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Advancing the understanding of factors which influence job satisfaction of care home staff

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ADVANCING THE UNDERSTANDING OF FACTORS WHICH INFLUENCE JOB SATISFACTION OF CARE HOME STAFF

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Declaration

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I hereby declare that this thesis is the results of my own investigations, except where otherwise stated. All other sources are acknowledged by bibliographic references. This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree unless, as agreed by the University, for approved dual awards.

Yr wyf drwy hyn yn datgan mai canlyniad fy ymchwil fy hun yw'r thesis hwn, ac eithrio lle nodir yn wahanol. Caiff ffynonellau eraill eu cydnabod gan droednodiadau yn rhoi cyfeiriadau eglur. Nid yw sylwedd y gwaith hwn wedi cael ei dderbyn o'r blaen ar gyfer unrhyw radd, ac nid yw'n cael ei gyflwyno ar yr un pryd mewn ymgeisiaeth am unrhyw radd oni bai ei fod, fel y cytunwyd gan y Brifysgol, am gymwysterau deuol cymeradwy.

ABSTRACT

Background:

Knowledge gaps remain about the factors which influence job satisfaction in the care home sector workforce, and the perspectives of staff need to be better reflected.

Study aim and objectives:

The main aim of this study was to add to the evidence base to understand factors which influence job satisfaction within the care home setting. Phase 1 of the study explored management practices, while Phase 2 explored staff views and attitudes on job satisfaction.

Methodology/Methods:

A scoping review of the literature illuminated approaches to support care home workforce practices. Nine themes were identified, giving direction to the next stage of the study. Case studies explored staff experiences and management practices, focusing on improving job satisfaction within the care home workforce. Data collected included face to face interviews (n=40) and documentation review (n=20). Case analysis and cross-case thematic analysis was undertaken.

Findings:

The scoping review findings showed that job satisfaction was a significant factor across all the themes. Case study findings highlighted 1) personal satisfaction, 2) organisational and management influences, and, 3) sustainability of the workforce, as the key issues influencing job satisfaction.

The findings advance understanding about factors which influence this workforce through the contribution of individual and organisational factors shown to support better job satisfaction. The concept of balancing the benefits and drawbacks was pivotal to influence staff decisions to remain (or not) in their care home role. A new managers' resource offering an original

contribution is presented, aiming to increase job satisfaction through improving working conditions and fostering employment stability.

Conclusion:

This study adds to the growing body of care sector evidence, broadening the understanding of influences on job satisfaction, whilst presenting the new resource. The study recommendations for research, policy and practice suggest ways in which a holistic approach to job satisfaction can support and retain this workforce.

ACKNOWLEDGEMENTS

FOREWORD

I qualified as a Registered Nurse in 1988 and a Registered Midwife in 1991. I am now employed as a Senior Nurse supporting Primary Care nurses working in General Practices. A focus of my role encompasses sustainability of this nursing workforce, education and development and ensuring the nurses have the right skills, knowledge and competences to provide the highest standards of nursing care. The workforce is the healthcare systems' greatest asset and I wanted to focus on exploring areas of potential workforce improvements, which would subsequently have a positive effect on clinical practice and nursing care.

Prior to my current role, I worked closely with the care home sector to support the nursing staff to promote excellent standards of care, whilst safeguarding residents within these organisations. I recognised the value of lifelong education and development, and the importance of this workforce in identifying areas of improvement and encouraging change processes to maintain quality driven safe care. Commissioned care within care homes with nursing is often not a favoured workplace for staff, and often lacks the standing of other healthcare establishments. Consequently, this setting is frequently overlooked and lacks the recognition as a key provider of specialist and complex nursing care for many highly vulnerable residents. This role and this insight led me to explore workforce issues in this healthcare setting, with a focus on exploring factors impacting on the recruitment and retention of staff.

The Professional Doctorate in Healthcare has provided me with the opportunity to develop and synthesise empirical, professional and organisational knowledge. My Doctorate programme journey has been challenging, thought-provoking and rewarding, enabling me, through the taught module programme to gain a greater understanding of subjects, such as change leadership, implementation science and advancing professional knowledge. The culmination of this learning, with the development and undertaking of a research study, making an important contribution to practice, is presented in this thesis.

A key aim of the study was to identify factors which could provide a greater understanding of this often-overlooked staff group. Being knowledgeable of the changing climate for professional nursing roles, and the current national drive towards the delivery of healthcare service closer to patients' homes, improving the conditions for care home sector staff is imperative to drive forward quality in healthcare.

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GLOSSARY OF TERMS

Care home managers	Managers of care homes in the UK are employed in a variety of posts, such as manager, nurse manager or a joint owner/ manager role, they undertake a leadership role, and have responsibility for regulation of services. For this study, any of the above posts will be included.
Care homes	For this study, care homes which provide nursing care for residents over the age of 18 years and which require registered nurses in full-time employment are included.
Case study	A case study is an empirical research approach used to investigate a contemporary phenomenon within its real-life context.
CIW	Care Inspectorate Wales (CIW) regulate and inspect adult care, childcare and social services in Wales. CIW was formerly known as Care and Social Services Inspectorate Wales (CSSIW), and was renamed in January 2018.
Health Board	The local NHS organisation which has contractual responsibility for the care homes included within this study.
Nursing assistants	Unregulated staff members who provide direct patient care and support the registered nurse in the care home sector.
Registered Nurses	Nurses in UK employment who have completed a recognised programme of education and learning, and are registered with the Nursing and Midwifery Council.
SCW	Social Care Wales (SCW) is an organisation which sets clear standards of conduct and practice expected of social care professionals in Wales. SCW was formerly known as Care Council for Wales (CCW), and was renamed in April 2017.

ABBREVIATIONS

ASSIA	Applied Social Science Index and Abstracts
CCW	Care Council for Wales (now known as SCW)
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CIW	Care Inspectorate Wales
CPA	Centre for Policy on Ageing
CPD	Continuous Professional Development
CQC	Care Quality Commission
CSSIW	Care and Social Services Inspectorate Wales (now known as CIW)
DBS	Disclosure and Barring Service
DH	Department of Health
HMIC	Health Management Information Consortium
HR	Human Resources
NICE	National Institute for Clinical Excellence
NMC	Nursing and Midwifery Council
NVQ	National Vocational Qualifications
ONS	Office for National Statistics
OSCAR	Online Survey, Certification and Reporting
PICOS	Population, Intervention, Control, Outcomes and Study Design
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
RCN	Royal College of Nursing
RN	Registered Nurse
SCW	Social Care Wales
SDT	Self-Determination Theory
WG	Welsh Government
WHO	World Health Organisation

CHAPTER ONE:
BACKGROUND TO THE STUDY

1.1   Introduction

In this first chapter, the context to the design and implementation of the research study reported in this thesis is provided. The care home setting as an alternative health care provider for essential complex care services will be explored. The political backdrop, legal frameworks and recent changes in UK policy which impact on the care home sector are reviewed, including resident and relative expectations and experiences within care homes.

There is a growing, but still fairly small, body of research evidence that relates to the care home sector in comparison to hospital and community care settings. This current study builds on existing knowledge of workforce practices within a care home setting, (expanded on later in the thesis), and leads onto the need to further explore job satisfaction within the workplace. The exploration of current policies and guidance relating to workforce recruitment and retention highlights the importance of the care home environment, the gaps in the current evidence, and the associated challenges of making improvements within this sector.

The *first section* provides an overview of key definitions used in the thesis, an overview of the current care home sector which helps to frame this study and explores some of the significant challenges and complexities faced by this workforce.

1.2   Defining the Care Home

The following section expands on a selection of key definitions used within this thesis, with additional explanations and definitions provided in the Glossary of Terms section.

1.2.1   Care home definition

Care homes are registered to provide personal care, and in many homes will also deliver nursing care (Age UK, 2017). Care homes which provide personal care such as assistance with meals, toileting and taking medication, are termed care homes (without nursing) or commonly known

as residential care homes (Goodman et al, 2016). Whilst, care homes offering registered nursing are now termed care homes (with nursing), previously known as nursing homes. For this thesis, the term *care homes* will be deemed to relate to care homes which provide adult nursing care only, supporting residents over 18 years of age, through permanent or temporary placements. Registered nurses must be employed full-time to meet nursing care requirements. Residential care homes, children's establishments, domically care or own-home living will not be included within this study.

1.2.2 Recruitment and retention definition

Staff may take up employment or may leave a job for a variety of personal or work-related reasons (Arthur, 2001). Within this study, r*ecruitment and retention* relates to issues and reasons why staff may take up or leave employment within a care home setting and involves all levels and types of staff. The study will not look at staffing in relation to quality, outcomes or specific medical disease areas, only in relation to factors which may influence why staff start or leave a job in this setting.

1.2.3 Social care manager definition

Managers may be employed in a variety of different posts, such as manager, nurse manager or they may have a joint role as owner/ manager within an adult care home (Care Council for Wales, 2016). For the purposes of this thesis, any of the above positions are included if currently registered with Social Care Wales (SCW) (formerly Care Council for Wales (CCW)), and Care Inspectorate Wales (formerly Care and Social Services Inspectorate Wales (CSSIW)). The working term used throughout this thesis to maintain consistency and ease, will be *Care Home Manager.*

1.3 Care Home Sector – an overview

This *next section* provides an overview of the care home sector, highlighting the necessity for this provision of care, whilst exploring some of the significant challenges and complexities faced by this workforce, with these issues guiding the direction of this study.

Care homes are vital for the provision of healthcare in the community, even more so following the national drive for care to be delivered closer to a person's home (Welsh Government (WG), 2010). As NHS acute care is currently overwhelmed and brimming to capacity (Care Quality Commission (CQC), 2016), its argued that the demand for care home residency is based on supporting strained discharge processes, rather than the importance of driving the need for better care establishments (WG, 2018a). The Institute of Fiscal Studies reported the cost of adult social care in England in 2015-16 was £16.8 billion (Simpson, 2017), whilst in Wales, it is suggested that the ageing population is greater than other parts of the UK (Jones, Patrignani, & Peychev, 2014), thus reinforcing the need to urgently and consistently support this sector (Cousins, Burrows, Cousins, Dunlop & Mitchell, 2016).

Across the UK, residents are reported to be entering care homes with higher levels of care needs (Royal College of Nursing (RCN), 2010), often near the end of life, and thus experiencing higher levels of dependency (Lievesley, Crosby & Bowman, 2011). The demand for places is high alongside the increasingly complex health needs (CQC, 2014). Rubery et al. (2011) reported the decline in care staff numbers along with the reduced desire of family members to perform unpaid carer duties, has further added to the growing need for social and health care provision.

