approaching when she would not be able to have this. Eventually she would be connected to a peg feed. During the recorded interview, she started to talk to me about the events leading up to her diagnosis with Motor Neurone Disease which she thought had been caused by a doctor's mistake and talk about how unhappy she was.

Participant: *I feel very bitter.*
Interviewer: *You don't show it. Well (pause) that's very understandable.*
Participant: *Hope don't live too long.*

(Dolores, Windley Lodge)
As demonstrated by this example, extremely emotive issues can be raised in an interview. In this case, the participant was sharing that she was so unhappy about her future and that she did not want to continue living very long. In these situations, the researcher gave the participant time and opportunity to talk through their issues and only moved the conversation on when it felt appropriate to do so.

Emotions experienced by the researcher are not often addressed in the literature, however in establishing rapport the interviewer is not a “cold slab of granite” or insensitive to human issues that may be revealed during the interview (Patton, 2002: 405). The effect that these situations can have on the researcher can also be intense and draining. As I had previously worked with older people in care homes I was aware that I was likely to have to deal with some emotional issues, for example the death or sudden illness of participants, their depression or loneliness. I was also conscious that some care homes might be extremely difficult places to research if the provision of care was poor and the emotional dangers that this would place upon a researcher (Lee-Treweek, 2000). It is essential to ensure that the researcher is supported with debriefing and opportunities for discussion. This was one of the benefits of working with a supportive project team and I also had personal support from my husband who works in the social care sector.

4.7.6 Discussing sensitive topics

Another factor for consideration during the research with residents was the discussion of sensitive topics around the body. These issues were raised within interviews with some residents, and through staff interviews or observations. For example, one of the most significant disruptions of sleep for residents of care homes is going to the toilet or incontinence care. Discussions with staff highlighted that many residents wear incontinence pads of some sort at night. Some wear them as a security measure but will still get up to use the toilet or commode. Observations and staff interviews indicated that in some homes incontinence pads were routinely changed
during the night whether or not a change was required and that this was a factor in sleep disruption of residents. Incontinence care is a sensitive topic for most residents to discuss and perhaps was something they did not think about when agreeing to participate in research about sleep. Talking about sleep is very different to discussing personal and intimate care with a researcher. This raised the question of how much a researcher should probe about this topic, if the participant did not volunteer the information, especially when I already knew that they received regular incontinence pad changes during the night. Discussing this issue with other researchers revealed mixed views. Some felt that the researcher should not refrain from asking about this sensitive issue as the participants might really want the opportunity to talk about it but may feel it was inappropriate for them to raise the topic.

Many residents in care homes have to cope emotionally and physically with their 'uncontrolled' bodies. Older people may relate their incontinence to a 'normal' process of ageing and deterioration of physical functioning (Horrocks et al, 2004). However, due to social stigmatisation they may want to keep such information private and not discuss it with a researcher.

**Effective management (ie concealment) of incontinence is absolutely vital if incontinent people are to maintain their social position and self-esteem. Central to this management is the control of information about the self, through care taken not to reveal the problem to any but the very closest others, and hypervigilence with respect to “wetness” or other evidence of “accidents”.** (Mitteness and Barker, 2000: 314)

When talking about sleep in their interviews, participants dealt with the topic of incontinence in different ways through either not discussing it at all, by giving some basic information but not elaborating or by talking openly about it. Some participants seemed able to talk freely about incontinence and volunteered information. Phyllis talked openly about the topic and she did not seem uncomfortable doing this:

> I can't remember if it was today or yesterday but I wet the bed. Yes. That was horrible. It was an accident of course, but you know, by the
time you get out to go to the toilet, you know, you have done it all. I felt really embarrassed. They washed me down.

(Phyllis, Bascombe House)

Another female resident spoke with a matter of fact manner about going to the toilet and wearing pads. For example:

I think because I wanted to wee and someone doesn’t come into me, or I can’t get there quickly enough, I often wet my pants. I did this morning.

(June, Bascombe House)

There were a minority of participants who offered personal care information unprompted and seemed quite happy to discuss these issues. Where participants did not offer information, I used gentle leading questions to give them the opportunity to raise the matter. However, some people did not want to talk about it and, contrary to some researchers’ views, I did not feel it appropriate for me to push these boundaries. My view was that it is not the role of the researcher to cause stress to participants by pressuring them to discuss matters they do not want to, or to “go after a piece of information doggedly ignoring the pain of the interviewee” (Rubin & Rubin, 2004:102). Power dynamics exist in all interview situations in that the researcher is in control of the research process and also usually takes the lead through asking questions (Eder and Fingerson, 2002). Care home residents are considered to be a disadvantaged and vulnerable group and I did not want to contribute any more than necessary to further disempowerment. However, care must also be taken in not constructing the vulnerability of participants that denies them any agency throughout the research process (Russell, 1999). During the interviews there were times when the interviewer was not ‘controlling’ the direction of the interview and it is clear that participants chose aspects of disclosure or non-disclosure (Russell, 1999).

4.8 Observations

Patton (2002) notes that the use of observation in qualitative research is:
(1) to describe the setting, activities, behaviour, people, interactions and meanings from the perspective of the observed;
(2) to adopt an open, inductive and discovery oriented approach;
(3) to observe things occurring within the social context that may escape the awareness of the people in the setting;
(4) to discover things that people may not reveal in interviews, and
(5) to enable the researcher to draw on personal experience and knowledge during the analysis.

In each of the four care homes a number of observations were carried out over a two week period. In addition to field notes generated from all aspects of the research, specific periods were set aside to focus solely on observation and note-taking. These observation periods generally took eight hours. Observations were designed to cover the full 24 hour period of the day. In each home the aim was to undertake two morning observations (approximately 6am-2pm), two afternoon observations (2pm-10pm) and two night observations (10pm-6am). I undertook six periods of observation in the first three care homes, and four observations in the last home. The other researcher undertook the two overnight observations in the last care home. This amounted to approximately 48 hours of observation in each care home or a total 192 hours of observation across the four homes.

Although I was not an official participant in the setting, other than through the research process, the observations took on the characteristics of participant observation as both participants and researcher became more used to me being part of care home life for the duration of the study. "The extent of participation is a continuum that varies from complete immersion in the setting as full participant to complete separation from the setting as spectator" (Patton, 2002:265) and this variation was experienced in this research. As staff and residents became more used to having me around in the home, they would often stop and talk about matters other than the research topic, or ask me to perform tasks or favours.
The nature of the observation varied depending on the home and the time of day. For example, the early morning observations started at 6am and most residents were still in bed. This meant that I would walk around the corridors noting who was up or awake. I would watch and listen to what was going on and sometimes staff would keep me informed of what they were doing. I did not go into people's rooms at this time of day, unless invited by the resident, as it was a time of getting up and many residents received personal care. In a home where they did not use the dining room for breakfast, one carer invited me to do her morning breakfast round with her as she was too busy to talk to me because of staff shortages that morning. As people got up in the morning, and depending on the home, some residents use the communal areas and these would also be observed until after the lunch period. The afternoon (2-10pm) observations started after the lunch period and covered the 'going to bed' part of the day. Again, the communal areas were observed but I would also make regular journeys around all the corridors of the home, noting what was happening. This was useful to observe the interactions of carers and nurses with residents while they were going to bed. The overnight observations tended to differ in that there was sometimes much more contact with the staff as they had more time to talk to me than during the day. Upon arrival the senior member of staff would usually ask me what I was going to be doing all night and would tell me appropriate times for interviewing the staff members taking into account the busy periods and their break times. During these periods I was able to ask the staff about incidents that happened during the night. In Kimble House residential home the two carers invited me to sit with them in the lounge during the quieter periods where I was able to talk to them in more depth and listen as they talked to each other, catching up on what had been happening in the home while one had been away. The overnight observations finished at 6am and therefore I was able to observe the final night time rounds of the carers and the beginning of the getting up period.

The aim of the observations was to become familiar with the physical environment, social environment and daily life of the home for the residents and the staff. Jotted notes were taken and these were expanded upon when
I was able to find a quiet corner to sit down and write. These notes were then typed up fully as soon as possible following the observation session to produce full field notes. Field notes included a running, concrete description of people and events, but also the impressions and feelings of the researcher (Lofland & Lofland, 1994). I would usually try and leave the observations to the latter part of the two week data collection period in each home as by then staff and residents had become more used to a researcher being around and I could be more than just an unknown observer. I was able to engage and interact with the people in the setting, although the nature and extent of participation changed depending on the home and the time of day that the observation was taking place. Being observed can make people self-conscious, anxious and alter behaviour, however the nature of the research did not require covert observation techniques (Patton, 2002).

The staff and residents knew that research and observation was taking place and I tried to be as discreet as possible by not using large notebooks, but rather using unobtrusive pocket sized books that enabled me then to write up more full notes in quieter moments when I was able to be alone (Henderson, 1995).

Observations have limitations in that the researcher may affect the behaviour of staff, residents and the entire care home in ways that cannot be identified (Patton, 2002). Even though the researcher tries to write down as much description about the physical and social environment as they can, there is still the possibility that the research may be characterised by what Emerson et al (1995: 106) described as ‘analysis in description’ in that the description itself is selective through what the researcher paid attention to during the observation, or what they felt was significant or simply what they managed to recall during the write up period. However being reflexive about this throughout the data collection and writing up period can go some way to mitigate against this. Additionally, working with another research team member was useful for discussion about feelings and impressions about the home, staff and events. The presence of ‘strangers’ in a care home during the day is not unusual for residents as there may be visitors, health or social care professionals coming in and out during the day and it can have many
characteristics of a public space. Although staff members were aware of the
research, I feel that establishing rapport first and leaving the observations to
later on during the fieldwork period was a successful strategy. By that stage
they knew more about the research, had had the opportunity to be
interviewed and also to ask me questions about what I was doing. Staff
seemed to be more comfortable as they got to know me and would talk to
me casually during the observation period.

I was aware that staff might think I was ‘spying’ on them, especially given the
generally negative perceptions of care homes in our society. The physical
environment of care homes sometimes made it difficult to try and appear
‘casual’ or ‘natural’ in the setting. Some homes fully utilised their communal
areas, which was a good place to spend some time interacting and
observing. However all care homes in the study had corridors, where there
were residents’ rooms and bathrooms, and it was difficult to appear ‘casual’
in these spaces. There was no apparent reason for me being in a corridor
other than to observe. If I felt uncomfortable just hovering, I would adopt a
more purposeful walk as if I was on my way somewhere. However, the
physical environment meant that the corridor walking was sometimes
uncomfortable:

“(T)he square layout of the floors means that I am constantly walking
around corners – ie (a) I don’t know what I am going to see or come
upon, (b) don’t want to startle residents, I am a relative stranger after
all, (c) don’t want staff to feel like I am spying on them (which I am of
course!)” (Field notes, Kimble House)

Although I did not hide around corners, I also feel that I heard conversations
as I was approaching unseen that I am not sure I would have heard if I had
been standing right next to the carer. Interesting data can often be collected
when participants have seemingly temporarily forgotten that the research is
taking place (Lawton, 2001).

In any observation, there may be a ‘covert’ or deceptive element. This may
take the form of pretending to share values and beliefs with participants in
order to avoid friction (Patton, 2002). Hammersley and Atkinson argue that in
ethnographic methods, the researcher must hold some part of themselves back, maintaining "some social and intellectual distance" (1983: 102) in order to allow space for the analytical thoughts. I sometimes heard views and witnessed interactions which I did not agree with and was shocked by. In one sense, this reassured me that to some extent staff were not censuring their behaviour completely in front of me. On occasions, I met care staff and nurses who behaved towards residents in a manner I did not like. I would not necessarily express my negative opinion openly and in this sense it could be argued that I was deceptive to some degree by keeping my 'true' thoughts hidden. However, relationships in the field are still subject to norms of behaviour and impression management that we undertake as a matter of course in everyday life (Hammersley and Atkinson, 1983).

In terms of recall and cognitive ability of some residents, it was possible to utilise information gained in the observations to reflect upon and sometimes validate information received in the interviews and this made the observations a valuable tool in the collection of data. Observations contributed significantly to a more rounded picture of life and culture in each care home, but also enabled observation of particular participants' routines and behaviour which could be compared to the interview. For example, a resident Cathy told me that she never got up during the night. She said that 'as soon as her head hit the pillow', she was fast asleep until the next morning. However, below is an edited extract from the overnight observation:

23.55 - I notice Cathy is asleep in the chair by the ground floor lift. She is dressed in daytime clothes. I go to the office and tell the carers and they say it is best to leave her dressed. Sometimes if she gets up in the night they said they can dress/undress her five times a night which is much more disturbance for her sleep.

A few minutes later I hear Margaret (carer) talking gently to Cathy, rousing her "Come on it's 12 o'clock at night, let me take you upstairs".

04.27 - I see Cathy coming downstairs with her stick. I say to her "hello?" Cathy says "I just got up" I tell her that it is 4 am. She says "Is it? I'd better go back to bed or I'll get murdered" (smiles). She stops and thinks and then says - "What are YOU doing here so early?"

(Field notes, Kimble House)
According to the staff this was usual behaviour for Cathy. So there was an interesting position for a researcher where what was revealed in an interview was completely different to that which was observed. The narrative provided by the participant was contradicted by the observation and occurrences like this enabled me to reflect on the possible influences. A participant may prefer to present in the interview a socially desirable view of ‘good’ sleep because they did not want to disclose deviation from what they perceived as ‘normal’. Another interpretation is that of resistance. If someone perceived a lack of sleep to be associated with ageing, they may want to resist this interpretation and label. Alternatively, the participant may not remember — perhaps Cathy did not remember her wakefulness at night. In this particular case, Cathy was showing signs of dementia, however less extreme examples were important in thinking analytically about the data collected during interviews.

4.9 Analysis

Each of the 77 interviews were recorded, except one member of staff who had not consented to a recording, using a digital recorder and fully transcribed verbatim in MS Word. Following the transcription, hard copies of all interviews were printed and read through by the researcher to promote familiarity with the data.

To support the manual tasks of coding and analysis, the Word data files were imported into a CAQDAS (computer-assisted qualitative data analysis software) package Atlas.ti. The use of such software assists the practical aspects of the coding process and also facilitates the retrieval of printed output that may be required for specific aspects of analysis.

The method used for analysis in this study draws on a grounded theory approach first proposed by Glaser and Strauss (1967) and developed in more recent work (Strauss and Corbin, 1997, 1998). The use of CAQDAS for coding and retrieving data is considered compatible with a grounded theory approach (Bryman, 2001). This technique of analysis was preferred as it offers an inductive approach where key concepts and themes are drawn out from the empirical data. This approach is “likely to offer insight, enhance
understanding and provide a meaningful guide to action" (Strauss and Corbin, 1998: 12). According to Pidgeon (1996), a grounded theory approach emphasises the participants' accounts and requires the researcher to "engage in interpretive work, unravelling the multiple perspectives and common-sense realities of the research participant" (Pidgeon, 1996:77).

It was considered that this approach to data analysis was appropriate for this study as it is compatible with both an interpretivist framework which underlies this research and the broader research aims of understanding of residents' and staff views about sleep within the specific social environment of a care home. In accordance with the basic principles of grounded theory, the approach to data analysis involved collecting data through interviews, observations and field notes on an ongoing basis throughout the study period. Following transcription and a period of familiarisation with the interview transcripts, the data were open coded and categorised by identifying and naming concepts found in the data that were considered to be of relevance and interest to the research topic. The initial phase in the process of analysis involved examining interview and observation data. Using the software, data were coded into areas of descriptive interest which appeared significant to the researcher on an initial reading of the data (examples in Table 4.4):

<table>
<thead>
<tr>
<th>Descriptive Code</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>admission</td>
<td>how moving to the care home affects sleep</td>
</tr>
<tr>
<td>good sleep</td>
<td>how participants describe good sleep</td>
</tr>
<tr>
<td>getting up</td>
<td>how participants describe getting up in the morning</td>
</tr>
<tr>
<td>continence</td>
<td>how continence impacts upon sleep</td>
</tr>
<tr>
<td>checking</td>
<td>how participants describe the overnight checking</td>
</tr>
<tr>
<td>ageing</td>
<td>how participants talk about ageing and sleep</td>
</tr>
<tr>
<td>strategies</td>
<td>what residents do when they have bad sleep</td>
</tr>
</tbody>
</table>

*Table 4.4 Examples of descriptive codes*
In the coding and analysis process, the computer software made possible a filtering system which facilitated the interrogation of data by care home, participant type and other useful categories. Strauss and Corbin (1998:103) identify the process of conceptualising as grouping events, objects or action/interaction which are similar or related under a more abstract heading to form categories. Both the interviews and observations were coded in this way. Text in different documents, either interview transcripts or observation notes, could link to the same codes. As such a descriptive code, for example 'Getting up in the morning' could include data from residents and staff interviews, and also include observational data relating to that code. The codes could also be interrogated and filtered by groups of documents, so that it was possible to view in isolation the perspectives of staff, residents or researcher observations as well as filtering coded data by other categories as indicated above. Patton (2002) identifies a general description of 'content analysis' which refers to "any qualitative data reduction and sense-making effort that takes a volume of qualitative material and attempts to identify core consistencies and meanings" (2002: 453) through the discovery of patterns and themes.

During the analysis, the identified concepts were reviewed to develop provisional relationships between the categories. The ongoing results of this process were compared to and reviewed against incoming data as the data collection progressed and further data was analysed. Provisional hypotheses were developed to contribute to a broader understanding of the interrelationship between the participants’ accounts and perceptions of sleep and the social and physical context of a care home. Following the earlier process of descriptive coding, the data were subsequently reviewed to identify higher level, more abstract concepts. This involves a shift from describing the data to interpreting the data which means attaching significance to what was found, making sense of findings, and "interpreting the beliefs and behaviours of participants" (Janesick, Valerie J, 2000:387). Linking the analysis of interviews and observations in the manner described
above facilitated pattern and theme analysis (Patton, 2002) searching for patterns in the descriptive data and identifying emerging themes.

4.10 Conclusion

This chapter has presented the main aims for this study of sleep in care homes for older people. The use of qualitative methods is appropriate for the exploratory nature of the research which endeavours to broaden the understanding of the lived experiences of the older people who live in care homes with specific reference to the social context of their sleeping environment. Discussion of the methodology acknowledged the specific challenges of researching in a care home and with Fourth Age participants who may be physically and cognitively frail. The staff play a fundamental part in care home life and the lives of the residents, therefore their perspective was a key part of the research process, facilitating a more holistic understanding of sleep as part of the culture and organisational processes within the homes. The use of participant observation was important for broadening the researcher’s understanding of, and immersion in, the care home setting and also provided valuable data as a method of exploring different aspects of care home life. The unique research environment of a care home has also been discussed, acknowledging the blurred boundaries of public and private space and the dilemmas this may present for a researcher.
Chapter 5
THE MANAGEMENT OF SLEEP IN CARE HOMES

A good night's sleep to me is when you settle in bed, you don't want any disturbance, noise, lights, squeaking doors, you know, any other kind of disturbance.
(Mary, Care Officer, Kimble House, Nights)

5.1 Introduction

This chapter will explore sleep in a care home environment, mainly from the perspective of the staff. Rather than focusing exclusively on the night, the aim is to explore sleep across the 24 hour period and examine the general routines and procedures in care homes within which the residents carry out their daily lives and staff carry out their work. The first section will set out the general structure of the 24 hour period in a care home and the main events throughout the day and night. Using the staff interviews, the issue of sleep overnight will be discussed and will examine the influence of personal circumstances and organisational practice. Staff monitor sleep overnight as an indicator of the health and welfare of the residents in the home. In addition to their monitoring role overnight, staff also viewed their role at night as one which supported sleep and included practical, emotional and medical support.

The issue of daytime sleeping is discussed from the perspective of the staff, who distinguish those residents considered to need daytime bed rest and sleep for health or other reasons from those residents who tend to ‘doze’ in chairs. Staff perceived boredom and lack of activity as a major contributing factor to daytime sleeping and contrasted residents’ sleep behaviour inside and outside the care home environment. Finally, the general views of staff about sleep and ageing are discussed.
5.2 Care Home Structure of the Day

In order to explore further the impact of the routines and practices of the care homes, this section will provide a brief, general overview of the major events and routines for residents and staff over the 24 hour period in a care home. Although there was some variation between care homes in relation to practices and timings, a common structure could be identified.

The morning tasks are started by the night staff who are required to prepare the residents and the home for the day staff. This involves a continence pad change or emptying commodes at around 4.30am or 5am. The night shift staff will also assist some residents in the morning with washing, dressing and any medication that is required at that time. Some homes will also provide a morning drink, such as a cup of tea for all residents. When the day staff arrive, usually around 7am or 7.30am, there is a handover meeting to pass on information from the night shift to the day shift. The day staff continue the tasks of assisting the residents to get up in the morning and have breakfast, which is usually around 8am or 8.30am, although this varies between homes and for individual residents. For instance, one diabetic resident in Kimble House Residential Home had an early breakfast in her room. It varies across the homes whether residents have their breakfast in their rooms, in a dining room and whether there is a choice about this. After breakfast, residents will remain in their rooms, go to one of the public areas of the home or attend a scheduled activity.

While staff continue their work with individual residents and other tasks required by the home there is also a mid-morning drinks round and snack (usually biscuits, but it may be fresh fruit or a cake) offered to all residents and usually visitors too. Lunch is usually around 12.30pm and therefore before this time, staff will be assisting residents to the toilet and to make their way to the dining room. Those residents who can make their own way may do so early in order that they can sit in their preferred places. Lunch is usually served by care staff and is a two course meal consisting of a main hot meal and a dessert. There are often alternatives to the main meal available, such as jacket potatoes or salads, however I rarely observed
residents having any of these alternatives. One of the nursing homes in this study had a choice of two hot main meals and also two meal 'sittings' at both lunch and dinner times so that everyone did not need to go to the dining room at the same time. After lunch, staff assist residents to where they would like to go, usually their rooms, communal areas or to participate in an organised activity. At about 3pm there will be a mid-afternoon drinks (and biscuits) round. Staff will assist residents to the dining room for 5.30pm (and 6.15pm for the home with the second sitting). Residents return to the lounges or their rooms and there is a further drinks round at approximately 7pm.

At around 7.30pm or 8pm, it varies between homes, there is usually a handover meeting for the night shift staff which are usually much reduced in numbers from the day time staff. All homes in the study had what they called 'short days' or 'earlies/lates' and this was a split shift of 6 or 7 hours. The timing of these varied across the homes. There were also 'rounds' for medication with each home running their own system. Residents were in theory able to go to bed at any time although this was affected by the timetable of the individual homes and the staff available to help them, if needed. Generally, it appeared that the majority of residents would be in bed by the time the night staff were on duty, usually 8pm or 8.30pm.

Overnight there were a number of tasks for staff, including checking residents, providing medication, incontinence pad changes, moving people in bed which will be discussed in more detail below, then followed by the morning preparation. In addition, night staff may have specific jobs to do preparing the home for the next day including administration, laundry, preparing breakfast and tidying.

These are the key markers in the 24 hour care environment, and the general timetable within which staff and residents manage the home and their lives on a daily basis.
5.3 Task Management of Sleep

Martin and Bartlett (2007) note that the main concern of health and social care staff supporting older people was a task-focused organisation of sleep, including assisting residents with getting up and going to bed, and the surveillance of sleepers overnight.

The 'going to bed' and 'getting up' routines are affected by the timetabling and structure of the care home day and have an effect on the sleep environment. For example, the shift pattern or mealtimes may impact on the time available for assisting people to bed. If time is short or there less staff available due to staff shortages or emergencies within the home, this may contribute to extra pressure on the working staff, which can then have a knock on effect on the quality of care provided and the interactions between staff and residents. Therefore the demands of the timetable and shift pattern can mean that the staffing role in the 'going to bed' phase of the home is primarily one of task management highlighting a contrast with the act of going to bed for the individual resident as a private and personal undertaking.

In this study, staff presented their role in the 'going to bed' phase as being mainly one of organisation where they prepare people and the home for night time and sleep. This involves a number of tasks ranging from the routine and mundane through to some complex and sensitive interactions. Tasks included undressing, washing, helping people to the toilet (‘toileting’), offering drinks, giving out medication, a range of personal care, making comfortable and settling down in bed. Nursing care may also involve attending to catheters and peg feeds. Residents' rooms also need preparing for night time by placing a commode in a convenient and safe position or by ensuring that certain objects are in reach for the resident from their bed. All these tasks are usually started and mostly completed by the day staff before 8pm, and then continued by the night staff. This is facilitated by a handover session where the incoming shift are briefed as to what has been completed and what needs doing. In most homes a handover meeting for staff is usually held in an office, however in Longford Manor nursing
home, the handover session had the feeling of a hospital ward round with the nurses going from room to room, standing outside each resident's open door and then discussing the person without interacting with them.

I: And when you hear them talking outside about whether you had a good night or not, is that in the morning? Is that like a hand over or something?

R: Yes, about twenty past seven usually.

I: And do they get it right?

R: They always say whether my pad was dirty and things like that.

(Interview, June, Resident, Longford Manor)

Longford Manor residents, if they are awake at the time, listen each morning and evening to a conversation between nursing staff in the corridor about their night time that includes some very personal details. Although it is recognised that people in nursing care are there because they need a level of medical support, here their information was discussed in a public space seemingly without regard for the individual. Staff, however, appeared proud of this system, claiming that this is good for the residents because it ensures that no individual resident is forgotten about in the handover meeting. This practice highlights how the nature of some 'homes' can feel hospital-like and institutional. It also highlights how the residents have to compromise areas of their life that may otherwise be kept private and that are closely linked to notions of dignity and taboo. Such practice indicates the imbalance in the relationships between the health or social care 'professionals' and their 'subjects', where it is considered acceptable to hold public discussions about private or personal matters. It is through acts like this that residents of care homes can find private information made public in a way which undermines their control of how they wish to 'present' themselves in public, in accordance with some of the factors identified by Goffman (1961) relating to depersonalising the individual as an organisational tool. In this case, the organisational aims were staff communication and body management.

The 'going to bed' periods are shaped by the timetabling of the particular home and the structures of the day and have an effect on the sleep
environment. For example, the shift pattern or mealtimes may impact on the time available for assisting people to bed before the day shift ends. This may contribute to extra pressure on staff, which can then have a subsequent effect on the quality of care provided and the interactions between staff and residents.

After twenty past nine, clients that need two (carers), I can't take that person to bed. I will then ask the person... I will take the top bit off, the top clothes off and then say to the person, my time is running out. I will say 'well I have got to go' but I will make sure that person is safe and comfortable. I don't leave them not safe. And then we will let the nurses, tell the nurses Mr or Mrs So and So is halfway ready for bed awaiting the night staff. Then they will pass it on when they are having hand over.

(Lana, Carer, Bascombe House, Days)

The perspectives offered by the staff about the morning periods in the homes indicate similar themes to that of the going to bed period. In the staff interviews there was an emphasis on how residents' have the choice about when they get up and have breakfast but that it is a busy time for the staff who have many tasks to complete within a certain timescale.

R: So that is just it really. And then at 6 o'clock, I think Joy’s told you, we have to get certain people up and we rotate it and things like that. So it is all go. It goes really quick. It does actually. That time in the morning and then you have got an hour for the breakfast.
I: What, to get the breakfasts...
R: To give them out. I think we give most of the breakfast out and then I think it’s... there is the new lady and she is a feed as well. I think, so that is about six feeds I think.
I: What you actually have to help someone have breakfast.
R: Well from 7 till 8 o'clock. So ... but yes from 6 to, well, half past five we do a pad round.
I: Okay.
R: And then at 6 o'clock we start to wash and dress and get the ones up that we are getting up that day.
I: Yes.
R: Which takes us up to about quarter to seven. So we get the kettles going and there are a couple that have a cup of tea at seven. And then from 7 o'clock to 8 o'clock. I mean really from half past five til eight it just goes really quick.

(Dawn, Carer, Windley Lodge, Nights)
Dawn's description of the schedule was typical of carers interviewed and this was confirmed by observations where staff worked systematically through a busy and tight schedule. Therefore from the staff perspective the act of sleep for the individual resident is mediated by the organisational structure and task management needs of the home. Interviews with staff highlighted how the tight timetables of staff routines produced a required approach to the work that focuses on achievement of tasks and leaves little room for the individual or the personal. This produces an environment where the staff appear to exercise little control over what can feel like a rolling machine that requires tasks to be achieved within a determined timeframe in order that the next part of the system can function smoothly.

5.4 Staff perspective of sleep disruption

This section will consider the issue of sleep disruption for residents from the perspective of the staff. Staff were asked about the quality of residents’ sleep and what they thought were the factors that impacted on their sleep. The emerging picture is dense and multi-faceted and this complexity was raised by some staff.

*It depends on their age, yeah, their problems. Then sometimes if they come here it will take a minimum three to four weeks to.. settle down you know. And even they have settled down, after this and relatives come and they have their problems... and the meals, and medication. So many things here interfering sleep pattern. [sic]*

(Dilip, Carer, Bascombe House, Days)

The key themes of sleep disruption discussed by staff were factors that centred upon the individual and factors related to living in a care home. Different attributes of these two themes interacted and aspects that at first appear to relate to the individual, may be shaped by the particular institution.
5.4.1 Sleep disruption due to the individual

Many staff felt that much of the sleep disruption of residents was due to individual circumstances and related to their ageing bodies and particular health problems. Commonly discussed aspects were pain and confusion. When staff talked about pain as a problem that woke people up, it was presented in an uncomplicated way with the usual remedy being pain management medication. Although it was a common issue brought up by staff it was not widely elaborated upon, other than to discuss individual cases. Wakefulness at night caused by confusion was mostly perceived to be related to dementia and age and particularly focused on the resident not knowing whether it was day or night time. Although temporal disorientation seemed to be disruptive to sleep, staff also identified residents being unsure of where they were or being distressed or agitated by memories that seemed current.

Or I mean some of the residents they don't even know that this is night. They will think it is day. They are confused...They don't know what is day and what is night.

(Rashmi, Nurse, Windley Lodge, Nights)

Continence and going to the toilet during the night was a frequently discussed problem. Some residents would have a commode in their room or an en suite toilet, but others may need to walk down the corridor to the toilet which, staff felt, woke residents up even more. Those who were incontinent wore pads overnight and may be disturbed by being wet or uncomfortable as well as the fact that pads needed changing at regular intervals which caused disturbance to residents.

R: But when we go in to change their pad, their sleep is disturbed, isn't it?
I: Oh they wake up then?
R: But we have to do that, because we can't leave them wet.

(Rashmi, Nurse, Windley Lodge, Nights)
Staff acknowledged that as well as being disruptive to sleep, occasionally residents did not seem very happy with the continence pad changes.

*I:* What are the residents like when you go in to change their pads?
*S:* Some are asleep and some awake. Some residents don't sleep. Some are disturbed.
*I:* What are they like if you have to wake them up?
*S:* Some are a bit grouchy, yeah.

(Raitah, Carer, Windley Lodge, Nights)

On some occasions, the pad changes may be an even greater disturbance to the resident if the person's night clothes and bed sheets need changing too.

Other reasons for sleep disruption that related to the individual were generally associated with health and medical matters including medication that may keep people awake at night or make them sleep too much during the day and catheter problems. Urinary tract infections, a further potential disturbance to sleep, may also cause a degree of confusion in the affected person. Residents with extremely limited mobility would also need to have their position changed in order to prevent the development of pressure sores. Staff called this practice "turning" and they would turn some residents every two hours. Some staff also reported a small number of residents being hungry or thirsty during the night.

In addition to the physical causes of wakefulness during the night, there were psychological and emotional factors that staff felt affected the sleep of residents. A small number of staff cited bad dreams or residents just wanting someone to talk to. Staff were aware that residents were sometimes anxious or had worries and these mostly were perceived to be concerns about family or other personal issues. Thinking about home or the family could be a potential source of excitement or upset, depending upon the individual and the circumstances. Talking about what disturbs residents during the night, this nurse noted that
If they have something worrying, which it might be personal or in their family or if they are upset it also contributes. That is what I have found. (Camille, Senior RGN, Longford Manor, both days and nights)

However, this participant also noted that residents may also become excited or agitated about seeing their families.

If they have, they know that they are having to go out, whether they go out with their family or they go out on an appointment or whatever. If you tell them like two or three days before, trying to prepare them, we find that it sort of makes them excited or it works on their mind...And they end up not sleeping well. (Camille, Senior RGN, Longford Manor, both days and nights)

It was widely acknowledged that most residents had a ‘settling in’ period, whereby their sleep would be fractured and poor for the first period of living in the home.

And otherwise, it is the change of environment. They just come into the nursing home from their freedom at home and then they come to this routine whereby you have to put them to bed like they are in boarding school. (Ama, Senior Carer, Longford Manor, both days and nights)

Staff indicated that the length of time it took for a resident to ‘settle in’ or ‘adjust’ could take anything between a couple of days and a few weeks. Some staff talked about this in a matter of fact way, however others expressed their empathy for what they perceived to be an emotional and challenging time for the person.

I have seen people, as I said, they come in very unsettled, it is an emotional time for them. And then as they think ‘well it is not that bad a place’, you can see them settling, most of them do and they are fine. You know, they settle in and they are sleeping better. I know myself if I had to leave my home and everything and come in, I would be unsettled. (Mary, Senior Night Carer, Kimble House, Nights)

This is an important point as staff suggested that many residents suffer with sleep disturbance caused by their arrival in the new environment. The quote
above suggests that there is a period of adjustment but also indicates that not all people ‘settle’ and adjust to the new routines of the home.