Attempts from the care homes to respond to the rising complexity of care, has resulted in a changing and more advanced health and social care workforce (Imison, Castle-Clarke, & Watson, 2016), which has impacted on the requirement for greater staff numbers and training requirements. Although changes to the current approach to care provision is required, the external providers of care i.e. care home owners, are largely not involved in supporting new ways of care delivery (Hughes, Chester & Challis, 2009). Public opinions are driving forward greater expectations for care at home and greater control over personal and social care requirements (Coulter & Jenkinson, 2005). Social care is at a critical point in the UK (Centre for Policy on Ageing (CPA), 2014) with an urgent need to challenge workforce planning at an earlier stage, to meet the challenges of an ageing population (RCN, 2014), with a focus on the care home sector (Skills for Care, 2014)

1.3.1   The UK political backdrop

In the UK, the 1989 White Paper, Caring for People established the backdrop to the current commissioning and contracting levels of the independent sector (Department of Health and Social Security (DHSS), 1989). Government pressures, with constraints on social care budgets moved forward procurement efficiencies (Rubery et al, 2011). The drive towards Local Authority responsibility for commissioned care, directed "the development of a flourishing independent sector alongside good quality public services" (Ware et al, 2001, p.334). The withdrawal of Local Authority residential care followed, which resulted in a growing reliance on the independent sector, and by 2004, 77% of local authorities provided domiciliary care (Knapp, Hardy & Forder, 2001).

From 1997 onwards, government initiatives consistently emerged which led to the integration of health and social care services in conjunction with joint commissioning. The emphasis on meeting future care needs was strengthened with the *Integrated health and social care in England* document (RCN, 2014), through a reduction of "duplicated or organisational boundaries", argued to enhance accessibility of care across health and social care sectors (p.3). Positive benefits were clear with improved quality outcomes, including early discharge and enablement towards independence for older people (Ham & Walshe, 2013). In England, this has led to resident occupancy being three times as high in care homes (nursing and residential) than in NHS hospitals (Goodman, 2016). Critics suggest health needs have outweighed social care needs in the community, causing increasing financial and workforce demands on care provision (Skills for Care, 2014). This has heightened local authority pressures, with suggestions that residents are admitted into care homes, rather than being provided with improved care services at home (Challis & Hughes, 2002).

1.3.2   Legal frameworks for care homes

Care homes are complex business establishments, with the Care Homes (Wales) Regulations 2002 providing a legal framework for care service in Wales (Welsh Assembly Government (WAG), 2011b). The Care Standards Act (2000) and National Minimum Standards for care homes clearly sets out care expectations. As commissioned services, they must deliver care aligned to these frameworks and standards to safeguard the health and welfare of residents (WG, 2018b).

The Welsh Government provides the legal basis for registration of this social care workforce, with Social Care Wales (formerly CCW) formally overseeing and regulating this process. The Care Standards Act (2000) established a workforce register, which provides the evidence that all individuals satisfy certain essential criteria and comply with their Code of Professional Practice for Social Care (SCW, 2017a). The Social Care Manager Guidance acts as a tool to support managers to lead on the delivery of high-quality citizen centred services (WAG, 2011a). *Sustainable Social Services for Wales* advocates a strong voice and greater control for service users and carers in the design and delivery of social services (WAG, 2011a).

1.3.3   Challenges and complexities of commissioned care

The *next section* identifies the challenges facing the care home sector, reflected across both international settings and similarly in the UK.

Globally, many challenges have led to a reduction of capacity within care homes, mainly associated with an increasing ageing population, with growing co-morbidities (Estabrooks, Squires, Carleton, Cummings & Norton, 2015). Adding to the rising demands for care provision, the uncertainly for this sector has been compounded by, for instance, international nurse recruitment issues and growing financial pressures placed on external providers (RCN, 2014; Skills for Care, 2014; RCN, 2015). Both abroad and across the UK the mounting demands placed on healthcare services, has given rise to the emerging inability of this sector to support future care needs, and sustainability of their services.

Following the Community Care Act (1990), the provision of care homes in the UK flourished, whereby additional payments incentivised providers and as such the growth of this market took off (Lievesley et al, 2011). Within the UK, care home bed occupancy is now greater than those provided within NHS establishments (CQC, 2016). Over twelve thousand care homes provide care for nearly half a million people in the UK (Laing & Buisson, 2015). Public funding for adult social care has however reduced by 26% over the last few years, with ongoing reports of local authority spending cuts (Humphries, Hall, Charles, Thorlby & Holder, 2016). Subsequently, the *State of Health Care and Adult Social Care in England* Report 2015/16 (CQC, 2016, p.41) commented that "since April 2015, the growth in nursing home beds at a national level has stopped". This concern is further heightened, with suggestions that the need

for care home places is set to increase by 49% in coming years (Wittenberg & Hu, 2015), thus, adding to the growing urgency to ensure sustainability of these services.

The current pressure on UK health and social care services is exacerbated by a population having progressively more complex needs (CQC, 2014). An increasing gap between care home places and the growing population has been recognised, thus widening this unmet need in social care services (CQC, 2016). The number of people aged 65 years and over had risen by 22%, from 2001 to 2014 in England and Wales, whilst people over 85 years had grown by 33% (Office for National Statistics (ONS), 2014). Whilst in Wales, it is estimated that people over 65 years, will soar to 47% by 2037 (ONS, 2014).

Sustainability of services is reported as increasingly more difficult for providers, with the growth of staffing costs estimated at 80% of total costs (CQC, 2016). Financial stability remains uncertain, with providers struggling with the profitability of their organisations putting increasing pressures on the workforce (CQC, 2016). This has seemingly worsened following the introduction of the National Minimum Wage and the national living wage, which has added to ever-rising staffing costs (Lievesley et al, 2011). Whilst a report from Laing and Buisson (2015) reports between 2014-15, a "capacity loss from closures has for the first time exceeded, by 3,000 beds, capacity gains from new openings" (p.1). The fragility of the care home sector is evident with some providers withdrawing from social care contracts, thus the desire to respond to workforce challenges and safeguarding high quality care is considerable.

1.4   Care home context in Wales

The earlier section has focused on the wider care home sector, whilst this *next section* narrows the focus and explores the care home context in Wales as the country in which this study took place.

By 2005 across the UK, large organisations with over 11 care homes accounted for over 30% of care home placements, with these care homes tending to be larger in size and capacity than in previous years (Lievesley et al, 2011). This was accompanied by a trend towards corporate owned homes in England, rather than individual or family ownerships (Lievesley et al, 2011). However, the position differs across Wales, with the rurality of the Welsh landscape giving rise

to some care homes situated close to large towns, whilst others are in very out-of-town locations (Moultrie & Rattle, 2015). Consequently, professional colleagues and supporting services vary widely, with some care homes positioned many miles from the district general hospital. Across Wales, the ownership and management provision within care homes is fluid, demonstrated by the rise of single home providers to 57% across this sector (Moultrie & Rattle, 2015). Noticeably, the organisation's size and catchment area influence the uptake of employment, a factor impacting on recruitment and ongoing retention (Paget & Wood, 2014).

Care homes provide nursing care and residential care or a combination of both depending on their registration (CCW, 2016). Within Wales, service provision has been influenced by local need, with establishments providing varying services offering care for adults, older peoples mental health, young adult mental health, or residents with learning difficulties (Age UK, 2017). The capacity and size of the care home impacts on their financial status, which subsequently influences the workforce size, skill mix and workload demands (Moultrie & Rattle, 2015). Within the Welsh care homes, the provision of leadership varies with both clinical and non-clinical managers taking responsibility (Moultrie & Rattle, 2015).

Across Wales, of the 1,100 care homes delivering health care needs, 32% (n=406) of these homes were delivering care for older adults (CCW, 2016). In 2015, 22,706 placements were available across Wales, doubling since 2013/14 (StatWales, 2015). Whilst care homes with nursing make up 49% of the available placements, they only make up 36% of all care homes. Nationally, bed occupancy numbers vary, with some organisations providing large numbers of placements. Whilst in Wales, care homes with nursing tend to be notably larger in size (with a mean capacity of 45 beds) compared to those without nursing (with a mean capacity of 27 beds) (Moultrie & Rattle, 2015).

1.5   Workforce Management

This *next section* explores workforce management and employment practices, initially from a broad perspective which subsequently narrows to focus on care homes. The current apprehension associated with recruitment and retention of staff, helps to shape this study and guides its direction towards exploring workforce issues.

The concept of workforce management encompasses key principles and an integrated set of processes that an organisation utilises to optimise the productivity and effectiveness of their employees (Beauregard & Henry, 2009). Workforce management (known as personnel or human resource management) includes elements of staff recruitment, employment services (i.e. sickness /leave management), training and learning, performance management, workforce forecasting, payroll and benefits, and contingency planning (Ulrich & Dulebohn, 2015). In the current climate of staffing challenges and difficulties, the focus for this study is on employment practices rather than productivity and effectiveness, with the emphasis on strategies and approaches to support the workforce within this healthcare setting.

Workforce management processes were introduced through business practices, but is now well established in many other sectors, notably within the healthcare sector (Diallo, Zurn, Gupta & Dal Poz, 2003). Healthcare workforce management varies slightly from its initial origins, due to the nature of delivering healthcare to a population with changing healthcare needs and demands. Healthcare priorities are often nationally driven to ensure high level care services are delivered in a timely and efficient manner (The Health Foundation, 2016). For instance, Prudent Healthcare is a key aspect of delivering healthcare services across Wales, recommended in *Achieving prudent healthcare in NHS Wales* (Bradley & Willson, 2014). Any potential interventions must recognise and address current financial difficulties across all healthcare sectors, combined with the need for long term cost savings.

1.5.1 Employment practices

Across healthcare organisations, workforce management practices vary, with Kitson, Wiechula, Conroy, Muntlin Athlin, and Whitaker (2013) reporting that organisational factors and the contextual environment are key influences on performance and the delivery of quality nursing care. A Department of Health (DH) commissioned report identified educational, clinical and managerial developments as essential components of effective health and social care systems (Hurst, Ford, Keen, Mottram, & Robinson, 2002). The evidence recognised staffing numbers and how the subsequent reduced skills mix can impact on the delivery of care, ultimately affecting resident outcomes. Consequently, the need for workforce planning systems within healthcare services was identified to encourage efficient and effective care (Skills for Care, 2014). Employment practices need to be reflective of the care home setting, which reinforces the importance of the focus of this study.

1.5.2   Social care workforce profile

The adult social care sector employs over one million workers (Moriarty, Manthorpe, Hussein & Cornes, 2008), however it remains one of the lowest paid employers in the UK labour market (Low Pay Commission, 2009). The care home workforce has been described as "an overlooked professional group, with no defined career pathway and no specific training" and development requirements identified (Spilsbury, Hanratty & McCaughan, 2015, p.6). The RCN Foundation (2015) project report detailed that very little was known about this workforce, with inquiries aiming to identify future research and development priorities (Spilsbury et al, 2015). A whole systems approach was recommended to promote partnership working, with a need to understand the contribution of registered nurses working in care homes. With many registered nurses working in this sector reporting feeling isolated, it was thus crucial that ongoing development, recruitment and retention issues were addressed for this workforce (Spilsbury, Hewitt, Stirk & Bowman, 2011).

1.5.3   Care Home manager role

The Care Home Manager's role is to "lead and manage an excellent, integrated, ethical and inclusive service which meets the needs of individuals, safeguards and promotes well-being and development of people" (SCW, 2017b, p.8). Management activities include staff recruitment, financial and payroll duties, performance management, daily managerial tasks, training and learning, and in many cases, additional clinical duties and responsibilities (SCW, 2017b).

Care home managers originate from clinical and non-clinical backgrounds, offering their providers various experiences, skills, qualifications, knowledge and abilities (SCW, 2017b). An understanding and appreciation of workforce management theories, tools and approaches can directly influence health and social care practices, with an efficient and effective application facilitating positive resident experiences and outcomes.