5.4.2 Sleep disruption due to routines and practices of the care homes

Disturbances to sleep are not just located within the individual, whether physical or emotional reasons or both. There are aspects of living with a large number of people that may impact on sleep, as well as the unique conditions found in care homes for older people with particular routines and practices. Most staff considered that certain aspects of life in a care home disrupted the nights of many residents. This included particular practices that occur during the day shift and night shift, as well as the situation of sleeping in an environment with numerous other people.

You know you have to face reality. This is a big home and the bedrooms are all together and things like that. So if they complain somebody’s television is too loud. So that is okay. We go there and say “look somebody is trying to sleep, do you mind?”

(Kimberly, Night Carer, Bascombe House, Nights)

The simple reality of other people being in the same sleep environment can be a disturbance to residents. Many residents did not like to use the call bell system and preferred to call out when someone is passing. Some may have confusion or dementia and shout out loudly, often repeating phrases, and this may happen during the night especially as residents with dementia are more wakeful at night. The bedrooms are close together in most homes and in the observations it was noted that sound often travelled well, both along corridors and between floors, even with fire doors shut. Staff talking to residents or each other is a fact of care home life and if residents are not wearing their hearing aids or staff do not think about it, their voices can be loud. Additionally there may be emergency incidents during the night where ambulances are called or relatives visit and this is another source of general disturbance.
In addition to the difficulties of living with a large number of people, staff identified a number of their own routines and practices which they felt were a cause of sleep disturbances. In accordance with the findings of Kerr et al (2008) the continence pad changes and checking routines were considered a main cause of waking people up. The homes in this study had set schedules of routine checking usually hourly but sometimes every half hour, and continence pad checking and changing, which provided the basic routines of the overnight shifts.

R: As a RGN when I come in at 7.30 I get hand over from the day staff which takes 30 minutes up to 8 o’clock and then at 8 o’clock we start giving medication. Yes. Which goes on up to 9 o’clock p.m. And then if we get through we start changing pads of those who are incontinent. After changing them.... and then the carer I am working with will put those who are not yet in bed. And then as soon as I finish I will join her, and we change pads and put those people who are not in bed, yes, and that goes on up to 10 o’clock. Then from there we have... the carer will go for 30 minutes break, and I remain on the floor, and when she comes back and I go for 30 minutes break and then it will be by that time 23 hours and then we’ll check them. There are people with the bed rails, we check them every 30 minutes to ensure their safety. Yes. And keep on checking that one.

I: Oh what throughout?
R: Yes. And recording and doing the other things. And then at 2 o’clock we are supposed to check pads once again.
I: Check pads again.
R: Yes, and change those who are wet. And then at 4 o’clock again we are supposed to change pads and then at 6 o’clock we start washing those who are supposed to raise up early in the morning.... and dress them. And those who we are leaving in bed, we check pads also to make sure that we leave them dry.

(Judy, RGN, Longford Manor, both days and nights)

The staff who were interviewed noted the potentially disruptive effect that routine checks and routine continence management had on the sleep of the residents. Staff were comfortable about going into the residents’ rooms overnight and this is unsurprising given that the whole home, including bedrooms, are their places of work. However, a small minority acknowledged the act of going into someone’s bedroom while they are sleeping could feel
unusual for the resident, drawing on how they themselves would feel in the same situation.

It all depends on the resident. I mean there are some residents, obviously, if we keep disturbing them they don't like it, which you can understand that, because I mean when I am at home, if somebody opens my bedroom door it is sort of, I know, I wake up.

(Dawn, Carer, Windley Lodge, Nights)

Checking and continence pad changing 'rounds' are the main reasons overnight for going in to the bedrooms between 11pm and 5am. However, many residents spend a long time in bed, much longer than six hours, and other routine 'rounds' that occur in the earlier part of the evening may also cause sleep disruption to residents.

R: Like for instance if they go to bed at 6 o'clock obviously they, still at 10.30 they are woken up by the night nurse who goes around for hot drinks. They are all supposed to get a hot drink in the night.
I: What sort of time?
R: Some of them get Horlicks, Some of them coffee. Some of them tea. Some of them have milk. Anything they really want.
I: What time is that roughly?
R: Between 8.30 and 9. And then they are disturbed with medications at 10 o'clock.

(Sue, Senior RGN, Windley Lodge, days)

Therefore residents who have gone or been put to bed earlier in the evening, may be woken up for drinks and/or medication. Clearly, giving medication is an important function. In care homes, however, drinking is also important as hydration is considered to be a critical health matter for older people. One carer felt that she "couldn't argue" with being asked to wake people up for drinks due to the medical imperative of keeping residents hydrated.

The morning period in a care home starts early. If they have had what they consider to be a quiet shift, the night staff note the change in pace as morning approaches. This can start as early as 4.30am with continence pad changes, commodes emptied and returned, and staff commence assisting people up in the morning with drinks and personal care. In the observations
undertaken in the homes, it was noted that from about this time, there was more general noise and activity as people started to wake up and the carers carried out their morning tasks. Bathrooms and sluice rooms seemed particularly loud places. The morning period is described by a carer.

R: Oh usually they start waking about 4.30 so you have to assist with the morning wash by all means because they can't manage. So wash, dress, cup of tea, empty the commode. Actually when we start 4.30, until 7.30 you can't stop for a second. It is really rush, rush times. It is quite a lot to do.  
I: It is yes.  
R: Like Graham, he is supposed to sit on the commode because he is taking a lot of pills and things like that to go to the toilet. So it takes time. So you have to deal with a lot of people. All they are using commodes. Most of them needs change the bed sheets or wash and dress.  
I: Yes. And you change pads don’t you at 3.30 or 4?  
R: Oh yes. Of course. Not only the pads, some of them they take off the pad and all bed is wet.  
I: So you have got to do the whole bed.  
R: Yes. You have to change bed sheets, night dress, everything. And you have to wash because of the skin getting sore, the skin it is part of the care.

(Wanda, Night Carer, Kimble House, nights)

Managing the needs of all the residents at that time of the morning is complex when there are not many staff members available. Balancing this activity, as well as responding to the call bell system activated by residents, is complex and can be hectic for staff. The resulting noise and activity is perceived to wake up residents in the morning.

And you know when you start, we talked of noise, and I am next door and I am talking to this person, and the water is running, the door is opening. So and so is also bound to wake up, yeah.  
(Mary, Carer, Bascombe House, days)

Other environmental factors such as light, temperature and fresh air were also perceived by staff to impact on the residents’ sleep. Apart from the factors relating to the individual, there is much in the care home environment that can disturb a night’s sleep. As one senior nurse observed, “there is
really no continuous, like, eight hours sleep” (Sue, Senior RGN, Windley Lodge, days).

5.4.3 Conditions within individual homes

The general characteristics and practices within a care home discussed above may not be conducive to promoting good sleep. In addition there are also other features, found in particular homes, which may contribute to poor sleep. One example is the call bell system in operation at Windley Lodge. All the care homes utilised a call bell system whereby residents had a button they could press to gain the attention and support of staff. However, the call bell system at Windley Lodge was very loud compared to the other homes in this study.

R: Well I could say they are disturbed first and foremost of the calls. Because some residents call, no matter what time of day. It is like...
I: Is that the buzzer thing?
R: Yes. And when they call, of course, it is heard everywhere on the four corners of this building.
(Sue, Senior RGN, Windley Lodge, days)

As the nurse above notes, residents use the call bell system day and night. The alarm sound was piercing and, at times, would be activating for half an hour at a time. To the uninitiated researcher (myself), it felt relentless at times. This was also raised by the staff of the home.

When I first started doing nights here. When I used to go home during the day, I used to actually wake up thinking I could hear one. And I would think no I am at home. And honestly I used to dream I could hear a buzzer going off, but you get used to it, you do.
(Dawn, Carer, Windley Lodge, nights)

It seems paradoxical that a system designed to increase the safety and comfort of residents, and increase the efficiency and effectiveness of staff
support in this home could be perceived as detrimental to the quality of the environment, particularly overnight. Other homes in the study utilised a pager system targeted at alerting individual staff, as opposed to the entire home and sometimes the alarm would also ring in the reception area.

Temperature was another issue raised by staff at Kimble House residential home. The researchers found many care homes to be uncomfortably warm, however this building was particularly stifling at times, and it was noticed by residents and staff.

\[ R: \text{Sometimes it's the temperature gets hot.} \]
\[ I: \text{Yes.} \]
\[ R: \text{Some people complain it's too hot here.} \]

(Takira, Carer, Kimble House, days)

The managers of the home had bought fans and air-conditioning units, however staff explained that the electric fans in resident’s bedrooms were noisy and often were turned off because they disturbed the sleep of the people in adjacent rooms. The resulting heat of the home was perceived to contribute to the health problems of the residents.

\[ \text{You have to make sure the windows have to be on the catches, which isn't a lot of air, not when it is hot. They have got fans in their rooms which do help now. They didn't used to have them even and Samantha (the Deputy Manager) got the air conditioning units. She bought them this year because it has been unbearable in here. And the residents actually are ill, because they don't drink enough and they are getting all the urinary infections because they are so hot. Most of them are anyway. That is not very good that bit.} \]

(Mary, Senior Night Carer, Kimble House, nights)

The association made here that the residents were more prone to urinary infections due to the temperature in the care home and lack of fluid intake highlights the relationship between the individual factors that affect sleep and the structural factors of the care home. A problem such as a urinary tract infection could be viewed as a problem within an individual however it is
possible to see that this could be a wider structural problem caused by the environment of the care home.

The staff perspective of sleep disruption in the care homes presents a complex picture, however the notion that many residents suffered from disturbed sleep was a common theme. In addition to factors relating to the individual, staff described night time care routines that did not promote sleep and viewed timetabled sleep disruption as a necessary part of night work. Staff appeared to accept sleep disruption was inevitable and that they were not able to complete their work without disturbing people’s sleep. Much of the night-time work was described as task-based activity, focusing on residents’ bodies rather than an individual’s sleep. Some staff expressed concern that the routines disrupted sleep, but did not seem to feel that they were in a position to change the current practices. Many staff gave the impression of working within a rolling machine that they were either unaware of or able to change. Residents’ sleep was described as being disturbed by combinations of personal issues, mostly related to the ageing body, and environmental factors. The age-related nature of the personal factors may contribute to the view that sleep disruption of the residents may be more easily accepted by staff and may also contribute to night worker’s low expectations of residents’ sleep quality.

5.5 Promoting and managing sleep

In addition to their task management role described earlier in this chapter, staff highlighted further aspects of their role overnight. Generally, staff who had the most experience of working nights seemed more at ease talking about sleep and offered further insight into the night-time environment of a care home. These other aspects focused less on the practical tasks of supporting people getting ready for bed or getting up in the morning, and more on their role promoting sleep and monitoring the well-being of the residents using sleep as an indicator. Night staff also had an important role offering emotional support during the night-time and recognised this as a feature of their work. Night staff were aware that there were perceptions that
it was quiet at night in the care home and were keen to point out that they are usually quite busy. However they did note that the quietness creates unique windows of opportunity for ‘one to one’ interaction of staff with residents in an environment which is ordinarily defined by communal living.

But she (a resident) will come out sometimes and have a cup of tea. She quite likes a chat, you know, a lot of them do. Because it is sometimes easier for us, night time, to do a one to one because you haven’t always got everybody up, and they quite enjoy that sometimes, you know.

(Denise, Senior Carer, Kimble House, nights)

5.5.1 Monitoring sleep as an indicator of health and well-being

Fluctuations and deviation from expected patterns of sleep for individual residents could signal to staff that there may be psychological or physical health issues. This engenders for members of staff a heightened awareness that there may be a potential problem with an individual’s health. Staff who regularly worked at night developed an awareness and understanding of the residents’ usual sleep patterns and night time behaviour. When they became aware of emerging or sudden changes, staff were alerted to investigate. This may be whether residents were unusually awake or unusually asleep.

R: You have to be aware how they sleep, do they need something, you have to know their usual habits during the night because they have

I: They have their own...

R: Oh yes, their habits you know. Like Mo asking for a cup of tea two or three times a night. And soon Glenda will ask for the commode. If they are not asking I am thinking ‘well is something wrong? They have missed their usual.’ ‘Okay she is not downstairs, I wonder why she is sleeping all night. What is wrong with her?’

(Wanda, Night Carer, Kimble House, nights)

Where residents were unable to verbally interact with staff, the appearance of their body or their position in the bed could indicate to staff that they may be uncomfortable or in pain.
Those who yeah, have pain, either they can communicate it, or during rounds, they are very unsettled. You find them tossing and turning.
(Mary, Carer, Bascombe House, days)

In addition to indicators of pain or ill health, it was highlighted that sleep could be viewed as a sign of a resident’s emotional or psychological well being.

You know if they are feeling a bit wobbly and upset. I mean it affects your sleep doesn’t it? It is usually a sign, a thermometer I think, is the way a person eats and they way they sleep. If they have got a fairly good appetite and they sleep well it shows they are mentally okay. I think it does anyway.
(Mary, Senior Night Carer, Kimble House, nights)

Night staff therefore used sleep as a signal that informed the wider processes of monitoring residents’ health and well-being. By getting to know the residents and their particular sleep habits, routines and preferences, staff felt they were able to support residents who may be experiencing difficulties.

5.5.2 Helping residents sleep at night

Staff also have a role in promoting sleep at night for residents and this generally was to respond to the needs of the individual resident. The Senior RGN at Longford Manor described the home’s approach to promoting sleep as ‘palliative’ in that it may alleviate some symptoms, but not solve the underlying problem. If residents were having difficulty with sleep, then staff would talk with them and offer an appropriate response. Practical problems such as being too hot or too cold, hunger or thirst had obvious solutions. Where staff were unclear as to the particular problem, the provision of a hot drink or bath was suggested as a strategy to promote relaxation, which in turn it was hoped would aid sleep. If unable to offer a sufficient remedy, carers were likely to refer the problem to senior or medical staff. It may be that a review of medication was required or pain management solutions. Where staff felt it necessary, sleep problems may be referred to the GP
although there were a variety of staff views on the use of sleeping medication. No clear consensus emerged from staff interviews on the benefits of or problems with sleep medication for residents but it is important to note that staff only acted as a referral point to GPs and did not make decisions about sleeping medication.

A further aspect of sleep promotion by staff, particularly staff working overnight, was a reassurance role, when they felt residents needed comfort. This could take the form of 'a chat' to keep someone company and bring them up to date with the latest news.

*And sometimes they want just to chat. Even at night yes. 'I can't sleep' and then you ask 'why', 'I just want to chat with someone'. So you say 'yes'. So you just sit there and you talk and chat, maybe someone'll tell a story or something. And there are a few residents who I know who want to know what's happening on the outside world, because they are not there.*

(Ama, Senior Carer, Longford Manor, both days and nights)

However, sometimes it is necessary to offer more in-depth support at night to someone in distress.

* R: But they have been really confused, you can't explain because they don't listen. 'What are they doing here? What is this place?'
 I: Ah yes.
 R: So it is hard really to reassure them. They can't listen. They wander. 'It is not my room. Where is my family'. So ..'
 I: And how do you deal with that? Just try and be ..
 R: They get tired. They will go back to bed and then suddenly jump again, 'why am I here? My Mum's waiting for me. Let me go'.
 So.
 I: Yes.
 R: You hardly can say something, because they don't listen actually. They just want to find out for themselves what they are doing here. So it is not always easy. You say 'well you are in a residential home'. 'Why? Why is my family not here with me?'
 So, sometimes it is a difficult question. Actually they don't want to listen to you. They just want the family to be with them or somebody. You know, so you just have to listen to them and just try to sit with them for a while. Ten minutes sometimes is enough. So they are talking, talking, and then decide 'oh well, probably when I go to sleep something can change'.

(Wanda, Night Carer, Kimble House, nights)
This quote from Wanda highlights the distressing emotions that a resident may experience during the night and how important the reassurance role may be. Staff felt there was more opportunity at night to provide meaningful interactions which would draw on their existing relationships with and knowledge of the residents, as well as their communication skills. However, it is notable that Wanda did not feel she had adequate responses for the resident with dementia in distress.

Finally, in relation to promoting good sleep at night, the perception was that this could sometimes be affected by the amount of sleep residents may have had during the day.

_Sometimes I think that is a problem, you know, so try and encourage them to stay awake more during the day._

(Dawn, Carer, Windley Lodge, nights)

The stereotypical image of a care home lounge populated with dozing people is not always that far from reality, as previous studies have indicated. This was also noted in observations in this study and additionally raised by staff as an issue which they felt affected the quality of the residents' sleep at night.

### 5.6 Daytime sleeping

When staff talked about residents sleeping during the day, they distinguished between someone going to bed purposefully for a 'sleep' or 'nap' and someone sitting in a chair ‘dozing’ and which, it was felt, was likely to be unintentional sleep occurring often through boredom. Residents sleeping during the day was generally considered by staff to be a potential factor in poor sleep at night. Although staff recognised there would be natural variation in the amount of sleep that different people required or wanted, it was largely felt that short ‘cat naps’ were not likely to do much harm to night time sleep, but that those residents who were seen to sleep all day would probably experience problems at night, potentially ending up in a "vicious circle" (Judy, RGN, Longford Manor, both days and nights).
I: Do you think that has an effect on how they sleep at night?
R: I don't think a lot because it is quite healthy to have a little nap in the afternoon. I think it is really good. Even half an hour, so why not? But some of them they are sleeping most of the time. So it really affects their night's sleep.
(Wanda, Night Carer, Kimble House, nights)

5.6.1 Intentional/Unintentional sleep

As indicated by the quote above, some staff felt that a certain amount of daytime sleep may benefit some residents, mainly those who were more frail, who do not get good quality sleep at night.

I think it helps them. Because they don't really get enough. Like I said they don't really get straight sleep in the night. They are disturbed. So honestly I think it would be a good idea for them to take an afternoon nap.
(Sue, Senior RGN, Windley Lodge, days)

In the nursing homes where there were people with very limited mobility, it was felt that some residents' bodies needed a change of position to prevent the development of pressure sores and they would often have a period of time in bed during the day so that they were not sitting in one position for too long. Where there were individual health problems that medical staff felt would be helped by the resident lying down, staff would assist people back to bed.

So we tell them definitely 'you have to go on bed rest'. Yes. So those, we put them to bed, whether they want it or they say no, I say 'no you cannot sit there all day if you have swollen legs or whatever, so you have to lie down'.
(Ama, Senior Carer, Longford Manor, both days and nights)

Here it is possible to see the way in which relationships between residents and care staff conform to a hierarchical relationship such as might be found between a nurse and a patient. The carers are prescribing sleep or rest for the resident because it is felt that this will be beneficial for them even if it is something that the resident does not want to do. This type of interaction was
not uncommon during observations in the care homes and it is possible to see how incrementally a resident’s responsibility for their own sleep can be removed and taken over by the professionals, ultimately giving less power and control to the individual resident over what should be a personal and private function.

It was felt that the medical conditions or frailty of some residents called for sleep during the day for rest and recuperation. It was also considered that some residents with confusion or dementia were likely to be wakeful at night and therefore needed to sleep during the day. Staff appeared to differentiate between those residents they thought ‘needed’ daytime sleep, and who were actively encouraged to go to bed for a while during the day, usually in the early afternoon, and those residents who slept in chairs in their bedrooms or in the lounges. For those people going to bed during the day, it was felt that an hour or two would be considered a good sleep. However, this accepted benchmark of sleeping time was less for people who slept in chairs where staff considered 20 minutes to half an hour was a sufficient nap time.

Comparable to night-time sleep (or lack of it) as an indicator of health and well-being, staff reported that unplanned and uncharacteristic day time sleep could also be a sign that something was wrong with the resident.

I personally touch them and ask ‘you alright?’ Because if they are dozing off you don’t know what is wrong with them. It could be anything. They could be in pain, they could be not very well.

(Keisha, Carer, Bascombe House, days)

Most staff reported that they would not disturb residents who had fallen asleep during the day. However uncharacteristic daytime sleep may be an indicator of a person’s ill-health and, as such, the staff member quoted here felt justified in disturbing their sleep.
5.6.2 Dozing in chairs

According to staff, residents who did not need to go to bed during the day mostly preferred to sleep or doze in chairs. Depending upon the type and the nature of the care home, residents may be likely to do this in their own rooms or in the communal lounges and public areas of the care home.

_They normally don’t like to go to bed at all at day time. They just doze and you have to give her time to rest if she is dozing. Because ‘are you tired?’ and the resident says ‘yes I’m tired’. You say ‘would you like to go to bed?’ ‘Oh no, no, no. I’m just having a doze’._

(Faith, Carer, Kimble House, days)

Some staff felt that residents preferred to stay in their chairs as they were more likely to sleep, than if they went to bed. Additionally, some staff thought that the effort of moving out of the chair and walking to their room would probably wake up the person so that they would feel less tired when they got to their room and would not be able to sleep. This is an interesting point considering that staff felt that residents dozed in chairs during the day because they were bored or due to a lack of physical and mental activity.

_I suppose it can be through sort of boredom, they will just doze off. Like now, if you went and spoke to some of them, they would be awake obviously and they wouldn’t go to sleep. But then if you went the same time tomorrow they would probably be asleep because they are sort of bored._

(Lisa, Carer, Bascombe House, days)

All the care homes in this study had an activity programme, however these tended to be group activities which do not appeal to everyone and the quality and quantity of activities depended on the capacity of the individual homes and the activity co-ordinators. However, staff also noted how some residents may fall asleep during ‘activities’ and this was usually felt to be due to the individual or to the effects of medication, not because the activities were boring. Receiving a visit from friends or relatives provided a resident with
people to talk to or engage in other activities with, which staff noticed would keep people awake who might usually be dozing.

_If they have quite a few visitors then they are awake a lot more. But I mean if they don't see anybody from day to day then they tend to just fall asleep in the chair._

(Pauline, Carer, Windley Lodge, nights)

A resident may see many people on a day to day basis considering there are other residents and staff in the home, however it is the presence of people from outside of the care home that is likely to keep them stimulated and awake. Although there may have been a number of residents sitting in a lounge, it was not uncommon to note that they were not talking to each other. Some lounges had a television and people may have been watching this, but in other lounges there was not always a ‘focus’ and people may have been reading or just sitting. This was noted by one carer who, despite their heavy workload, tried to make time to talk to people sitting in the lounges to keep them company and provide some activity for individuals,

_Because sometimes they (residents) just sit there, they don't talk to each other._

(Georgia, Carer, Kimble House, days)

However, on a day to day basis staff in care homes do not often have the spare time to sit and talk with residents for very long and it was not an unusual scene to see residents dozing in chairs, whether in their rooms or in the communal areas. Where residents doze in chairs, staff mostly said that they would leave the resident asleep unless they looked physically uncomfortable or unwell. During the daytime, routine events such as meals can be utilised by staff as a reason to wake people up who they feel may have been sleeping too long.

_It is just because of the institutional rules we have to wake them up now and say 'it's time for meals', and like that. Give them a chance they can sleep the whole day, some of them._

(Judy, RGN, Longford Manor, both days and nights)
There were 'rounds' done mid-morning and mid-afternoon where a member of staff would take a trolley with refreshments and give all residents a drink and a snack. This was another time where it was considered acceptable to wake up residents who were dozing.

*Normally we just leave them. The only time we would wake them up is if we were going round with the teas. To wake them up for a cup of tea.*

(Takira, Carer, Kimble House, days)

Stephen viewed the afternoon tea round as a clear attempt to wake people up who were sleeping during the day.

*I mean if you have got a couple (of residents) snoozing, it's about 3 o'clock the tea trolley will come round, they'll soon hear that, like, you know. So that is sort of an attempt to sort of wake a couple up if they are snoring.*

(Stephen, Carer, Kimble House, days)

Staff considered that meals and refreshments were an opportunity to wake residents up if they were dozing in chairs, however the consumption of food was also considered by staff to have a soporific effect on residents. It was noted by staff and in observations that residents often dozed after breakfast and after lunch. Lunch was a two or three course hot meal and was considered the main meal of the day and the afternoon supper tended to be a lighter meal.

*R: ..especially once they have had breakfast, it is always once they have eaten really. Like after lunch. They have had a good dinner, because they have, like you know, a good meal at lunch time.*

*I: Yes, they do.*

*R: It makes them tired, but then that would be me as well.*

(Lisa, Carer, Bascombe House, days)

Other aspects considered by staff to bring about daytime sleeping included the effects of certain medication, the warm temperature and lack of fresh air circulating in the homes. Some staff reported trying to find opportunities to open windows in the home, for example while most residents were in the dining room, because many residents would ask for windows to be closed.
This was noted in observations as the researcher in this study was often asked by residents to close windows. Staff felt that the sedentary nature of care home life and certain types of medication meant that the residents felt the cold.

5.6.3 Daytime activity and the impact on sleep

As discussed above, staff perception was that a lack of physical or mental activity contributed to the likelihood of residents dozing during the day, which in turn affected their sleep at night.

I think if they are tired they get good sleep, like when they are doing activities here. It's very good because it keeps their mind busy and when they are tired, they have something to eat, they can have a good night's sleep as well.

(Faith, Carer, Kimble House, days)

Some staff considered daytime dozing to be a pattern that residents fall into. This carer felt that daytime sleep could become a habit if residents were not physically or mentally active during the day. Talking about activities, she commented:

Their mind has been sort of activated and they have got their minds on something else, rather than sleep. I mean you know yourself if you sit in the chair you can doze, whereas if you are occupied you sort of keep going and keep going and you forget the time don't you. It is only at the end of the day, you think oh God I am really tired. But I think if you do sleep you do tend to get into that habit.

(Denise, Senior Carer, Kimble House, nights)

However it was not just keeping residents awake during the day that staff felt was important. Some staff did not necessarily think that activities contributed to good sleep but nevertheless had an important role in keeping the residents stimulated, alert and active. The different homes had a variety of scheduled activities and the nature and frequency of activities were shaped by a number of factors, including the personality and interests of the activity co-ordinator and the commitment of the home management to
providing activities, which was probably further influenced by financial and staffing capacity. Scheduled activities were mostly led by the activity co-ordinator in the home, but sometimes sessions were run by people from outside the home. Each home in this study employed either a full-time or part-time activity co-ordinator. There were also occasional trips out locally and further afield, and two homes (local authority run) also took a small number of residents away for a holiday each year.

Although it is not the intention of this study to provide a detailed analysis of the organised daytime activities, it was considered by staff to be an influence on sleep quality and therefore merits some attention. The nursing homes had more people in wheelchairs and who required a significant level of physical support and this may have an effect on the type of activities provided. One home found that the high dependency of the residents made it difficult for them to carry out some activities because of the staffing levels.

R: They (activities) are supposed to be important but I am afraid there is not really much activities during the day.
I: Oh, okay.
R: Because of the high dependency that we, it is not just high, very high dependency that we have got. So we could just imagine with six carers doing all the jobs for 25 people it is quite difficult for them to have activities in the morning. So their (residents) routine really is to read their newspaper while waiting for the carer to come and wash them. But there was once a time, yes even now, I think they get at least once a week some form of an exercise.

(Sue, Senior RGN, Windley Lodge, days)

In contrast, Longford Manor had a busier schedule of different activities, which also included occasional evening and weekends, unlike other care homes in this study. Additionally, if the activity co-ordinator was off duty or doing something else, the staff at Longford Manor took over running the activity session. As well as ensuring activities went ahead, this also provided an opportunity for staff and residents to interact in a different way, that was not just about tasks or personal care. The two local authority homes, Kimble House and Bascombe House, occasionally provided evening entertainment and sometimes linked together to do this so that residents
could meet people from the other home. Even if staff felt the activities were good, staff reported that there were sometimes difficulties with residents wanting to take part.

*I think sometimes people in residential care they get into a little rut, don’t they. You know, you get up, you have breakfast. I mean Dianne (activity co-ordinator) is very good here with the activities, but some clients don’t participate.*

(Denise, Senior Carer, Kimble House, nights)

Kimble House was trying to move towards a model of care called the Eden Alternative which promotes, among other things, spontaneity and variety. The activity co-ordinator, Dianne, was endeavouring to adopt these principles for the activities but was finding some aspects difficult, including trying to get new ideas from residents themselves or asking residents to be more proactive in choosing what they wanted to do. Kimble House residents were, on the whole, more physically able and made use of the communal lounges. Socialising and activities were sometimes perceived to be more difficult in homes where residents usually stayed in their bedrooms. This nurse compared the residents in the nursing home, with the adjacent “EMI” (Elderly Mentally Infirm) part of the home.

*If you have seen them, we don’t have such thing like the EMI where the lounge is full of people walking to and fro. They are just … ours are just confined in their rooms or happy reading the paper, watching the television, doing their own thing, they want to be alone. Yes. Very rarely do they want to join anything.*

(Sue, Senior RGN, Windley Lodge, days)

In addition to activities provided by the home, staff felt that activity from outside the care home was valuable to residents, for example visits from residents’ friends and relatives. Staff also discussed how visits from relatives could sometimes upset and agitate residents, particularly if they did not know when the next visit would be or if there was a long time between visits. However, such occasions were often a positive event in the lives of
If visitors come, I think they are a bit more bubbly because maybe someone that they haven’t seen for a while turns up. And they will brighten up and shake themselves up you and say ‘oh how are you?’ and you know. I think they perk up a bit more sometimes when they have visitors. That is a big important part of their life as well to see visitors as they actually know who that person is.

(Kelisha, Carer, Basombe House, days)

Even where residents were not able to be physically active, the interaction with people was felt to have a positive effect on residents sleep and well-being. Talking about gentle activities, this carer commented:

Yes. I think if there is something like that, that you can stimulate them with it, it helps them to stay awake and therefore they will probably have a better night. Not always. But most times. I mean we had a man in here and we had a woman come in every day and she would play noughts and crosses with him or chess or something like that, you know, for a couple of hours. And that kept him awake. Whereas normally he would be asleep in the chair.

(Pauline, Carer, Windley Lodge, nights)

As well as residents’ enjoying visits from people to the home itself, staff also noted a change in residents on visits outside of the home. All of the homes in this study provided occasional opportunities for some residents to go ‘on visits’ outside of the home. Again, the frequency varied between homes. Some visits consisted of a walk to the local high street pub for lunch or may have been a group outing to lunch or visiting a place such as Kew Gardens. As previously stated, some homes also provided annual holidays for a few residents. Staff were consistent in their views that residents did not fall asleep or ‘doze’ on outings such as these, even people who would nod off during the scheduled activity sessions in the home.

Some of them go to sleep through the activities. I must admit when we have taken them out they all stay awake. We take them out shopping. We take them out for pub lunches quite a lot. They go for outings and that. They are always awake.

(Lisa, Carer, Bascombe House, days)
During an interview with one member of staff, the topic of residents dozing during the day was discussed and I asked her about the holidays, as she was one of the members of staff who went on the holidays with residents. It should be noted that English was not her first language, but her meaning is understandable.

I: So do you find people dozing on holiday?
R: No, they do different sleep. Not even want it. They are all sleeping at night, not day time.
I: Not in the day time?
R: No. Because we’re out, watching everything, doing so much. By the time we come home, we wait for our dinner, they are tired.

(Georgia, Carer, Kimble House, days)

In addition to changes to their sleeping patterns, staff also perceived other changes in residents on visits outside of the home including people becoming more talkative, telling stories and reminiscing. Even those who they perceived to be ‘confused’ appeared to become more lucid and chatty, according to staff. Some staff participants said they did not know why there was this difference in residents, but others thought that it was the change of environment and the increase in, what they term, ‘one to one’ interaction.

Daytime sleeping is a significant issue in care homes and potentially relevant to the quality of night time sleep. Many staff felt that residents would have better sleep at night if they slept less during the day. According to staff, a short ‘nap’ could be considered beneficial however residents who slept too much were likely to be effecting their night time sleep. While acknowledging potentially contributing factors such as medication and ill health, staff also felt that the residents often slept during the day due to a lack of stimulus, despite the homes having scheduled activities. This was underlined for staff when they considered the same residents in a totally different environment outside of the home where they did not doze or fall asleep during the daytime.
5.7 Staff perceptions of sleep and later life

Through discussions with staff about sleep in the care home emerged notions about sleep and old age in general. There was a belief amongst staff that it was normal for older people to have poorer quality of sleep and that old age in itself produced an inevitable change in sleeping patterns. The two main themes to emerge were related to poor night time sleep and excessive daytime sleep.

In general, staff considered the quality of sleep in old age to be poorer because older people were seen to need less sleep. It was felt that older people slept lightly and were easily disturbed from their sleep, spent extended amounts of time worrying at night time and were more likely to get up early. These factors were seen to be normal characteristics of sleep in old age and these beliefs highlight the staff perceptions of older people's sleep.

And then some, they develop insomnia maybe just because of ageing or whatever. They don't sleep. They only sleep for a few hours, they are awake most of time. I don't know why.

(Judy, RGN, Longford Manor, both days and nights)

Another key aspect was that older people are more likely to sleep during the day and this was perceived to affect their night time sleep.

Some of them I think it does affect it. If they have a sleep during the day, they don't sleep properly at night. But then what can you do. They are old people. They can just sit there and they don't do anything.

(Lana, Carer, Bascombe House, days)

Some staff linked this to physical inactivity as discussed in the previous section, boredom or the effort of physical exertion for older bodies.

And I said 'that is because you are sleeping during the day'. Your body, as you are older, you are not so active, so you are not going to need as much rest. And you can't sleep day and night. It's, you know, it doesn't work.

(Denise, Senior Carer, Kimble House, nights)
The belief that older people would inevitably have unique sleeping patterns defined by their age and physical abilities may impact on the expectations that staff have about the nature and quality of sleep that the residents 'should' experience. It is possible that this could lead to the acceptance of poor sleep quality in the belief that this is inevitable and normal for people past a certain age. Therefore it is possible that a care home environment normalises this perception of sleep in older age and continues with practices that impact negatively upon the sleep of residents. This could create a vicious circle where poor night time sleep and excessive daytime sleeping in residents is seen as evidence of old age, and not as the consequences of the care home environment and practices.

5.8 Conclusion

This chapter has provided an overview of sleep from the staff perspective within the structures of the care home over a 24 hour period, rather than solely focusing on the night. A description of the general structures and timetables of the care homes has been provided at the beginning of this chapter to set the scene and establish the broad environment within which resident's personal lives are conducted. The staff perspective of preparing the home for night time is primarily one of organisational activity and task management, providing a contrast with the personal and (usually) private act, for those not in a care home, of going to bed and to sleep for an individual. The timetables and key events of the day in a care home may often affect when residents go to bed depending on the staff available. In discussing sleep, the staff participants identified a number of factors relating to the individual that they felt affected sleep quality, including both physical and emotional causes. Additionally overnight, there were a number of routines and practices that staff feel interrupt residents' sleep, even though they may be deemed necessary for health or hygiene reasons. Some interruptions may be more 'necessary' than others and this highlights how 'one size fits all' policies can have a detrimental effect on sleep quality.
overnight. Further to this, personal factors that may be more usually associated with an individual, such as a UTI or anxiety, can be caused by aspects of care home life and therefore draws attention to the complex and interactional nature of the relationship between the care home organisation and the resident's sleep. As well as practices that were perceived to disturb sleep, it was also noted by staff that residents spend a long time in bed at night, but that their sleep may be disturbed by the general night time and early morning activity in the home, which can start as early as 4.30am.

Staff noted that many residents sleep during the day. This may be deemed essential for health reasons where residents were advised to spend a period of time lying flat or in a different position, or they may be very frail or ill. Other residents slept or 'dozed' in chairs either in their rooms or in communal areas. It was understood to be 'normal' that their day was punctuated by intermittent sleep and this was felt to have an effect on their overall night time sleep quality. Staff perception was that these residents who dozed in chairs were doing so due to boredom and a lack of physical and mental activity, even where a home provided a programme of organised activities. Daytime 'routines', unlike night time routines, allowed staff to intentionally wake up residents who they felt were sleeping for too long. Although staff felt that the lack of activity during the day may create the circumstances where residents are likely to be bored and fall asleep, it was also one of the dominant beliefs about sleep and ageing that older people generally sleep too much during the day.
Chapter 6

THE NORMALITY OF SLEEP DISRUPTION: RESIDENTS’ PERSPECTIVES

“Sleep is the least of my concerns”
(Thelma, Longford Manor Nursing Home)

6.1 Introduction

This chapter focuses on interpreting the perspectives about sleep of older people living in care homes. Residents’ perspectives on their sleep at the point of entry to the care home are discussed and put into context within the wider changes in an individual’s life at this important time. The relationship of the residents’ bodies and sleep is explored through the themes of discomfort and pain, disability and continence. Residents discuss the difficulties faced when pain or discomfort dictated the amount of sleep they were able to attain and the strategies employed to negotiate wakeful periods during the night to aid a return to sleep. Wakeful periods had a strong connection to emotion whereby time is created during the night that allowed space for residents to dwell upon potentially distressing or frustrating thoughts. For some residents, the care home environment is shown to provide a reassurance during these periods, whilst for others the environment is secondary to their concerns and worries. Residents’ discussions about their current sleep patterns are explored in relation to their personal biographies and are viewed as part of the process of an individual’s life course. Residents discuss the acceptance of disturbed sleep as a ‘normal’ part of their current life course stage.

6.2 The normality of disturbed sleep

Throughout the research, many residents reported having disturbed sleep for a variety of reasons, which will be discussed in this and subsequent chapters. Despite these disturbances, the majority of participants reported
that they felt their sleep quality was acceptable. There was a general acknowledgement that disturbances to sleep were seen as a normal part of the sleep routine in a care home and such disturbances did not necessarily lead to residents viewing their sleep as being ‘bad’. Waking up with pain during the night was not necessarily considered as constituting a bad night’s sleep, depending on the amount of time spent awake and the capacity of the resident to fall back to sleep without too many problems.

Well sometimes, I get pain, like in this arm, here. But it wakes me up and maybe it will take a long time before it moves, but then I can go off to sleep, so I mustn’t grumble.

(Edith, Longford Manor)

This perspective is adopted by the following participant, who experienced nocturia which she did not perceive as a problem. Anna identifies a ‘bad’ night as one where she would not be able to settle.

R: But yes, I sleep very well. I have to get up occasionally to go to the toilet and things like that. But most of the night I sleep very well.

I: And what about a bad night’s sleep for you, what’s that like?

R: Well I don’t think I really have a bad night…I can’t think what a bad night would be. Well, it would be tossing and turning and I don’t do that.

(Anna, Kimble House)

For Nina it was normal for her sleep to be disturbed at frequent intervals throughout the night, sometimes hourly, by her need to use the toilet. However, this was not viewed as a significant problem but an acceptable feature of her night time sleep.

R: Well I get up and go to the loo about two or three times. Sometimes every hour. But not too bad.

(Nina, Bascombe House)

What is highlighted here is that there is unquestioning acceptance of some very disturbed nights. Participants initially presented their sleep as being
good or acceptable, however further elaboration during interviews revealed that sleep was frequently disturbed or fragmented, although this would not necessarily result in an individual feeling that they have bad sleep.

6.3 Admission and adjustment to care home

During staff interviews, it was emphasised by some care staff that the admissions process included talking to the resident about their likes, dislikes and routines in order that the home would be able to accommodate these as far as possible. Sleep routines and preferences were reportedly included in this procedure, however, in interviews with residents none were able to recall any discussion about sleep during the admittance procedure to the care homes. This may have been because discussions about sleep and sleep references were not included in the admission process or that the details of these discussions had not been recalled by the residents. Taking into consideration the circumstances of individuals at the point of entering a care home, it is reasonable to imagine that an individual may not remember the administrative details of their admission and that at this important time the discussions of sleep preferences may not have taken a high priority. Those residents who talked about their admission to the care homes reported that they did so against a backdrop of major life events including illness, accidents and the loss of loved ones and homes. These events are then followed by a move into an entirely new environment, in itself a major event, and a potentially unsettling or distressing experience. These experiences for some resulted in disrupted sleep prior to entering the care home and afterwards, which had occasionally led to them being prescribed sleeping medication.

When asked directly whether their sleep had changed as a result of moving into a care home residents rarely reported any disturbance to their usual pattern. However further discussion would frequently include mention of the variety of disturbances to sleep that can be experienced within the care home environment. Some residents could not remember what their sleep was like before and were therefore unable to gauge whether their sleep
changed as a result of moving to the care home. Residents who could clearly identify changes in sleeping routines viewed their own individual circumstances and life experiences as influencing their ability to adapt to the new situation of living and sleeping in a communal environment. Many participants had experienced changes in health or long stays in hospital prior to admission, which some felt had affected their sleeping routines.

*I mean I always used to sleep very well, but I think last year I was in hospital for nine months and it was absolute hell. And oh everything went wrong. I had infection after infection which they couldn’t put right and it upset my sleeping pattern and since then it has been very poor.*

(Jean, Kimble House)

Periods of hospitalisation were reported as being disruptive to sleeping routines. Hospitals were considered noisy and not conducive to good sleep, with participants reporting being woken up early every day, sometimes leading to changes in their sleeping patterns that remained with them when they moved in (or returned) to the care home.

When discussing their sleep, adjusting to sleeping in the care home was one part of a much broader picture of major change and disturbance in residents' lives. Aspects that were discussed included changes in their physical and mental health, the death of or separation from their spouse, loss of family and homes, periods of hospitalisation, adjusting to new medication, losing contact with pets and having to sort out what happens to furniture and possessions. Individuals could be affected by any number of these changes which may interact with their previous experiences of sleep and could influence their ability to adjust to a new sleep environment.

### 6.4 Perspectives on the effect of life experience upon sleep

When discussing their sleep, participants sometimes interpreted their current sleep in the light of their individual life experiences. Previous life events or social roles were used by participants in interviews as a reference point for residents when considering and talking about their sleep.
Some participants related their current sleep patterns and preferences to previous work or paid employment. One participant discussed night work and whether this made him more adaptable to sleeping during the day and more susceptible to waking up at night, having been 'on call' overnight for much of his working life. A common association made by residents was the act of waking up early in the morning. Some participants felt that their current patterns of waking up early were routines formed from their years of working.

Dora, who linked her ability to sleep well at night to her life of 'hard work', felt that the 'habit' of getting up early in the morning formed through employment had stayed with her.

R: But it is a creature of habit. I have had to do that. I mean I have been guided through right through my life more or less, you see, with my job and what have you. And I think it is something you get into and you just can't break it.

I: Yes. Because you get up quite early, don't you?

R: Yes. I do. And always have done, but then again being in domestic service, you see that is another. I have good training, I had good training on that.

(Dora, Kimble House)

Being in domestic service and having to get the house ready before breakfast meant that Dora had got up very early and she felt that this period of work had shaped her sleep pattern for life. Another resident, Lois, had been in the Air Force during the Second World War. She was a very early riser and was normally washed, dressed and in the communal lounge with a cup of tea by about 6am.

I: Have you always been like that? Have you always woken up early?

R: Yes. I suppose, really, it was military training you see.

I: Military?

R: Military training. We had to get up all sorts of hours, you know, during the war.

(Lois, Kimble House)
Although Lois mentioned her time in military service and felt this was the reason for her early rising, it is worth noting that this ability to get up before everyone else afforded her a unique position within the home. She was one of the only people up and dressed at that time and had dedicated support from the night staff who spent time with her getting dressed and ready. Lois then sat in the lounge with a cup of tea and a biscuit brought to her by the night staff and watched the breakfast news on television. This appeared to provide Lois with a period of privacy in what was otherwise a communal living environment.

One participant, Reggie, attributed his ability to withstand difficult or unusual sleeping environments (i.e. the care home) on his description of himself as an 'old soldier', he too having been in the Air Force. Talking about noise in the care home environment, he commented:

*You get the bangs and the noises, from time to time. You get your this and that. Oh yes, it is alright here. But I have been in some rough situations in my life, so I think I can withstand quite a bit, you know.*

(Reggie, Bascombe House)

When discussing their sleep, some participants recalled key life events which had affected their sleep at the time, and which they perceived may have continued to impact on their sleep routines. These events were negative or disrupting experiences that can have life changing consequences. Residents who had previously looked after elderly or ill parents reported that this had a negative effect on their sleep quality, with some participants being prescribed with sleeping medication at that time.

*I think when my Mother was very ill, I was nursing her, I was working in the bank and I was also looking after Dad. And the two of them. It was too much, you know.*

(Elizabeth, Bascombe House)

Elizabeth had visited the doctor and been prescribed what she called 'mild' sleeping tablets, which she found a help. The use of sleeping medication was also discussed by a resident who had suffered the loss of one of her children many years ago.
But there was a period when I had to have something at night, but that was a long time ago when I lost my daughter. I had a terrible job, terrible, really terrible. I could walk about at night, I could do our house down at night.

(Flo, Kimble House)

Bereavement of close family members or partners was often reported as causing sleep problems for residents. As well as having to cope emotionally with the loss, bereavement may also lead to a substantial change in living circumstances for the resident.

I: What was your sleep like before you came in here? I think you said
R: It was bad, yes.
I: Has that been like that all your life, really.
R: Well no. Since my husband died and I moved down here. That is what it is. I left everything behind. My house and everything.

(Frances, Bascombe House)

Such life events of this magnitude were reported by residents to have a substantial negative impact on their sleep and which some felt continued to have an impact for many years. Some residents felt that past events continued to shape their sleeping patterns and as well as distressing events, positive aspects of people’s experience were felt to influence this. However, it is important to note that in interviews, some residents may have wanted to present a positive image of themselves and that drawing on socially valued roles, such as being a hard worker or a soldier, may have been a way of preserving a sense of identity and individuality in a communal environment. It is also possible that being an early riser had social value within the home, particularly with staff who may appreciate being able to complete their tasks in preparing the home for the day, and was therefore worth maintaining for some residents.

6.5 Sleep and the body

As will be discussed in this section, aspects of the body become more prominent in sleep for some residents. The physical changes that occur may
take place gradually over a period of time, however people also experienced
sudden changes in health status. Dolores had been diagnosed with Motor
Neurone Disease and who, at the time of the interview, spoke with the aid of
a type-talk machine. When discussing changes in her sleep she expressed
the effect that the diagnosis had on her and the shock of suddenly losing the
use of her legs. Another resident expressed that the significant physical
changes that had happened to her as a result of her stroke three years
previously had caused the biggest change to her sleep quality.

When discussing current sleep, the body in relation to physical health was a
key aspect raised by residents in their interviews. Participants identified
changes in the way that their bodies functioned leading to changes in their
sleep routines and causing disrupted sleep. They discussed a range of
health problems, circumstances and experiences that potentially disrupted
their sleep, however the main bodily aspects centred around physical pain,
discomfort, disability and continence.

6.5.1 Discomfort and pain during the night time

Discomfort and pain was a central theme in the discussion of sleep for many
residents. Participants reported being acutely aware of their bodies during
wakeful periods in the night. This could range from experiencing a dry
mouth, itchiness, aches and generally feeling unwell to high levels of pain
that required medication. A sense of general discomfort was identified as
delaying the onset of sleep and contributing to prolonged periods of
wakefulness during the night.

Well I get a lot of... no it doesn't actually wake me up, but I have got
very bad arthritis and mainly it's in the knees and the tops of the legs.
So when I do wake up I am moving them around and massaging them.
(Margaret, Longford Manor)

Pain was identified as actively intrusive to sleep at night. The issue of pain
was sometimes introduced by participants very early on in the interview,
indicating it to be a prominent feature that shaped their sleep and their ability to control it.

I: How would you describe your sleep?
R: Sleep. I sleep (pause), depends on the pain that I have.

(Ravi, Kimble House)

Some participants reported that pain was managed with medication and therefore did not usually interrupt their sleep. This creates a situation whereby those who experience mild and moderate levels of pain could experience higher levels of disturbance to sleep than those whose greater pain warranted medical intervention and control. Of the participants in receipt of pain relief many did not know what medication they were on, but some were able to talk about it. When asked direct questions about sleep medication, participants sometimes stated that they were not on sleeping medication, but that they were on pain relief, which helped them sleep.

Well it does help. Because it helps relieve pain, the paracetamol. And I mean it doesn’t always, it doesn’t necessarily send me off to sleep, but it does help.

(Annie, Longford Manor)

The use of pain relief however was not always effective. There were some residents who continued to experience pain and disturbed sleep, in spite of the medication. For Glenda, below, this in turn affected how she felt about her sleep environment.

No it doesn’t really worry me. Not unless I am in a lot of pain and then I know I can’t have any more pain killers. And that is one reason why I have the light on, because after I came out of hospital I had some very bad nights here occasionally. And being in really bad pain and in the dark, I think there is nothing worse. I just hated it. So now I keep the light on.

(Glenda, Kimble House)

In discussing the effect of pain on sleep, participants identified a relationship with their bodies whereby individuals did not perceive themselves as being in control of their own sleep but rather that they felt reliant on their body to
allow them to sleep. This feeling of having to work to attain sleep in spite of their own body was compounded for people with physical disabilities and limited movement.

6.5.2 Physical disability and sleep

As well as being disturbed during the night with pain and discomfort, bodily limitations were experienced by participants in relation to other aspects of sleep and their sleep environment. More physically active participants spoke about going to bed at the end of the day as a fairly pleasurable event, which did not take very long.

And then, within about 10 minutes I decide it’s high time I was in my nightie and getting into bed, which I do, and I, honestly, I really don’t think I’m exaggerating if I say that I... just, I’m hardly in bed at all, then I’m sleeping.

(Barbara, Windley Lodge)

Barbara reported that she “loved” to go to bed at the end of the day and that she fell asleep quickly. Queenie, another resident who was fairly physically active and did not require any assistance from the care home staff, adopted a pragmatic perspective to her bedtime routine which appears to be quite straightforward.

Just go there. Get changed. Go to the loo. Lay down. Sleep hopefully. That is it.

(Queenie, Bascombe House)

For those with health problems or physical disabilities, going to bed may be a more complicated, lengthy and painful process. Some needed assistance changing their clothes, or getting into or out of bed. For those with severe physical disabilities, staff used a hoist to move people from their chairs or wheelchairs into bed. Residents who spoke about this issue did not like the use of the hoist, some stating that it could be painful. The hoist could also serve as a stark reminder of the person’s changed and ageing body, while they are ‘hanging’ in the air.
R: I hate that.
I: You don't like that?
R: Well no. No I don't. Well it shows you how hopeless you are, helpless you are.

(Josephine, Longford Manor)

Josephine had several physical difficulties following a stroke and had limited mobility on one side of her body and her experiences of going to bed provide a contrast to those described by more physically active residents. Once Josephine was in bed with the help of the staff, she then had to spend time adjusting her body to a position where she was comfortable enough to be able to sleep.

I: And when you are in bed do you go off quite quickly normally? Do you sleep quickly?
R: No.
I: No?
R: Not here anyway.
I: Okay, it takes you a while does it?
R: Yes, well partly to get this arm to sort of go down by the side, because if it doesn't it starts roaming over here. It doesn't work really but night times sometimes it does. And I get my legs sort of... you know, see this leg it doesn't work like that one, and I have to get that sorted out. So that can take some time.
I: Yes, takes you a little while to get comfortable?
R: Yes. And I can't... I can't really turn over, you know, like you would from one side to the other so that makes a difference.

(Josephine, Longford Manor)

Another resident also describes here how her body dictates the position of sleep, which she finds uncomfortable. Participants had to compromise, lying in an 'awkward' position to cool a part of the body which had got hot from being in the same position, or lying in a particular position to relieve pressure from another part of the body.

R: Yes. Because I have to sleep on my back which I really don't like. And, but there is no alternative, I mean.
I: Is that because of medical reasons that you have to sleep on your back?
R: Yes, because of my leg. And I have a pillow. That left leg on a pillow.

(Annie, Longford Manor)
These accounts highlight further the difficulties experienced by residents who needed to exert a degree of effort in order to gain enough control over their bodies to allow them to find positions and comfort enough to sleep. For some residents there was a feeling of having to work at being able to sleep, which contrasts to the usual perceptions of sleep as being an activity free of physical effort. Elizabeth, a participant who used a wheelchair and had to rely on staff to assist her in and out of bed, talked about her difficulty at night when the effort was unsuccessful and sleep was not achieved.

_Terrible. I just lie there, you know. But I can’t do anything at all. I can’t, because of my hip. I can’t do a lot of walking about and all of that._

(Elizabeth, Bascombe House)

This underlines one of the problems for an individual with physical disabilities who cannot get to sleep. The only option perceived by this resident was to lie in bed with no alternative strategies available to either help herself get to sleep or to pass the time while lying awake at night. Disabilities and sensory impairments can also impact upon a residents’ ability to employ strategies to attain sleep. Participants with sight problems were not able to read books or watch the television even if they were able to reach a book in the middle of the night, or get out of bed to switch on the television, and most participants could not use or did not want to use a television remote control. Another physically disabled participant who reported having trouble sleeping, stated that she could not get comfortable enough in bed to read, even though reading was a way to make her fall asleep.

_R: _Or I can doze off as soon as I start reading the paper, very easily. But I can’t…. I used to be able to read in bed but I can’t read in bed now, because I can’t get comfortable._

_I: _To do it._

_R: _Since I had the stroke…Unfortunately. And that is another thing I can only more or less now lay on this one side. I can’t lay on that side. But that is nothing to do with waking me up or anything like that._

_I: _No. But you can’t sort of turn over to sleep on the other side?_ 

_R: _No. That doesn’t help because I am too heavy this side to try and lift up. I just can’t do it._
I: Okay, so that [bar] should be something you can pull on.
R: That is.
I: Pull on, to sort of help you?
R: Oh yes, it is a big help, with lifting me up, the top part, but as for getting over onto this side. No. They [staff] have started putting this cot side [up] and then I can...
I: Push against it?
R: No. I can reach over and pull myself over. I rest my back on that, because otherwise you are more or less always laying on your back...and it never gets an airing, so, I have that to pull myself over and hang on like that.
I: Yes, okay, okay.
R: Lay there most awkward, like, but it's cool.

(Shirley, Longford Manor)

This section has highlighted how, for some residents, the act of going to bed was not simply a matter of getting into bed and falling asleep. The process of trying to achieve sleep could be ongoing throughout the night and was something that may have to be worked at. In discussing the effect of pain and sleep, residents identified a relationship with their bodies whereby they did not always perceive themselves being in control of their own sleep, but rather that they were reliant on their body to allow them to sleep.

6.5.3 Continence and Nocturia

The effect of continence on sleep was almost universally experienced by resident participants. Although continence was raised by all who participated in this study, the way in which continence affected sleep and the night-time varied for each individual. Factors which could affect this included health status, cognitive and physical disabilities, the toilet facilities and the continence management culture of individual homes.

Residents reported their night time sleep being broken because they needed to go to the toilet at some time or even several times. Some residents found this an irritation but reported going back to sleep quite easily.
I: And do you ever wake up during the night?
R: Usually at 2 o'clock in the morning to go to the toilet.
I: Okay.
R: But I soon go back to sleep again.

(Gladys, Longford Manor)

Participants sometimes attributed the need to urinate to particular types of medication. Some felt that it was a failing or symptom of their changing bodies, either due to age or the onset of particular health problems.

I do get annoyed over that. I think to myself 'oh damn'. Sometimes I have only been in bed an hour. And yet I always go before I go to bed but I think there is a bit of weakness there. It must be.

(Flo, Kimble House)

Flo used a walking frame mobility aid but was able to get herself in and out of bed. However, other participants who needed the assistance of staff to help them out of bed were reliant on staff being available at the necessary time. A situation where staff are not on hand or the resident is not able to move as quickly as they need to get to the toilet, can result in an incident that may cause the resident feelings of shame or indignity.

R: I can't remember if it was today or yesterday, but I wet the bed. Yes. That was horrible. It was an accident of course but, you know, by the time you get out to the toilet, you know, you have done it all. I felt really embarrassed. They washed me down.

(Phyllis, Bascombe House)

Some residents who were not usually incontinent wore incontinence pads at night as a precautionary measure. Longford Manor offered the use of a bedpan to some residents who were not wearing pads but had difficulty manoeuvring in and out of bed. Some participants had a commode placed near the bed at night so that they did not have to walk far, even if their room had an en suite toilet (which was not available in all care homes). Residents, possibly under the guidance of the care staff, took such measures to try and minimise the likelihood of such bodily 'accidents'. Another method used to minimise having to go to the toilet or other continence problems during the night was to limit the amount of liquid consumed in the evening.
It is not very often I drink very much at night, otherwise I need the loo.
(Phyllis, Bascombe House)

A further continence management approach was to make pre-determined visits to the toilet, rather than waiting for the 'call of nature' to arrive. This may involve going to the toilet just before getting in to bed or going if they wake in the middle of the night (even if they did not immediately feel that it was necessary) to prevent further periods of wakefulness or incontinence during sleep.

I don't think it is that that wakes me up. But once I am awake I think right I will go and spend a penny now and have a restful, peaceful night.
(Frances, Bascombe House)

Residents who are incontinent will, as noted in previous chapters, receive proactive involvement from the care staff in their continence management. According to the staff, many residents wore incontinence pads and would receive regular checks by staff during the night to establish if the pad needed changing and some care homes routinely change pads at certain times during the night. The residents were therefore woken during the night to receive personal care, by a member of staff (who is potentially a stranger if agency staff are being used by the home). The majority of participants who wore continence pads did not discuss it in the interview and, as discussed in Chapter 4, I did not pursue this unless it was raised by the participant. Where continence pads were discussed, it was in a matter of fact and descriptive manner, talking about the physical act of a pad being changed rather than discussing emotional responses to wearing them.

Occasionally I am a bit sleepy when they come in and put the light on. And it only takes a couple of minutes to do, you know...they have got their system of doing it. It is usually get that (bed) side up and I can roll that way quite well.
(June, Longford Manor)
It is difficult to report how people felt about the continence management practices of the home. However, the general disturbance by staff coming into the rooms during the night is addressed in Chapter 7.

Two participants, both with limited physical mobility, reported that they were fitted with a urinary catheter which is a tube inserted into the body allowing drainage of urine from the bladder. It is expected that a catheter would not necessarily disrupt sleep however there may be occasions when a resident is disturbed. The participant below described how the staff usually put on a larger catheter bag at night so that the resident is not woken up by having the bag changed. When a larger bag is not put on, either through error or because they do not have one, the resident may be woken up.

\[R:\] Occasionally I feel a light come on me, like someone with a torch. And occasionally well it might happen when they haven't got the big bag twice this week they came in to empty it. Now that is unusual, even if they haven't got the big ones. I mean it is better for me, but of course it does sort of unsettle me a bit.

\[I:\] Okay, so they need to come and change the bag if they haven't got the big one?

\[R:\] Yes.

\[I:\] Okay. What, a couple of times is that?

\[R:\] Well this week it has happened twice, but I mean sometimes they will leave me all night without doing it. But if it gets ...sort of heavy then I have to ask them to come and do it because it hurts inside.

(Josephine, Longford Manor)

Josephine's description highlights how the management of the catheter by staff in the home could have an effect on her sleep and may also result in her physical discomfort and pain.

This section has highlighted how issues relating to continence, physical disability and pain made residents aware of their bodies during the night time and did not always allow them to feel in control of their bodies in the sleep environment. This was underlined by descriptions of needing to manipulate the body in order to achieve sleep. These experiences were sometimes related to feelings of anxiety, lack of control and frustration.
6.6 Residents' strategies to promote sleep

This section will explore any methods discussed by residents to help them sleep, particularly if they wake during the night. As noted above, pain relief medication may be provided to residents to aid sleep by reducing physical aches and pains, although the medication is almost always held and provided by the care home staff, not by the individual residents. Also noted in the previous section is that residents may try particular approaches to mitigate against nocturia or continence problems. This may involve tactical timing of visits to the toilet or the limitation of fluid intake in the early evening. Residents therefore presented mixed views on whether they thought a drink before bedtime or during the night was a helpful aid to sleep or not. Only one participant said that she would turn on the television during the night if she was having trouble getting back to sleep, and this resident spent most of the time in her room watching television both daytime and evening.

For those without visual impairments and who were able to reach for and hold a book comfortably, reading was another practice that was perceived to help if a resident was having trouble sleeping.

>I have a drink by the side of my bed and that is it. And a book, and you know if I have woken up and I can't sleep again I read my book. Because I am quite a big reader.

(Frances, Bascombe House)

This reflects one of Frances' regular daytime activities, as she was usually found sitting in the large lounge reading books, magazines or the paper.

The main approaches identified by residents to help them get (back) to sleep appeared to be internal or passive strategies such as counting, counting backwards from 100 or counting objects in the room. Although the effectiveness of these methods was sometimes uncertain:
R: And I am so desperate now that I count backwards from a hundred.
I: Okay, and does that work sometimes?
R: No.....well I am saying no, but now and again I can't remember ever finishing. But most times I finish it and I think 'oh hell, what do I do now?'

(Shirley, Longford Manor)

Participants described needing to find methods of distraction when they were aware that their thoughts were wandering, and potentially causing anxiety.

*Well the only thing that I would do is just have either an aspirin or ... just say to myself 'come on girl, please relax, don't keep on thinking about things. Let your brain empty out'.*

(Lois, Kimble House)

Residents did not always take any particular steps to try and promote the onset of sleep or get back to sleep if they were awake during the night, adopting a more passive approach where they just lie there and "hope for the best" (Hazel, Longford Manor). In the light of this, it is interesting to note that while some stated that they would talk to staff if they were having sleeping problems, a considerable number said that they would not seek assistance.

Talking to the staff if they felt they were having sleeping problems was an option taken by some who would discuss it with whoever happened to be around, or seek out their key workers.

I: And if you were having trouble sleeping is there someone here you could talk to about it or ...
R: Well yes, the nurses, everybody has a named nurse.
I: Oh okay. That is good.
R: And that is the idea. That there is someone that they can talk to about anything that they are worried about.
I: Oh okay, okay.
R: And also everybody has a named carer.

(Annie, Longford Manor)

While two participants stated that they may mention their sleep problems, but would not want to 'make an issue of it', a number of people reported that
they simply would not want to talk to the staff. This was mostly due to the opinion that the staff would not be able to do anything to help solve the problem. During her interview, Glenda reported that she often had problems with disrupted sleep and laying awake during the night.

I:  Have you talked to anyone about it, you know, waking up a lot during the night?
R:  No, I haven't, no.
I:  It is not something you would consider talking to the staff [about]?
R:  I don't think they can do anything about it, no.

(Glenda, Kimble House)

Concerns about being prescribed medication to help them sleep prevented some from talking to staff within the home. Flo had used sleeping medication previously in her life and did not want to use it again.

I:  So does it worry you, not being able to sleep?
R:  No. No. Because I know I have only got to mention it and they give you something to make you sleep and I don't want to do that. I want to go to sleep naturally, not drugs, you know. Once you start taking the drugs, hmm.

(Flo, Kimble House)

Highlighted here is how Flo implies that she would have no choice in whether to take the medication or not and therefore would not take the chance of talking to the care home staff about her sleeping problems.

For the majority of participants the physical limitations they experience inhibit them adopting a more ‘active’ approach to helping themselves with any sleep difficulties through more conventional methods (such as reading, getting up, making a drink, used to address sleep problems or wakeful nights). The limited ability to physically effect their sleep environment means that the strategies used were mainly internal and were often limited in their scope and effectiveness.
6.7 Emotions at night

As discussed earlier in this chapter, the sleep of older people in care homes may make central the body in a number of ways including continence, pain and bodily limitations. Notably, participants on the whole did not talk about these aspects with obvious 'emotion'. However, the interviews with residents highlighted some emotional responses to sleep and the night time including worrying about family or finances and contemplating their current and past lives. As will be discussed in Chapter 7, residents may spend longer in bed than they want to because they are reliant on staff being available to help them get into and out of bed. For example, when awake and lying in bed in the morning waiting for the care home staff to assist her out of bed, June thought about earlier periods in her life.

.. when I am on the bed day dreaming and thinking of all sorts of things from the past. And, going back as far as I can remember.

(June, Longford Manor)

Thinking about things and having an 'active mind' was also referred to by participants as a factor in delayed sleep onset at the beginning of the night, and as a contributing factor to preventing falling back asleep if they woke up during the night. A number of participants talked about lying in bed and thinking, but did not necessarily express what they were thinking about.

I: Do you fall off to sleep straight away or does it take you a little while?

R: A little while. You know, as I say, I sit there thinking, but I gradually go off.

(Ruth, Bascombe House)

Participants reported that they may have thoughts going round their heads when trying to go to sleep and they are mulling over the events of the day, particularly if they have seen visitors or watched something stimulating on television. When people talked about their 'active mind' as essentially keeping them awake, this indicates that they were having an emotional response to their thoughts. In the following example, the use of the word
'bad' as a description of the night suggests that the thoughts were causing a difficult emotional response.

But sometimes I get bad nights where I wake up and I have got something on my mind, and I keep on thinking about it, and I can't get off again.

(Josephine, Longford Manor)

Being able to keep a 'blank' mind was perceived to be an aid to the onset of sleep at night by not keeping the individual awake with their thoughts. Where residents did discuss the emotions they had while experiencing an 'active mind' when they felt they should be sleeping, they predominantly talked about negative emotions such as worry and concern.

No, no, I just get in position. Snuggle myself down, shut my eyes and bonk. Very, very, yes, I will say within five minutes. Because my mind is completely blank. I keep it that way if I possibly can. You know, unless of course there is something particularly worrying me. If there is something particularly worrying me, well then that take me much longer, because I mean your thoughts tend to sort of run away with you and then it sort of builds up into a mountain and that is it, you know, so I try to avoid that if I possibly can.

(Dora, Kimble House)

Dora said that she "hates" nights such as these. She spoke of the tendency to think the worst at night and therefore she actively tried to clear her mind to enable sleep and to stop the thoughts 'running away' with her. Night time worries were often associated with anxieties relating to practical and personal matters outside of the care home that they were concerned about or felt needed attention. This was compounded by having to rely on other people, usually family and friends, to help them proceed with these matters.

At the moment I am in the throes of.... one, two of my cousins helping me to sell the house and these are the things that I would have on my mind during the day, and sometimes at night. But then most people who come in here have those problems of course.

(Margaret, Longford Manor)

Margaret was in regular contact with her family who were helping her sort out her estate. She also had someone that she described as a 'carer', a person she employed when she was living in her own home and who visited
her bringing in mail and other items from home. Margaret also had regular contact with solicitors and accountants. She was dealing with a number of property and investment matters which she stated kept her occupied during the day, and sometimes played on her mind at night. She also recognised that having to address such property and financial matters as a result of moving into the care home was likely to be something experienced by other residents. Margaret had family, professionals and employees to assist her with these tasks, however other residents may not have many, or even any, people available to them.