In 2016, 1,263 adult care home managers were registered and working across 1,100 adult care home establishments in Wales, with the majority in older adult care providers (CCW, 2016). Of these positions, 72% were managers, 5% were owner/managers and 3% were nurse managers (or matrons) (CCW, 2016), showing the wide variability in the role. 22% of all

managers were also registered with the Nursing and Midwifery Council (NMC), whilst only 3% occupied a nurse manager post (CCW, 2016). A small number of care homes (4%) had a vacant manager post.

An approved qualification is required to be a registered manager with CIW (formerly CSSIW). Currently managers hold the Level 5 Diploma in Leadership for Health and Social Care Services (24%), with predecessor managers holding the approved Registered Manager Award (36%) (CCW, 2016). During 2015-16, 51% of new managers who joined the Register were aged 46 years and over, reflecting an increase in an older workforce within this sector. The percentage of managers over 60 years had grown from previous years, whilst overall, the average age was 49 years (CCW, 2016). A larger female workforce of 81% women compared to 19% men was reported (CCW, 2016), this affirms Skills for Care (2013) findings that over 85% of care workers in care home (with nursing) are women. This suggests that, although continued female recruitment is essential, there is also a growing need to make this healthcare sector more appealing to men.

1.5.4   Expectation and experiences of care from staff, residents and relatives

Recognising the need to support the care home sector with its changing landscape and the shift of care provision away from NHS hospital care, this *next section* emphasises the changing needs of the care sector workforce, residents and their relatives.

Brook, Salmon, Knight and Seal (2015) suggest employers need to focus more on valuing their employees and combined with utilising their natural strengths, can build a positive culture of motivation and trust. Espinoza, Lopez-Saldana and Stonestreet (2009) reiterate the need for an environment where staff are fulfilled in their roles and they feel their contribution is appreciated. Training programmes promote a more satisfied, engaged and productive workforce (Schmidt, 2007). The current healthcare workforce is overstretched and working under immense pressures daily, which has resulted in higher staff sickness rates (Rauhala, et al, 2007), a reduction in the quality of care being provided (Needleman, Buerhaus, Mattke, Stewart & Zelevinsky, 2002), with these factors adding to the challenges of upskilling a healthcare workforce (Pringle, 2017).

A number of serious investigations in hospitals and care homes, reported in the Mid Staffordshire and Winterbourne Inquiries, have reflected the heightened criticism of Emergency Department services, along with delays in ambulance care and poor practices (Francis, 2013; CQC, 2011). The public voice is more noticeable within the last few years, with a greater recognition of deficiencies in care, with people frequently speaking out against poor practices and lack of service provision (King's Fund, 2012). Despite the Commission on Residential Care (2014) highlighting numerous case studies of good practice, care homes regrettably continue to be viewed as places of dread and a last resort (Quince, 2013). Consequently, with the added media negativity on this sector, this has helped to compound workforce challenges, with few staff taking up posts and many staff leaving (Shirey, McDaniel, Ebright, Fisher & Doebbeling, 2010).

1.6   Recruitment and retention of staff

Recruitment and retention of the workforce is viewed as a measure of job satisfaction (Hudgins 2015) and is considered an important concept within this study. Thus, current recruitment and retention issues are explored in *this next section*, with the impact of this situation on the provision of care presented, accompanied by the national responses which focused on addressing them.

Recruitment has been a growing concern with all healthcare organisations coming under increasing difficulties, with staff shortages clearly apparent (CQC, 2016). The age profile for nursing is shifting, with one in five registered nurses on the NMC register now over 50 years old (Buchan, 1999). Fewer nurses are joining the profession, many are leaving to take up non-nursing employment and a large number are facing retirement (Glasper, 2018). Consequently, the Home Affairs Committee acknowledged this ongoing shortage, by placing nursing on the Shortage Occupation List which temporarily places the profession on an exemption list according to Tier 2 Immigration Rules (RCN, 2015).

Data from Skills for Care suggested that in England, half of nursing staff work full time, staff turnover is high at 31%, and more than half the nursing staff have been employed in their current roles for fewer than three years (Spilsbury, et al, 2015). Whilst, Castle (2006a) reports a turnover of unregulated care staff in American nursing homes, ranging from 63-81%. Moreover, low staffing across all staff groups, has caused the cost of agency staff to rise, not

only increasing financial pressures on the care home providers, but worryingly impacting on the continuity, quality and safety of resident care within care homes (RCN, 2012). This study therefore focuses on recruitment and retention of care home staff including job satisfaction.

Healthcare organisations have for several years been looking at new ways of working to deploy their workforce (Dubois & Singh, 2009). Current Registered Nurse shortages at a national level, have seen an emphasis on recruitment and retention of staff, advancement and extension to existing roles coupled with a more flexible approach to managing the workforce (Health and Care Professions Council (HCPC), 2014).

1.6.1   National response to staffing crisis

Over the last few years, a range of healthcare settings have experienced escalating staffing shortages, with a substantial shortage of registered nurses (RCN, 2015). Increasing economic pressures combined with the changing political environment have added to the growing recruitment and retention pressures, particularly within the NHS (Baker et al, 2010). Staff retention is reported to be grounded within both personal and work-related factors (Dieleman & Harnmeijer, 2006). Many UK NHS organisations have consequently widened their recruitment campaigns, with strategies attempting to attract overseas nurses, whilst reinforcing their value within UK healthcare services (Gerrish & Griffith, 2004). Within many pre-registration nursing courses, the preparation for a role in the care home sector is still evolving, and as such, is highlighted as a concern for future care provision (Spilsbury et al, 2015). Arguably short-term solutions are frequently proposed (Bovbjerg, Ormond, & Pindus, 2009), whereas longer term sustainability of this workforce remains a significant concern (Brook et al, 2015).

The UK Government has responded to this impending nurse recruitment crisis, with solutions focusing on reducing and capping costs for nursing, medical, managerial and administrative staff (Baker et al, 2010), with suggested savings of approximately £400million a year for the NHS. The Nurse Staffing Levels (Wales) Act (2016) aims to promote consistent staffing levels, advising 1 registered nurse to every 7 patients in Welsh hospitals (Thomas, Thomas & Boyce 2015). However, what is not clear is how this will be implemented at a local level when nurse recruitment is low, and staff are difficult to find. This recommendation is not intended for the care home setting with its rising complexity of care needs, however, safe staffing levels for care

homes are currently being explored within a workstream of the All Wales Nurse Staffing Programme (1000 Lives, 2017).

There is evidence which reflects the use of national and local strategies, which are responding to current recruitment difficulties within this sector (Chenoweth, Jeon, Merlyn, & Brodaty, 2010). The WHO Report (2006) *Improving health worker performance: in search of promising practices,* suggested multi-level strategies must address these multi-faceted causes (Dieleman & Harnmeijer, 2006). Recommended interventions include for example, improving HR policy and planning, addressing working conditions, supporting professional development and enhancing "the living conditions of individual workers", all aimed at improving staff performance and the quality of healthcare (Dieleman & Harnmeijer, 2006, p.1). The uptake of these various approaches is not universal, with the wider influencing factors and constraints considered unclear. These challenges guided the development of this study towards further exploration of workforce practices, with the intention of realising workforce improvements.

1.6.2 Impact of staffing on quality of care

From an international perspective, safe staffing levels is a growing concern when delivering effective services, particularly with the increasingly complex care and current delays in hospitals discharges (Estabrooks et al, 2015). The registered nursing workforce has a direct bearing on the quality and safety of care delivered in an array of healthcare settings, reflected also within care homes (Stone, Dawson & Harahan, 2004).

A high turnover of staff in care homes impacts on the workforce skill mix, which reduces staff morale and impacts on resident outcomes (RCN, 2012). A strong relationship between registered nurse numbers and workload "left undone" or "missed care" on hospital wards has been reported (Ball, Murrells, Rafferty, Morrow, & Griffiths, 2013, p.1). Within the hospital setting, it is important to reflect that staffing is only one element of management systems (Kalisch, Tschannen, & Lee, 2011), while other important influences (i.e. type and frequency of nursing interventions and resident dependency) should not be neglected (Hurst et al, 2002). Significant consideration is needed as to the transferability of these staffing issues to the care home environment (Lacey, 2010).

Ball (2017) took the staffing and quality of care link further, by reporting an association between the number of registered nurses and mortality /adverse patient events within a hospital setting. Whilst Kane, Shamliyan Mueller, Duval and Wilt (2007) identified, not only was acute hospital patient care influenced by staffing levels, but it was affected by skill level, education, experience, organisation and leadership, which subsequently determined the nursing performance delivered. An Australian systematic review reported a link between quality nursing care and the decision-making abilities of nurses, studied across numerous diverse healthcare settings (Kitson et al, 2013). Clarke (2006) suggested contextual factors heightened the relationship between low nursing levels and poor-quality care in hospitals, whilst Estabrooks et al. (2015) links culture and organisational context to positive patient outcomes, within long term care establishments.

What is evident is that staff performances and their impact on patient care is complex, with no clear linear relationship established, as such strategies within both developed and developing countries, across a range of healthcare settings need to be clearly targeted at all levels of an organisation (Dieleman & Harnmeijer, 2006). Kitson et al. (2013) suggested a multitude of factors are influential, such as organisational infrastructure, skill-mix, workload and staffing levels, which highlights the need for further exploration. Consequently, the development of national and individual work-based strategies to promote new interventions is required, targeted at influencing their successful implementation, whilst recognising organisational contextual factors.

1.7   Job Satisfaction

The *final section* of the chapter explores job satisfaction, and leads onto measures of satisfaction, and dissatisfaction, with its resulting effect on the workforce. This proceeds onto, and supports the rationale, aims and objectives of the study.

Job satisfaction is the extent to which people like or dislike their jobs and is influenced by varying factors (Bakotić, 2016). For some people, work is central to their life and they enjoy it, whilst others dislike their job and only remained because they had to (Spector, 1997). Job satisfaction and dissatisfaction has been widely studied by researchers, with an ongoing consensus that our understanding, particularly within long term care establishments, remains limited (Squires et al, 2015). As an extensively examined variable within organisational

behaviour research more broadly (Judge, Thoresen, Bono, & Patton, 2001), it has been reported to enhance employee relationships and improve individual performances (Bhatnagar & Srivastava, 2012).

Studies have explored job satisfaction across many different organisational settings, such as educational and business establishments (Raziq & Maulabakhsh, 2015), with increasingly more studies undertaken within healthcare organisations (Gazioglu & Tansel, 2006). Squires et al. (2015) reinforced the importance of job satisfaction on both the individual and the organisation's performance, with the impact of dissatisfaction recognised on the quality of care delivered (Farman, Kousar, Hussain, Waqas & Amir Gilani, 2017) and staff sickness rates (Roelen et al, 2013). Whilst Gazioglu and Tansel (2006) reported that staff working in the education and healthcare sectors appeared to have less sense of achievement than other non-public sector workers. Spector (1997) offered a utilitarian perspective, advising that job satisfaction directly affects an organisation's functional ability, and reported that staff health and well-being were closely linked to a happy workforce, with its effect of boosting work productivity.