You see, so that is the financial side of it. But that is one of the things that worries me. If anything keeps me awake apart from this foot, it is worrying about getting the bills paid. You see I have to rely on my little girl, Sonia, she is not a relative of mine, she is a friend and she lives locally, and she brings me in the mail. But if it is a bit late, see she is on her third year training as a nurse. And the time that she has to put in there, it is very demanding. So if I don't get the mail, I don't know what my bank balance is. I could be in trouble now.

(Reggie, Bascombe House)

Reggie talked about being kept awake worrying about money as he was not able to keep up to date with his bank account. Reggie did not have any family locally and relied on a neighbour and this may have potentially increased any anxiety experienced, particularly if the people they rely on were not always available to help. Family were another source of worry for residents, and something that could contribute to lying awake at night. Talking about reasons that kept her awake at night, Gwen often thought about her family, who she did not see often because they lived in another country.

If I go to bed with too much family, what do you call it, thinking about my husband and all that. My daughter's... and she is getting married Saturday and I wish I could have gone. (tears in eyes)

(Gwen, Longford Manor)

In addition to these concerns and worries, participants described being contemplative, thinking about their lives and re-assessing what is important. Martha had a large, local family and was often visited by her sisters and
other relatives. She had not been in the care home long and was still settling in. Martha felt that as you got older, you had more to think about or thoughts kept you awake more. During this account where she talks about her daughter taking her money, Martha evaluates what she thinks about and what 'really matters'

R: Well I think it has a bit, yes, yes. And I think....... well I mean when you are younger, you know, you go to sleep. But I think when you got older, you know, like I have got Barbara and I think about her, not so much now as I used to. But I think about things that doesn't really matter (sic)...How much money I have got in the bank and ... is it going to last.

I: What, you think about things when you are in bed?

R: Yes, yes. I think oh I must get to the bank and see how much is going in and how much she's taken out. Because Barbara she used to go and she used to take some out, you know, but well it was my fault really because I said to her if you get a bit short, I said, go to the bank. But she started going to the bank too much (laughs).

(Martha, Kimble House)

Frances connected her disrupted sleep with normal ageing. Even talking about a good night, she described fragmented sleep and associated this to reflective thoughts about her life.

R: Then again, you know, when you get to my age you do toss and turn and you do start thinking how you should have done anything different. I mean that is a natural thing for an older person. You have got to come to that yet, girl (laughs).

I: I have yes. And what would you say is a bad night's sleep?

R: Well if I go to bed and I fall asleep and I wake up about an hour later and that is it. And then I am wide awake. I can't get straight off to sleep again.

I: Yes.

R: And again these things happen. It doesn't matter where you are. If I was at home it would probably be the same.

(Frances, Bascombe House)

The discussions with residents highlighted the perception that periods of wakefulness or difficulty getting to sleep may be the result of an 'active mind'. Negative emotions such as worry and concern about family members
or incidents from their past which may become amplified when alone at night were reported as keeping people awake.

The other key emotion referred to in the interviews about sleep is associated with 'reassurance', this being mostly connected to the presence of other people in the care home environment. For some participants, this may not necessarily affect their sleep quality, but provided some consolation if they were awake during the night.

I: And does it ever worry you when you lie awake at night, does it bother you?

R: Yes, it does... I think to myself if only I could go to sleep, er, wake up, you know, when it gets daylight I don't mind. Anyway, but I know there is company here, I know there is people around, you know.

(Gwen, Longford Manor)

Helen also found it comforting that, when she was in bed at night, she would be able to call upon staff if she needed to.

The fact that I'm in this home and when I want to go to bed I only have to...not blow the whistle, but ring my bell, and say 'I'm feeling very tired, d'you think I could go to bed?' And I only do that when it's the time for me to consider going to bed, you see. So it's a sort of set pattern in a way and it's lovely, it really is very reassuring, you see, if you're in a home that chances are, when you ring the bell, that somebody, well something will happen at any rate.

(Helen, Windley Lodge).

Where participants have health problems, they may be reassured by the close proximity of care home staff. Dora had angina, and dreaded having an attack in the middle of the night. Even though she had previously been living in a row of almshouses with a warden and a portable emergency alarm to summon help, Dora still felt alone and frightened during the night. She felt this anxiety affected her health even more, and welcomed the perceived immediacy of the assistance available within the care home. Dora felt that this feeling of reassurance by being in the care home had a direct effect on the quality of her sleep.
R: Well I think actually, since I have been here, I have slept better.
I: Have you?
R: Oh much better, yes, because, I think it is because I am reassured there is people around me. And subconsciously I am aware of that. But I mean when I was on my own, I was totally on my own and I felt dreadfully cut off. I know my daughter was within a phone call but that is not the same, no. And there were people like in the area, I mean in the almshouses. We were in a little complex and I mean there was people around, but that is totally different. I was in my flat and I was isolated, as far as I felt. Yes. Yes. And of course, consequently my health being like it was I wasn’t happy going to bed. Not really. Because I was afraid of an attack. I mean it was fear in that respect. Yes. And of course that agitated the complaint obviously. So one triggered, you know, one triggered the other off kind of thing.

(Dora, Kimble House)

This section has discussed both negative and positive emotions which were related to being unable to fall asleep or being awake during the night. Many of the negative aspects may also apply to people living in their own homes in the community. Although concern and anxieties relating to their lives in the ‘outside world’ were raised, participants did not directly relate their sleeplessness to being in the care home. It could be inferred that some of these anxieties were as a result of being in the home and therefore no longer feeling in control of their life ‘outside’ but this was not directly expressed by residents.

6.8 Perspectives on ageing and sleep

As discussed earlier in the chapter, some participants connected being older with the likelihood of being kept awake with worries and concerns. This may be true for the individual participants and is not an unreasonable notion considering some of the major and unsettling life events that often occur prior to entering the care home. When thinking about sleep through their lives, a number of participants felt that their sleep was no different to when they were younger, although some of these said that they could not remember. However, participants also expressed other perceptions of the relationship between ageing and the onset of changes in sleep quality and
sleep needs. The most prominent aspect of this was the decline in sleep quality due to changes in health status and the development of physical problems or sensory impairments due to getting older.

I: Do you think your sleep has changed since you have got a little bit older?
R: No I don't think so. I am just getting older and have a lot more aches and pains.
I: Okay, yes. And that sometimes wakes you up does it?
R: Oh yes.
I: Yes.
R: I have got pains in my knees now you see. For what reason I don't know, other than old age. That's all it can be.

(Ethel, Longford Manor)

Waking up during the night was therefore associated with what was interpreted as normal ageing and the resulting 'aches and pains'. Residents also related sleep quality to levels of 'energy'. Being older, more sedentary and not using energy was felt to contribute to differences in sleep.

Well when you are younger I think you sleep more...you sleep sound sleep, let's say like that...Whereas when you are older, you are not, I know I said it before, you are not using your energy. And I suppose that is the difference.

(Edith, Longford Manor)

The majority of participants felt that better sleep was associated with being younger, and in particular the energy attributed to youth whereby you are able to use up your energy and sleep at night. Being older was also associated with fatigue during the daytime and the increased likelihood of dozing or sleeping sleep during the day.

I'll get a book. And they are fatal with me and all of a sudden I've dropped to sleep. Now I've never done that. It might be old age. You don't know.

(Eleanour, Kimble House)

There was also an assumed general association found between ageing and a decline in the ability to sleep well. Shirley remembered sleeping well when she was younger. This had changed dramatically, and throughout the
interview at points, she would try to diagnose exactly what it was that had caused her sleep to change so much. Finding herself unable to determine why she currently slept so badly, she attributed the deterioration of her sleep to getting older, 'just one of those things'.

*R:* It is lovely to be young and be able to sleep...I know what it is like because I have been young myself...I can never, I can't remember ever having any difficulty when I was younger...I used to go to bed, because I would sleep and not wake up till the next morning when it was time to get up.

*I:* Yes, so is there anything in particular that you think brought it on or...

*R:* I just can't think of anything, nothing at all no.

*I:* No. Okay.

*R:* I can't afford to go and mope. It is just one of those things. Old age I suppose.

(Shirley, Longford Manor)

Therefore, those who felt that there was a difference in sleep throughout their lifetime and connected their declining sleep quality to old age, linked it to energy levels, lifestyle and daytime tiredness.

6.9 Conclusion

This chapter has examined the perspectives on sleep of the residents living in a care home. When moving into a care home, the status of sleep for the individual may not be a high priority against the backdrop of so many other changes that are occurring for them. Examination of the themes of discomfort/pain, physical disability and continence/nocturia, highlight the difficulties faced when residents' ‘failing’ bodies are a key aspect of sleep disruption and how residents respond to this. Bodily experiences intruded on sleep, highlighting the perspective that the body functions in a way that permits or inhibits sleep, rather than sleep maintaining the health and functions of the body. Physical disabilities affect the options available to residents who are experiencing disturbed sleep, resulting in limited strategies to manage wakeful periods. Strategies that were available were
often limited to internal processes whereby the residents would try and ‘think’ themselves to sleep without external resources to draw upon.

Difficulties during these periods can be compounded by the emotional response of the individual to their situation and wider life events. Relationships with families, the management of practical matters and previous life events were all reported to potentially impact on an individual’s current sleep quality. However in contrast, some residents reported feeling ‘reassured’ by the care home environment, linking this to the proximity of other people and the assistance available to them from the staff.

When talking about their sleep, residents linked their current sleep patterns to previous occupations and life events, in particular events in their life which had caused significant changes to their sleep patterns. With a deterioration in sleep quality being viewed as a normal part of ageing, the ‘normality’ of sleep disruption and acceptance of sometimes very disturbed nights may underpin why residents were not likely to talk to staff if they were having problems. It is important to note that the resident participants in this study were generally the most physically and cognitively able within the care homes. The issues discussed in this chapter relating to sleep and disabilities, sensory impairments and pain would probably be much greater for many other residents living in care homes.
Chapter 7

CHOICE AND CONTROL IN RELATION TO SLEEP IN CARE HOMES

7.1 Introduction

This chapter will explore the theme of control relating to sleep in care homes, particularly focusing on sleep at night rather than daytime napping or dozing, using analysis from staff interviews, residents’ interviews and observations. Control over the sleep environment was a re-occurring theme in the interviews and in observations within the homes. Despite the varying needs of residents and differences in physical and cognitive abilities, a lack of control over their sleeping environment was identified in this study. In some instances this was occurring even when residents were clearly able to articulate their preferences.

Power dynamics in health and social care services have been recognised as a policy issue as demonstrated in the modernisation programme *Shifting the Balance of Power within the NHS* (Department of Health, 2001c) and the White paper *Our health, our care, our say* (Department of Health, 2006), as discussed in Chapter 3. A recent publication by the Department of Health specifically refers to the concept of agency for older people receiving health and social care support services:

*Agency in later life: The days of perceiving older people as passive recipients of services have disappeared, and the NSFOP recognised older people as active agents of their own support. The old welfare-state model within which people were ‘clients’ of beneficent service providers has been replaced to some extent by the neoliberal model of people as service users with responsibility for holding the reins of their own package of services. This model, however, still applies less well to pronouncements about services for older people, which often appear to endorse the view that older people are passive recipients of welfare, than it does to those for younger age groups.*

(Department of Health, 2008:18).
The systems within the care environment limit choice over sleep preferences, and individuals need to be able to negotiate and decide how to compromise on their preferences. The ability to negotiate or compromise reduces with increasing cognitive disabilities as residents are less able to recognise or articulate that there should be choices available. People who are physically disabled may recognise that there should be such choices available and can express their preferences, however they may be forced to give in to the organisational culture and routines because they are not in a strong position to negotiate. The more dependent a resident is for physical support, the higher the frequency they have to enter into interactions and therefore attempt negotiations with staff. If the relationship is unbalanced in terms of power dynamics and the control of the resident is diminished, this may have an effect on their sense of independence and identity.

It is not unreasonable to assume that as adults generally control their own sleeping times, when residents have to compromise or argue about a basic aspect of their life that they have previously taken for granted it may be a fundamentally disempowering experience. While staff utilised a discourse of residents' choice, findings identify that shift patterns, staffing levels and organisational structures did not always allow residents' choices to be realised. This chapter will address these issues and also explores the ways in which residents adapt to and cope with these circumstances.

7.2 Control and the concept of home

The starting point for this discussion will adopt the position that reflects the experience of most participants before they moved into a care home. That is, in contemporary Western society, household bedrooms and sleep time are constructed as private and intimate spaces (Elias, 1978/1939). However, residential care and nursing homes may bring a particular set of circumstances and potential sleep disturbances (Morgan, 1987). Within the spatial ordering of living accommodation, bedrooms are not always uniquely domestic or private spaces. They can also be the workplace of the health
and care staff in residential homes (Lee-Treweek, 1994) and in private households in cases of chronic illness or disability.

Higgins (1989) has argued that ‘home’ is essentially a metaphysical concept and it cannot be reproduced in residential settings through the provision of “more single rooms, more privacy, more resident involvement” (1989:172).

Debates have moved on from the ‘at home/in a home’ dichotomy. It has been argued that there has been too much focus on the depersonalising aspects of care homes (Baldwin et al, 1993), ignoring how older people may create positive meanings to times of transition in their lives (Reed and Payton, 1996). Domiciliary care within private households may be inflexible and routinising and it has been suggested that it “may not be so very different from being cared for in a residential home” (Oldman and Quilgars, 1999: 377). However, the concept of ‘home’ can be an important factor in the power dynamics of care.

Twigg (2000) has argued that older people receiving home care in their own homes may, to some extent at least, resist the dominance of care staff because the ‘home’ belongs to the service user and can be conceptualised as the embodiment of their identity. The service user can refuse admission to people in their home and the time spent there by the carer is limited. This increases the service user’s power to say ‘no’ or be in control, because it is not ultimately the paid carer’s territory. Additionally, home may be the embodiment of identity through possessions and memories, which limits the extent to which people can be depersonalised and are “an important buttress of the individual” (Twigg, 2000:82). While not wanting to idealise the concept of home, which can be a lonely and isolating place, these elements are said to impact on the dynamics of care and the extent to which older people may feel in control of the basic and everyday aspects of their lives. Albert, a resident of Bascombe House, was clear about the distinction between his home and living in a care home and what this meant to him.

This is a different sort of existence, you probably realise, in a place like this. You know, when I was younger I might watch a football match or I wouldn’t. One or the other. It wasn’t something I stayed awake definitely to watch. People who come in, live in places like this, live
entirely different sort of existence from when they lived in their own houses. Life is so different for somebody like me when they get older. (Albert, Bascombe House)

This quote indicates that for some residents, living in a care home was entirely different to living in their own home. Therefore it is possible to assume that the expectations may not be the same as being in their own home. This may go some way to explaining some residents’ acceptance of reduced control over the living environment. The separation from ‘home’ may facilitate a tolerance for a sleep environment that would not otherwise be considered acceptable in your own home.

7.3 Control over sleep environment: staff perspectives

The staff participants demonstrated an understanding of current social policy which emphasises the service user’s choice and control over the care and support that they receive. However, in interviews staff demonstrated that an understanding of this discourse did not necessarily translate into services that were able to offer choice and control for residents. It was also highlighted that occasionally their practice ran contrary to the social policy ideals and guidance.

7.3.1 Admission procedures

When talking about residents’ sleep, some staff initially referred to meetings that took place before or during ‘admission’, when the new resident had entered the care home, which was an opportunity for an individual to explain their routines and preferences around sleep as well as other aspects of their lives.

We don’t want to change their routine. So when they come in, when we do the plan together with the resident and the family, one of the things which we go into particularly is their sleep. We want to know what time is it suitable for them to go to sleep. Some will tell you okay, I sleep with two or three pillows and I want to sleep immediately after my supper, and before I will really retire I like to read a book, or watch telly. Others will tell you that the last thing before she goes she likes to have
a drink, like hot chocolate, coffee, Horlicks, whatever. So you will find that residents go to bed at different times, according to their choices.

(Camille, Senior Nurse, Longford Manor, both days and nights)

Before we get a certain resident we go in and assess them in hospital or wherever they come from, from their homes, or from another nursing home. We get all their likes and the dislikes, their pattern of sleep, what time do they want to go to bed. Do they want an afternoon nap, or they don't want to. All these sort of things. So we will take notes of that and then we follow that, so that we won't break their sleeping patterns.

(Sue, Senior Nurse, Windley Lodge, days)

These quotes highlight how staff understood that sleep preferences would vary and may be unique to an individual and was something which needed to be understood and maintained after admission to the care home.

Contrary to the above quotes, most residents did not recall being asked about their preferences upon admission to the care home. However at such a time of major transition in their lives, it may be a detail that they had forgotten about. Alternatively, it may be that the residents were not asked.

The admission process and drawing up a care plan for each new resident was standard procedure in all of the care homes and is set out in the National Minimum Standards for Care Homes for Older People (Department of Health, 2001b). The Standards also state that service users should have the opportunity to exercise their choice in relation to a number of aspects of life, including 'routines of daily living'.

7.3.2 Staff discourse relating to choice and control

The discourse of the staff often emphasised the choice that the residents have over their sleep routines. When talking about residents' sleep and their choices, some staff members were able to recount the policy ideals and standards promoting independence and choice. When talking about assisting people to bed or helping them up in the morning, these staff participants commented:

We will see they go to bed, but not all of them because it is not all of them like to go to be very early. So if you ask them would they like to
go to bed ‘are you ready?’ and they say no, you can’t force them because this is their home so we just leave them until the night staff comes in to do their duty and they will take over.

(Keisha, Carer, Bascombe House, days)

Oh yes, yes, sometimes six, seven people there are downstairs, because you can’t force people go to bed. You know, like, at home, sometimes you don’t want to go. Usually you go at eight o’clock but you decide well I will stay till eleven. So you have to let them. They have choice, they have.....so it is their choice. You shouldn’t decide on their behalf.

(Wanda, Carer, Kimble House, nights)

The above quotes illustrate that staff used and understood the ideological language which is used in social care policy and guidance. Denise was able to give an example of how the support she provided could be tailored to an individual, suggesting some flexibility of practices.

I mean someone might get up early one day who has done it for weeks and weeks and then another day, ‘oh I don’t want to get up today’. ‘Fine stay in bed’. You know, but I mean it is the same in the mornings, when the girls come on they know who likes to get up a bit earlier, because I am not in at that time when they start. But you just get to know your own little getter uppers and layers in don’t you. And Kay Mundle last night, she had a particularly bad night because she had a lot of indigestion and I did say, you know, don’t worry about getting her up, so she laid in until nearly lunch time. So you have to play it by ear really don’t you. I mean it is not like us having to get up for work for a morning. So I mean if they were in their home, they would get up when they wanted to, which is what they try to strive for here, you know, treat it as your home.

(Denise, Senior Carer, Kimble House, nights)

Staff recognised the need to consider personal preferences and adapt their support to suit the individual residents. The quote above shows some flexibility of practice however it is important to note that this incident relied upon the individual staff member allowing a resident to sleep based upon what she thought a resident may need or want that day, rather than proactively supporting their choices.
7.3.3 Staff practice relating to choice and control

There were instances in interviews where staff reported situations in their day to day practice where they felt the choices of residents were necessarily outweighed by their responsibility to provide the 'correct' level of support, particularly in relation to ill-health or frailty.

And we have a few whom we put to bed in the afternoon whether they like it or not, because they are ill. Maybe, they need it for swollen legs so we want them to rest.

(Ama, Senior Carer, Longford Manor, both days and nights,)

Hettie is someone who talks, who knows her rights and all those things. She is so clear, you even feel like guilty [going against her wishes]. In the best interest of her health, we can't allow her to sleep all the time.

(Camille, Senior Nurse, Longford Manor, both days and nights)

These quotes highlight previously discussed power dynamics that can mimic those found in medical environments. Care home staff are determining when residents should and should not sleep based upon their professional judgement. Similarly, Laticia shows how staff decisions could also shape the time that someone chooses to get up.

Some of them want to be first to get up. So once they.... after 8 and they don't see you, some of them press the pager to say 'oh are you coming to me?', or 'I'm awake and I'm sitting there'. Sometimes you tell them 'no I want you to rest a bit'.

(Laticia, Carer, Kimble House, days)

As such, it appeared that ultimately a resident's choice could be overridden.

I mean some of them they don't like the door to be open. So we just close it. It is basically their preference. Whatever they want. But we have to change their decision, being a nurse like. If somebody is not well, so we will leave the door a little bit open.

(Rashmi, RGN, Windley Lodge, nights)

Rashmi was talking about whether residents liked their bedroom doors open or closed at night and the quote indicates how residents' preferences may
only be respected when they do not contradict the wishes of the nursing staff who wish to monitor someone more closely.

7.3.4 Staff routines impacting on choice and control

Care home staff sometimes feel that the residents need to rest more. Celia, below, was talking about a resident who liked to stay up until 11pm or midnight. However staying up past midnight did not seem acceptable and demonstrates the informal 'rules' of the home shaping the time that someone chooses to go to bed.

But we believe in how do you call this one, to give them the rights, but I mean sometimes we have to interfere because it is already very late at night.

(Celia, Carer, Longford Manor, both days and nights)

This quote also highlights previous discussion about the rhetoric of choice and control, and this residents' choice and control appeared to end before midnight. Decisions about bedtimes could therefore depend upon the member of staff on duty.

It is not only medical issues and frailty that staff described as reasons for taking precedence over a resident's choices, but the routines and structures of the home also compromised the choice of the residents in determining their own going to bed times and getting up times.

And then at 6 o'clock, I think Joy's told you, we have to get certain people up and we rotate it and things like that.

(Dawn, Carer, Windley Lodge, nights)

Our routine is we have got about four or three people who are bedridden. We get them up in the chair like 10 o'clock or 11 o'clock and then 2 o'clock is our next round after we hand over then we change them into a nightie because that is the time we put them to bed, because there is no point putting them to bed with their dress on and then we change them into a nightie and disturb them again. So it is just one full activity for the same time.

(Sue, Senior Nurse, Windley Lodge, days)
The above quote from Sue clearly links the timetabled structures of the care home to the residents’ sleep environment. It appeared that, far from having choice and control, the only option available to these residents was to be out of bed clothes for the four hours accorded to them by the staff shift structure.

The references to routine and the notion that staff rotate who they are getting up at 6am is indicative that the residents may not be choosing to get up at that time. The structures of the home impacting on residents’ choice also related to staff being available. Residents with higher dependency who needed the assistance of two staff members were limited in choice by shift patterns and shift times. For example, during one overnight observation I was told by a carer finishing her night shift at Windley Lodge that they do not use the hoist until the day staff come on, which means that any resident who needed the assistance of a hoist to get into or out of bed was only assisted during the day shift hours. Shift patterns therefore were a significant structural factor affecting the assistance available to residents.

_No, we do discuss with them what time and if they don’t want to go to bed, they don’t go to bed. As long as it is explained that if they need help to get ready for bed, then they will have to have the help when it is there._

(Pamela, Rehabilitation Officer, Bascombe House, days)

Resources, in the form of staff availability, therefore have a role to play in respecting and supporting residents’ choices around their sleep. The residential care home, Kimble House, and the private nursing home, Longford Manor, had more flexibility about bed times and getting up times than the other two nursing homes. The residential care home residents were lower dependency and the home also had a ‘day’ shift that finished at 9.30pm. This was later than the day shifts in the nursing homes that finished at 7.30pm or 8pm and that appeared to give staff and residents more flexibility about bed times. Longford Manor nursing home had more night staff on duty than the other three homes which also seemed to allow slightly
more flexibility, however it also appeared to have an organisational rule for bedtimes:

*Half of the residents the day staff put them to bed, and the rest the night staff.*

(Roberta, Care Assistant, Longford Manor, both days and nights)

Nursing homes have residents who are higher dependency than residential homes, and therefore helping people out of bed in the morning, and to help them wash, dress and have breakfast was a long process. This was of course affected by the number of staff available, and could therefore impact upon the whole morning for the resident.

In contrast to structures that negatively affected residents being able to choose their own daily routines, one notable example demonstrates a model of support whereby a member of staff took a proactive interest in supporting residents as individuals. Noting that some residents would occasionally appear depressed and wanting to stay in bed, Stephen highlighted how he felt his role was also to monitor their health and well-being on an ongoing basis, which sometimes involved motivating residents to get up in the morning.

*If a resident says to me ‘I don’t want to get up’ within reason I ask them like, you know, are you not feeling too good? Fair enough, like, you know. And I’m one of these, it is their home, they can do what they please. Like I want to do in my home, but there again I’d also think, you stayed in bed yesterday, get up today, you know, see how you’re feeling. So I try to compromise on.. Not only that, but I mean you’ve gotta be careful for them just staying in bed cos of pressure sores. Like I say, I like to tell them, you know, they can do what they want in there, but we suggest maybe it would be a good idea if they got up today, rather than kipping.*

(Stephen, Carer, Kimble House, days)
Staff participants expressed their understanding of the current language used in social care policy relating to service user choice and control. They discussed that their priority was to understand individual choices and preferences of residents and this began even before an individual moved into the care home, during the assessment and admittance procedures. However, staff were not always able to demonstrate how resident choices were promoted or honoured but more frequently highlighted situations and practices that negated individuals’ choices. There was a disconnection between what staff felt they should be doing, and what they considered to be the reality of their everyday work. The reasons for this were often linked to organisational routines and practices which were rarely questioned and were normally accepted as inevitable. Other reasons for not respecting resident’s choices were related to professional dominance within the care home setting.

7.4 The differential experience of choice and control

During the interviews, observations of care homes and informal conversations with residents and staff, it emerged that many residents could not exercise control over their sleep environment. The capacity of residents to exercise such control over their sleep was varied and there was a correlation between this and the varying abilities of residents. The amount of control that residents were able to exercise over their bodies and sleeping environment appeared to reduce with increasing physical disability and cognitive impairment. For example, in Windley Lodge and Bascombe House nursing homes it was noted that the staff started ‘putting people to bed’ particularly early, at about 5.30pm. As previously noted, the Senior Nurse in Windley Lodge said that some ‘bedridden’ people were changed into their nightclothes following the afternoon handover session at 2pm. The time that these people spent in their daytime clothes therefore generally ran only from 11am to 2pm while they were sitting in a chair in their room. They also rarely used the communal areas and so these residents were permanently in their
bedrooms. This is one example of the common practice of sleep environments being defined by the routines and organisational structures of the care homes and their staffing patterns and the lack of separation between the sleep environment and their 'daytime' environment.

7.4.1 The limitations of choice and control for residents with cognitive impairment

During interviews and informal conversations, a few staff identified the complex nature of autonomy for people with cognitive impairment. It was recognised that residents with the capacity to communicate without difficulty were more able to overtly state their wishes to staff. In response to a question about whether residents' bedroom lights are usually on or off overnight, one carer described an approach whereby she made a decision based upon the cognitive ability of the individual resident.

Well basically as far as I know we should be turning them all off, but the ones who can't speak I just dim the light, but the ones who can I turn them off.

(Raitah, Carer, Windley Lodge, days)

Further reasoning for this approach may be the potential for people to be scared of the dark. This is not an unusual position considering that many residents reported liking some light in the room overnight.

You ask them exactly what they want and they are able to tell you. I mean if they cannot communicate, they cannot talk, but at least when you dim the light you can see their face expression, that she is scared or he is scared.

(Cynthia, Carer, Bascombe House, days)

For residents with limited communication ability, staff reported that they had to use observation to judge whether it was the right time to assist them out of bed in the morning, or to help them to bed at night. The carer below felt that residents in the evening ‘by that stage’ needed bed rest:

Well we just ask them, I mean most people, no matter how confused they are, you say to them 'would you like to go to bed now?'; they will
say ‘yes’ or ‘no’. It is only in a really bad case scenario when they can’t, and then you would help them to bed, because you know that when they get to that sort of stage they are glad to get to bed, usually they are. There are not many people when they get to that stage that they don’t want to go to bed, because usually they have had enough.

(Mary, Senior Night Carer, Kimble House, nights)

During the research process, resident participants (without cognitive impairment) sometimes commented on others being put to bed early. For instance, Flo was usually found in the first floor small television lounge, where there were two other residents with quite advanced cognitive impairment, one of whom used to sit in the armchair next to her. Flo observed:

\[ R: \] They never come in to me. I have never been told to go to bed. But the lady next to me in there, she does. She has to go to bed about half eight. I would hate that. I told her once. I said they wouldn’t make me go to bed at that time. And she went (pulls face)

\[ I: \] Yes.

\[ R: \] I suppose there is a reason. I wouldn’t know but she seems all right.

(Flo, Kimble House)

Residents with advanced cognitive impairment were not interviewed as part of this study, however when exploring aspects of control in relation to sleep, some relevant issues emerged during my observations in the homes and during conversations with staff. In Bascombe House I observed that some residents with dementia were wheeled out of the television lounge to go to bed without care staff asking or informing them where they were going. This type of practice is reflected in the use of language by care staff in interviews. In talking about their work, they frequently used language that denoted the worker doing something ‘to’ a person (or their body) rather than ‘with’ them or ‘supporting’ them to undertake tasks themselves.

The theme of ‘doing to’ or ‘controlling’ bodies was also apparent when staff attempted to manage difficult relationships between residents. Mildred was a resident at Bascombe House with fairly advanced dementia who was also
physically disabled and in a wheelchair. Communication with her was, at first appearance, difficult. She often loudly repeated phrases and this made it difficult for other residents to spend time with her. One evening, her persistent shouting in the lounge was irritating other residents who were shouting back at her to be quiet. Up until this point Mildred had been unsupported by staff in the lounge and the situation had been allowed to escalate to a high level of tension. At about 7.30pm a carer came in and removed Mildred from the lounge and took her straight to her bedroom where the carer put her into bed. The carer asked Mildred if she wanted to go to bed and Mildred replied ‘yes’. However it did not appear that Mildred wanted to do that because after the carer had gone, Mildred talked constantly while in bed in her dark room, as these extracts from my fieldnotes indicate:

20.15 From outside her room, I can hear Mildred having a full blown conversation with herself. I sit and listen for a while. If you actually listen to what she is saying there is a lot of repetition but in between the ‘Helps’ etc she is saying things like “I’m not tired” “Wake me up please”. Mildred continues to talk “Please. Please go to sleep for goodness sake”. Eventually a carer pops in to see her. The carer says “Mildred, you’re in bed. Go to sleep.”

(Observation field notes, Bascombe House)

Over an hour later, Mildred was still talking loudly from her bed. Mildred, as usual, was speaking slowly and deliberately and therefore I was able to write down exactly what she was saying:

Help me.
Wake up please.
Wake me up please.
Tonight.
Now actually.
Now.
Can you do that?
Yes I can.
So, in response to a difficult situation earlier in the evening between residents, Mildred, without asking, was taken by staff out of the lounge to her room and ‘put to bed’ by the staff. However, she was clearly not ready for sleep as she continued to call out for over an hour, despite carers telling her that it was time to sleep.

Another example of sleep being overtly controlled by staff involved Iris in Kimble House residential home. Iris had cognitive impairment but was physically active and in fact spent most of the day walking from room to room or walking about the reception area and she rarely sat down for any length of time. During an overnight observation, I was sitting in the first floor lounge with two carers, Wanda and Mary.

Wanda said “They [senior staff] told me to get Iris up but I said “she is tired, but” (shrugs shoulders like she had to do what she was told).”

Mary replied “refer them to me, I don’t mind saying”.

Wanda said that she didn’t want to get Iris up before she was ready because she goes to bed late and because she walks around constantly all day, so she must need to sleep. Wanda commented “Imagine dragging Sylvia Hooper out of bed?!”

Mary agreed, “Well, they wouldn’t, would they? But it’s the same, they’ve got the same rights”.

From the way this was described I understood that Sylvia Hooper would make a fuss or complain about being woken up, whereas Iris who had a cognitive impairment would not.

(Observation field notes, Kimble House)

These two carers were unhappy with the differential treatment they were expected to give to Iris who had dementia, according her less rights to sleep and less control over her sleep than another resident.
Some residents with cognitive impairments, with or without physical disabilities, may not be perceived as coherently articulating their preferences and therefore staff may make decisions about sleep and the sleep environment which they consider are in their best interests. However, residents with cognitive impairments may also be subject to more negative impacts of staff time efficiency and organisational routines within care homes and were often afforded less control over their sleep environment. It was also suggested that, at times, residents with cognitive impairment were afforded less status that other people living in the home on the basis that they would not complain.

7.4.2 The impact of routines for residents with physical disabilities

It is not only those with cognitive impairments that struggle to assert control over their sleep. People with physical disabilities in care homes may experience high levels of dependency on staff and are therefore more vulnerable to the negative impacts of care home routines, because fitting in with these routines is sometimes the only way to receive needed support. An individual’s ability to act on their own preferences appears to decrease as their physical dependency increases, and therefore power dynamics in the relations of care can seem more overt and create feelings of powerlessness. People with physical disabilities who were reliant upon staff talked about a lack of control over their sleeping times and patterns. This point was highlighted by Hazel who had bone cancer and, due to her pain, required the physical assistance of staff to get out of bed.

R: And then, another thing they wake you at 6 o’clock if you are asleep and give you a wash or a shower and get you dressed.
I: Oh yes.
R: And you are wide awake, it is terrible.
I: I know I was going to ask you about that actually about what happens in the morning.
R: Yes, just after six they come and get you up and to the toilet and wash you. And it takes ages for that water to heat up when it’s freezing to start off with and you get put back to bed until about quarter to nine, before you have your breakfast and it is an awful
long time. They give you a cup of tea and two biscuits or one biscuit.

(Hazel, Longford Manor)

Shirley was explaining how good she was feeling after an evening entertainment in the residents’ lounge and how she would have liked to sit up in her armchair for a while, but because she needs a hoist, the carers made her go straight to bed.