1.7.1 Measures of job satisfaction

Raziq and Maulabakhsh (2015) reported individuals have different views on different aspects of their job and their perspective varies across different workplace settings. As such, according to Rand's conceptual theory of emotion, job satisfaction has various understandings, such as satisfaction, dissatisfaction, value, emotion and appraisal (Judge, Weiss, Kammeyer-Mueller & Hulin, 2017). Whilst the Herzberg's theory of motivation, suggested four different characteristics linking work values and job satisfaction, which were reported as one's influence over their job, amount of pay, sense of achievement and respect from supervisors (Gazioglu & Tansel, 2006). A systematic review exploring job satisfaction in long-term care, identified a range of associated factors including co-workers, job security, personal opportunity, pay/benefits, sense of accomplishment, promotion, autonomy, emotional climate, professional status and helping others, to name but a few (Squires et al, 2015). While, greater engagement of this workforce could help to better understand and recognise their individual needs (Spilsbury et al, 2015).

1.7.2 Effects of dissatisfaction in the workplace

Job dissatisfaction reported to reduce nursing commitment, has been associated with staff turnover intentions and actual turnover (Chien & Yick, 2017), with manifestations of increased sickness, poor working practices, unhappiness and lack of motivation (Estabrooks et al, 2015). Stress and leadership issues perceived to exert negative influences also increased staff turnover (Coomber & Barriball 2007). They reported an individual's achieved level of education and pay, were also associated with job satisfaction, although this was not deemed to be consistent. Arguably, turnover intentions were mainly linked to the workplace environment (Coomber & Barriball 2007) rather than individual factors, suggesting that one isolated factor is never the only cause for staff leaving their job (Messmer, 2005).

New staff frequently required additional support and greater development of broader skills, although management commonly overlooked staff errors and concerns based on the burden to retain staff and the need to reduce leavers (RCN, 2012). Low morale has taken its toll on the workforce, with the impact of this being directly linked to the quality of care provided (RCN, 2012). With the challenge of improving quality of care an important issue in care homes, increasing job satisfaction and commitment in this workforce is imperative (Squires et al, 2015).

1.8 Rationale for the study

With UK healthcare demands rising, the growing need for care home provision is evident. The evidence in this chapter has highlighted current staffing challenges with rising workload demands, weighing heavily on job satisfaction, with a potential risk of staff leaving their employment (RCN, 2014), reinforcing the need to invest in this workforce (Imison et al, 2016).

Although the number of research studies undertaken in the care home setting is slowly increasing, the evidence base remains limited (Stow, 2016). Further inquiry into employment practices, particularly focusing on and enhancing job satisfaction is needed. The perspective of the various staff groups needs to be better reflected (Stow, 2016), thus stressing the importance on focusing on this evidence gap and exploring the care home workforce further. This need is also demonstrated in the scoping review by Bostrom, Slaughter, Chojecki and Estabrooks (2012) and *Facing the Facts, Shaping the Future* report (Public Health England et al, 2017). The context of this study offers the opportunity to understand reasons why staff stay or leave

their employment within care homes. This decision, subsequently steered the study towards better understanding the influences and impact of job satisfaction, reinforcing the importance of this research focus.

1.9   Study Aim and Objectives

The main aim of this study was to add to the evidence base to understand factors which influence job satisfaction within the care home setting.

1.9.1   Study objectives

The study objectives were completed in two phases:

Phase 1 - a scoping review of the literature. The findings from this review gave direction to the next stage of the study.

1. To explore management strategies, approaches and tools which assist care home workforce practices.
2. To explore which of these workforce practices work well within this setting

Phase 2 - the exploration of staff experiences and management practices, focusing on improving job satisfaction within the local care home workforce in four homes. This provided the basis for the development of an implementation plan to support care home managers.

1. To explore the views and attitudes of the care home workforce in relation to:

   a. job satisfaction / dissatisfaction,

   b. their knowledge of current strategies and approaches to promote job satisfaction,

   c. identification of whether these practices are being employed in the workplace, and,

   d. what staff believe the effect of these practices have on them

2. To consider factors between different care homes (i.e. size and type), in terms of management practices currently being used

3. To develop an implementation plan to assist care home managers to better understand staff experiences and help in the management of job satisfaction.

1.10   Summary of Chapter

This first chapter has provided the backdrop to the challenges which exist in the care home sector. The identification of recruitment and retention issues, accompanied by the climate of reduced staffing, has given direction to the next stage of the research process, that of the literature review. The focus being to explore current management practices, with an effort to identify current evidence gaps, crucially with an emphasis on supporting the care home workforce, with an intention to advance this contribution in the wider evidence base.

The thesis comprises six further Chapters:

- **Chapter 2** reports the methods and findings of the literature review process. Different types of literature reviews are considered, with an appreciation of the scoping review methodological framework used.
- **Chapter 3** describes the philosophical and methodological approaches chosen for this study, alongside an appreciation of the contextual environment.
- **Chapter 4** reports the case study approach, and explains the selection of the case, recruitment sampling, data collection and data analysis methods, together with ethical considerations.
- **Chapter 5** provides a comprehensive description of the four cases and the study participants, including case study characteristics which provide the contextual setting. Cross-case study findings are reported, with a short summary of the differences and similarities within each case, with the main report reflecting the evidence across all cases.
- **Chapter 6** presents a discussion of the findings.
- **Chapter 7** reports the conclusions, whilst the study methodology and processes are reflected upon. The contribution of the findings is outlined, and recommendations for practice, policy and research are made, including an implementation plan to assist care home managers.

CHAPTER TWO:
SCOPING REVIEW OF THE LITERATURE

2.1   Introduction

Chapter one positioned the current study within the care home context and demonstrated the value and need for further research to explore job satisfaction within this highly fragile and complex environment. Evidence presented showed how recruitment and retention issues pose an enormous challenge to numerous key stakeholders such as the NHS commissioners and providers of care, local authority, care home providers and the social care workforce. The impact on these challenges on the provision and delivery of high quality care is reflected in the experiences of the residents, and the concerns of their families.

In this chapter, a greater understanding of workforce practices within care homes was required to help establish and focus the subsequent research study. Consideration was given to different types of literature reviews and their suitability for the review question, and the rationale for the selected type is presented. The literature review is reported on and the findings presented. An appreciation of the methodological framework used for the scoping review is explained with clear justification for its selection, that of the Arksey and O'Malley Framework.

2.2   Methodological approach

A clear component of any research study is the familiarisation with the existing literature which underpins the subject area, whilst excluding unnecessary evidence (Grant & Booth, 2009). Mapping the evidence helps drive the direction of travel within healthcare research (Gagliardi & Alhabib, 2015) and is achieved using an incremental approach to the gathering of data (Rumrill, Fitzgerald & Merchant, 2010). Reviewing the literature enables the evidence to be collated, evaluated and presented, which is an essential component of research studies (Arksey & O'Malley, 2005). Collating all relevant evidence from a range of sources presents challenges to the researcher, whilst inconsistencies in their terminology and uses can often result in confusion (Cronin, Ryan & Coughlan, 2008).

2.2.1   Approaches to literature reviews

Synthesising the evidence base has led to a wide selection of review type approaches, with variations in processes, structures and methods distinguishing one type from another (Grant & Booth, 2009). Literature review strategies help focus the research question guiding the review type and its subsequent research methods (Gough, Thomas & Oliver, 2012). Kastner et al. (2012) suggested no single review fits all types of studies with some reviews having a closer fit to addressing different research questions, such as qualitative or quantitative in nature. Thus, the identification of the most appropriate review type and knowledge synthesis method to the research question can be complex (Kastner et al, 2012).

Some of the more traditional types of literature reviews conducted include systematic reviews, meta-analysis, rapid reviews, (traditional) literature reviews, narrative reviews, research synthesis or structured reviews (Arksey & O'Malley, 2005). In this study, consideration was given to several key review types, with the rationale and selection of the preferred approach detailed later in this chapter.

2.2.1.1 Narrative review

A narrative review brings together a range of studies to summarise what is known about a subject, with the ability to provide a comprehensive overview of the topic (Fitzgerald & Rumrill, 2005). Rumrill et al. (2010) suggested through reshaping what is known about existing evidence, it contributes new perspectives, including the generation of theory, often on complex or controversial topics. This subsequently results in the advancement of theories, which enhance and improve upon current professional practice whilst informing future research.

Through building upon previous research findings, current knowledge gaps can be seen (Fitzgerald & Rumrill, 2005). An inclusion strategy helps avoid duplication of the related published evidence and reinforces the completeness of the findings (Grant & Booth, 2009). Consequently, narrative reviews tend not to have specific research questions in mind, mostly incorporate large amounts of literature and can often lack clearly defined descriptions of the methods used (Ferrari, 2015).

2.2.1.2 Systematic review

A systematic review uses standardised systematic processes and methods, including searching of evidence, appraising and synthesising the research findings (Ferrari, 2015). The review methodology follows explicitly defined methods which are identified prior to the start of the process, with this transparency in reporting adding consistency and promoting replication (Grant & Booth, 2009). Statistical methods (meta-analysis) may or may not be used to analyse and summarise the results of the included studies (Higgins & Green, 2011).

Frequently, systematic reviews are considered more suited to a single study design and often appear less suitable when answering several knowledge synthesis questions (Gough et al, 2012). As such, systematic reviews commonly investigate the effects of healthcare interventions or clinical trials prevention, treatment and rehabilitation, supporting healthcare policies and practice such as NICE guidance. A strength of the systematic review, linked to its purpose, is its focus on the effectiveness of an intervention, although occasionally deemed not as effective at explaining why certain interventions work in one setting rather than another (Pawson, Greenhalgh, Harvey & Walshe, 2005).

Dixon-Woods, Agarwal, Jones, Young and Sutton (2005) argued systematic reviews have limitations in reviewing all relevant evidence, resulting in uncertain implications for decision makers, a potential limitation of this review type. Whilst, the generation of a clearly formulated research question renders this approach useful in responding to empirical research evidence from quantitative study designs, with the inclusion more recently of qualitative evidence (Gough et al, 2012).

2.2.1.3 Scoping review

The scoping review is a relatively new approach, which permits a large amount of literature to be searched on a broad topic (Halas et al, 2015). A lack of quality assessment processes allows for more rapid searching techniques, enabling a more in-depth overview of the subject area (Mays, Robert & Popay, 2001). Mays et al. (2001) recommend using scoping studies to "map rapidly the key concepts" underpinning a research area (p.194), especially if complex and not extensively reviewed previously (Anderson, Allen, Peckham & Goodwin, 2008).

The iterative nature of the review can alter the direction of the searches with its structured approach, whilst not being too focused, avoids the searching of specific study designs and certain literature review methods (Arksey & O'Malley, 2005). Kastner et al. (2012) echoed this, reinforcing the need to base the evidence on a selection of studies rather than a single type of study. Anderson et al. (2008) reinforced the value of scoping studies as a mechanism for enabling policy makers and commissioners to ask the right research questions, with Davis, Drey and Gould (2009) proposing policy development is often the incentive. With the ability to disseminate research findings or provide evidence of gaps in the literature (Peters et al, 2015a), this methodological approach is appreciated when influencing wider populations through clinical practice guidelines, policy briefs and decision-making tools (Straus, Tetroe & Graham, 2009).