And it was a feeling that you had been out for the evening. Well that is my feeling. I didn’t want to go to bed but I had to, because they have to hoist me, because I am so heavy as they say it’s not worth them having to hoist me into there [indicates chair]. And then coming back half an hour or an hour later to hoist me into bed. So I had to go to bed.

(Shirley, Longford Manor)

Unlike some people with cognitive impairment, the residents with physical disabilities were able to communicate clearly to staff their wishes, however in some cases their wishes were routinely ignored. For example, Glenda was a wheelchair user and relied on staff for physical assistance. She compromised on the time that she wanted to get into bed so that it fitted in with staff timetabling. The staff handover fell at Glenda’s desired time to go to bed and she was therefore given the choice to either go to bed before the handover or after, which she felt was too late.

I mean I am written up to go to bed at half past eight, because they go off duty at half past nine. So they don’t like doing it after half past eight. And they will come in at, well the other night one came into me just after 6 o’clock. And she stood in the doorway. So I looked at her. She didn’t say anything. So I said “yes what do you want?” “Come to put you to bed.” I said “No you won’t.... I am not a baby, I don’t go to bed at this time”. “Oh what time do you want?” So I said I always go to bed at half past eight “so if you come back at half past eight please.” She walked out without a word. Anyway, she came back about ten past eight so I thought “oh better get on with it.”

(Glenda, Kimble House)

If a hoist was required for carers to help someone into bed, then residents would have to wait for two members of staff to be available and this often
impacted on their preferred going to bed and getting up times. Shirley liked to get up very early while the night staff were still on duty and she explained how not respecting her choices around getting up impacted on how she felt for the whole morning:

R: I like the night staff to come and get me up, yes dear. It is a hardship if they don't. I feel bad tempered if they don't. If they haven't had the time. And I am not very happy for the rest of the morning.

I: Does it make you a bit grumpy if you don't get up?

R: If I have had to lay there all that time. Because when I was younger, I was always up early. I never ever laid in bed, ever.

(Shirley, Longford Manor)

These two examples are from physically disabled women who were fairly assertive in their manner and were able to articulate clearly about the times they wanted to go to bed or get up. However, both felt that their choices were eroded by staff practices and this had an effect on both their mood and sense of control. This can be seen in Glenda's statement that she did not want to be treated like a baby and Shirley's statement that she has always been an early morning riser. The example from Glenda, in particular, demonstrates how she was already compromising, but eventually felt she had to 'give in' to the carer who clearly wanted her to go to bed.

7.4.3 Experiences of more independent residents in relation to sleep routines and preferences

The minority of residents who do not depend upon staff for physical assistance can exercise greater flexibility over their sleep preferences, in terms of when they want to go to bed and get up. Various factors influence their going to bed and getting up times, such as individual preferences, mood, tiredness and being physically uncomfortable. However, there may also be a perceived lack of choice or a feeling that residents are expected to
fit in with existing care home routines. For example, Nina had recently moved into the nursing home and did not require any physical assistance from the staff and recalled her first evening when she was in the lounge:

*I think the first day I was here, they said, 'Going to bed now, time for bed'. I said 'Well, no'.*

(Nina, Bascombe House)

Being asked by staff about going to bed, especially for a resident who does not need any assistance, may give the impression that they are expected to go to bed, particularly if other residents have gone earlier. The above quote from Nina indicates that some residents’ are able to choose their own sleep patterns and reject systems being suggested to them. However, other residents who are able to decide when to go to bed may find that their choices can be influenced by the culture of the home or a lack of alternative activity in the evening.

*I: And what sort of time do you like to go to bed normally?*
*R: Here I'm trying to go to sleep, go to bed by 8.30 (...) Because everything is closing down, you know.*

(Ernest, Kimble House)

Residents may perceive a ‘closing down’ atmosphere as office and managerial staff leave the building and the care staff and nurses leave at the end of their day shifts. Where communal lounges are in use, this ambience of ‘closing down’ may be intensified by other residents being assisted to bed leaving a large lounge feeling bare with lots of empty chairs around. Additionally, the usual busy parts, such as offices and reception areas, become much quieter. This lack of company and activity emphasises the social norm within a care home; that daytime ends and bedtime starts when staff begin to help residents to bed, usually towards the end of the day shift. More independent residents who are able to choose their own bed times may sense a winding down atmosphere and perceive that they should go to bed, or at least to their room, in order to fit in with this social norm. Also,
these residents may find that as they have little to do and no one to talk to, they ‘may as well’ go to bed; which is their ‘choice’, but only because there is no viable alternative.

More independent residents also referred to routines, practices or events in their respective homes which impacted on their sleep environment and which meant they did not have complete control over this aspect of their lives.

I: So can I ask you, Eleanour, what sort of time you like to get up in the morning?
R: Me? Well I usually get up about, probably about, what, [er] well I get up very early. 5 o’clock. 6 o’clock.
I: Right
R: Because I used to have to do that when I was working. Now I’ve got to wake up now early too. And I’ve got to get up the time I can have a bath and that sort of thing now. Here I’ve got to go at times when I can have them, even though you pay for them. So [laughs].

(Eleanour, Kimble House)

Gwen had moved fairly recently into the home and felt that the staff wanted her to go to bed earlier than she liked, which was usually around 9.30pm, after she had asked them to come back later.

I: Do you find your sleep has changed since you have come here though at all?
R: Well it has, because I didn’t used to go to bed until half past eleven.

(Gwen, Longford Manor)

As well as the impact of routines and the culture within the home effecting sleeping routines, the practice of staff going into people’s rooms during the night to ‘check’ on them did disturb their sleep and they did not always feel it was necessary. This is an example from Virginia who did not really want the checks during the night on her but stated with resignation that they ‘had’ to be done. Virginia described how she has found these nightly intrusions to her bedroom:
I notice that they do that [come in to check her], you know, when I have been in bed for about half an hour, someone comes in and looks at me, you know. I thought it was funny at first, but it has got to be done.

(Virginia, Longford Manor)

Queenie objected to the lack of privacy of her bedroom and the actions of staff which she felt implied that she was unable to control her own sleeping environment:

There is a light outside and I just pull my curtains across and a chap comes in in the morning, about six o'clock in the morning and I say “Hello”. They just walk in, you know, I think they think it is a loony house or something and you know, they just do as they like. I say “What do you want?” “Well, just come to open your curtains.” I say “You leave those curtains alone” and he goes out. They do, they really think that each of you is needing, I don’t know what they think.

(Queenie, Bascombe House)

In addition to these issues raised around the private/public nature of their bedrooms, the routines and practices of the home would sometimes take precedence over their sleeping preferences. For example, residents talked about having to wait for someone to give them their medication or to help them with a small task, such as taking off their shoes.

Last night, I was sitting on the bed waiting for the medication to come and it didn’t come until after midnight. Then by the time you lay down again, you are awake. So I read a bit of my book and fiddled around, you know.

(Nina, Bascombe House)

Therefore, despite the differences in physical and cognitive abilities of residents, a lack of control over their sleeping environment has been identified. In some instances this was occurring even though residents were clearly able to articulate their preferences. The routines, organisational structures and culture within the care environment can reduce choice over sleep preferences, and individuals have to compromise within this setting.
People with cognitive disabilities are afforded less choice than other residents and are not always in a strong position to articulate their choices and rely on the support staff to recognise this. People who are physically disabled can express their preferences, however they may be more reliant on staff availability and therefore more susceptible to the institutional culture and routines. Being reliant upon staff for physical assistance means that the amount an individual may need to compromise increases with the level of support they require. For more independent residents, the culture and routines which exist in the care homes appeared to exert an influence on their own daily routines. Residents having to continually compromise and (often unsuccessfully) negotiate about a basic aspect of living may have the incremental effect of reducing their expectations that choice and control over their sleeping environment can exist.

7.5 Resident responses to lack of choice and control

Residents were not in a position to control their sleep environments and, as suggested by Townsend (1964), it is possible that residents may be more critical of care homes than they were at first prepared to admit and therefore may suppress their own dissatisfaction with this situation in their discussions with others. One member of staff, Cynthia, felt that the residents would say that they did not worry about their sleep being disturbed, even if they did, because they were powerless to change the circumstances.

Even if they don't sleep, that is how she has to tell you, that he doesn't care or she doesn't care. But, I think they care. He has to tell you like that (sic) because he cannot change anything. He can't change anything.

(Cynthia, Carer, Bascombe House, days)

Residents who did discuss a disempowering experience relating to their sleep environment sometimes expressed anger and frustration at their situation. However most attempted to normalise their circumstances by
demonstrating their willingness to fit in with the care home routines and also by expressing an understanding of the difficult job that the staff were attempting to carry out. Participants also expressed a sense of inevitability about the structures of the care homes.

I: And do you doze off at all waiting for breakfast or not.
R: Not really. I get cross.
I: Oh, do you?
R: I get cross very easily. And I try, because the staff have to do their duties, don't they.
I: So what makes you cross, just the whole thing?
R: Yes.
I: Doesn't start your day very well? Is that kind of what makes you cross?
R: Yes, all the things. Just waiting.

(Hazel, Longford Manor)

And let's face it we pay a lot of money to be here and sometimes they treat you with a lack of respect. I get very cross sometimes and there you are. You really just decide, you have got to live with it.

(Margaret, Longford Manor)

The frustration expressed by some participants interacted with a sense of resignation. Residents cared about their situation and had expectations about the support they should receive within the care homes, however they did not feel they were in a position to change anything. Because of their position in their life course, participants rationalized their situation by downplaying the importance of their sleep and choices.

I: So do they sometimes leave it [getting up] a bit late for you?
R: Yes, they do I am afraid, yes. It doesn't matter. I haven't got to get to work have I?

(Reggie, Bascombe House)

I get a bit cross sometimes, you know, knowing I shall have to wake up early. As I say, you can sleep on and off once they start here, but. I mean it is not to say that I am doing anything energetic, is it, to make me tired.

(Josephine, Longford Manor)
Both participants here play down the importance of them getting enough sleep as they were not working the next day or doing anything which required much energy. As such, by minimising the importance of sleep to them, they are also minimising the importance of controlling their sleep environment and deflecting attention away from what is possibly a difficult and disempowering situation.

A few participants did express negative emotions when discussing the impact of the care home upon their everyday choices. However, residents on the whole did not appear to want to criticise the homes or the staff. For example, Albert was evasive about whether his sleep was disrupted but implied it was disturbed by being in the care home.

I: Do you sleep well?
R: I think so. I think I sleep okay.
I: If you have a bad night what is that like? If you have a bad night's sleep?
R: Well, I really can't tell you.
I: Do you ever wake up in the night?
R: I think it is true to say there are times when I am woken rather than I wake up.
I: Oh okay.
R: If you know what I mean.
I: Is that outside things disturbing?
R: That is what it would be, yes. Yes.
I: Are you woken up by the staff coming in?
R: That could be the reason yes. They might wake me up.

(Albert, Bascombe House)

This is consistent with Townsend who stated that residents of care homes were reluctant to criticise and that “often, however, such people started by giving a favourable response and then went on to reveal uncertainty or dissatisfaction.” (1964: 183). Albert commenced by stating that he thought his sleep was 'okay' but went on to cautiously disclose that he was woken up during the night by staff entering his room.

Most participants did not want to complain and were either resigned or prepared to compromise for the good of the home. This is not unusual and residents often may compensate or balance any criticism they levy at the service (Kellaher and Peace, 1993). Residents referred to care staff being
busy and that they did not want to contribute further to their difficult and demanding jobs. The workload of the staff was acknowledged by residents.

_He said 'why do you worry, why don't you just pull the button?' I said, 'well I don't like doing that'. I don't like doing that a bit. I think well they may be busy._

(Sybil, Windley Lodge)

_Well I am on an early morning tablet, and it's for your bones. It strengthens your bones. I think that's what it's for anyway. I used to be wakened at 6 o'clock for the tablet, that was every morning. But now, the firm that puts these tablets out have made one tablet for the whole week, which is a great thing, because you only get it on a Saturday so they don't have to waken you so early. They still waken me quite early, but that is because there is quite a lot to do._

(Josie, Longford Manor)

Margaret, below, was being critical of how some staff treated her like a child or with a lack of respect, however she then went on to talk about their demanding job and how difficult some of the other residents can be.

_R: I always feel perhaps the day staff are perhaps more amenable, more helpful. But the night staff, well I mean. If they don't get sleep in the day, I don't know how they do it quite frankly. I mean and you expect respect and care and a friendly attitude. I suppose most of them have that but one or two, they come in and complain about their own health. I mean some are reasonable cheerful, and the way you expect, and don't treat you like an eight year old. That is my point._

_I: Yes._

_R: I suppose a lot of the people they deal with, well they do have problems, they do have problems with the way they think. But I mean their mind isn't as active as it has been. And there is one dear old lady next door who has never hurt anybody, screaming out. And the nurse has got to cope with all that and not lose their temper._

(Margaret, Longford Manor)

Many participants also indicated that they compromised because they did not want to be a ‘burden’ or considered ‘difficult’ or a ‘trouble maker’.
Queenie let herself get physically sick rather than say she did not want what she was given for supper as it made her feel queasy at bedtime.

*Well for instance, if they gave you cheese on toast at night. Fatty. And then of course you have got to go and be sick in the basin. And I can't take things like that. But I can't say, I wouldn't say to them 'look I can't take things like that'. I won't have them saying “fussy old thing” you see. So I just go on bringing it up and don't say anything you see.*

(Queenie, Bascombe House)

The comment from Queenie provides a powerful example of how disempowered she felt within her environment and it is worth noting that Queenie was an articulate and seemingly confident individual.

Dora talked about the routine checking overnight which sometimes disturbed her. Dora was a physically active and independent resident and so I had asked her if she had requested the staff not to check on her overnight.

*R: No, no, I don't make any, you know, demands upon them in that respect. I think 'well let it go' and it doesn't bother me to that extent, if you have got my meaning. I don't sort of put a bar up or anything like that.*

*I: Lock the door?*

*R: No, no, I take things as, you know, as it comes, more or less.*

(Dora, Kimble House)

Dora felt that asking the staff not to enter her room during the night was equivalent to making demands upon the staff, which was something she did not want to do. As well as not wishing to be perceived as a burden by 'making a fuss' and standing out, residents would fit in with the routines by being flexible and accommodating to the needs of the staff and the home as a whole.

*I And what sort of time do you go to bed. About 11.30 is that right - get into bed?*

*R Depends who on and how busy.*

*I Right, so do you mean if they've got other things to do you'll go later?*

*R (nods) I'm flexible.*

(Dolores, Windley Lodge)
I: So you normally, you wait for them just to come when they are ready?
R: Yes.
I: So you are happy to go to bed about that time are you?
R: Oh yes. I do as much as I can to help.

(June, Longford Manor)

This is not an unusual position as it has been argued that fear, dependence, powerlessness, institutionalisation and not wanting to appear ungrateful to staff may result in residents accepting inadequacies and being uncritical of care home life (Booth, 1993). The many participants who did not want to appear critical of the care homes may also have retained a sense of self and dignity through the narrative of compromise or settlement. The construction of a discourse which placed them not in the control of care staff, but in control of their own actions such as being flexible, negotiating, agreeing to compromise, and being helpful, may have helped them to avoid feelings of powerlessness and dependency. It is undetermined whether this is a mechanism for coping with these feelings or whether it was a means for diverting attention away from such feelings when in discussion with a researcher.

7.6 Conclusion

When addressing the concept of agency, it is often associated in policy terms with such language as empowerment, choice and promoting independence which are located within broad outcome-focused narratives. However, the evidence from participants presented here indicates that choice is lacking at an everyday level. Finlay et al (2008) have argued in relation to people with learning disabilities that

When discussing choice and control there is a danger of focusing on the bigger choices in a person's life: choosing a holiday, choosing
where and with whom one lives, choosing activities or clubs outside the home, and so on. We might then neglect the much more frequent, everyday areas in which a person can experience empowerment and disempowerment. (2008: 353)

Residents of a care home can, at a basic level, have difficulty in retaining control over their own bodies – they can be moved without discussion by staff, be unable to get up or go to bed at their preferred time and/or be subject to unnecessary observation and disturbances while they sleep. This appears to be experienced differentially and correlates with physical disability and cognitive impairment, although more independent participants still reported a lack of agency over their sleeping environment and being affected by the culture of the home in relation to bedtimes. Taking into account an unwillingness to criticise care providers often exhibited by residents of care homes, a minority of participants expressed frustration at their inability to exercise choice. This was coupled with an empathy for the difficult role that the staff have to perform and recognising the demands on staff time. Other strategies for psychologically managing this loss of agency were to try to recoup feelings of control through negotiation, agreeing to compromise their own wishes and through being helpful to staff. However, underlying much of the discourse was a sense of resignation and inevitability about having to succumb to the routines and structures of the home regardless of their personal preferences.

Staff expressed an understanding of the requirements of current policy to promote and respect individual choice in relation to the support residents receive, and related this to the specific area of sleep. Choice and control for a resident was sometimes affected by their hierarchical relationship with care home staff who felt that they had the final decision about residents’ sleep. Staff felt that resident choice was not always possible within the existing structures and routines of a care home. Residents’ choices were only able to be honoured when they fell within these structures. At best, care home practice expects some degree of compromise from residents in their choices about sleep and at worst fails to recognise that the existing structures did not
allow the choices to be made in the first place. The routines of the care home were described by both residents and staff as reducing the ability for individuals to control their environment. Although the effect of the routines was acknowledged in different ways by both residents and staff, neither identified opportunities to change or the potential to challenge it.
8.1 Introduction

Using data from observations as well as staff and resident interviews, this chapter considers how individual residents are introduced to the concept of themselves being a site of risk. This particular process begins upon entering a care home and is confirmed through staff interactions with residents. There was a perception amongst staff that the routines and checking practices involved in overnight monitoring helped protect both themselves and the residents from risk. The culture within the homes therefore focused on the reduction of perceived risk to residents as a priority. This focus leads to a discourse which can encourage residents to view their own bodies as a site of risk, which underlines and justifies practices which ultimately reduce individuals' agency over their sleeping environment. The influence of risk in shaping and generating procedures that are experienced negatively by some residents will be discussed.

The focus on physical care and the perception of risk in physical terms appears to take priority over any potential effect that identifying an individual as risky has at an emotional level. Fears of being held accountable influence the staff and encourage the attempted containment of risk through care home procedures. Residents have heightened awareness of their risky bodies, acquired through bodily experience or internalisation of the beliefs of wider society and care home priorities. However findings also reflected the potential for the care home environment to be disabling, increasing the general risk of them having accidents or falls. This indicates a shift in the culture is required, to provide a more enabling environment along with a supportive model of care, as opposed to a task based and medical model of care.
8.2 Older people moving into a care home and the acquisition of risk status

Although moving to a care home will be a welcome and positive choice for some residents, for others it may be the result of a particular set of circumstances or events. For many older people, the decision to move into a care home may be taken by others, or under difficult circumstances, with physical and mental health problems being found as the most common reasons for admission to a nursing home (Office of Fair Trading, 2005). Before moving into a care home, a person is likely to have undergone an assessment of their needs under the Single Assessment Process for Older People, which may include specialist assessments and an evaluation of potential risks to independence (Norman, 2005). The perspective of the individual is part of the assessment process, however Gilleard and Higgs (2000) argue that the negative perceptions of old age within our culture are also internalised by older people themselves. This serves to undermine the individual’s concept of themself and their confidence in their physical and mental abilities. They argue that mistakes which would go unnoticed in the younger individual become proof of a failing body and confirmation of society’s perceptions towards it. If a move to a care home is agreed, the person is likely to receive a further assessment by a member of staff from the potential care home to ensure that the home can adequately meet the needs of that person (Department of Health, 2003). Therefore the move to a care home may underline or affirm for the older person their ‘high risk’ status as individuals. For example, assessments for being discharged from hospital tend to focus on physical risk and incapacities and ignore any emotional or psychological risks (Huby, 2004).

For residents, experiences of the body pointed to a heightened awareness of possible danger, particularly falls, and this was coupled with perceptions of themselves as a risk understood from friends, family, health or social care professionals before and during their lives in the care home. Other concerns included risk of sudden illness or heart attack.
Particularly as I came in here as the result of an accident falling down the stairs, you see.

(Reggie, Bascombe House)

I just could not manage at home any more. And the final thing was I had had a bad fall, been in hospital for six weeks and I was walking very badly with a frame. And they walk behind me with a wheelchair and they suddenly decided I was okay to go home. I went home one afternoon and that evening I fell and I had to call for help and my neighbour came in and did help me to get back to bed. The next morning I was having to cope on my own and I fell again.

(Margaret, Longford Manor)

Margaret's experience of being discharged from hospital without appropriate support within her home resulted in her having two falls within 24 hours. These falls contributed significantly to her resulting move into a care home as she would have been viewed as a 'risk' to herself by professionals and unable to cope in her own home. This could have also contributed to her perception of herself as a risk and her confidence in her abilities to remain in her own home.

Relatives may also contribute to an individual's perception of themselves as a risk to themself or their families. Ethel described how distressed she was at selling her home but she felt she had no choice in moving to the care home because her daughter was finding it difficult to continue helping her:

Well I have had to do this because I couldn't manage on my own any longer. My daughter was always helping me but she was finding it a trial, so it was coming here or die, kind of thing. So I have got rid of my flat now, and I have given them notice and my son is going to arrange about putting my stuff in store. Because I have got a house full of, you know, a flat full of furniture and stuff that I have lived with all my life, which is very distressing when you've got to get rid of it all. So that's the situation I am in.

(Ethel, Longford Manor)

Another resident, Josie, was influenced in her decision to move into a nursing home by her niece who felt that Josie needed medical help.
I was in a little - a year, two years I think I was in a small... what do they call it, sheltered accommodation. But there was no medical help there. They were awfully good and awfully nice. But I felt, well... actually my niece felt it was time I had more help nearby, in case. Because I am getting older. I think that was the way it was.

(Josie, Longford Manor)

The above quotes highlight that moving to a care home was not necessarily a proactive decision taken by an individual but one which could be significantly influenced by perceptions of someone's ability to 'manage' in their own home. Health or social care professionals as well as family and friends may contribute to these perceptions. The concept of 'managing at home' largely equated to the physical safety of the individual and the level of risk they were perceived to pose to themselves.

8.2.1 The confirmation of risk status

Previous research has also suggested that feelings of loss and anxiety experienced in moving to a care home can be masked by the coping mechanisms of stoicism and passivity which can continue into their new life in the care home (Reed & Morgan, 1999). A sense of self as a 'risk', whether to themselves or their families, may be re-affirmed by care staff once the person is living in a residential care environment. Assumptions and beliefs about ageing bodies and risk may be adopted by both staff and residents and be part of the culture of the care home environment. Unlike rehabilitation units, the emphasis within a care home setting is on the provision of health care and personal care and not on preventative services or rehabilitation. Bascombe House had a rehabilitation unit within the nursing home although it had its own separate kitchen, lounge and dining area for the rehabilitation residents. These service users generally came to the rehabilitation unit from hospital for rehabilitation and assessment about whether they would be able to go home. The distinct focus of the unit on rehabilitation was present in the discourse of the staff:
They no longer need to be in hospital but they are not quite well enough or got enough confidence to go home. So they come to the unit, to hopefully promote their independence and we have regular weekly meetings with the intermediate care team. That is the physiotherapist, the occupational therapist, a nurse and somebody from the social work team. And as I said, every week, just to discuss how they are getting on and when we think they are ready to go home and what sort of package of care they will need when they go home.

(Pamela, Rehabilitation Officer, Bascombe House, days)

They sort of get accustomed I suppose to just being, especially in hospital where you have everything done for you, probably more than ... the idea of coming to rehab is so that they can start getting ready to go home and do more things. Make a cup of tea, make some snacks, you know, just generally. We are there, and there if they need us, you know.

(Kerry, Rehabilitation Officer, Bascombe House, days)

In the National Minimum Standards for care homes, rehabilitation is only mentioned for service users who are admitted for intermediate care for a set time period with a view to returning home (Department of Health, 2003). In care home settings, residents are generally not encouraged to undertake tasks for themselves. This may be because residents may take longer completing tasks and it is more efficient for staff to do it for them. This also may be because of the perceived risks of certain everyday tasks, like making a cup of tea or getting into bed. On a basic level, it appears that within a care home environment, it is acceptable to view people as risks and openly tell people that they are no longer competent at performing daily tasks for themselves. It is hard to imagine this occurring in other social care environments where the focus is on building and maintaining skills and independence, for example younger adults with physical disabilities or learning disabilities. The opinions of staff are readily shared with the residents and this may contribute to the residents’ internalised view of themselves. Compare the quote above from the rehabilitation officer whereby residents are encouraged to make themselves a drink, to the one from Flo below who says she is going to ‘get caught’ doing the same thing because she is told by staff she might have an accident.
R: Sometimes when I can't sleep I go out and make myself a drink. And I am going to get caught one of these nights.

I: You are allowed to do that, aren't you?

R: Well I should tell them. You see one of them did advise me. One of the staff, she said "look, Flo, we don't mind you having a drink" she said, "but let us know. We only want to know in case you have an accident". I thought here we go again... accidents. It is only because I have got a limp. They are always on about an accident. So really I should say to them 'I want a drink' and they will make one, but if I do want it I will make it myself and I go to bed.

(Flo, Kimble House)

Even when staff are trying to reassure, they may confirm the risk status to the resident. Below, Mary recounts how she was reassuring Cathy who was feeling down about not being in her own home, however the focus of Mary's reassurance is on Cathy's inability to manage rather than on the positives of living in the care home community.

I think she thinks she can still manage at home. She is that type of resident and I say to her 'Cathy if you were at home do you think you would be...... I always say this to her "how do you think you would manage. Do you think you'd manage alright?" And then you go round it that way and some of them say 'oh yes I could manage' and I say 'well could you cook for yourself and, you know, manage everything at home'. And they say 'well no, not really'. I say 'well really in a way it is a good job you are here with us now', perhaps. And I know it is not like your own home, there is nothing like your own home is there. But I said if you try and make the most of it, you will find it is not that bad, you know. And try to do it that way, just talk gently to people.

(Mary, Senior Night Carer, Kimble House, nights)

Residents were aware of staff fears around the body and risk, particularly in relation to getting in and out of bed.

R: Well as a matter of fact I don't like going to bed here because they make you go to bed early.

I: Oh do they?

R: Yes. I ask for a bit later, you know. I know they have got to have rules and regulations you know, but it is silly I am not 21 or 16. I
said "give me a little break". But of course they like to come back and put me into bed, because this (the bed) is high and the getting in.... and they are frightened I will fall, so.

(Gwen, Longford Manor)

Here Gwen recounts how she felt that she was not able to go to bed at her desired time because the staff were afraid she would fall if she did so without their support. As previously discussed, the routines of the home may significantly impact on the culture of bed times within a home or staff members may encourage people to bed for the convenience of work efficiency.

Therefore through the assessment and admittance process to a care home and through initial interactions with staff where guidance requires discussion with the individual about risks as part of their care plan, residents may internalise these perceptions of themselves in terms of risk. Experiences prior to entering the care home may be compounded by everyday interactions with care home staff that serve to underline the assumption that their ageing bodies are unsafe.

8.3 The dominance of risk at night and implications for practice

Heightened feelings of risk may be prominent at night time. A recent study has shown that due to the difference in culture and organisational practice between night and day at care homes, night staff may feel isolated, vulnerable and experience high levels of 'what if' anxiety (Kerr et al, 2008). There are less staff on duty overnight, although the numbers varied between homes in this research. As set out in Appendix A, the residential home Kimble House had two carers on duty overnight for their 38 residents. Two nursing homes, Windley Lodge and Bascombe House (25 and 44 residents), had 3 staff (one RGN and two carers) and Longford Manor nursing home with 43 residents had 5 staff on duty overnight (two RGNs and 3 carers). This equates to a variation in the homes in this research study between 1 member of staff for every 9 residents to 1 member of staff for every 19
residents. The nursing homes have more staff on duty as there is always an RGN and it is expected that the dependency of the residents will be higher than in a residential home. However, the nurses will have different duties from the carers, focusing on medical matters and staff supervision, although they are available to assist in an emergency or in the event of being short staffed.

Unlike the daytime, it is extremely rare that a manager, inspector or any other visitor would arrive during the night shift and as a matter of course the external doors are locked for security. Staff may feel isolated, in contrast to the more 'open' daytime where there are many other staff, administrators and managers present as well as visits from relatives or other health or social care professionals.

*It is different in the day because during the day you have got so many hands to help I mean during the day. And in the night we have got only two carers. If we have got some emergency or something like that, then it is really difficult.*

(Rashmi, RGN, Windley Lodge, nights)

R: You don't know what is going to happen. It could be anything like the gas goes, you know what I mean, or an emergency, or somebody falls on the floor and I have to get the 999 in.

I: Is that to pick them up?

R: Well just to check that they are all right. You know, you could have somebody with a broken hip, you know, it just depends.

(Mary, Senior Night Carer, Kimble House, nights)

8.3.1 Night time routines of checking

During the night time, the 'what if' anxiety contributes to a culture where the focus is on the management of risk, with residents being viewed the main sites of risk. In this environment systems are employed that attempt to minimise risk through monitoring and surveillance. This culture of risk control resulted in 'checking' routines that are concerned with incontinence, falls, health status and breathing, with all 'negative' incidents or activities being recorded meticulously as required by inspectors and regulators. Staff
attempt to minimise risk (i.e. negative incidents) by taking proactive, and at
times invasive, actions that appear to focus more on safety than the quality
of the sleep environment of residents. This is highlighted by staff who
comment on the fact that their night-time practices may disrupt sleep or
upset residents, but which they continue to do. On the whole, the
minimisation of risk was the key driver of practice at night.

The practice of checking involves entering residents' bedrooms at set
intervals, usually hourly to determine that residents are still 'safe' in bed,
whether they need an incontinence pad change and or need any assistance.
Night staff at all homes advised that they were supposed to do hourly checks
on residents, however Longford Manor increased this to every 30 minutes for
those residents who had side rails on their beds.

R: We check them. We check them hourly. Those with the bed
rails it is every 30 minutes and those with no bed rails we check
them every hour.

I: Okay and what are you checking for?

R: To make sure that they are sleeping, they are safe, they are in
bed, they have covered themselves, and if they have moved we
cover and do various.”
(Judy, RGN, Longford Manor, both days and nights)

Guidance on the use of bedrails has been recently updated (MHRA, 2010)
although there was previously and remains risks of injury associated with the
use of bedrails which is why the checking schedule was increased to every
30 minutes.

Everybody has to be checked once an hour. Unless they request they
don’t be disturbed but then they have to put it in the care plan
themselves. Or their families. Otherwise we have to. We are legally
bound to check them every hour.
(Pauline, Carer, Windley Lodge, nights)

Pauline illustrates the high levels of importance that staff place upon the
checks and minimising risk overnight. It is striking to note that she felt she
was 'legally bound' to check residents every hour and may be indicative that
she feels she would be legally punished for not carrying out the blanket checking routines in place in the care home.

Kimble House Residential Home, like the nursing homes, had a policy of hourly checks during the night however night staff stated that they did not always adhere rigidly to the hourly schedule where it was recognised that checking would be unnecessary and intrusive, or where residents had specifically requested that they were to be left alone.

_We just pop our head round the door, if they are awake, you know, to see if they are all right, if they want anything. And just to make sure everyone is safe and not on the floor, because obviously when we are going round we have found them on the floor before now, if someone has got out to use the commode or fallen out of bed or... whatever. But it is just mainly as I say we just peek in and there are certain clients that we don’t. That, you know, Dora doesn’t like it, she doesn’t. Ernest doesn’t like being disturbed. Who else is there. Una doesn’t like to be disturbed. So the ones that we don’t and there is some clients that, although we know they are on an hourly check, you are better to leave them every other hour, because you know as soon as you open that door, like Cathy is for one, as soon as she hears anything she is up and down [stairs]. You know, so you have got to use your judgement really haven’t you, you know._

(Denise, Senior Carer, Kimble House, nights)

Carers in Kimble House used their judgement and knowledge of the residents to determine the level of checking they felt necessary. Safety, particularly in relation to falls, is prominent in the carer’s mind. However, even residents who did not like being disturbed overnight were checked every two hours, including those who were most independent. Nursing home staff did not appear to have autonomy in the way in which they applied the overnight checking practices and this may be reflective of the level of dependency of the residents and the influence of the medical model of care more prominent in nursing homes.

In addition to checking and changing incontinence pads, staff felt the checking was necessary to alert them to potential problems and, in particular, falls:
I mean in the night time, in the middle of the night you check on the residents, if they are okay or not, slip from the bed or something.

(Laticia, Carer, Kimble House, days)

We do, we tend to do every hour, we tend to do a round. Because if somebody has fallen out of bed and they haven’t been able to get to the bell.

(Dawn, Carer, Windley Lodge, nights)

In addition to continence and falls, staff were checking a number of other factors including skin colour, breathing pattern, general safety, catheters and bedcovers. Checking whether residents were still alive was also a significant factor.

No it is everything, like because some residents here are, some residents are, like, some are just, they are dying so we also have to take in observation if they are still breathing. It is just it is not just the incontinence thing.

(Celia, Carer, Longford Manor, both days and nights)

So, or we have had it where somebody has died. We have gone in and found them dead. So we have to check them every hour. You never what is going to happen.

(Pauline, Night carer, Windley Lodge, nights)

It was felt by staff that hourly or two hourly checking routines helped prevent accidents and even death and this may go some way to understanding the unquestioning way in which carers do not challenge this regime even when they know that the people they are supporting do not want to be regularly checked. It is possible to understand how these blanket checking policies may identify when somebody has died or had a fall, and therefore prevent an individual being left for a long period of time without help. It does not explain how these procedures prevent such occurrences. As a preventative mechanism, the checking procedure is a blunt, one-size fits all instrument.
8.3.2 The impact of night-time checks

Even where residents have expressed that they do not want to be disturbed during the night-time, either formally through the care planning process or informally to the staff, it appeared that they would be advised by staff that the checks still needed to be carried out.

> We do talk about their sleep and we do document it. Because we have to find out what time they prefer to go to bed, what time they prefer to come out of bed. ...Do they want to be checked. Of course some people they will tell you ‘I don’t want....otherwise you will be disturbing me’. Usually we agree to, say “okay what about if we check you two hourly, will that help you, because we need to."

(Judy, RGN, Longford Manor, both days and nights)

It is therefore not always easy for residents to have their night-time requests respected as indicated by this quote from Judy who highlights that they will not readily agree to not checking someone. This is indicative of the power relations between care home staff and residents whereby care home staff feel they cannot meet the requests of residents and it is residents who are expected to compromise.

The night-time care practices and routine checking of residents has been demonstrated to be a disturbance to their sleep. In one study of 10 care homes, it was found that 42% of waking episodes lasting four minutes or longer were related to noise, light or incontinence care activity and 76% percent of all incontinence care practices resulted in people waking up (Rahman and Schnelle, 2002). This study also supports the findings of Kerr et al (2008) who argued that the checking routines of staff were a disturbance to the sleep of residents. While some residents clearly found the presence of staff in the home reassuring, some found the overnight monitoring an annoyance and disturbance during the night (as discussed in Chapter 6). For example, in response to being asked how well he slept, Reggie said:

> It depends how many visits I get! (Reggie, Bascombe House)
Reggie objected to the lack of privacy accorded to his bedroom by the care home staff and was referring to the regular night-time visits from care home staff. This experience was shared by others who also commented that the night time checks disturbed their sleep:

*They do come round, I don’t know, they come round during the night and I see the door just closing so...I suppose that just about wakes me up.*

(Mrs Rothwell, Windley Lodge)

*Well in the night time, there’s a lot of people shuffle around here sometimes...And they can’t speak a word of English...And that door will open, and you’ll hear the door. And it will just be one of them look round the door and they’re gone. But it wakes me up, wakes me up.*

(Eleanour, Kimble House)

For some residents, there is a clear link between their disrupted sleep overnight and the actions of care staff who are coming in and out of their bedrooms overnight. Depending on the practices of the home and individual staff the levels of light from the corridor and noise from having the bedroom door open and close is a contributing factor. Residents who wear incontinence pads may also be disturbed by the staff member finding out whether the pad has been used.

Concern was also expressed about how the checks were carried out, as their experience was that the checking regime sometimes caused more of a disturbance than they felt was needed. For example, Hilda was talking about a carer coming into her room and adjusting her bed covers that she had removed because she was too warm.

*She pulled the [bed]clothes over me, dumped them over me, and she caught hold of my leg and flung me over to one side which was very painful, made me shout out.*

(Hilda, Bascombe House)

This example also highlights how the carer did not talk to Hilda to establish if she wanted the bed covers back on her. Another example is from Dora who felt that the carer woke her up even more by talking to her.
The only time that I will not go back (to sleep) quickly is if I have been disturbed. Like for instance, one night in the week, the carer came and of course as soon as that door was opened I wake up, and she spoke to me. Now had she not spoken to me perhaps I would have gone off, but she spoke to me and I answered her and she said “it is alright, Dora, I have just come to see if you are alright”. And I said “I am fine thank you very much”. She said “Sorry I have disturbed you” and I said “That is all right”. You know, I thought ‘go away’. And then, that then takes me a little while to drop back off.

(Dora, Kimble House)

Residents of care homes are subject to overnight checking procedures which are often experienced as intrusive and disruptive to their sleep. The rhetoric of choice and control present within policy and staff discourse was absent in the night time practices of the homes in this study. Residents were largely unable to opt out of receiving regular checks. Where residents were refused, however gently by staff, to opt out, this reinforces for the resident a disempowering, hierarchical relationship with care home staff.

8.3.3 Staff perspective of the impact of night time checks

During the interviews, a few of the night staff talked about the need to try and be quiet when doing their rounds at night. It was recognised that checking routines would affect the sleep quality of the residents, but that they felt they were a necessary part of their job to avoid risk and ensure the safety of the residents.

But we have to check, we have to change, we have to do all that. We also have to have time to rest. Because, but they’ll tell you, the other residents will tell you and say “oh you girls, you keep walking round, all round the night, banging doors” you know. So you say “Oh sorry, were we make (sic) a noise” and they say “Yes... and we were just trying to sleep. You were coming in. I was trying to sleep in my room.”

(Ama, Senior Carer, Longford Manor, both days and nights)

Ama highlights how she is told by some residents that staff are disturbing them overnight however she indicates that she does not have a choice about checking.
Dawn, a care assistant, thought that the check calls on residents were a main cause of sleep disturbance during the night.

I So can I ask you what do you think are the main causes of residents waking up?
R: Well, one is us disturbing them just by ... because we have been had a go at before... so we try not to. We don't go in and turn lights on.
I: Oh right, you don't turn lights on?
R: No. Because it is not fair is it. We have got dimmers, so I mean we can just turn it up and have a look. But Mrs Rothwell, we try not to, bless her, because she does have a go at us. Well every hour if somebody was walking into your room and it was waking you up, it would annoy you wouldn't it. So you have to consider..... I wouldn't like it.

(Dawn, Carer, Windley Lodge, nights)

Dawn cites night time checking routines as a main cause of disturbance to sleep and acknowledges that this is something which residents do not like and find intrusive or disturbing. Even though Dawn can empathise with their position and states that she would not like it herself, she still feels it necessary to override resident’s wishes and continue with night time checking procedures. While staff may acknowledge a conflict between disturbing residents’ sleep and their perceived ‘safety’ procedures, it did not appear that they felt it necessary to resolve this conflict. The checking procedures took priority and this seemed to be because care staff felt that they were an important and unalterable part of their night time work.

Dawn also highlights a point raised by other staff which was the need for them to alter what is private sleep environment in order to be able to carry out their work. In the example above, she discusses turning on the lights in residents’ rooms in order to check on them and carry out care tasks. This underlines the conflicting statuses of the bedroom as both private sleep environment and a work place for the carers. Typically, the status of the bedroom as a private space will be subordinate to the use as a work space. This again may reinforce for residents their lack of control over their sleep environment.
8.4 Staff perceptions of risk

During interviews, staff discussed risk as though it resided solely within the individual resident and did not acknowledge where practices or the physical environment could also pose a risk to the physical safety of residents. In discussing the requirement for check calls overnight, Dawn related her concerns around risk to a particular incident of a resident falling.

_We do, we tend to do [checks] every hour, we tend to do a round. Because if somebody has fallen out of bed and they haven’t been able to get to the bell. Like Mrs Rothwell said to me, you know, [she had had a fall] and I said what the same place again? It always seems to be the wheelchair. And she said “yes the wheelchair fell on top of me” and she said “of course I couldn’t reach the bell”. So, she had to, like, crawl out into the corridor. So because we do every hour we do a round, if somebody had have fallen out of bed they wouldn’t have been out of bed that long. Which we have done that. We have walked into a room and thought “oh God, are you alright?” “Oh we have been waiting for you”. So you know it is a good thing that you do. She was quite poorly and especially just lately. I mean since Christmas we have had everything you know. And there is still a couple that are quite ill now. So I mean we check them more often anyway. But they can be … obviously we have been moaned at. Like, Mrs Rothwell, “you keep waking me up”. You know, but we are only there to._

(Dawn, Carer, Windley Lodge, nights)

This incident, which had also been recorded in my field notes from a conversation with Mrs Rothwell, involved her falling whilst walking around her room using a walking frame and did not happen during the night-time. Mrs Rothwell’s room contained many of her personal belongings and furniture that had come with her from her own home. Whilst this gave her room a very personal feel, it was a comparatively small space and was difficult to manoeuvre around with a frame or in a wheelchair. The carer, in her narrative, had linked this to the check calls on residents and dangers at night, however Mrs Rothwell had not fallen out of bed and the incident did not happen at night. This is an example of the ‘risk’ factor being attributed to the older person, and not the environment which may have been a contributing or even a predominant factor. In general, the care home staff constructed the older person as the cause of risk. However, in assessing risk they did not appear to place the same emphasis onto the physical
environment of the care home itself. For example, in one home although it was acknowledged by the senior nurse that bedrails could increase risk of injury, particularly for those who are cognitively impaired, they continued to use them but with an increased checking regime.

8.4.1 Risk and the physical environment

While staff identified residents as the centre of risk within the care home environment, few acknowledged that the environment itself could pose a risk to the resident. The residents however were frequently able to identify aspects of their surroundings that contributed to the risks that they experienced.

_I had three quite bad falls in there, nothing to do with going to the loo. So now I am not allowed to go in there unless there is somebody... I don't know why I fell each time. I was trying desperately, there was a small loo and...people dump all their junk in there too and I tried to move from one place to the other and fell and it happened three times._

(Sybil, Windley Lodge)

The 'junk' Sybil is referring to are items left in her bathroom by the care home staff. In the homes where bedrooms each had en suite bathrooms, it was not uncommon for bathrooms to contain other medical or personal care items and equipment which sometimes created a cluttered environment. Rooms were also sometimes cluttered and Ruth describes how the arrangement of the furniture in her room caused her difficulties when moving around it.

_No I won't sit on (the chair), because the chair is right behind the door. And it is about sort of here and I find I slip because the carpet is here, my shoes and that, I have slipped before. Yes I have had a couple of falls you know._

(Ruth, Bascombe House)

For residents, perceptions of bodily risks were also linked to the bed. Mobility difficulties, pain and perceptions of the risk of falling heightened increased concerns about safety in bed. Another factor was that the beds
used in the nursing homes were more likely to be higher from the ground, similar to those used in hospitals. However difficulty was not just experienced with the hospital style beds as the rehabilitation unit used ordinary divans.

*Otherwise I think it is just because they are not at home. It is not their bed. Or because they are used perhaps at home sleeping in a double bed even if they’re just on their own, but a single bed, it is a bit.... So occasionally we turn the beds round so they can’t fall out because they are just ordinary divans.*

(Pamela, Rehabilitation Officer, Bascombe House, days)

The issue of the use of single beds was the most significant factor raised by residents. Those who had been used to sleeping in double beds expressed difficulty adjusting to a smaller size and felt insecure in the bed.

*When I was home, you see, I used to put his... one pillow at the back and his other pillow I used to cuddle. So I felt more comfortable. Of course the bed was bigger. I could stretch, but I have got to watch here I don’t tumble out.*

(Gwen, Longford Manor)

*But they are looking out for another room for me so I can have my double bed here. Because this is not very wide when you come to turn over, when you are used to a double bed. You know, and I am getting near the edge for falling out of bed half the time.*

(Ethel, Longford Manor)

Further than just feeling insecure, participants reported actually falling out of bed which they felt was due to the change from a double to a single bed.

*When I first came here, I suppose I was turning over and I went too far and I fell off the bed.*

(Virginia, Longford Manor)

*The first bed I had, I think it was six inches less than this one. Because I did find you know that it wasn’t quite big enough and I fell out (laughs), so they got me this one. And I thought oh yes, it is just that little bit wider and it does make a difference.*

(Josephine, Longford Manor)
If the older person is viewed as the sole cause of risk without taking into account the physical environment and their personal experience and changes from previous sleeping practices in their home, this does not help in identifying effective interventions. The response appeared to be to increase monitoring and surveillance in an attempt to mitigate against serious consequences rather than attempting to reduce the possibility of incidents. Consequences that the care home would want to avoid were being seen as potentially negligent or simply giving poor care. However there does not appear to be any attempt to minimise the likelihood of risky occurrences through a more holistic consideration of risk which may include a potentially disabling environment, as well as any emotional and psychological risk associated with the loss of agency experienced by an individual over basic aspects of their life. The routines in a care home at night time, as a response to perceived risks, may disturb the sleep of residents which, in turn, may have an effect on daytime functioning and well-being (Ersser et al, 1999). However, care home staff did not identify lack of sleep as an additional factor to physical risk.

8.5 The body constituted in care homes as a site of risk.

The focus on the body as the site of risk in care homes results in care practices and a culture that is not only risk averse but relies on surveillance and disruption of individual privacy, rather than exploring methods of risk reduction through modifying the environment. For example, within the community there has been an increase in the use of innovative technology, commonly referred to as ‘telecare’, used to enable people to remain living independently in their own homes. It is possible that such technological solutions could be employed to increase the individual’s independence within a care home environment. One example would be a bed occupancy sensor which detects when someone has left their bed. The sensor can turn on a light to increase visibility and then alert support staff if the bed remains unoccupied for a preset period of time. However, the use of technology and the development of telecare is located within a preventative discourse in
policy aims and practical terms. The funding basis for the guidance document *Building Telecare in England* is the Preventative Technology Grant and one of the specific aims is to contribute to the development of preventative services (Bernard, 2007). The guidance specifically mentions sheltered housing but not residential care. The issue here is that care homes are not part of this preventative framework. Although a move to a care home may be a positive choice for some older people, this is not always the case as a decision to enter residential care may depend upon a number of factors and may have to be taken quickly and under pressure (Peace et al, 1997). Although it has been argued that residential care should not be considered as a last resort (Oldman and Quilgars, 1999) care homes are not part of the ideology associated with preventative care and therefore are widely perceived as being the appropriate response when independent living, whether alone or with family, is no longer considered a viable option. Telecare should not replace human contact but could be offered as an option for residents of care homes who would prefer it to reduce unnecessary monitoring or sleep disturbance overnight. Residents of care homes should not be excluded from access to new social care initiatives and policies.

However, successfully implementing changes to physical environments to enhance privacy and choice requires a culture of care that supports individual decision-making by residents and also requires residents to perceive that they have choice (Barnes, 2006). This involves a shift in dynamics within the culture of care, requiring staff to give up some of their control and power (Adams, 1996).

The issue of risk may be a central concept in older people having control and choices (Bernard, 2007). The Commission for Social Care Inspection (2006) discussion paper drew extensively from consultation with older people who acknowledged that risk was part of everyday life and that meeting their choices and aspirations could sometimes involve a degree of risk. The Commission also commented that “organisations and individuals with an interest in promoting the well-being of older people need to consider whether they have got the right balance between enabling the personal choices of individuals versus the perceived risk to organisations if things go wrong”.

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(2006: viii). However, the emergence of risk perception leads to regulatory creep (Better Regulation Commission, 2006) and inspection regimes have a profound effect on the practices of care homes. There is a conflict within the role of care staff between promoting the independence of their residents and ensuring there is the required standards of hygiene, health and safety evidenced through a paper trail for a successful inspection (Finlay et al, 2008). This study has highlighted how overnight checking procedures are considered by care homes and staff to take precedence over the wishes of residents, despite it being acknowledged by both staff and residents that regular checks are a disturbance to sleep, thereby potentially reducing the sleep quality of residents, many of whom are frail or have long term health conditions.

National policy, therefore, asserts a tension between autonomy and risk. How this translates into the provision of frontline care services remains blurred. Risk can be seen as a normal and unavoidable feature of everyday life; the way in which an individual chooses to negotiate that risk is part of individual identity and respecting those choices can be seen as enhancing dignity (Titterton, 2004). Stalker (2003) highlights that risk may have displaced need as the primary focus of social care. Currently, it appears that the concept of risk is owned by the care homes. The risk discourse of the staff within care homes centred on both them as individuals and the organisation having responsibility when things ‘go wrong’. Therefore the goal was to reduce the amount of incidents that could pose a threat to the reputation of the organisation and this would take precedent over individual resident preferences. In this relationship dynamic, the individuals responsibility for themselves is removed and with it the opportunity to negotiate risk on their own terms as an adult. Hockey and James (1993) highlight how ‘personhood’ is constructed through contemporary Western ideas of “autonomy, self-determination and choice” (1993:3). They suggest that, in residential care, the concept of personhood may be reduced as their freedom to choose is gradually eroded by the infantilising practices of care. The older person may “experience a deepening sense of lost status as persons’ as a result” (1993:49). Risk cannot be completely eradicated from
our everyday lives and how we negotiate and respond to the concept of risk will vary as an individual. Similarly, how we are supported by formal care services in our daily lives will need to adjust to those differences to respect our ‘personhood’.

National policy aims, including promoting independence, well being and choice (Department of Health, 2006) are not always easily translated into frontline services, including residential homes for older people. Stalker (2003) notes the lack of research exploring the service user perspective on risk in care environments. When focusing on large concepts such as risk, choice and control, “we might then neglect the much more frequent, everyday areas in which a person can experience empowerment and disempowerment” (Finlay et al, 2008: 353). Talking to staff and residents in care homes about the everyday matter of sleep has identified an area of basic agency, over sleep environment and sleeping bodies, as lacking. The effect of risk averse care home ideology and practices on the lives of older people has been highlighted. It became apparent that residents lacked control and agency over their sleep environment and many were concerned about consistent use of surveillance which made them feel uncomfortable and disturbed their personal space. However, in accepting there is diversity of personality, behaviour and biography, as well as cognitive and physical effects of ageing, it is not unrealistic to assume that an individual’s approach to risk may also change throughout their life course. Some resident participants reported taking comfort from not feeling on their own at nighttime and from the audible and visible presence of care staff.

8.6 Conclusion

This chapter has explored the theme of risk in relation to sleep in care homes. Regardless of physical or cognitive ability, residents reported a lack of control over their sleep environment. Even those residents who were most able discussed aspects of care home practices that they felt affected their privacy and their sleep. This was underlined by wider societal constructions of the ageing body as vulnerable and a site of risk. Disabling
practices in care homes, such as the provision of high and single beds, may be a factor in exacerbating falls out of bed and therefore affirm this risk as a reality. The overnight risk averse culture, highlighted through interviews with staff and residents, centres on the body (falls, health, being alive) as the source of risk and rarely focuses on the environment. This risk culture within care homes may be exacerbated by a number of issues. This includes the influence of inspection regimes, the absence of the body from social care policy and the position of care homes within the wider welfare system as places for people who are considered too 'at risk' to live in their own homes. Care homes are not perceived as places of promoting skills and independence and are excluded from the innovation and prevention discourse associated with community care initiatives such as telecare.

Yet this focus on minimising the consequences of risk to the body has the real effect of disturbing sleep and this may have consequences for residents in affecting their daytime functioning as well as their sense of well-being. The checking procedure is one-size fits all approach and is an area that would be improved by the use of assistive technologies such as bed occupancy sensors and fall detectors. However, the disruption of sleep was not identified by staff as a contributing risk factor. The approach adopted by care homes, that of routine monitoring and surveillance, is a strategy for mitigating against worst case scenarios rather than exploring more preventative alternatives. This strategy is applied broadly to all residents regardless of the level of 'risk' they are perceived to have and denies residents the opportunity to exercise control over their home environment because they have little choice but to fit in with the established culture.

The arguments presented in this chapter do not wish to ignore that a significant amount of residents are frail, ill or rely on staff for physical assistance which, in some instances, may require a level of monitoring or medical supervision. However it is argued that there are instances where this is not necessary or required and it is in these cases that personal choice can be eroded. The tendency for care home routines to prevail over the individual, and the prioritisation of risk management, means that choice can only be exercised within the boundaries set by care home procedures and
practices. Routines of the care home ensure there is regular monitoring and observation of residents sleeping bodies during the night-time. For most people sleep is a time of privacy and intimacy, however in a care home the residents have people walk in their bedrooms during the night and if agency staff are being used, these people may be strangers. The notion of observed sleep in care homes and the control of the sleep environment by the staff, rather than the individuals, demonstrates unequal power relations and undermines the notion of residents' choice and independence in the most basic aspects of their daily lives. In extreme cases, this may result in the use of bedtime as a form of 'restraint'. However, there is also a tension between competing policies, how policies translate into practice, and how this creates conflicting roles for the staff in care homes. The staff did understand that their practices had an impact on the sleep of the people who lived there however expressed, through the discourse of risk, that they must balance this against the duty of care they have to ensure the health, hygiene and safety of the residents overnight.
Chapter 9

DISCUSSION: THE SOCIAL CONTEXT OF SLEEP IN CARE HOMES

9.1 Introduction

As an empirical qualitative study of sleep in care homes, this research builds upon existing sociological work on sleep and contributes to the understanding of the interrelationship between sleep and its social context. Forming part of the New Dynamics of Ageing funded Sleep in Ageing (SomnIA) project, the study used qualitative methodology including observations in four care homes covering all parts of the day and night and interviews with 38 older people who lived in care homes and 39 nursing and care staff who worked in them, to record, analyse and interpret the experiences of sleep in care homes and the views of staff who work there.

The research findings from this study highlighted that the physical and social environment of a care home influenced the quality of residents’ sleep. The physical environment included residents’ beds and bedrooms, noise, doors and the home layout. The social environment included other residents, care home staff and the culture and practices within each home, which are in turn subject to wider social and cultural influences. Personal factors affecting individual residents can include their personal biography, physical and mental health, pain and continence issues. These data not only provide insights into the subjective experience of sleep for older people in a care home environment, but also can highlight fundamental issues associated with personal autonomy and organisational structures in the residential care setting.

This chapter draws together and discusses research findings, focusing on the impact of organisational routines and practices in care homes. The study found that there was an imbalance of power within the care home environment which allowed care routines and the practices of the home to dominate the night-time sleep environment. Care home routines and in particular shift patterns were so influential on the sleep environment that they
determine the length of time that many residents spend in bed and the sleep/wake pattern for everyone living in the home. The way in which choice and control over the sleep environment is affected by the care routines was experienced differentially according to a resident's physical and cognitive abilities. At a basic level, individuals lacked control over their sleep environment and this disrupted contemporary ideas of bedroom privacy and the home.

This study found that sleep in care homes was affected by wider social and cultural influences. Staff perceptions of sleep and later life were found to influence their approach to supporting care home residents. Assumptions about sleep in later life contributed to care staff disturbing sleep for residents and having low expectations of what sleep should be like for an older person. Some residents shared these views and had reduced expectations of the sleep quality they should expect based upon their stage in the life course. Residents tolerated regular disturbance to their sleep by staff routines not only because of their perceptions of sleep in later life, but also as a result of the medical style relationships they had with care home staff. Staff adopted the position of 'professionals' who determined when an individual should sleep or be disturbed. The dominance of risk management upon the night culture in care homes underpins care practices that routinely disturb and fracture residents' sleep. Many residents downplayed the importance of their own choice and control over the sleep environment and constructed an alternative view of their situation whereby they attempted to be flexible and tolerant in order to cause less difficulty to the staff. As such, individual preferences are devalued in order not to disrupt the dominant organisational structures of the home.

9.2 The impact of organisational routines and practices

The impact of organisational routines and practices was evident over the 24 hour period in the homes in this study, with each stage of the day being defined by staffing shift patterns and a timetable of tasks to be achieved. Against this backdrop, residents had little control over their sleep
environment. If residents attempted to assert their preferences, this involved explicit negotiation with staff and because of the imbalanced power dynamic between staff and residents, these negotiations would frequently lead to compromise by the residents. This section discusses the dominance of routines over individual choice. It is proposed that by constructing day and night as shifts, and approaching the night-time sleep environment as primarily a time for surveillance and to complete set tasks, the organisation of care homes removes choice and control from residents which impacts negatively on the sleep environment and the quality of residents’ sleep and night-time experience.

9.2.1 The dominance of care routines

Previous research in care homes has examined the nature of the ‘total institution’ approach to care, identifying a model in which care home routines are the basis for the support provided (Gubrium, 1975; Lee-Treweek, 1994, 1996; Diamond, 1992). The organisation of care homes is such that what would be considered everyday activities are structured and formalised in ways that they cease to be simply tasks that are carried out by an individual and become instead a routine of care that is provided to the individual. This set pattern of care revolves around key events of daily living including getting up, going to bed and mealtimes as well as other events such as using the toilet, having a cup of tea and engaging in leisure activity. These events reflect activities that many people will carry out in their own home and therefore it is not the activity or even personal routines that have been the subject of criticism in previous care home research literature, but the dominance of organisational routines over personal routines in the care home environment.

If an individual has been assessed as needing support with personal activities, the availability of staff to provide support will be a key factor and this would be the case whether someone was in a care home or receiving ‘home care’ support in their own home. Walker and Walker (1998) have argued that health and social care services for older people operate in a way
that constructs dependency and note that older people are now the only group of people for whom larger residential care units are considered an acceptable and appropriate model of care. Challis et al (2000) note that some people entering care homes have 'low dependency' needs and could benefit from more rehabilitative therapies which are not generally available in care homes. It could be argued that by creating an environment where rehabilitative therapies are not available and where there is an inflexible approach of routinised care, residents have little option to exercise their independence or regain previous skills. If independence is not actively promoted and supported within care homes, the potential increases for residents to accept and be constrained by routinised care.

In a care home, the availability of staff to carry out the key events in the care home timetable is an important factor and therefore the staffing patterns will significantly affect the provision of care. In this context, the ability of an individual to choose their own personal routines is dependent on the availability of staff to support them to carry them out. This research suggests that the sleep routines of older people in care homes are not only affected by the practices and routines of the individual care home but are made to be dependent upon them. The going to bed and getting up times of many of the participants were dictated by the structure of the care home timetable as participants required physical support to help with the activity associated with going to bed, such as dressing and going to the toilet. Staff discussed a demanding and pressured workload and that even one member of staff being on leave or off sick without cover would have a significant impact on their ability to give adequate time to the people they supported. From the staff perspective, the times of going to bed or getting up for individual residents had to be balanced against the organisational structure of the home and the task management needs of their shift, despite many staff participants stating that residents had choice about when they went to bed or got up in the morning. Gubrium (1975) noted that in Murray Manor there were problems in the morning for staff who needed to ensure that all residents were up and dressed for breakfast. This pressure was not apparent in the evening when staff were getting people ready for bed. The
night shift at Murray Manor started at 11pm, much later than in any of the homes in this study. The earlier start of the night shift times that were observed in this study ranged from 7.30pm – 9.30pm which put pressure on staff to support residents to go to bed before these times.

Facilitating going to bed or getting up may also require the use of a hoist and the homes in this study, not unusually, had rules that these needed to be used by two members of staff who may not always be available at night, depending on the numbers of staff on duty within each home. Other standard care ‘rounds’ such as giving out medication, giving out drinks, continence pad checking and changes and general regular check calls on residents throughout the night were all perceived by both staff and residents to impact upon sleep.

This study supports previous care home research in finding that the provision of routinised models of care takes precedence over encouraging and supporting independence and individual routines. Through focusing on sleep, the findings of this study highlight the dominance of those routines over the whole 24 hour period. Although sleep and the night-time in a residential home may be overlooked as a ‘dormant’ period, the effects of routinised care can be considered more pervasive at night because those routines enter into the ‘private’ sphere of sleep and bedrooms. The majority of staff participants were very aware of the broad themes in health and social care policy of promoting choice and control in terms of the residents being able to have ‘choice’ and ‘control’ in relation to their own personal sleeping routines and preferences. These themes and ideals are also reflected in their local policies and care home marketing and documentation. A few staff participants gave examples which did highlight some flexibility of practice where they were able to consider individual needs and also respond to spontaneous requests or events, such as residents being ill during the night and needing to stay in bed during the day or simply wanting a lie-in. However these situations tended to be associated with particular health related occurrences rather than social or personal choices of the resident. Some staff also recounted feeling affronted at being asked by other staff or managers to ‘put’ a particular person to bed or get them up at a certain time.
to fit in with the needs of the home. However, the routines and structures of
the home, as well as decisions made by individual staff members, were
noted by both staff participants and residents to compromise the choices of
residents in determining their own going to bed and getting up times.

9.2.2 The establishment of 'day' and 'night' as shifts

In a care home, understandings of 'day' and 'night' are broadly defined by
the shift pattern of the staff. The time that the night staff commence their
shift effects what is identified as the night-time within that home. This has
subsequent effects not only on the general ambience at certain times within
the home but it also can dictate when residents are expected to be in bed.
An overriding imperative or constraint appears to be that the majority of
residents who need assistance should be in bed by the time the day staff go
off duty, as there are less staff available at night to support residents. The
onset of the night time produces a 'winding down' feeling in the home.
Evening activities are rarely provided by the activity co-ordinators and with
many residents moving or being moved to their rooms after supper, this may
courage more able residents to move from the public areas within the
home to their bedrooms, and potentially to bed earlier than they would in
their own homes. This can be actively promoted by staff who feel it is
appropriate to encourage people to bed rather than staying up later.

The demarcation of the night as reflected by the shift timetable of the home
can mean that the night time is long, potentially over 12 hours which was the
longest night shift time encountered in this study. Residents may be in bed
for a long time, however it does not necessarily follow that the time spent in
bed is time spent asleep. As well as the impact of care home practices and
routines which may disturb sleep, the nature of communal living brings with it
a certain amount of noise and activity even in the middle of the night. As
well as potential disruptions during the night from other residents and staff
activity, the homes tend to start the 'waking up' process very early in the
morning. As found by Gubrium (1975), the night staff may commence the
morning duties and this may be as early as 4.30am. The morning is a busy
time and the activity of the staff who are trying to complete their tasks as quickly as possible can create an undercurrent of noise which signifies the start of the day to residents in their rooms. While night and day may be clearly defined by the shift patterns, the task management of the care home spans these boundaries. While a day shift may start at 7.30am, the ‘day’ may start at 4.30am with night shift staff commencing the ‘morning’ tasks.

To more fully understand the impact of care home routines and practices on sleep, it is necessary to view the full 24 hour period and to explore the setting as an environment in which staff work and where people live. However, within a care home environment there is an imbalance towards the staffing patterns and structures that leads to the day being defined by the work of the staff, and not by the life of the individual resident. These findings are consistent with previous care home research, going back as far as the findings of Townsend (1964), Gubrium (1975) and Lee-Treweek (1994), however these previous sociological studies have tended to focus on the day time. In contemporary Western society, the night-time is considered as a dormant, private period where individuals withdraw from wider society. This is reflected in social policy, regulations and practice guidance which largely ignores night-time care. The contribution of this research is to pay particular attention to what happens overnight. Within care homes, sleep environments are not private and are also a place of work for care home staff. This conceptually creates a conflict between the private sleep of the resident and the work of the care home staff. Since Townsend’s seminal work, there have been many physical changes to care homes. Legislative and policy developments have given care homes a new language of consumerism, choice and control and have potentially set higher expectations for residents and families. However, the conflict between the effects of structured routinised care versus the choices and autonomy of the individual, described in previous sociological work, remains a prominent theme.
9.2.3 The differential experience of choice and control

During interviews, the staff displayed knowledge of health and social care policy ideals, particularly that residents should have autonomy and be able to adopt personal routines, however they also recounted many examples of where residents were not able to exercise choice in matters relating to their sleep. This study found a relationship between greater physical / cognitive ability and residents having more freedom to exercise choice. Residents with cognitive impairment may be at a disadvantage if they are not able to communicate easily and appear to be accorded less control by staff. People with physical disabilities are vulnerable to the negative impact of care home routines due to their reliance on staff to provide them with the support that they need, particularly for getting in and out of bed.

Residents requiring less physical assistance from staff were also affected by the care home routines. With the majority of the residents being in their rooms or in bed after supper by about 7.30pm, the communal lounges felt large and empty. Rarely any activities were provided in the evening and the usually busy places such as the office and reception areas were dimly lit and quiet. Staff were reduced in numbers at night and were often with people in their rooms which also contributes to the quieter atmosphere. As such, some residents talked about ‘going with the flow’ of the home and not staying up as late as they would have done in their own homes. This indicates cultural norms within the homes being adopted by the people that live there, rather than continuing with and maintaining their previous routines of living. The model of care relating to the more dependent residents therefore impacts on the more independent residents through the generation of cultural norms in the environment.

Despite the varying needs of residents and differences in physical and cognitive abilities, a lack of control over their sleeping environment has been identified. In some instances this was occurring even though residents were clearly able to articulate their preferences. The existing systems within the care environment restrict choice over sleep preferences, and therefore
individuals have to explicitly negotiate with staff or implicitly negotiate their social environment. Negotiations are not just particular situations in isolation but are influenced by and take place within wider structural factors (Strauss, 1978). Additionally, negotiation need not necessarily take place as a conscious strategy and can be either explicit with open discussion, or implicit with no open discussion (Strauss, 1978). As such, negotiations "need not imply that full agreement is reached and all parties go away satisfied at the end" (Finch, 1989:181). Wider structural factors such as power or gender can influence negotiations and it cannot be assumed that each party negotiates from an equally strong position (Finch, 1989). Allen (2000) found that on a hospital ward, despite a philosophy of 'family involvement', there was an asymmetric negotiation relationship between the staff and the established family carers of older people on the ward. While the family carer presented challenges to the ability of the staff to control their work, it was noted that during interactions the family carers were "oriented to nurses' professional expertise and their status as arbiter of the ward rules" (Allen, 2000: 160).