The lack of rigidness in the scoping review's questioning offers an alternative to a systematic review when addressing broader research questions (Halas et al, 2015), although Beecroft, Rees and Booth (2006) reinforce the need for a focused research question. Arguably the lack of a defined systematic strategy permits several elements to be incorporated such as timeframe, country of study origin and research sources (Rumrill et al, 2010). Although DiCenso et al. (2010) described similarities between scoping and systematic review processes, with both reviews using rigorous and transparent methods. Critics have reported scoping as a widely used but poorly defined term, with a lack of clarity on matching the appropriate review design to the research question proposed (Kastner et al, 2012). The ability to address complex interventions within complex settings adds to the researcher's dilemma when selecting a methodological framework, thus for policy makers judging, interpreting and applying the evidence formulated subsequently poses difficulties due to its perceived reliability and trustworthiness.

2.2.2   Rationale for choosing the Scoping Review approach

The research questions being posed: what evidence is available about recruitment and retention strategies, approaches and tools to assist care home workforce practices lends itself to a scoping review.

Drawing on the above information, the scoping review methodology was considered most appropriate to help facilitate a greater understanding of workforce management issues in care homes (Kastner et al, 2012). Its ability to incorporate quantitative and qualitative studies was

an important factor during decision making and enabled different study designs to be included (Rumrill et al, 2010). An additional consideration was that selection criteria were identified after the reviewer had familiarised themselves with the literature (Gagliardi & Alhabib, 2015), with all these elements judged influential and important for this study.

2.3   Scoping Review method

Arksey and O'Malley (2005) devised the first methodological framework for conducting scoping studies, setting out a structured phased approach, supporting methodological rigor (Valaitis et al. & Strengthening Primary Health Care through Public Health and Primary Care Collaboration Team, 2012) and transparency (Mays et al, 2001). For this study, their recommended 6 stage approach was used:

- Stage 1   Identify the research question

- Stage 2   Identify relevant studies

- Stage 3   Study selection

- Stage 4   Chart the data

- Stage 5   Collate, summarise and report the results

- Stage 6   Consultation to inform and validate findings (Optional)

2.3.1   Stage 1: Identify the research question

An exploratory search of journals, web-searching and database browsing was undertaken, which focused on workforce management challenges within the care home sector. This permitted the broad topic area to be guided and narrowed, which helped to inform and identify the subsequent research topic (Hardwick, Anderson & Cooper, 2015).

Keywords were used in this exploratory search strategy which related to workforce management and theoretical models, its associated practices and processes, which included its application, resources and techniques currently used in best practice settings. The search briefly looked at workforce management issues and how they were aligned to various stakeholders, ranging from the business sector to several healthcare settings, although the emphasis was the care home setting.

In line with the guidance in the framework, four local stakeholder discussions were carried out to help shape the focus. These were undertaken on an informal basis and comprised of care home managers and care home leads (n=4). Although suggested by Arksey and O'Malley (2005), as an option for later in this process, it was considered that undertaking these discussions at this point added to the researcher's knowledge base, which helped guide the ensuing literature search. The main ideas to emerge from the discussions are detailed below.

Main Ideas
• Staff shortages
• Recruitment
• Retention
• Fees
• Training
• Workload & rotas
• Management & leadership
• Immigration
• Student placements
• Costs
• Health Board delays

Table 1: Stakeholder main ideas

The open-ended approach to the discussions helped to prioritise the key issues, and it was at this stage that a broad research question was generated, focusing on recruitment and retention of care home staff. A scoping review methodological protocol was developed which confirmed the direction and processes to be undertaken.

2.3.2   Stage 2: Identify relevant studies

The scoping review process reiterates the need to ensure breadth not necessarily depth within a broad search strategy (Arksey & O'Malley, 2005). Thus, the focus was to obtain a comprehensive evidence base appropriate to answering the research question. An iterative search process facilitated a finely tuned search strategy for the ever-expanding volume of academic and research literature (Daudt, van Mossel & Scott, 2013). Working definitions for the main concepts and clearly defined terminology avoided the selection of irrelevant studies and promoted clarity and consistency (Arksey & O'Malley, 2005).

The iterative nature of the scoping review meant the provisional research question (which focused on wider workforce management issues), was subsequently amended following the searches. The local stakeholder findings clearly reflected national care home concerns and certainly helped to shape the research question, which was not unanticipated (Arksey & O'Malley, 2005). This process established the chief focus of the research study prior to commencement of the main literature search.

2.3.2.1 Search strategy

The initial attention on workforce practices supporting recruitment and retention issues, (as a reflection of job satisfaction), was explored within the detailed literature review, responding to Phase 1 objectives, with the aim of helping to direct the next stage of the research process. Thus, consideration was given to selection of the databases, with those offering the highest rates of evidence were subsequently selected. Although the scoping review process did not require a quality appraisal stage, the researcher did appreciate the importance for high quality peer review journals to be searched, adding credibility to the research findings (Houghton, Casey, Shaw & Murphy, 2013).

A wide variety of databases were chosen for searching the evidence, broadening the scope of the evidence, see listed below. Access to the organisational databases (such as HMIC) promoted a more comprehensive search and optimised the capture of primary research studies (Arksey & O'Malley, 2005). Key international healthcare databases were also included, such as, NHS Evidence Health Information Resources, health and social care databases and business databases. Ehrlich-Jones, O'Dwyer and Stevens (2008) suggested the term 'evidence' encompassed a wide array of information from a variety of sources, which underpinned clinical decision-making. Whilst Conn et al. (2003) reported the value of searching for grey literature, comprising of health and governmental documents, which were not necessarily captured in commonly used databases. Hence, hand searching of reference lists, key journals and grey literature was also undertaken (Lacey, 2010). Search strategies can be found in Appendix 1.

The databases (n=9) searched were:

- CINAHL

- ASSIA

- MEDLine

- HMIC

- Cochrane Library

- OpenGrey

- SocialCareOnline

- EMERALD Management

- ScienceDirect

The assistance of an information scientist helped to refine the search strategy, which helped to avoid gaps in the literature, whilst promoting replication and consistency of the process. Regular supervisory team discussions enabled reflexive practice to take place, whilst ensuring quality of the searches, and served to maintain clarity, consistency and appropriateness of search findings, and guiding the iterative nature of the scoping review.

The search strategy format included Boolean terms, keywords and subject headings, which aided the ease of searching and gathering of evidence. Search limits were applied to all databases, where permitted; this decision was made due to practical reasons of time and financial constraints. A key national document, The Care Standards Act (2000), which sets out statutory regulations, minimum standards and guidance for care homes, was chosen as a suitable start date for identification of current care home literature (WAG, 2011b).

Recommended by the Joanna Briggs Institute, the elements "Population, Concept and Context" were used (Peters et al, 2015b, p.7). This aided the formulation of the research question for Phase 1 of the study, and helped to identify key search terms, which facilitated the search strategy (seen in Appendix 1). Such as the terms 'recruitment and retention' which were used as a measure for job satisfaction in this workforce. This search strategy was permitted in six of the nine databases selected, however it required minor refinements depending on the database used. For three databases (OpenGrey, ScienceDirect and Emerald Management) a Boolean search was used (Appendix 1). Search terms and headings were comprehensive which promoted precision selection of relevant articles (Mays, Pope & Popay, 2005).

2.3.2.2 Inclusion criteria

Preliminary inclusion criteria were established, as at this stage, it was unclear what study types would be identified. The inclusion criteria were determined post hoc and following increased familiarity of the literature, in line with Arksey and O'Malley's suggestions. Detailed searching enabled a greater understanding of the variable topics and study types, thus further refinement enabled a more detailed inclusion criterion to be established (Valaitis et al, 2012). See below:

Inclusion criteria	**Exclusion criteria**
Care homes (with nursing)	Studies which focused on the following:
Search dates from 2000-2015	Staffing and quality -Not linked to recruitment and retention
English language articles only	Staffing and outcomes
National and international evidence	Resident views on staffing
Empirical primary study or policy document	Staffing and research projects / patient linked
	Staffing skill mix – based on shift numbers on a shift, not recruitment and retention
	Studies not in care homes with nursing
	Staffing and the law, litigation and patient abuse

Table 2: Inclusion and exclusion criteria

2.3.3   Stage 3: Study selection

A comprehensive list of articles for each database was obtained, with study selection achieving the final articles for inclusion in the scoping review. Elimination of the articles is detailed below and occurred when the studies did not address the research question, did not meet the inclusion / exclusion criterion or were duplicated articles (Valaitis et al, 2012).

2.3.3.1 Test of relevance

Using a step by step approach, assessment of the studies for their potential suitability for inclusion within the scoping review was undertaken (Mays et al, 2005). Studies which were deemed not to meet the inclusion criterion were eliminated. Following this, studies were eliminated at several different stages, firstly after reviewing the title only, secondly, after

reading the abstract, and lastly, following assessment of the full paper. Two researchers completed this stage, promoting greater accuracy. Articles with subject topics deemed not relevant to the research question were excluded (detailed in Appendix 2).

Reporting of the literature flow (see Figure 1 below) was achieved using the PRISMA flowchart (PRISMA, 2016). The PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) flow diagram offered a transparent and complete reporting of the research flow. Thirty-two studies were considered to meet the test of relevance for inclusion in the final review, with those articles given a unique identifier. Appendix 3 provides full details.

Challenges obtaining papers and subsequently determining suitability were encountered, although supervision and following discussion, clarification was achieved. A 4-month deadline for completion of this stage was anticipated, whilst even with some minor delays, this process was completed within the timescale.

Figure 1: Literature flowchart

CINAHL (n=728)	ASSIA (n=200)	Social Care Online (n=353)
Medline (n=1015)	HMIC (n=132)	Science Direct (n=44)
Cochrane (n=459)	OpenGrey (n=54)	EMERALD (n=3)

Total hits
n=2988

Excluded n = 686
e.g. duplications, not within date limits)

Title screening
n=2302

Excluded n = 1872
e.g. not empirical study or policy/ resident care/symptom management/ quality of care improvements, outcomes, interventions /regulations & standards/ surveys & trials

Abstract screening n= 430

Excluded n = 328
e.g. not empirical study or policy/not nursing homes, unrelated clinical issues, staffing ratios/levels, outcomes &quality of care, informal caregivers, author reply&/ commentaries, unrelated to recruitment /measurements/causes of leaving/staff turnover & quality of care/ organisational & environmental factors on turnover/ student placements/ absenteeism /agency staffing /migrant workers/ updates on homes in crisis

Full detailed review n=102

Excluded n = 70
e.g. not empirical study or policy/ unpublished thesis/ causes of leaving only/ duplicated author/ not in English/ protocol only/ unable to obtain article or author response.

Final included articles **n=32**

2.3.4   Stage 4: Charting the data

Adhering to the Framework, Stage 4 charting the data, was accomplished. A data extraction form was developed (Appendix 5), based on Arksey and O'Malley's recommended dataset characteristics (see Table 3 below). Data was extrapolated from the studies one by one, which promoted accuracy and ensured a uniformed approach was achieved (Arksey and O'Malley, 2005). General information about each study, alongside specific datasets was recorded.

Data Characteristics
- Title of study and author   - Year of publication   - Aims of the study   - Country where the study was conducted   - Type of study design and methods   - Characteristics of study populations – including size, ownership and management   - Types of tools, resources and approaches used and study duration   - Outcome impacts or effects   - Main findings   - Features and issues – including ongoing reflections to build up a commentary

Table 3: Data extraction characteristics

The charting process involved making key decisions about the data. Pawson (2002) described this, as similar to the descriptive-analytical methods utilised within a narrative review, referring to synthesising and interpreting qualitative data akin to data extraction (Arksey & O'Malley, 2005). This stage was aligned to those of Ritchie and Spencer (1994) which recommended sifting, charting and sorting the data according to key themes and issues.

A vast amount of general information in relation to recruitment and retention was captured, broadening the understanding of this topic area. Completion was time consuming due to new challenges faced in terms of understanding the processes, however the supervisory team helped guide this.

2.3.5   Stage 5: Collate, summarise and reporting of the results

Following data extraction, a descriptive summary for each article was presented, which provided an impression of the dominant areas of research, whilst helping to identify significant gaps in the data (Arksey & O'Malley, 2005). By applying a consistent approach to this analysis stage, this enabled comparisons across interventions to be made, whilst providing a comprehensive and thorough review of the available literature.

There was a clear need to present an overview of the evidence, which was achieved using a tabular format, which helped to identify the various strategies, approaches and resources from the data. This first step provided an insight into a large array of multi-levelled strategies and approaches, identified initially for each individual article. Next, these strategies, approaches and resources were grouped together based on their similar ideas and subject matter, which from this process generated a number of themes. A total of nine themes were identified (see Table 4 below), with full details of the strategies per theme identified in Appendix 7.

Final Themes
• Improving job satisfaction
• The care industry
• Environmental
• Education, training and development
• Partnership working and engagement
• Financial features
• Staff roles and care practices
• Workforce and labour market
• Recruitment and employment practices

Table 4: Final 9 themes

Arksey & Malley (2005) suggested the quality and robustness of evidence could not always be determined, hence, in line with the approach, quality appraisal of the included studies was not required, and therefore not undertaken.

Reporting of the study findings provided comprehensive information on the study demographics and characteristics of the populations studied. Reporting of the themes, and the

subsequent discussion, introduces a range of recruitment and retention practices assisting care homes (Appendix 7).

2.3.6   Stage Six: Consultation

Although described as optional, this stage helped to inform and validate the review findings, with the stakeholder findings adding expert knowledge and providing an additional dimension to the scoping review process (Arksey & O'Malley, 2005). Informal discussions were undertaken at key stages throughout the research process, in line with the Framework, which suggested including stakeholders such as statutory voluntary bodies, managers and practitioners, and key informant carers (Arksey & O'Malley, 2005). They recommended the findings be considered within the broader context and could aid practical implications for future research, policy and practice.

2.4   Scoping Review findings

This *next section* reports the findings from the scoping review, and is presented using the following headings:

- Description of the evidence base

- Reporting of the themes

- Discussion on the themes and evidence provided

2.4.1   Description of evidence base

This *first section* offers a comprehensive analysis of study characteristics, including the study locations and population participants. This provided an insight into the demographics and characteristics of the populations studied which was considered important when determining the transferability of the evidence presented. The scoping review comprised 32 papers (see Appendix 3 for all included studies). The demographic data which was extracted, highlighted the models and theories which underpinned the individual research studies.

2.4.1.1 Geographical settings

For the selected papers, geographical settings varied from single countries studied (US, UK, Korea, Taiwan, Canada and Japan) to an international based study. In total, selected papers reported studies from 9 different countries, (Table 5 below), and 1 study reported on an international systematic review. Of the 32 selected papers, the majority of studies (20 in total) were carried out in the US (62.5%) and 7 within the UK (21.9%). The 7 UK studies included 4 studies which reported on UK wide data, 1 study reporting English data, one reporting data from a Welsh context, and one reporting data from a Scottish context.

Most geographical settings attributed within the studies were from the US. This was primarily due to the availability of National level datasets such as the 2004 OSCAR dataset (Online Survey Certification and Reporting), 2004 Area Resource File (data on population characteristics), 2004 National Nursing Assistant Survey and the 2005 National Nursing Home Turnover Study. These datasets provided many studies, with the ability to perform secondary analysis alongside individual primary research projects.

Country in the study	Number of papers (n=32)
• US	• 20 (62.5%)
• UK	• 7 (21.9%)
• Canada	• 1
• Worldwide	• 1
• Japan	• 1
• Korea	• 1
• Taiwan	• 1

Table 5: Overview of countries

2.4.1.2 Study approach

The evidence base represented a significant diversity of study approaches and methods, with 28 empirical studies (87.5%) drawn from primary research studies and studies using secondary research datasets. Table 6 below details the study types and approaches represented.

2.4.1.3 Settings

All included evidence collected within the review was generated from research on care homes (with nursing). A few papers (n=5) also incorporated long term care establishments and residential care within their participating study population. The number of care homes reported in each study, ranged from 1 or 2, up to approximately 600 care homes within a national secondary research study.

Of the primary research studies (n=17) a distinction was made between profit and non-profit organisations in several papers (profit n=2 / non-profit n=2). However, many papers (n=13) did not provide this data and frequently there was no distinction made in the type of home being studied. The nature of the care home providers included in the primary studies was diverse, with large organisations (n=4), small individual companies (n=1) and a mixture of both types (n=13). Of the studies using secondary data analysis (n=11) data were collected from both large and small companies which included both for profit and not for profit care homes.

The maximum capacity of the care home was determined largely by the size of the premises available and dictated by the Care regulators, when owners set up their initial establishments. The reporting of the overall capacity and size of care homes in the studies varied widely.

Although quality appraisal of the included studies was not undertaken, an assessment of the quality of the included evidence base was performed. The application of "technical knowledge and individual judgement" helped to assess the strength of included studies within the evidence base (Department for International Development, 2014, p.2). The evidence base was diverse with a range of study types, with empirical studies taking up the largest proportion, while qualitative studies, quantitative studies and briefing papers were also included. Studies which performed primary data analysis provided the largest proportion of the evidence, with secondary data analysis studies accounting for just over a third of the evidence base. The strength of the evidence appeared comparable to other scoping reviews, supporting similar study designs and methodologies (Pham, 2014). An evidence table detailing full study details is presented in Appendix 4.

Types of studies	Empirical studies		Health & Social Care Reports
Number of articles Total =32	Total 28 (87.5%)		Total 4 (12.5%)
Type of research	Primary data 17 (60.7%)	Secondary data 11 (39.3%)	Briefing report
Countries of studies	USA x10 UK x3 Korea x1 Taiwan x1 Canada x1 Japan x1	USA x10 International x1	UK x4
Workforce	All staff x7 Nursing teams x2 Care worker only x6 Registered nurse only x1 Administrator x1	All staff x1 Nursing teams x2 Care worker only x7 Registered nurse only x1	Social care workforce x4

Table 6: Summary of study types

2.4.1.4 Models, theories and programmes identified within the studies

The *next section* explores the underlying research models and theories from the evidence which formed the basis of the selected studies' research proposals and projects. For some studies, this formed the basis for their hypotheses and theoretical developments, whilst other studies drew on previously known evidence for their research approach.

The evidence base identified several different methods which underlay their research approaches, which varied quite widely. Some studies used different evidence sources which directed their research study towards the chosen field of investigation. Specific theories and models were reported on in several studies which underpinned their research investigation. A summary of these are reported below:

Conceptual Models	Theories
• Job satisfaction & intent to leave model • Turnover & organisational characteristics • Resident centred job satisfaction – predictor of turnover intent model • Conceptual model of facility & profession turnover • Hypothetical model of high performance work practices • Conceptual model for predicting turnover - effects of leadership, individual characteristics & turnover opportunities on turnover • Dual driver model– individual factors can distinguish reasons why staff stay or leave • Model perception of staff job characteristics & work environment-on staff turnover • Organisational & empirical evidence that supportive workplace promotes satisfaction • Conceptual model of staff turnover and attitudes & benefits	• Management theory and research • Peer mentoring • Leadership and learning theories. • Theory & empirical research on staff turnover • Theory – self managed work teams • To evaluate the Herzberg 2 factor theory of motivation -for retention • Theory & model predicting extrinsic factors – based on social psychology

Table 7: Summary of theories and models

Theories, models and frameworks which underpin many research studies, help to guide the "process of translating research into practice" (Nilsen, 2015, p.1). The conceptual models underpinning many of the above studies were frequently formulated from known literature findings. They were based on, for instance, recruitment and retention (one example helped the employers manage their current workforce), determinants and modelling of predicting turnover (such as predicting extrinsic factors based on social psychology), review of current workforce initiatives (an example was a peer mentoring programme) and characteristics influencing job satisfaction (such as the effects of leadership and individual characteristics on turnover opportunities).

One example of the conceptual model which linked job satisfaction and job characteristics to staff turnover is shown below in Figure 2. This model demonstrates the organisational characteristics associated with staff turnover in registered and unregulated nursing staff (Castle & Engberg, 2006).
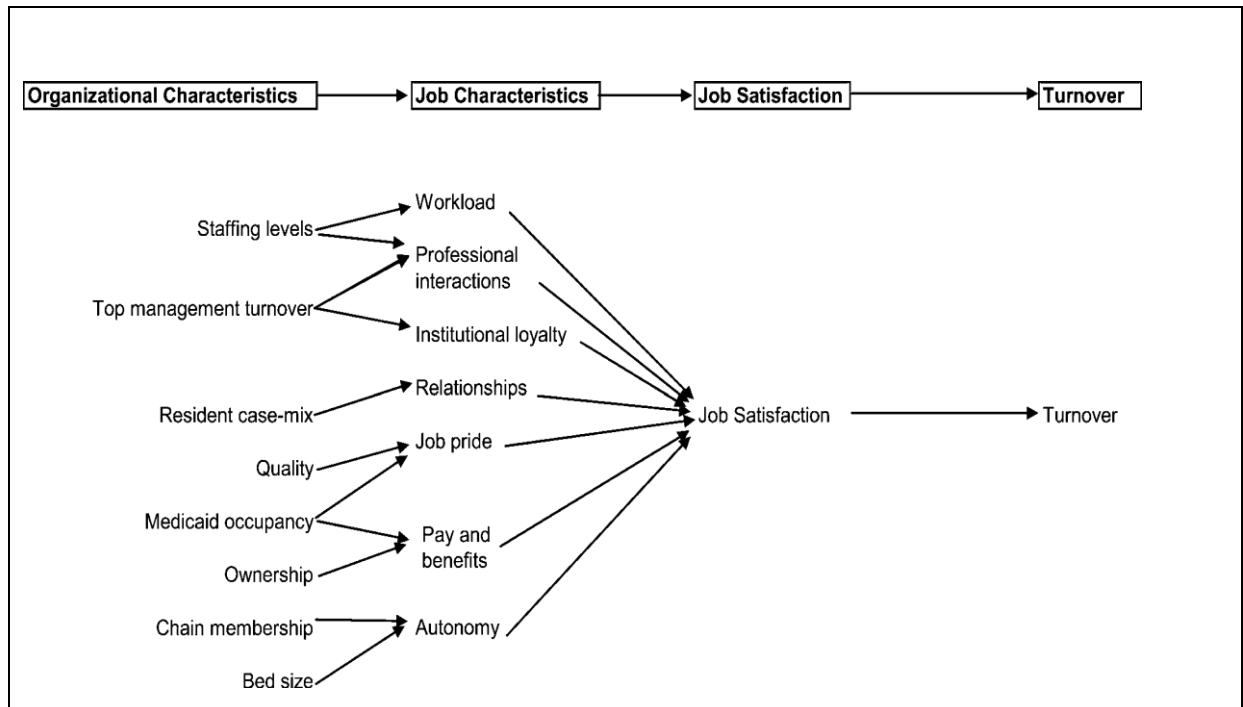
**Figure 2: Conceptual model showing organisational characteristics and staff turnover
(Castle & Engberg, 2006, p.63)**