For residents of care homes, the ability to negotiate reduces with increasing cognitive disabilities as residents are less able to recognise or articulate that there should be choices available. As the ability to negotiate decreases, the amount of compromise by the individual increases. As discussed in Chapter 7, people who are physically disabled may recognise that there should be choices available and can express their preferences, however they may be forced to give in to the institutional culture and routines because they are not in a strong position to negotiate due to their disabilities. The more dependent a resident is for physical support, the higher the frequency that they have to enter into interactions and therefore negotiations with staff. If the relationship is unbalanced in terms of power dynamics and the power of the resident is diminished, this may have an effect on their sense of independence and identity. A number of resident participants described having to negotiate, argue and compromise about their sleep preferences as a fundamentally disempowering encounter. Some staff appear to have flexibility of practice but this can be outweighed by their perceived 'duty of
care' and the organisation’s responsibilities towards residents, usually who were particularly frail or had medical conditions. Residents preferences often appear to only be respected when they do not contradict the requirements of the home or the views of the staff, particularly nursing staff.

Negotiations take place within existing structures and power dynamics and in care homes this often results in compromise by residents. Finch argues that one outcome of negotiation is a shared understanding. These shared understandings then

*Are carried forward to form part of the background against which the next application of a particular normative guideline will take place.*

(Finch, 1989: 184)

It is possible that this process of unsuccessful negotiation and inevitable compromise leads to residents ceasing to attempt to negotiate, whether explicitly or implicitly. Any attempts at negotiation may therefore eventually give way to care home routines and practices. Residents may find the option of presenting or constructing themselves as a stoical individual who ‘fits in’ with and for the good of the home is preferable to viewing themselves as having little power and being consistently unsuccessful in negotiating aspects of their home life.

9.2.4 Bedroom privacy

The night-time experiences of residents in a care home often ran contrary to what could be considered normal for an environment that is called ‘home’. These experiences were linked to disruption of the privacy of the sleep environment by regular visits and night time checks by staff. The additional intrusion of the wider care home setting into the individual’s private bedroom through noise, light and care home routines and practices was a dominant theme of residents’ experiences. The notion of care throughout the night is ever present in the bedrooms of care home residents. Twigg’s research on bathing and community care (2003) identified the potential of the introduction of care into an individual’s home to produce profound changes to the way an
individual experiences that environment. This could be through the periodic visits of care workers to the home, the presence of new equipment or the rearrangement of the spatial or temporal ordering of living. However, unless someone receives 24 hour support at home, the domestic household remains largely under the control of the owner or occupier who can refuse people, including care professionals, into their home. Peace (1998) notes that 'privacy' relates to more than the spatial element of providing care home residents with single rooms.

*In all settings, the important issue in relation to privacy, both in territorial space and personal space, becomes the maintenance of boundaries and control over access.*

(Peace, 1998: 120)

The lack of separation between residents’ bedrooms and the communal spaces of the care home is evident at night with the main work of the care home taking place in the individual’s bedroom. The introduction of care and surveillance into these ‘private’ spaces alters the nature of the space and privacy during the night time. This research found that the frequency and nature of these visits had an effect on the sleep environment and experience of individual residents. Early sociological work highlighted how sleep is linked to identity and social status through respect for the sleeper and control of the sleep environment (Schwarz, 1970). The accounts of residents and staff in this study clearly identified a lack of control over the sleep environment, compromises to sleep identity through this loss of control and an acknowledgement of the low status of care home residents compared to the dominance of care home practices. The notion of observed sleep, surveillance and lack of sleep privacy has also been linked to infantilisation of people in institutions (Taylor, 1993). The experience of residents was that they were not always treated as adults who could determine their own sleep preferences.

Lee-Treweek (1994) highlighted the ambiguous status of the bedroom in care homes with the bedroom serving both as a ‘private’ room of the resident and a ‘public’ work space of the staff. However my research has found that this tension between private and public space is particularly heightened at
night. The established care home practice around room privacy during the day is that the staff should knock on the door or announce themselves before entering a bedroom and treat it as the private space of the resident. At night however, this practice is discontinued as staff walk in and out of residents' rooms unannounced. It appears that the reason for this is to reduce noise at night-time in an attempt to respect the overall sleep environment, however the effect is that the privacy of the night time bedroom is compromised and different to that of the daytime bedroom.

9.3 Wider social and cultural influences on sleep in care homes

This section considers how the sleep environment in a care home is undermined by wider social and cultural influences. Staff and resident perspectives on sleep and ageing are shown to conform to stereotyped views of older age and serve to reinforce low expectations of sleep in old age. Further to this the medical influence within care homes focuses on the ageing body as the primary object of care practices and can undermine confidence in an individual’s ability. This is compounded by a risk averse culture within care homes that constructs the ageing body as the focus of risk, removes a resident’s responsibility for their own risk management and justifies excessive overnight surveillance practices.

9.3.1 Staff and residents' perspectives on sleep and ageing

When discussing their sleep, some older people in this study related a decline in their sleep quality to the general ageing process, or particularly linked it to physiological changes and disabilities. They linked being older with an increased tendency for daytime sleeping and with more likelihood of waking up during the night-time. In discussing their sleep, participants talked about using less energy during the day and the lack of stimulation which they felt may contribute to a good night’s sleep. This was linked to not having done anything the previous day to attain a feeling of being ‘worn out’
and ready for sleep. Daytime sleeping was identified by both staff and residents as a contributing aspect of poorer night-time sleeping.

Daytime sleeping could be ‘intentional’ or ‘unintentional’. Many residents they felt could benefit from daytime sleep if they were ill or if they did not get good enough sleep at night. Staff said that physical conditions may also require that residents spend time in bed during the day in order to achieve a change of physical position and that this may encourage daytime sleeping which was then perceived to affect their ability to sleep at night. Therefore, daytime sleeping may be recommended by staff to residents for physical rest or recuperation or to compensate for lack of sleep at night, particularly for residents with dementia. This has the potential to result in a vicious circle, if residents get too much sleep during the day and reduced sleep quality at night. Although it is acknowledged that many residents have poor health, pre-existing assumptions or stereotypes about ageing should not be underestimated. Ageist assumptions about the sedentary nature of older people or that older people “should be allowed to sit back and relax” (Walker and Walker, 1998:132) may contribute to the reduced expectations of levels of daytime activity for older people living in care homes.

‘Unintentional’ sleep usually occurred in chairs, whether in public areas or in bedrooms. Staff related ‘unintentional’ sleep to a lack of physical activity, a lack of interaction and the effects of medication and ill health. The usual ‘activities’ provided within care homes were acknowledged to not always be sufficiently stimulating to keep people awake. As such, the daytime ‘rounds’ undertaken by staff relating to mealtimes, drink times and personal care were considered an opportunity to wake up residents who may be asleep. This reflects social norms of not interrupting an individual who is sleeping because staff only felt able to wake someone up from their daytime sleep if they had a particular reason for doing so. These reasons were often related to nutrition, hydration and medication so staff were able to justify their actions.

Staff perceived the significance of residents being awake during the day time was not just important for their being able to achieve sleep at night, but
would also contribute to their wellbeing through keeping people alert and active. The physical and cognitive impairments of some residents were perceived to impact on the nature of organised activities that care homes felt able to run, although this is probably more to do with resources and creativity than the capabilities of the residents. One activity is likely to be provided for the majority of the residents at any one time and it is difficult for one activity to meet the widely varying needs and tastes of all individuals living in the care home. Staff were particularly animated in talking about holidays or trips out of the care home, where they stated that residents never fell asleep during the day. Staff often are unable to provide one to one interaction which they feel is necessary to stimulate people because they are too busy and many residents do not attend or appear interested in the scheduled group activities. This has implications for the model of 'activities' provided in care homes. Nursing and care staff have to prioritise physical needs of residents and 'objectification' may occur as a result of the lack of social interaction between staff and residents (Ryvicker, 2009). This was indicative of some of the language used by care home staff when describing residents which was consistent with Paterniti's (2003) discussion about how care home staff categorise the residents by physical characteristics.

For many residents, there appeared to be an acceptance of disturbed sleep as normal as they would not necessarily describe frequently broken sleep as 'bad'. With a decline in sleep quality being viewed as a normal part of ageing, participants appeared to accept a 'normality' of sleep disruption and some very disturbed nights. Staff views appear to echo these beliefs that older people would inevitably have changed sleeping patterns defined by their age and this may impact on the expectations that staff have about the quality of sleep that older people experience. It is possible that this could lead to the acceptance of poor sleep quality in the belief that this is inevitable and normal for people past a certain age.

Despite the average length of time that residents spent in bed being approximately 11 hours (Luff et al, 2011) there was a belief amongst staff that older people need less sleep and have a tendency to wake up earlier. Staff also feel that older people are more likely to worry at night which may
keep them awake and that their sleep is lighter and more easily disturbed. If this was the case, then the checking routines would be expected to have a greater adverse impact than upon a deep sleeper. Beliefs that older people may unavoidably have these sleep characteristics may shape the expectations that staff have about the nature and quality of sleep that is achievable by the residents, potentially leading to an unquestioning acceptance that poor sleep is inevitable and normal for people as they age. These beliefs may also underpin night time practice in care homes for older people. It is difficult to imagine a residential home for younger adults with disabilities where routine disturbance to sleep would be considered accepted practice. Additionally, people who live in their own homes, even those in receipt of intensive home care services, are not subject to the overnight care routines and surveillance found in residential care settings.

9.3.2 The medical influence on care homes

The care home routines not only shape the structure of the day but also affect the quality of the interaction between staff and residents. Staff presented their role in assisting residents at night as being mainly one of organisation and task management where they prepare the people and the home for night time and sleep. This does not take into account the social and emotional aspects of sleep which may have previously shaped an individual’s bedtime habits. In Longford Manor, residents’ night began and ended with a hospital style ‘ward’ round conducted by the nursing staff whereby individual residents were openly discussed in the public areas of the home corridors and in earshot of the occupant and potentially other residents. Residents were discussed by staff using terminology common in medical environments (for example, ‘bowels open’, ‘input/output charts’) and which also broke the night-time down into a series of physical tasks that had to be carried out during the night by staff. A similar ‘handover’ meeting happened in all the participating homes however this example is striking due to it happening in a public area, audible to those around, and highlighted the task-based nature of overnight care. Henderson (1995) has reported that
nursing home culture encompasses the medical values of time efficiency and care focused on physical tasks. It has also been argued in the U.S. that nursing homes in particular have an ongoing identity problem:

_Nursing homes continue to be organized as health care facilities, although relatively little health care is provided there. They continue to be organized around health professional hierarchies, although relationships in nursing homes should be very different from those in other parts of the health sector. Care planning is driven by an enumeration of residents' deficits, not their capabilities." (Vladek, 2003:3)._

Similarly, in UK care homes, the influence of a medical model of care can be seen and health professional hierarchies are present. For the individual resident, their experiences may influence their perception of their environment as overtly medical and this may elicit a certain amount of compliance. In the care homes, many residents did not distinguish between nursing staff and care staff, calling a member of staff a 'nurse' even if they were not. This aspect of living in a care home may influence the relationship between staff and residents and reinforce the professional authority of the staff and their position of power in the environment. In addition to an individual’s physical and cognitive functioning, the professional 'dominance' in the care home environment may contribute to the bodily experience of ageing by undermining the confidence of older people in their abilities (Gilleard and Higgs, 2000).

9.3.3 Risk management and the impact on night time culture in care homes

The tension between balancing risk and allowing individual’s autonomy and independence is acknowledged in social care policy and practice guidance (Department of Health, 2007; Better Regulation Commission, 2006; Commission for Social Care Inspection, 2006). Although a tension is acknowledged, it has been noted that policy and guidance can rarely address the complexities of the work of health and social care professionals (Taylor, 2006) and may not be able to adequately address diversity and subjectivity around perceptions of risk (Mitchell and Glendinning, 2008).
The physical safety of the residents of care homes is an important matter and one which staff undertook a 'duty of care' to provide. The difficulty arises where there is a one size fits all approach leading to many residents being regularly disturbed during the night-time. As Kerr et al (2008) noted, night staff may feel isolated, vulnerable and experience 'what if' anxiety. My research found that during the night time in a care home the checking procedures which disturb the sleep of some residents, are systems employed by staff in an attempt to manage risk through close monitoring and surveillance. Managing risk in this context is largely minimising risk to the staff and care home rather than adopting a proactive approach to prevent accidents happening. Staff enter resident's rooms during the night at regular intervals to check on their well-being and safety. Where appropriate, they also check whether the person in the room requires any continence care. Such checks are undertaken as a matter of course as a care routine at night and very few residents were able to opt out of receiving the checks, even if their sleep was disturbed by the act of someone coming into their room regularly at night. Checks mainly focused on physical factors including continence, breathing, falls, catheters and whether residents were still alive.

The overriding view of staff in relation to the overnight checks was the potential for a negative event to happen for which they or their home would be held responsible and accountable. This 'responsibility' for negative events is considered a risk to the staff and care home. In terms of finding a balance between risk management and individual choice, it is risk management that takes priority. Generally staff autonomy for supporting residents to have their own personal routines is limited by workload, care home routines and a risk averse culture. It is also of interest to note that staff in the residential home appeared to have more autonomy about the check calls overnight than the staff in the three nursing homes, potentially reflecting the health status of residents as well as a more formal medical environment. The regular checks, sometimes hourly (or every 30 minutes for some residents in one home) are a part of the risk management of the home, which is more prominently felt overnight when there are less staff on duty. Exactly how the checks are carried out is down to the individual care
workers' interpretation of what is acceptable in that instance for that particular resident. There appears to be no uniform approach to how these night-time surveillances are carried out. The organisational response to perceived risks is to increase monitoring and surveillance to mitigate against the consequences rather than reduce the possibility of incidents. Surveillance in the form of regular health and well-being checks overnight are believed by staff to reduce risk. However, staff were aware that the checks in themselves did not stop residents from falling or injury, but would simply act as a mechanism for discovering accidents after the event and responding to them more quickly. Some staff identified the potential death of a resident as one of the reasons for night-time surveillance. However, they were not clear as to whether these checks would prevent death and it appeared that they would only be effective in discovering the death and being able to provide information to management, the authorities and families.

Where residents requested not to be checked at regular intervals during the night, staff did not usually agree to this request but instead offered a compromise of slightly less checks during the night. The care homes appeared to adopt a policy of trying to avoid risk, rather than managing it, and one which did not take into account the diverse level of abilities of residents or engage with people's willingness (or not) to accept a degree of risk (Boyle, 2004). The standard procedure of checking was applied as a blanket approach and did not take account of the residents' capacity to make their own decisions regarding the care that they received. The accounts of the staff did not contain discussion about individuals' capacity to make their own choices and no reference was made to the important guidance in this field such as the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. The Mental Capacity Act offers guidance on allowing individuals to make choices, even if they seem unwise decisions to health and social care professionals.

Staff and the culture of care practice appeared to be tied to ideas of risk management whereby the organisation owned and took responsibility for risk, and individual residents were not allowed to make decisions about risk
created through their own choices. This culture in care homes curtails individuals' freedom to make decisions and have those decisions respected. This runs contrary to legislation and policy which is dedicated to promoting the independence and choices of health and social care service users. Where organisations 'own' the risk of individuals, the choices available to the individual reduce and the more this happens, the more that individual's liberty is curtailed. This is particularly so for older people with physical disabilities within care homes, whose autonomy could be described in Collopy's (1988) terms as decisional, rather than executional because individuals are increasingly required to allow the organisation to carry out 'risky' tasks on their behalf. Within a care home setting, 'risky tasks' can include getting out of bed, making a cup of tea or going to the toilet without the assistance of staff.

Staff viewed residents as a risk to themselves yet the potentially disabling environment of care homes was not raised as an issue. Medium to large sized, purpose built care homes, such as those that participated in this study, do not appear to have been designed to take account of ideas of enablement and independence within the homes. The public areas have long corridors to negotiate and heavy fire doors which can be difficult for frail residents or those with physical disabilities. Bedrooms may be small and some are cluttered with furniture, frames and wheelchairs and some of the ensuite bathrooms were cluttered with equipment. Another aspect is the use of high beds making it difficult for residents to get in and out without the assistance of staff. Residents reported that they were more likely to fall out of single beds if they were previously used to sleeping in a double bed.

The physical environment in care homes is not enabling for frail or disabled residents and this is exacerbated at night where there are reduced staff numbers available to support residents. In this way, it can be seen how the model of care coupled with the disabling physical environment can construct the dependency of care home residents. It is important to note that beds in medical and residential care environments serve a dual function of providing a place to sleep and a safe working tool for the support staff who are required to carry out manual handling tasks. Beds are designed with this in
mind and are often much higher from the ground than beds in domestic environments. This dual function means that the necessity to meet the safety requirements for staff working can leave residents with beds that do not suit their individual abilities and needs. The bedroom as both a sleeping and working environment results in a compromised position for the individual resident and the needs of the care home as a whole impact upon the sleep quality and preferences of the individual.

9.4 Personal experience and control of the sleep environment

This section considers the experience of residents overnight and their lack of autonomy in their 'private' sleeping environment. The dominance of nighttime routines leaves little flexibility for personalised care and for supporting residents in their own preferred sleep routines and choices. Pain and physical disabilities affect not only the quality of residents' sleep but also how they manage wakeful periods during the night, mainly resorting to internal strategies due to the lack of options and support available. The lack of autonomy experienced is rationalised by residents who downplay their own wishes and priorities, presenting their willingness to contribute to care home life by not placing extra 'demands' upon the staff and home.

9.4.1 Control of the sleep environment and personal choice

This research study showed that care home routines impact upon sleep in a number of direct ways from shaping people's going to bed and getting up times to actively waking them up at points during the night. As such, it can be argued that care home routines generally took priority over any personal routines, thereby reducing the choice and control of the residents. How residents experienced the impact of routines was varied. Firstly, the unique organisational structures of each care home can vary and therefore generate more or less flexibility within the system for residents to choose their own bedtimes and getting up times. Secondly, to what extent residents were able to exercise control over their own sleep routines was varied and was
experienced differentially. The amount of control that residents were able to exercise over their sleeping environment reduced with increasing physical disability and cognitive impairment. People with cognitive impairments were accorded less control over their personal routines and were observed to be taken to bed without asking. Some night staff demonstrated a flexible approach to individual's sleep patterns, particularly for people with dementia. However, in other cases, bedtime could be used as a form of restraint for residents who are particularly difficult to engage or who were put to bed early in order to facilitate a quieter early evening experience in the public areas for other residents.

People who are physically disabled may recognise that there are or should be such choices available and can express their preferences, however they were largely forced to give in to the institutional culture and routines because they were not in a strong position to negotiate and therefore frequently had to compromise. The more dependent a resident is for physical support, the higher the frequency that they have to enter into interactions with staff and therefore compromise about basic aspects of daily living. If the relationship is unbalanced in terms of power dynamics and the agency of the resident is diminished, affecting their sense of independence and identity. Where adults have to attempt to negotiate or argue about a basic aspect of their life that they have previously taken for granted, this may be an essentially disempowering encounter. Many residents however do not argue with staff or assert their wishes, instead acquiescing to the wishes of the staff and home. The minority of residents without physical or cognitive disabilities were less reliant on staff support and therefore able to exercise more freely their own preferences. However they still discussed routines and practices which impacted on their sleep environment, such as unwanted staff coming into their rooms at night. In discussing temporal and spatial autonomy, Lidz et al (1992) argue that people have more autonomy in their lives if they control their own time as "being able to control their time allows them to define who they are by controlling what they do at a particular point in time" (1992: 112). The lack of autonomy over bedroom privacy, personal sleep
timing and routines of daily living highlighted in this study therefore may profoundly impact on a sense of individuality and identity.

The existing systems within care home settings limit choice over sleep preferences and make it largely impossible for residents to adopt their own individual routines. People with cognitive disabilities may not recognise that there are, or should be, choices available. People with physical disabilities may explicitly articulate their preferences, however they are not in a strong position to negotiate due to the dynamics of care and the prioritisation of care home routines. In this situation, residents may give up leading to the passive acceptance of institutional, routinised care.

Exactly how far the concepts of empowerment, choice and control have materialised for older people living in residential care is doubtful. Progress at both a policy and practice level to increase financial control for individuals using services, for example through individual or personal budgets, still largely excludes older people who live in care homes and supported accommodation (Bowers et al, 2009) while they are an accepted system for other people who use services. The Care Quality Commission (2010) state of social care report notes that a “fundamental cultural shift is needed” (2010:18) so that people are able to control and make decisions about their care and maintain independence rather than fitting in to a ‘one size fits all’ approach. Scourfield (2007) states that the government agenda of ‘empowerment’ for those using services is impossible for care home residents due to a lack of advocacy and exclusion from wider society. The argument relates to the model of citizenship which is said to be based upon rights and responsibilities and he argues that the high levels of dependency for care home residents makes them a ‘hard to reach’ group and also problematizes their status as full citizens. He states that

"(t)he reality is that after nearly a decade of modernisation, older people in residential care appear to be as marginal to the rest of society as those surveyed by Townsend (1962) in the Last Refuge."

(Scourfield, 2007: 1141).
In services for people with learning disabilities, the larger institutional residential homes have been replaced with smaller community-based residential houses and these were advocated on the basis that smaller units were more likely to facilitate choice and self-determination (Hatton et al, 2004). However, while smaller residential settings may be more ‘homely’ in appearance, limited research concerning care homes with three or less older people resident suggest that the influence of the care home owner or manager, regulatory activity, ‘professional’ caring and public accountability can impact in such a way as to create a more institutional feel to the home (Peace & Holland, 2001).

Services and expectations for different ‘user’ groups vary, for example older people are most likely to be moved to residential care (Oldman, 2002). Higgins and Mansell (2009) undertook a quantitative study to explore a comparison of quality of life for people with learning disabilities in both group homes (for people with learning disabilities) and in older people’s care homes. The study suggested that older people with a learning disability experienced better quality of life outcomes in terms of ‘meaningful activity’ and ‘community access’ when they lived in homes for people with learning disabilities compared with those living in older people’s homes. The authors argue that the difference did not appear to be related to the learning disability as they found little difference between older people with or without a learning disability in older people’s homes when looking at ‘meaningful activity’ and the amount of community access outside of the residential home. The authors suggest one possible reason for this outcome is that homes specifically for people with learning disabilities were more likely to promote independence and have higher aspirations for the people who live there.

### 9.4.2 How residents experience lack of autonomy

My research found that people who live in care homes were often unwilling to openly criticise the care they receive as shown in other studies (Townsend, 1964; Booth, 1993). Bearing this in mind, some participants in
this study when talking about their sleep did express frustration and sometimes anger. Residents made obvious that they did care about their situation and had expectations about the support they should receive which was often coupled with a sense of resignation that they were not in a position to change things. As well as expressing an inevitability about the care home routines and structures, participants also said that they had a 'willingness' to fit in with the routines and that the staff had difficult jobs to do. They also downplayed the importance of their own priorities and needs due to the fact that they did not have to get up for work, or that they did not have pressing engagements to attend. As such, they reported that they were prepared to compromise for the good of the staff and the home and did not want to contribute further to the busy workload of the staff by making particular requests. The residents tended to downplay their own 'importance' in the care system and used age-related stereotypes to explain why they chose to compromise their own preferences. For example, not having anywhere to go or not worrying about bad sleep as they are not using any energy. However, a minority of the resident participants raised the issue that they were paying for these services, which were not always up to the standard they would like.

Rather than making demands of the staff, residents endeavoured to normalise their situation by expressing understanding of the difficult job of the staff. Brown-Wilson (2009b) has suggested that 'fitting in' to care home routines can be viewed as an active contribution by residents to the development of relationships with staff and a way they can play a part in the daily life and smooth running of their particular care home. However the notion of 'fitting in' with a care home routine is a long way from the ideals promoted in national and local policies which prioritise the choices of individuals who receive health and social care. Acknowledging residents' contribution to the smooth running of the home endeavours to bring a language of positivity and empowerment to residents fitting in with care home routines, however it is important to acknowledge that existing models of care and current practice may need to be questioned or improved.
9.4.3 The experience of sleep and the ageing body

As well as both the physical and social environment of a care home impacting on an older person’s sleep and their experiences during the night, residents discussed individual and personal circumstances that also contributed to their feelings about sleep and the night time. The staff perspective of disturbance to residents’ sleep can broadly be grouped into factors which emerge from either the individual or the care home. How these factors interrelate is complex and was acknowledged and discussed by some members of staff. Sleep disturbance which emerged from the individual related to their ageing bodies and in particular physical health conditions or cognitive impairment, most commonly continence, pain and confusion. Pain was presented in an uncomplicated way by staff as an issue which could be managed with medication. Similarly, continence could be managed by staff routines. Wakefulness, which staff often perceived to be caused by confusion and dementia, was generally discussed in relation to the resident being distressed or not knowing whether it was night or day.

From the perspective of the residents, the intrusion of their ageing bodies as something which influenced their sleep was a prominent issue with some common themes. Sleep being delayed or interrupted due to discomfort and pain was a key factor. The outcome of this may mean that those with lower levels of pain (i.e. those whose pain was not deemed ‘severe’ enough for medication) may have more sleep disruption from pain than those who were medicated. The effect of ageing bodies and physical disabilities highlighted a distinction between those who were able to ‘hop’ into bed when they wished, and those older people who required assistance. For some people, a great effort was required through slowly manipulating their body into a position comfortable enough to achieve sleep. Participants’ accounts highlight the difficulties and how they needed to exert a degree of effort in order to gain enough control over their bodies to allow them to find positions and comfort enough for sleep. For some there was a feeling of having to be able to work to be able to sleep, which contrasts to conventional perceptions of sleep as being an activity free of physical effort. Continence was also a common issue to affect sleep for all residents, for both those who managed
their own continence and those who wore incontinence pads and therefore received regular checks by staff during the night.

Disabilities and sensory impairments can also impact upon someone's ability to employ strategies to attain sleep. This highlights, how, for some residents the act of going to bed was not simply a matter of getting in and falling asleep. Achieving sleep can be an ongoing process throughout the night. Limitations of the body inhibited a more active approach for older people in finding solutions to their own sleeping problems. This was linked to physical ability, such as being able to hold and read a book in bed or use a television remote control. There was little desire to use the call bell system to ask staff for help with such typically 'mundane' tasks which were not considered by residents to be an emergency. This resulted in the use of more 'internal' strategies to help sleep or pass the time, such as counting or simply lying in bed. Fear of being prescribed sleeping tablets prevented some people from talking to staff about any difficulties with their sleep. This often was related to the perceived side effects of sleeping medication and the potential for becoming reliant on or addicted to such medication. However, this also points to the disempowerment felt by residents as they did not feel their choices would be respected or that they were in a position to refuse medical interventions.

9.5 Conclusion

Residents of care homes may appear to live uncomplicated lives, free from the 'burden' of running their own home, from no longer feeling reliant on family or feeling isolated. However, further exploration of one aspect of an individual's life, their sleep, has highlighted the complex relationships and organisational structures that residents need to engage in. In the care home environment, residents are adjusting to major life changes and their ageing bodies. They are also discovering and navigating the social and physical aspects of life in a care home. This includes building and managing relationships with other residents which can be challenging. It also involves building relationships with staff members and dealing with established
routines and procedures all of which contribute to an existing culture within a home. Residents discussed the need to adapt to care home routines and adjust to the idea that everyday activities were now scheduled as part of the wider care home timetable.

For the residents that took part in this study, their sleep was sometimes a difficult and complex subject to think about and discuss. This was in part due to residents not considering they had much to say about their sleep and in part due to the acceptance of sleep disturbance as a normal part of their night-time experience in the care home. When given the space and opportunity to focus on their sleep as a topic worthy of discussion and interest during the in-depth interviews, participants revealed a set of complex and interwoven challenges that they face in order to try and attain sleep. Sleep in a care home was commonly described as fractured, elusive and reliant on others or the environment. Coupled with external night time disturbances such as noise or checking that were common to many residents, at an individual level participants experienced physical pain, continence issues, disability, frustration and anxieties. Most residents expressed difficulties exerting control over their sleep environment and lacked strategies and support to do this. Personal control over sleeping routines and bedroom privacy was related to levels of physical and cognitive ability. This points to the inability of the current model of care provided in care homes to deliver individualised services that support choice and control over the night-time and sleep environment.

The night-time in a care home is dominated by the organisational routines and practices of care homes and this can create an environment where disturbing people’s sleep becomes routine and an accepted and necessary part of care practice. Much of this practice responds to an organisational perception of risk management and accountability. While some of the care practices overnight may be designed to alleviate difficulties such as incontinence experienced by individual residents, the wholesale approach to delivering care which runs to timetables instead of individual preferences does not provide an environment that is respectful of the importance of sleep.
Chapter 10

CONCLUSION

The aims of this study were to explore the experience of sleep in the setting of care homes for older people and to contribute to improving practice in this area. It does so in the context of a growing population of older people in the UK, particularly in the population over 85 years of age and with a predicted increase in the numbers of people living in care homes in the years to come. This chapter will consider the key research findings based on interpretation of 2 week observations undertaken in 4 care homes, and interviews with 39 women and men working in care homes for older people and interviews with 38 residents. As well as discussing the limitations of the study, suggestions for further development for research in this area are also addressed.

Drawing on the findings, broader implications are discussed for social care policy and practice development.

10.1 Concluding findings

This study contributes to the understanding of the impact of organisational routines and structures on the sleep environment within care homes for older people. This is achieved by not viewing sleep in isolation, but as part of the 24 hour provision of structured care. Far from being a dormant period, there is much activity during the night within a care home which maintains the general characteristics of the provision of daytime care. The impact of organisational routines and institutionalised care are highlighted by the contrast with the general notion of the private and intimate nature of sleep.

Understanding sleep in a care home setting also requires the recognition of conflict between an individual's control over their sleep environment and the dominance of intrusive, timetabled care practices. This study builds on previous research by Lee-Treweek (1994) in recognising bedrooms within care homes as not simply private areas but places of work for the staff.

Additionally, this study explores the impact of that tension from the
perspective of the residents and the effect upon their sleep. It also recognises that the work of the staff shapes the physical environment of the bedroom.

The language and ideology of consumerism and choice in social care policy has not removed the structured routines and rigid approach to the provision of care that remains at odds with an individual's choices and control over their living environment. This research confirms that some structured care and systems described in previous care home research (Townsend, 1964) are still present despite the aims of national policy to promote the rights and choices of individuals in receipt of care within care homes. This is most obvious in the finding that the basic daily living activities for residents of care homes of going to bed and getting up is not under the control of the residents and that they may spend long periods in bed during the night time with frequently disturbed sleep.

It is important to note that since Townsend's work, there have been both physical and social changes within care homes leading to much general improvement, despite the variable quality within the care home sector (Johnson et al, 2010). However, the support within the care homes was delivered through a set pattern and timetable of care whereby tasks of daily living ceased to be activities carried out by an individual, but became part of the formalised routines of the care homes. The homes created environments where rehabilitative support was rarely an option, and instead provided an inflexible approach to care which did not allow for residents to exercise independence, regain lost skills or learn new ones. In such an environment, the potential for individuals to depend upon routinised care is increased because there is little option for them but to accept it. This lack of a rehabilitative approach to care may be based upon assumptions about what people can achieve or want in later life. Supporting an individual to achieve a task themselves can also be more time consuming and economically inefficient, compared to completing the task for them.

This research found that the sleep routines of residents were as susceptible to care home routines as other parts of daily living. Staff described
pressures of having to balance the needs of individual residents against the organisational needs of the care homes. Night-time care is routinised task management that can conflict with the needs or preferences of individual residents and does not take account of the social and emotional aspects of sleep. Some staff recognised that their practices could run contrary to the needs of an individual and also contribute to disturbed sleep. However, most felt unable to change or affect the systems in which they worked and this contributed to the sense of both staff and residents being caught in a rolling timetable of care which they felt powerless to change. By focusing on the night-time this research has highlighted what has previously been seen as a dormant period and identified the pervasive nature of care routines into what can be considered the 'private' sphere of night-time bedrooms.

This study found a relationship between residents' physical and cognitive abilities and their control over the sleep environment. This is indicative of their power, in this environment, to exercise choice. People with physical and cognitive disabilities were more vulnerable to the negative impacts of care home routines. Residents frequently compromised their preferences about the times at which they get up and go to bed, which they may have previously taken for granted throughout their adult lives, and this was a disempowering experience. Professional dominance in the relationships between staff and residents, similar to those found with patients in hospitals, was evident in care homes. This relationship dynamic contributed to staff soliciting the compliance of residents, with the effect of reducing aspects of choice and control for residents.

The physical environments of care homes were also a barrier to independence. Care homes have certain aspects designed for people with disabilities, such as enough space for wheelchairs and bathrooms fitted with hoists. However other aspects such as long corridors, heavy doors and high beds may be disabling. This would be particularly experienced at night by residents due to there being so few staff available at night to assist with movement around the home. The dual function of beds being a place to sleep and a site of work for staff may leave residents with beds that are difficult to physically negotiate.
Within a care home environment, ageing bodies are constructed as a site of risk. This results in practices that are risk averse and rely upon monitoring, surveillance and reducing residents' choice rather than modification to the care home social and physical environment. This study found that night-time monitoring and surveillance designed to manage risk contributed to disturbed sleep for residents. Regular checks which primarily focused on physical well being (incontinence, falls, breathing, death) were routinely undertaken and very few residents were able to opt out of these procedures. Risk management for the staff and for the care home clearly took priority over individual choices. Care homes adopted a policy of risk avoidance rather than risk management and did not consult residents about the degree of risk that they found acceptable or wanted to take. Risk discourse of staff focused on them as individuals, and the organisations, having responsibility when things go wrong and therefore taking control of residents' risk. Aiming to reduce the amount of incidents that could threaten the reputation of the organisation to 'care' for older people, this took precedence over residents' choice. This approach to risk justified blanket overnight checking procedures to all residents regardless of individual attributes and abilities and the individual level of risk. Therefore an individual's responsibility for themselves is removed and with it the opportunity to negotiate risk on their own terms as an independent adult.