Another example of a conceptual model (below in Figure 3) was developed from a theoretical model predicting the effects of the individual, the organisation and the environment on staff turnover (Donoghue & Castle, 2009).
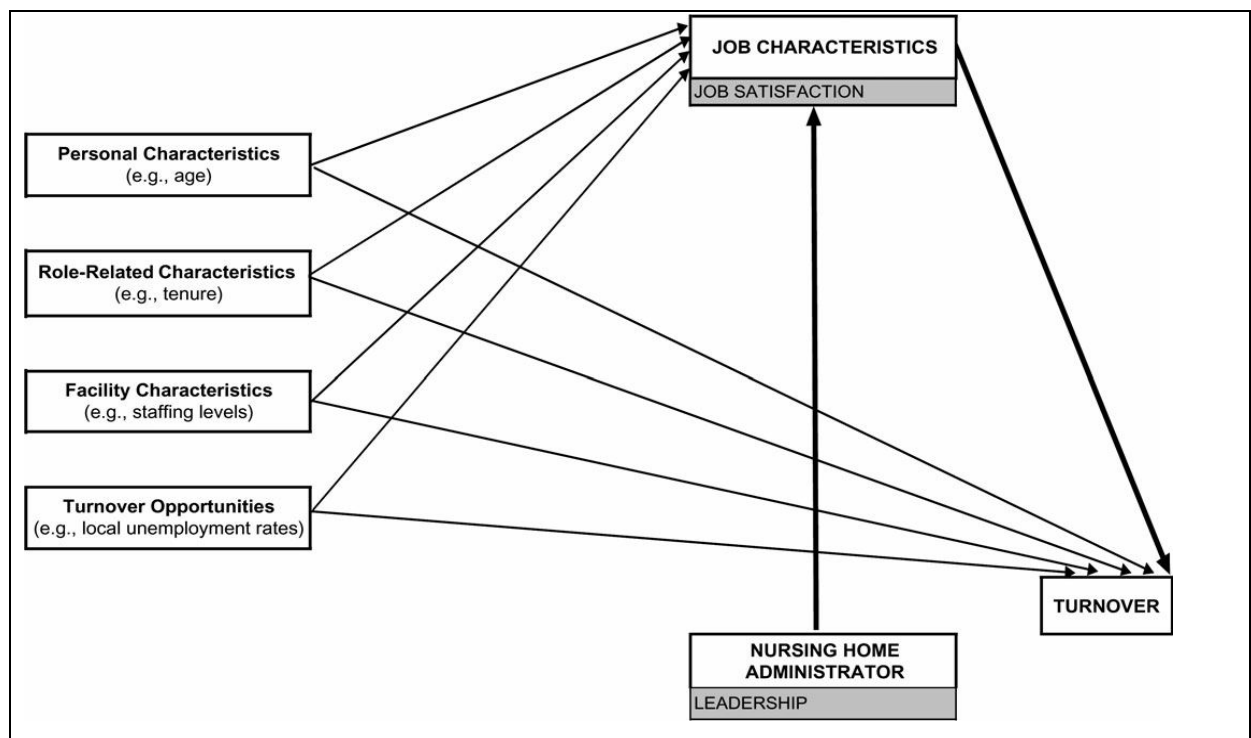
Figure 3: Conceptual model showing the effects of nursing homes leadership, individuals characteristics, facility characteristics and turnover opportunities on nursing home staff turnover (Donoghue & Castle, 2009, p.186)

An example of specific theories underpinning some of the research approaches included management theory and research, social psychology, motivation, leadership and learning theories. The primary and secondary studies varied greatly in their approaches and background to their research studies.

One study which provided a model to support staff was underpinned by current organisational and empirical evidence and the social exchange theory (Riggs & Rantz, 2001). This model reported on supportive workplaces which promoted increased job satisfaction, increased staff commitment for the organisation, which resulted in an improved retention of workers, see Figure 4 below.
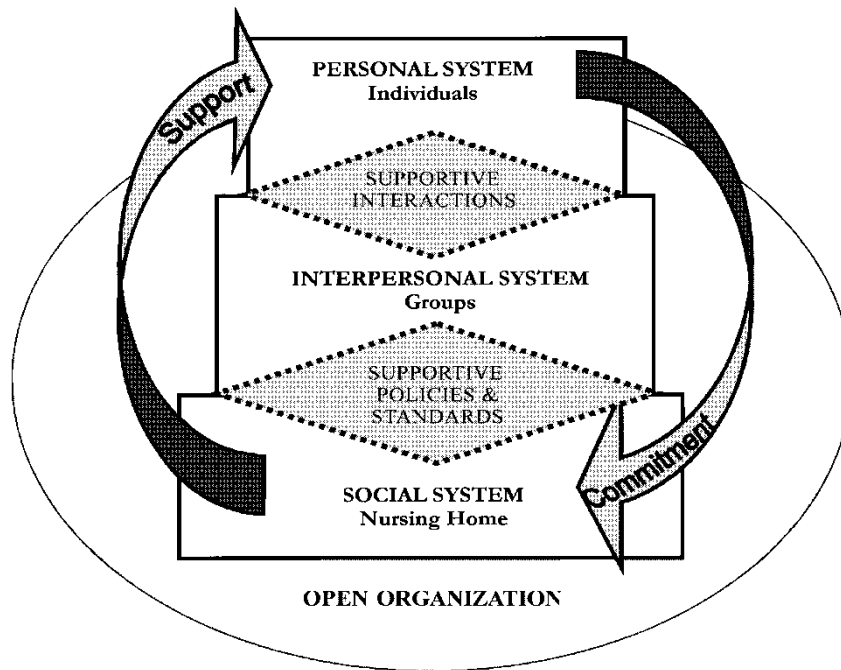
Figure 4: Model of staff support on care homes (Riggs & Rantz, 2001, p.50)

Several of the studies focused on the reasons and determinants for staff leaving or staying in an employment environment, along with what influenced them to leave the nursing profession. Generally, these approaches focused on retention factors within the organisation rather than profession itself (n=2). It was noted that many strategies and approaches were extrapolated from the data to address the ongoing recruitment and retention issues and were not always the chief focus of the study itself.

A few studies intended to strengthen existing knowledge on care homes in terms of safer recruitment practices (Care Commission, 2008), alongside a national systematic review which provided a comprehensive overview of international recruitment and retention strategies (Chenoweth et al, 2010), whilst another undertook previous desk work which informed their future methodology (Paget & Wood, 2014). The studies frequently sought to test several programmes within the care home sector, which included a new preceptor programme (Aaron, 2011), a mentorship programme (Care England, 2015) and peer support programmes (Hegeman, Hoskinson, Munro, Maiden & Pillemer, 2007), along with exploring the effects of high-performance work practices (Ha, Man Kim, Hwang, & Lee, 2014).

The selected studies reported on an array of academic literature with an assortment of research findings, which regularly directed the subsequent research studies, and formed part of their discussions. A summary of topics is detailed below.

Topics reported on within the studies
• Safe recruitment practices • Staff satisfaction – intention to leave • Continuous improvements • Literature to help employers manage current workforce • Previous influences on recruitment and retention • Staff benefits to enhance staff satisfaction • Strengthen policies through previous work force initiatives

Table 8: Overview of study topics

Several studies used existing literature to categorise their research question / proposal, for example helping employers manage their current workforce (Skills for Care, 2011) or data from previous study findings, such as staff satisfaction and their intention to leave the workplace (Decker, Harris-Kojetin & Bercovitz, 2009). For example, Figure 5 demonstrates a model based on previous literature which hypothesised that staff satisfaction along with the influence of staff commitment (intrinsically and extrinsically) would negatively impact on staff turnover (Karsh, Booske & Sainfort, 2007).
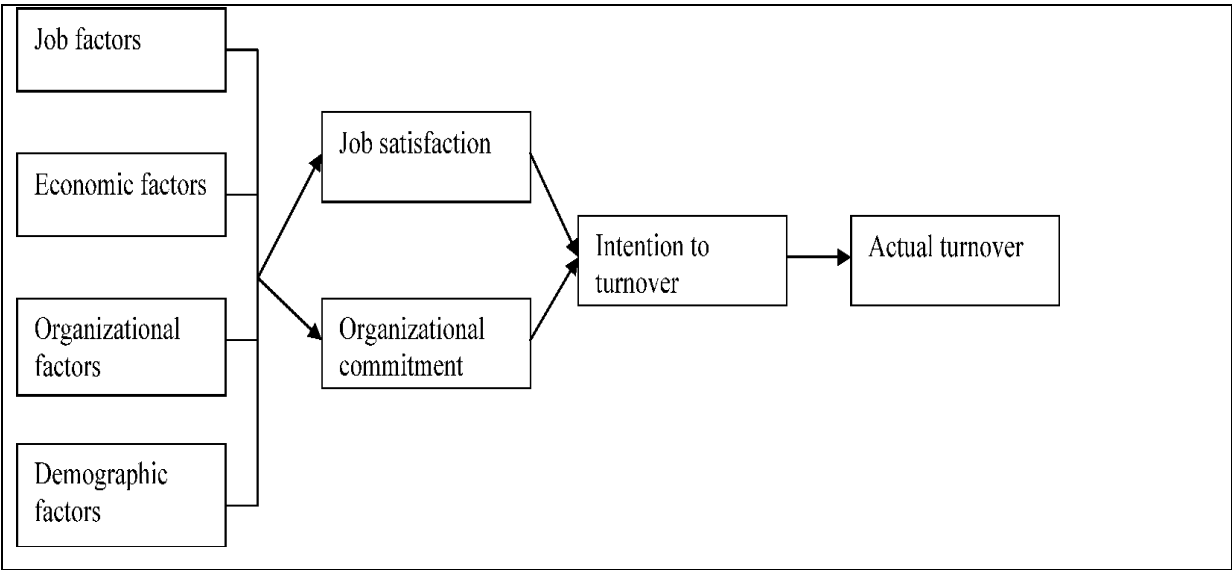
Figure 5: General model of nursing staff turnover based on job characteristics (Karsh et al, 2007, p.1261)

2.4.1.5 Nature of the workforce

The care homes employed a mixture of staff groups, whilst the studies explored various staffing issues from the perspectives of those staff.

There was a disparity of characteristics of staff, their roles and responsibilities across the care homes, which was related to the differing types of posts offered within an organisation. The opportunity for role development within individual care homes was also wide-ranging, which was reflected in the range and scope of roles within this sector and largely appeared to be linked to the size, type and management structure within the individual care home itself.