10.2 Limitations

The research methods and methodological issues were discussed in Chapter 4 and this section considers the consequences of those methods for the broader implications that can be drawn from the research findings. Limitations of the study mainly concern generalisability of the results. The qualitative exploration of the experiences and opinions of care home residents and staff allowed for an in depth examination of sleep in care homes, but it is unclear how representative the experiences are of older people living in other care homes, particularly homes which are much smaller or much larger in size. This was a small sample of 4 care homes.
which were of a similar size and also were all in a limited geographic location. Of the four homes that took part in this study, one had been rated ‘excellent’ by the Commission for Social Care Inspection, two were rated ‘good’ and one considered ‘adequate’. The homes agreed to participate in the study and, as such, were self-selecting. This suggests a level of comfort on the part of the care home managers in allowing researchers into their homes and may therefore mean that the sample was biased towards the ‘better’ end of the quality of care homes.

The resident participants, none of whom were diagnosed with a cognitive impairment, were also self-selecting as the study only included those who gave consent to take part in the research. While this may be a limitation of the study, it should be noted that these people were the most ‘able’ residents. The residents participating in the interviews were more able to communicate and to voice their opinions and concerns than many of the frailer or more cognitively impaired residents. If many of these more able and independent residents experienced a lack of choice and control, then it is reasonable to assume that other residents may experience even less choice, or be even more influenced by the care home culture, routines and ‘professional dominance’ and thus compromise their preferences.

The sample of resident participants was largely composed of white British women. It is conceivable that cultural differences may influence subjective experiences of sleep and the experiences of the night-time and that future research should focus on the experiences of different ethnic groups. In addition, the impact of gender was not considered explicitly as part of the research design or analysis. As care homes are largely populated by female residents and staff, a larger involvement of male participants may have offered different perspectives of sleep or power dynamics within these environments. Among the sample of staff participants, many nurses and carers were from overseas and did not have English as a first language and the effects of cultural difference between providers and receivers of services could have been more widely explored. Different social and cultural views may influence their opinions and interpretation of experiences relating to the research topic, as well as their engagement with the research process.
It is possible that resident participants may have been reticent in criticising their care homes, and staff participants may have understandably been reluctant to criticise their employers, colleagues and practices. Every effort was made, however, to make the research participants feel comfortable in the interviews and, as already mentioned, participants did voice areas of dissatisfaction. Finally, further validity checks would have strengthened the qualitative analysis. In particular, asking residents and staff to comment on themes from their own interviews and on the overall themes arrived at for the sample which would have added a level of participant validation to the analysis.

10.3 Policy Implications

10.3.1 Making night time care more visible

The findings from this and the night-time study by Kerr et al (2008) suggest that policy and practice developments need to focus on the 24 hour nature of care provided in care homes, rather than an assumed dormant night-time period. This includes raising the profile of night-time care in policy, regulations, training and good practice developments. A Care Quality Commission report on an inspection of one of the homes in this study (after the research data collection period; not referenced due to maintaining the confidentiality of the participating care home) gave details of a staff survey undertaken as part of the inspection. Views from staff collected by the inspector included those from night staff who stated that they were unhappy because they were expected by their managers, before the end of their shift, to get up two residents, wash and change all residents and serve and help with breakfasts for some residents. These comments from staff highlight an underlying approach which specifies a particular set of tasks to be completed during the night shift, rather than focusing on individualised care over a 24 hour period. The comments from staff provided to the inspector also indicated that they felt neglected by the management.
10.3.2 Improved practice around 'risk' in care homes

The issue of risk at night, particularly the identified issue of the risk of injury through residents falling out of bed, is indicative of a general risk averse culture in care homes. The accepted practice of encouraging residents not to do things themselves but to rely on staff to do most things for them is not only evident at night, but at any time during the day in a care home. This practice may not be explicitly talked about, but is commonly accepted among staff and managers in care homes. The issue of risk management is also linked to the concepts of choice and control for service users. If residents are encouraged to have choice and control, they may choose to take 'risks', resulting in a dilemma for staff between choice (risk) taking and perceived professional accountability. Risk is also a subjective concept which can be perceived differentially by staff, service users and their relatives. While a resident may want to maintain their physical abilities and mobility through ordinary daily activities, staff may consider them walking down the corridor or in the garden by themselves as 'risky' and therefore discourage it.

Risk has been identified as a relevant issue in recent policy guidance such as *Making Choices: taking risks* (Commission for Social Care Inspection, 2006), *Risk, Responsibility and Regulation: Whose risk is it anyway?* (Better Regulation Commission, 2006) and most recently *Independence, Choice and Risk: A Guide to Best Practice in Supported Decision Making* (Department of Health, 2007). However it is acknowledged that policy documents are largely unable to address the realities and complexities of the day to day provision of health and social care support (Taylor, 2006). On the frontline of service delivery in care homes, service users having the opportunity to make choices including risk taking is outweighed by professional responsibilities and perceived duties of staff to protect 'vulnerable' people. Acknowledging the responsibility felt by staff and care home management to 'protect' their service users in the face of public scrutiny, fear of litigation and in the context of limited resources to provide services (Kemshall, 2002) should be a consideration when developing and improving policy and practice in this area. Unless staff feel empowered to facilitate risk taking, it is not likely to happen. It is suggested that further
guidance is required on the nature of the relationship that care homes and staff have with residents and, more specifically, guidance is required on supporting residents to make choices and 'risk-taking' as part of maintaining independence. Such 'risks' as not being checked hourly overnight may not be perceived as a risk by individual residents.

The isolated position of care homes, both in society and in the health and social care system, have facilitated the development of a culture of practice that does not necessarily subscribe to current social policy aims of service user choice and control. Care homes, however, are aware of national requirements and can give the impression that they offer choice and independence to residents. However, it is argued that some care home practices represent a fundamental misunderstanding of the aims of national policy. At worst, criticism could be levied that care homes do little more than pay 'lip service' to the current principles of social care. The current regulation and inspection process does little to encourage choice and control for residents within care homes which would require a fundamental shift in culture. However, such a culture shift is more likely to occur if care homes are supported in making this change. Such support and expectation would have to be on many levels, including policy, practice guidance and training and from those commissioning the care provided by care homes. However, it would also require acceptance at a societal level that an over-protective environment within care homes reduces quality of life for the people that live there.

10.3.3 Autonomy and Independence for older people living in care homes

This research has identified that residents of care homes lack choice and control over aspects of their daily living. As this study focused on sleep, this was particularly evident around going to bed, getting up times and bedroom privacy during the night-time. The institutional aspects of a care home meant that 'choices' were frequently not available to residents. Where choices were made, they were either not respected or unable to be met due to the routines and structures of the home. This questions the ability of
routinised care to support individual choice. Staff did not make reference to
the key piece of legislation in this area which is the *Mental Capacity Act
2005*. This legislation allows people in receipt of health or social care to
make their own decisions even if those decisions seem unwise to
professionals or families. Under the *Mental Capacity Act 2005*, it is assumed
that an individual has capacity unless otherwise demonstrated. This
legislation protects the rights of residents to make decisions about the care
that they receive and how they wish to live their lives. Therefore care homes
need to recognise that residents have the right to make choices, and that
sleep preferences are part of how we choose to live.

Blanket policies of regular and intrusive checks overnight need to be
reviewed with regard to their compatibility with legislation such as the
*Mental Capacity Act 2005*, amended with the Deprivation of Liberty
Safeguards (DOLS) in 2009. This legislation provides protection for
individuals who have been assessed as lacking capacity to make specific
decisions and are not protected by the safeguards under mental health
legislation. The DOLS established that where individuals lack capacity and
their liberty needs to be curtailed in some way, for example being checked
half-hourly overnight, that this should be done in the least restrictive way.
Under this legislation, care homes need to be able to demonstrate that
routine and indiscriminate night-time checking procedures are the least
'restrictive' way of residents being safe overnight. In light of the lack of use
of assistive living technologies which may represent a less restrictive option
than regular overnight checks and which are widely available, it is possible
that care homes are not acting in accordance with DOLS for those residents
who do not have capacity to make decisions about their daily lives.

10.3.4 Care Homes for the 21st Century - Embracing Technology

The policy focus of keeping people living at home has fostered an increase
in the use of innovative technology, commonly referred to as 'assistive living
technology' or telecare, used to support people to remain living
independently in their own homes. The use of technology and the
development of telecare is located within a ‘preventative’ discourse in policy aims and practical terms and is solely aimed at preventing ‘dependency’ and promoting independent living. However, care homes are not part of the developments around telecare. Although it has been argued that care homes should not be perceived as a last resort (Oldman and Quilgars, 1999), they are not part of the ideology associated with promoting independence. The positive developments within social care aimed at promoting independence are currently excluded from care homes. Telecare is increasingly being used in people’s own homes and recent figures estimate between 1.6 and 1.7 million users (Clark and Goodwin, 2010). Since early 2009, references to telecare and telehealth have appeared in a number of policy reports, including the national dementia strategy Living Well with Dementia (Department of Health 2009a), Transforming Adult Social Care (Department of Health 2009b) and Building the National Care Service (Department of Health, 2010). These point to an emerging development of policy consensus on the future of a health and social care system that uses telecare and telehealth services.

Telecare utilises such devices as sensors for bed/chair absence, epilepsy, falls, enuresis and medication reminders as well as more recent ‘telehealth’ developments (for examples of telehealth sensors see www.tunstall.co.uk). This type of smart technology could complement the work of staff within care homes and be offered as an option for residents of care homes who would prefer it in order to reduce unnecessary monitoring or sleep disturbance overnight.

Policy developments should not exclude the residents of care homes from access to new social and health care initiatives however it appears they have been excluded from telecare developments. Currently, of all telecare provided by local authorities in two London Boroughs (Richmond and Kingston), only two door sensors have recently been provided to one care home for older people in Kingston (Caroline Manager, London Borough of Richmond upon Thames, personal communication 2010). Care homes are already using some technology in the form of the various emergency call bell systems. In this study, a resident in one care home had been given a ‘bed
absent' sensor to alert staff if they left their bed for a specified period of time. However, this was only one example and telecare was not widely used in the care homes in this study.

10.3.5 Care Homes Promoting Independence

Care homes currently appear to provide a 'medical' model of care and do not actively engage in promoting the independence of people who live there nor do they provide any programmes for skills building or rehabilitative activity which would support promoting independence. Assistive living technology is one aspect for promoting independence however it would not replace the need for staff support. Staff are a fundamental part of care home life and would be a key part of introducing change.

One of the principles of 'self care' relates to staff providing support for people to access and use technology. Skills for Care, a national charitable organisation developing standards, qualifications and training for social care staff, are promoting the notion of 'self care' developed alongside the organisation Skills for Health. This acknowledges that a significant cultural shift is required which can only be achieved alongside “changing the attitudes, behaviours and skill base of all people working in health and social care.” (Common Core Principles to Self Care, accessed 19/12/2010). Self care has been defined as

"the actions people take for themselves, their children and their families to stay fit and maintain good physical and mental health; meet social and psychological needs; prevent illness or accidents; care for minor ailments and long-term conditions; and maintain health and well-being after an acute illness or discharge from hospital."

(Department of Health, 2005)

Therefore the principle of self care, as advocated by Skills for Care and Skills for Health, expect that services would give people control over and responsibility for their health and well-being. It is acknowledged that supported self care is linked to issues of choice, decision making and the management of risk.

These principles for staff supporting self care have been developed in line with national policies on health and social care, and are designed to be
consistent with the seven outcomes expected from adult social care services set out in the multi-agency concordat ‘Putting People First’ (HM Government, 2007), the first outcome being to “live independently”. However, the entry point for a person into a care home typically occurs following an assessment that has identified them as being unable to ‘live independently’. This sets up care homes as places where those who can no longer be independent live and sets care home residents outside one of the main tenets of current UK social care policy. Therefore the definitions of what it means to ‘live independently’ need to be defined in ways that do not link them so explicitly to living in your own home. It is important to note that this is not necessarily the case in residential care settings for adults with learning disabilities, where strategies such as ‘Valuing People Now’ (Department of Health, 2009c) and the preceding White Paper in 2001 explicitly applied the principles of independence to all adults with learning disabilities, not just those living independently in the community.

10.4 Conclusion

This study has explored the night time in care homes which had been largely overlooked by previous care home research. Through the qualitative study of sleep, a number of important aspects of care home life have been highlighted from the perspective of both residents and staff and which can comment on current adult health and social care policy in the UK. The importance of considering the 24 hour nature of support in care homes and raising the profile of how practice at night-time in residential care settings can impact on quality of life has been highlighted.

Since the work of Townsend, care homes have undergone physical and social changes, however this research has identified significant aspects of support within care homes which remain routinised. Formalised routines which de-personalise the care environment as criticised by Townsend, were shown to have continued as a fundamental aspect of night time care. As such, the care homes lacked a focus on independence and rehabilitation that are main tenets in all other areas of social care. Researching sleep and the
night time has identified that the sleep routines of residents were similarly affected by care home routines as other aspects of daily living. An inflexible and routinised approach to care which does not encourage residents to exercise choice and control or maintain existing skills only serves to make people increasingly dependent in the care home environment and reinforces a culture of institutionalisation. Notions of privacy and autonomy being eroded by institutional practices make clear links to earlier care home research by Townsend and ultimately reflect the concept of institutionalisation and its impact on the sense of self as identified by Goffman.

The management of risk has been shown to shape and dominate night time practices in care homes, overriding the needs or preferences of the individual and ignoring the social and emotional aspects of sleep. This thesis demonstrated that risk management resulted in care practices that disturbed sleep and distorted the private nature of the bedroom at night. Staff discourse and care home practice, which contribute to the residents’ lack of control over their sleep environment, are linked to concepts of the ageing body as vulnerable and a site of risk that needs to be managed.

Night care practices are symptoms of the imbalanced nature of the relationship between the care home and the residents and are indicative of cultural perceptions of the nature of sleep and older age. Issues of autonomy, independence and choice have been highlighted and this research questions whether these are fully supported within care homes in accordance with current policy guidance and legislation. Utilising technology such as bed occupancy sensors or fall detectors that are routinely available to people living in their own homes, yet not to people living in care homes, may facilitate this. The lack of the use of technology in care homes also highlights that one of the fundamental principles of social care policy, the notion of ‘living independently’ may set care homes apart and exclude their residents from developments in social care. This consequently impacts upon the quality of support provided to residents of care homes and their quality of life.
BIBLIOGRAPHY


Department of Health (2001c) Shifting the Balance of Power Within the NHS. London: TSO.


Department of Health (2009a) *Living Well with Dementia*, London: TSO.


Windley Lodge Nursing Home
Care home with nursing, 60 places (35 for people with dementia).
Night staff: 2 carers, 1 RGN (1 staff: 8.3 residents)
Windley Lodge is a purpose built registered home providing nursing care services for up to 60 service users over the age of 60 years and those with dementia. The home is owned and managed by a charity. Bedrooms are arranged over two floors, which are lift accessible. The ground floor has a reception area, dining room, laundry and a small visitors room. There is a chapel and large lounge on the first floor. All rooms have en-suite toilet and wash basin facilities. The home has a separate secure environment for those residents who are diagnosed with dementia.

Bascombe House Nursing Home
Care home with nursing, 44 places.
Night staff: 2 carers, 1 RGN (1 staff: 14.6 residents)
Bascombe House is situated near the high street of a small Greater London suburb however the road on which the home is located is a quiet road. The home is purpose built and owned and managed by the local authority. The home provides both long and short-term care for up the forty-four service users over the age of sixty-five years. A small part of the home is a rehabilitation unit where service users stay for a period of rehabilitation with a view to returning to their own homes. Bedrooms are arranged over 2 floors with shared toilet facilities, however there are wash basins in each room. The ground floor has a large reception area, a small lounge (tv), a large lounge extending into a dining area, and a separate bar area. The upstairs floors have small dining rooms and kitchens on each floor.

Kimble House Residential Home
Care home, 38 places.
Night staff: 2 carers (1 staff: 19 residents)
Kimble House is a purpose built resource centre, owned and managed by the local authority. It provides residential accommodation for up to 38 older people. The home is situated in a residential area but close to a town centre. Bedrooms are arranged over two floors, accessible by lift or stairlift. There are shared toilet facilities however there are wash basins in each room. There is a large reception area, large bar area often used for activities, a small tv lounge, a larger tv lounge and a dining area. On the upper floors there are small dining rooms, lounges and kitchens on each floor.
Longford Manor Nursing Home
Care home with nursing, 43 places.
Night staff: 3 carers and 2 RGN (1 staff: 8.6 residents)

Longford Manor Nursing home is a care home which can provide nursing for forty-three people over the age of fifty-five. The home is privately owned and managed by a large UK provider. Accommodation is provided over three floors, accessible by a lift. A large restaurant, two lounges and bedrooms are on the ground floor. The first floor has bedrooms, a large lounge, shower room and a hairdressers room. The second floor has bedrooms, a small lounge, shower room, bathroom and a staff office. Thirty-eight bedrooms are single, with three double rooms. Longford Manor is located in a residential road of a greater London Borough, and is very close to a large shopping centre.
Mrs Resident
Home on the Hill
Suburb
Surrey

Dear Mrs Resident,

In order to help improve the sleep of older people living in care homes the University of
Surrey is conducting a research project funded by the Economic and Social Research
Council (ESRC). The project, which has University of Surrey Ethics Committee
approval, is being led by Dr. Ingrid Eyers who is experienced in conducting research in
care homes and who in her career as a nurse used to be a care home manager.

We are writing to invite you to participate in this research project. More detailed
information about what your involvement would be is set out in the enclosed information
sheet. Our research team will be in the home on ??/??/07 and if you would like more
information we would be happy to discuss the project in more detail with you and your
family or friends.

We look forward to your participation which would be much appreciated.

Yours sincerely,

Dr. Ingrid Eyers
Lecturer in Adult Nursing

Phone: 01483 682542
Email: i.evers@surrey.ac.uk
Information Sheet

Research Project: Understanding sleep in care homes

A research team from the University of Surrey is asking you to take part in research on sleep among older people living in residential homes. Before you decide whether you would like to take part or not, we need to tell you why the research is being done, and what you can expect if you do take part. We will be visiting the care home on ........and will discuss the project with you then, but in the meantime if you have any questions you would like to ask, please contact the project administrator Suzanne Foreman on 01483 689292.

Thank you for reading this.

Who are we?

We are a team of researchers from the Centre for Research on Ageing and Gender at the University of Surrey. The principal investigator is Dr. Ingrid Eyers and the two researchers are Theresa Richards and Emma Cope.

What is the purpose of this study?

The University of Surrey is currently conducting research into sleep among older people in care homes. It is hoped that this research will help identify ways in which sleep in care home can be improved. Better sleep improves both physical and mental abilities and thereby quality of life.

Do I have to take part?

It is entirely up to you whether or not you take part. If you choose to participate, you will be given this information sheet to keep. You will also be asked to sign a 'consent' form. If you then decide to take part you are still free to stop at any time without giving a reason. No questions will be asked if you wish to stop.
What will happen if I do take part?

You will be asked to keep a diary (see attached sample) that outlines your activities, your meals and medication for two weeks. This will be kept either independently by you or with the support of care staff or a member of the research team.

For a period of two weeks you will be asked to wear one Actiwatch monitor.

An Actiwatch-L is designed to monitor activity and light intensity. One Actiwatch-L is to be worn on your non-dominant wrist (i.e. on the left wrist if you are right handed) using the elcro strap. It needs to be worn at all times, including during sleep. Please vigorously shake your wrist for 10 seconds immediately prior to bedtime, and immediately after waking. The activity monitors are not waterproof and must be removed before showering or bathing.

You will also be asked to wear a light monitor. It must be worn over clothing to ensure the light sensing window is not covered. This monitor can be removed during sleep periods and left on the bedside table. Information extracted from the monitors tell the researcher about the amount of light you are exposed to and help to assess your sleep-wake cycle. The monitors will be downloaded and checked each time a researcher comes to visit you. They will be collected from you on the last day of the study.

You will also be asked if you are willing to be interviewed. During the interview you will be asked to tell us in your own words about your experiences of sleep and what sleep is like in the care home.

What will happen to the information I provide?
The information collected will be stored at the University of Surrey. This may be inspected by regulatory authorities to check that the study is being carried out correctly. Your name,
however, will not be disclosed outside of the research team. Records held will be identified only by code numbers and are kept in a secure place at the University of Surrey. The results from the study may be used for publication but all results will be kept strictly anonymous. All data use will be within the terms of the Data Protection Act 1998.

What happens if I want to stop taking part in the research?
You are free to stop taking part in the research at any time and you will not have to give any reasons. Information from participants who have withdrawn from the study will only be used if permission has been given.

Who has reviewed the study?
The University of Surrey Ethics Committee approved the study.

The research team will be happy to discuss any questions you might have regarding this study. If you are happy to participate in this project please sign the attached consent form and hand it to a member of the research team.

Contact details:
Dr. Ingrid Eyers
Lecturer in Adult Nursing
University of Surrey
Guildford
GU2 7TE

Phone: 01483 682542
Email: i.evers@surrey.ac.uk
Appendix D
Covering Letter for Staff

Dear .............

In order to help improve the sleep of older people living in care homes the University of Surrey is conducting a research project funded by the Economic and Social Research Council (ESRC). The project, which has University of Surrey Ethics Committee approval, is being led by Dr. Ingrid Eyers who is experienced in researching in care homes and who in her career as a nurse used to be a care home manager.

With the consent of NAME, the care home manager, we are writing to invite you to participate in this research project. More detailed information about what your involvement would be is in the attached leaflet. Our research team will be in the home on ??/??/07 and if you would like more information we would be happy to discuss the project in more detail with you.

We look forward to your participation which would be much appreciated.

Yours sincerely,

Dr. Ingrid Eyers
Lecturer in Adult Nursing

University of Surrey
Guildford
GU2 7TE
Phone: 01483 682542
Email: i.evers@surrey.ac.uk
Appendix E
Information sheet for staff

Understanding sleep in care homes

Who are we?
We are a team of researchers from the Centre for Research on Ageing and Gender at the University of Surrey. The principal investigator is Dr. Ingrid Eyers and the two researchers are Theresa Richards and Emma Cope.

What is the purpose of this study?
The University of Surrey is currently conducting research into sleep among older people in care homes. It is hoped that this research will help identify ways in which the sleep of older people living in a care home can be improved. Improved sleep improves both physical and mental abilities and thereby quality of life.

Do I have to take part?
It is entirely up to you whether or not you want to take part. If you choose to participate, you will be given this information sheet to keep. You will also be asked to sign a ‘consent’ form. If you then decide to take part you are still free to stop at any time without giving a reason. No questions will be asked if you want to stop.

What will happen if I do take part?
You will be interviewed at a time convenient to you and the interview may last up to about an hour. The researcher will be interested in your views on good and poor quality sleep and about the sleep environment of the care home.

Residents will be asked to keep a diary for two weeks that outlines their activities, meals and medication and they may ask you for help in filling it in.

For a period of two weeks a number of residents will be asked to wear an Actiwatch monitor.
An Actiwatch-L is designed to monitor activity and light intensity. One Actiwatch-L is to be worn on the non-dominant wrist (i.e. on the left wrist if you are right handed) using the elcro strap. It needs to be worn at all times, including during sleep. The activity monitors are not waterproof so they should be removed before showering or bathing.

The second monitor needs to be worn around the neck, attached to its cord. It must be worn over clothing to ensure the light sensing window is not covered. This monitor can be removed during sleep periods and left on the bedside table. Information extracted from the monitors inform the research about the amount of light they are exposed to and help to assess their sleep-wake cycle. The monitors will be downloaded and checked each time a researcher comes to visit. They will be collected from residents on the last day of the study.

For those residents in the four chosen homes for additional qualitative research, this additional paragraph will be added: There will also be an interview where some residents will be asked to talk in their own words about residents experiences of sleep and what sleep is like in the care home.

What will happen to the information I provide?
The information collected will be stored at the University of Surrey. This may be inspected by regulatory authorities to check that the study is being carried out correctly. Your name, however, will not be disclosed outside of the research team. Records held will be identified only by code numbers and are kept in a secure place at the University of Surrey. The results from the study may be used for publication but all results will be kept strictly anonymous. All data use will be within the terms of the Data Protection Act 1998.

What happens if I want to stop taking part in the research?
You are free to stop taking part in the research at any time and you will not have to give any reasons. Information from participants who have withdrawn from the study will only be used if permission has been given.

Who has reviewed the study?
The University of Surrey Ethics Committee has approved the study.
The research team will be happy to discuss any questions you might have regarding this study. If you are happy to participate in this project please sign the attached consent form and hand it to a member of the research team.

Contact details:

Dr. Ingrid Eyers
European Institute of Health and Medical Sciences
University of Surrey
Guildford
GU2 7TE

Phone: 01483 682542
Email: i.eyers@surrey.ac.uk
In order to help improve the sleep of older people living in care homes the University of Surrey is conducting a research project funded by the Economic and Social Research Council (ESRC). The project, which has University of Surrey Ethics Committee approval, is being led by Dr. Ingrid Eyers who is experienced in researching in care homes and who in her career as a nurse used to be a care home manager.

With the consent of NAME, the care home manager, we are writing to tell you more information about this research project enclosed in the attached leaflet. Please contact the project administrator Suzanne Foreman on 01483 689292 if you have any questions.

Yours sincerely,

Dr. Ingrid Eyers
Lecturer in Adult Nursing

University of Surrey
Guildford
GU2 7TE
Phone: 01483 682542
Email: i.eyers@surrey.ac.uk
Appendix G

Information sheet for relatives

Research Project: Understanding sleep in care homes

Who are we?
We are a team of researchers from the Centre for Research on Ageing and Gender at the University of Surrey. The principal investigator is Dr. Ingrid Eyers and the two researchers are Theresa Richards and Emma Cope.

What is the purpose of this study?
The University of Surrey is currently conducting research into sleep among older people in care homes. It is hoped that this research will help identify ways in which the sleep of older people living in a care home can be improved. Better sleep improves both physical and mental abilities and thereby quality of life.

Do residents have to take part?
It is entirely up to the resident whether or not they want to take part. If they choose to participate, they will be given an information sheet to keep. They will also be asked to sign a 'consent' form. If a resident then decides to take part they are still free to stop at any time without giving a reason. No questions will be asked if they want to stop.

What will happen if they do take part?
Residents will be asked to keep a diary for two weeks that outlines their activities, meals and medication and they may ask you for help in filling it in.

For a period of two weeks a number of residents will be asked to wear an Actiwatch monitor.
An Actiwatch-L is designed to monitor activity and light intensity. One Actiwatch-L is to be worn on the non-dominant wrist (i.e. on the left wrist if you are right handed) using the elcro strap. It needs to be worn at all times, including during sleep. The activity monitors are not waterproof so they should be removed before showering or bathing.

The second monitor needs to be worn around the neck, attached to its cord. It must be worn over clothing to ensure the light sensing window is not covered. This monitor can be removed during sleep periods and left on the bedside table. Information extracted from the monitors inform the researcher about the amount of light they are exposed to and help to assess their sleep-wake cycle. The monitors will be downloaded and checked each time a researcher comes to visit. They will be collected from residents on the last day of the study.

Some residents will also be interviewed where they will be asked to talk in their own words about their experiences of sleep and what sleep is like in the care home.

**What will happen to the information collected?**

The information collected will be stored at the University of Surrey. This may be inspected by regulatory authorities to check that the study is being carried out correctly. Names, however, will not be disclosed outside of the research team. Records held will be identified only by code numbers and are kept in a secure place at the University of Surrey. The results from the study may be used for publication but all results will be kept strictly anonymous. All data use will be within the terms of the Data Protection Act 1998.

**What happens if a resident wants to stop participating in the research?**

Residents are free to stop taking part in the research at any time and will not have to give any reasons. Information from participants who have withdrawn from the study will only be used if permission has been given.

**Who has reviewed the study?**

The University of Surrey Ethics Committee has approved the study.

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The research team will be happy to discuss any questions you might have regarding this study. If you are happy to participate in this project please sign the attached consent form and hand it to a member of the research team.
Contact details:

Dr. Ingrid Eyers
European Institute of Health and Medical Sciences
University of Surrey
Guildford
GU2 7TE
Appendix H

Consent form for Residents

Understanding sleep in care homes

Consent form for Care Home Residents

1. I the undersigned voluntarily agree to take part in the study Understanding sleep in care homes.

2. I have read and understood the information sheet provided. I have been given a full explanation by the researchers of the nature, purpose and likely duration of the study and what I will be expected to do. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given.

3. I understand that the interview may be recorded and the researcher will hold all information collected securely and in confidence, and that every effort will be made to ensure that I cannot be identified as a participant in the study.

4. I agree to comply with the research process and will co-operate fully with the researchers.

5. I understand that all personal data relating to volunteers is held and processed in the strictest confidence and in accordance with the Data Protection Act (1998). I agree that I will not seek to restrict the use of the results in the study on the understanding that my anonymity is preserved.

6. I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice. I understand that if I withdraw from the study my data will only be used if I permit this.

7. I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate
time to consider my participation and agree to comply with the instructions of the study.

Name of Participant
(Block capitals)
Signed Date

In the presence of
(name of witness in block capitals)
Signed Date

Name of researcher/person taking consent
(Block capitals)
Signed Date
Appendix I

Consent form for Care Home Staff

Understanding sleep in care homes

Consent form for Care Home Staff

1. I, the undersigned, voluntarily agree to take part in the study Understanding sleep in care homes.

2. I have read and understood the information sheet provided. I have been given a full explanation by the researchers of the nature, purpose and likely duration of the study and what I will be expected to do. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given.

3. I understand that the interview may be recorded and the researcher will hold all information collected securely and in confidence, and that every effort will be made to ensure that I cannot be identified as a participant in the study.

4. I agree to comply with the research process and will co-operate fully with the researchers.

5. I understand that all personal data relating to volunteers is held and processed in the strictest confidence and in accordance with the Data Protection Act (1998). I agree that I will not seek to restrict the use of the results in the study on the understanding that my anonymity is preserved.

6. I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice. I understand that if I withdraw from the study my data will only be used if I permit this.

7. I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions of the study.

Name of Participant
(Block capitals)

Signed  Date

In the presence of
(name of witness in block capitals)

Signed  Date

Name of researcher/person taking consent
Signed Date
## Topic Guide for Interview with Care Staff

**Information about participant**

<table>
<thead>
<tr>
<th>Qualifications</th>
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<tbody>
<tr>
<td>Job title</td>
</tr>
<tr>
<td>Full time or part time work</td>
</tr>
<tr>
<td>Number of hours worked per week</td>
</tr>
<tr>
<td>Number of hours worked per shift</td>
</tr>
<tr>
<td>Length of time working in care homes</td>
</tr>
<tr>
<td>Age group</td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>First language</td>
</tr>
<tr>
<td>Length of time living in England</td>
</tr>
</tbody>
</table>

**Sleep management in the care home**

- What is the care home routine in preparing for night time
- What the night is like in the care home
- Environmental issues (noise, light, temperature, clothing)
- Disruptions to sleep of residents – what are the causes?
- What are the interventions offered by care staff if someone is experiencing sleep problems
- What is the reasoning and justification for these interventions
- Use of sleep medication
- Record keeping
- Daytime napping
- How much discussion with resident about sleep and personal sleep preferences
- Are daytime activities important for sleep

**Perceptions of normative sleep**

- What is a good night’s sleep for you
- What is a poor night’s sleep for you
- What do you think is a good night’s sleep for a resident of the care home
- What do you think is a poor night’s sleep for a resident of the care home
- What do you think about resident’s quality of sleep

Any other thoughts on residents sleep in the care home?
Appendix K

**Topic guide for interview with ten residents in each of 4 care homes**

<table>
<thead>
<tr>
<th>Information about participant</th>
<th>Diaries of Activities ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Length of time living in care home</td>
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<tr>
<td></td>
<td>Medical Information</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Perceptions of normative sleep</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• What do you think is a good night’s sleep</td>
</tr>
<tr>
<td></td>
<td>• What is a poor night’s sleep like</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sleep experience</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• What the night is like in the care home.</td>
</tr>
<tr>
<td></td>
<td>• Environmental issues (noise, light, clothing, temperature)</td>
</tr>
<tr>
<td></td>
<td>• Comfort</td>
</tr>
<tr>
<td></td>
<td>• Any pre-sleep routine or personal strategies to help with sleep</td>
</tr>
<tr>
<td></td>
<td>• Disruptions to sleep – causes and responses</td>
</tr>
<tr>
<td></td>
<td>• Strategies to overcome difficulty getting to sleep</td>
</tr>
<tr>
<td></td>
<td>• Strategies for coping with waking in the night</td>
</tr>
<tr>
<td></td>
<td>• Seeking help for difficulty sleeping</td>
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<tr>
<td></td>
<td>• Napping</td>
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<tr>
<td></td>
<td>• Use of sleep medication</td>
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<tr>
<td></td>
<td>• If there are problems, what are the interventions offered by care staff</td>
</tr>
<tr>
<td></td>
<td>• How much discussion with staff about sleep and personal sleep preferences</td>
</tr>
<tr>
<td></td>
<td>• Do you think daytime activities are important to sleep</td>
</tr>
<tr>
<td></td>
<td>• What was your sleep like before you came into the care home</td>
</tr>
</tbody>
</table>

Any other thoughts on sleep?