The selection of the workforce participants studied was determined by the proposed research question. For example, several studies specifically explored a certain staff group and hence the study focused on that group (such as peer support in registered nurses), whilst other studies asked specific questions in relation to the organisation and therefore included all staff groups within their participants (n=8).

Most of the studies (n=19) focused on the nursing workforce, which included registered nurses, unregulated staff / nursing assistants, or the entire nursing teams. This was unsurprising as it reflected the largest workforce within these establishments and it was this group of workers who were directly responsible for the care giving.

Nursing assistants were the largest workforce group across the selected studies (n=13) with a further 8 studies incorporating nursing assistants in the total care staff workforce (21 in total). The titles and names for the unregulated nursing workforce varied both within and across countries being studied, for example, nursing assistants, care assistants, certified nursing assistants, direct care workers, and nursing aides (see glossary). The homogeneity in roles and responsibilities across this workforce was not always clear. However, in general, this workforce was described as unregulated nursing care workers.

Only two studies selected focused on the registered nursing workforce and this was in relation to preceptorship / peer support within the organisation. The titles for registered nurses varied and they were reported as registered nurses, licensed practical nurses, charge nurses and

licensed long-term conditions nurses, however it was clear these were all registered nurses (see glossary).

Four Health and Social Care Reports included in the review focused on the social care workforce within the care home sector, which provided suggestions and recommendations for improving recruitment practices.

Eight studies included in the review investigated the organisation itself and included the entire workforce. This encompassed all workforce structures, such as directors, administrators, managers and care staff. One study focused solely on the nursing home administrators.

2.4.1.6 Focus of the selected papers

All papers reported the purpose and findings of their studies in relation to either or both recruitment, retention, and /or intention to leave (the post/setting) as outcomes for their research. The purpose and findings of most studies investigated factors affecting the recruitment of staff, whereas retaining staff was covered in a much smaller proportion of studies.

Several papers reported a desire for a national approach to supporting and managing care homes, proposed by a countrywide focus on the long-term care industry (DH, 2006). Most studies explored individual strategies and approaches to supporting the organisation to manage their workforce.

A small number of studies (n=10) made a clear distinction between the approaches required for either recruitment or retention of staff, whilst the majority incorporated their strategies in more broadly and discussed their findings in terms of both new staff recruitment, staff leaving and staff staying in their roles. One study, for example, termed staff as 'stayers' or 'leavers' and discussed these in terms of retaining staff (Rosen, Stiehl, Mittal & Leana, 2011). Several studies (n=8) included 'intention to leave' as a predictor of staff leaving an employment, whilst two studies compared leaving the organisation itself rather than the wider nursing profession (Nakanishi & Imai, 2012; Rosen et al, 2011). These varied and different approaches were all worthy of discussion when supporting recruitment and retention strategies.

A selection of papers perceived recruitment and retention as requiring separate approaches to supporting the workforce, whilst other studies suggested similar and interlinking campaigns. Arguably, similarities exist with the themes overlapping, such that if sufficient staff were not recruited then ensuing shortages would have a direct effect on retention.

2.4.1.7 The process of identifying the themes

During the data extraction stage of the review, it was established that most papers reported on an array of themes and broad influences which were deemed to impact on staff recruitment and retention. Most studies conveyed these messages in the study background which suggested a precursor for further investigation forming the basis of the authors' underlying theories and hypothesis, or they presented their findings in their own research project's results section.

The scoping review evidence base highlighted a large volume of different strategies, approaches and tools used within different healthcare settings, which addressed the potential recruitment and retention of staff.

2.4.1.8 The process of grouping the individual strategies, approaches and tools

It was apparent that the diversity of the reported findings was largely due to the assortment of multi-factorial approaches employed across the papers. The individual strategies and approaches were grouped together based on several commonalities, which included the researcher's underlying knowledge of issues related to the care home workforce. Some strategies and approaches were not discrete to one themed category, with many of the approaches clearly suited to several of the themed headings.

The themes evolved through this process, changing as the evidence was presented until a small number of clearly defined themes (n=9), representing individual strategies and approaches (Appendix 7). Within each of the themes, the individual strategies, approaches and tools were further grouped together, which aided the following discussion process and helped to facilitate the reporting of the evidence (see discussion section later in this chapter).

2.5   Reporting of the themes

This *next section* reports the findings from the scoping review.

2.5.1   The grouping of the final themes

Through thematic analysis nine separate themed categories were generated which supported the care home sector and assisted the recruitment and retention issues, with the final themes presented earlier, page 35. Essentially, the themes were presented in an order, which broadly reflected the importance and effectiveness of the reviewed evidence.

2.5.2   Development of framework

A job satisfaction framework was developed, which incorporated the nine themes generated from the scoping review findings, see Figure 6 below. The framework illustrates the interlinking of each individual themes, whilst similarly highlighting job satisfaction as a key influential component across all of them.

Figure 6: Job Satisfaction Framework
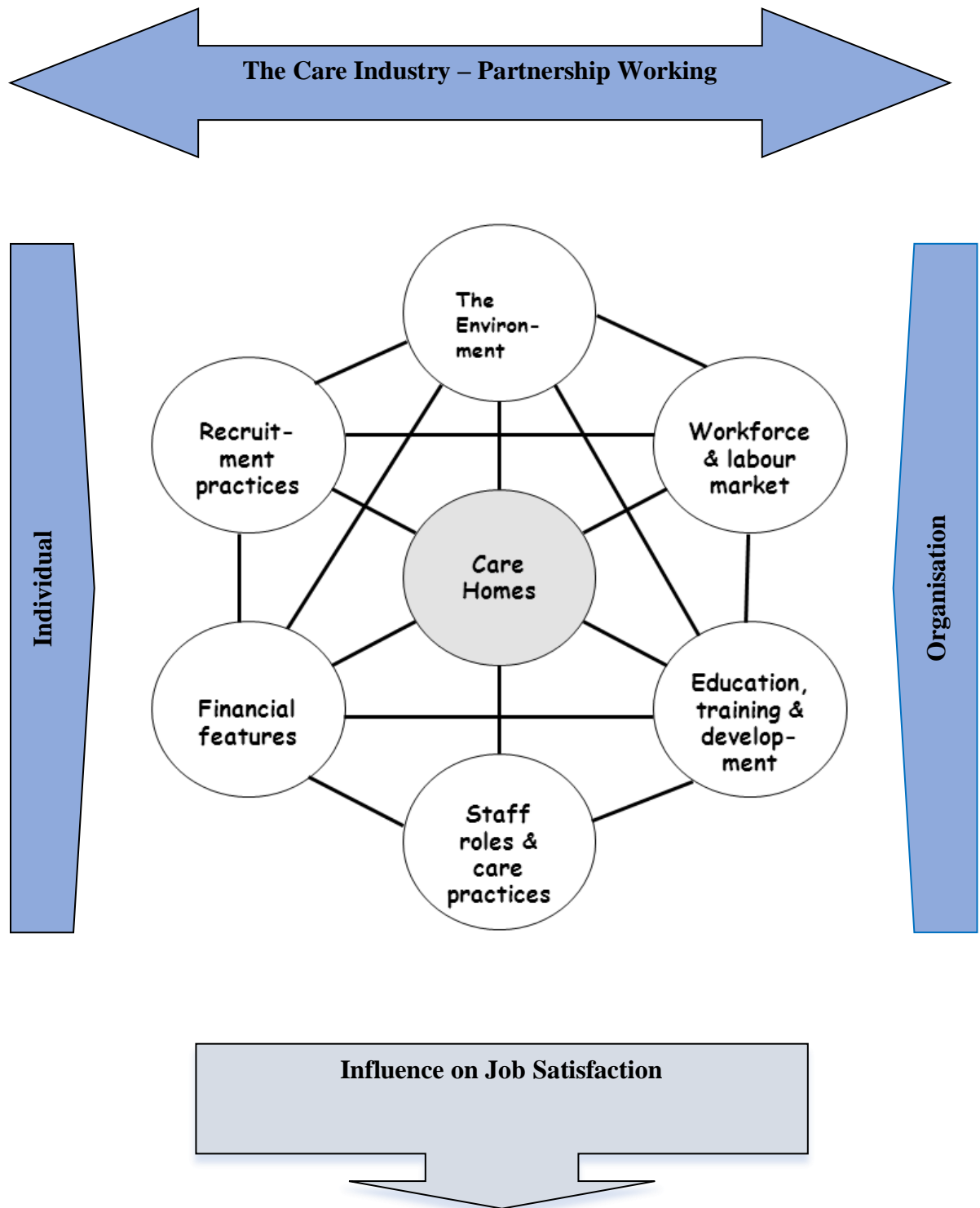
2.6   Discussion

The *following section* reports the themes uncovered earlier in the review (see main themes in Table 4, page 35), which informed the areas of management and workforce practices in care homes. The reporting of these themes contributed to a critical discussion about the evidence base which brought out various strategies and approaches. Of the 9 themed categories generated from the evidence, each theme is reported separately, which enabled the principal factors to be highlighted. Although reported separately, the evidence was not exclusive but was found to overlap across several themes.

2.6.1   Improving job satisfaction

Theme 1 relates to job satisfaction and the impact of both positive and negative effects on the staff's decision to either stay within their current employment or to leave the organisation. This evidence included a selection of personal, professional and work practices, which all impacted on job satisfaction. These issues are discussed in the *next section.*

2.6.1.1 Factors that influence job satisfaction

A number and range of intrinsic and extrinsic factors were reported to be associated with job satisfaction. These issues were found to impact on staff work and roles, which in many cases, determined whether they stayed in their current post (Hunt et al, 2012; Kemper et al, 2008a). Hunt et al. (2012) classified the issues relating to staff satisfaction into 10 categories - the residents themselves, co-workers, job characteristics, residents' families, work environment, learning and gaining experiences, supervisors, management, references and pay. Examples of pay related satisfaction were linked to additional pay rewards, paid holidays, pay recognition programmes, conference reimbursements, attendance awards, tuition reimbursement, and career development (Hunt et al, 2012).

Intrinsic factors of clear personal perceptions relating to feeling valued and appreciated, being listened to and treated with respect, these all contributed to increasing intrinsic job satisfaction (Ha et al, 2014; Kemper et al, 2008a). Stress associated with an unstable workforce resulted in low levels of satisfaction (Ha et al, 2014). Rubery et al. (2011) reported that the employee's ability to speak up was an important factor, with a lack of a staff voice strongly linked to reduced job satisfaction. Staff personal concerns impacted on how staff viewed their current

employment situation (Stearns & D'Arcy, 2008) with a lack of empowerment, work autonomy and feelings of emotional exhaustion were all associated with low job satisfaction levels (Ha et al, 2014; Karsh et al, 2005).

The development of resident relationships and the introduction of consistent assignment were suggested to influence positive working relationships with residents by increasing feelings of being valued (Choi & Johantgen, 2012; Kemper et al, 2008a). A sense of accomplishment, recognition and appreciation increased carer job satisfaction was found from working with, and helping the residents (Chou, 2012). Staff reported real affection between themselves and the residents they cared for, and for one study, 85% of staff stated the only reason they stayed in their job was due to residents' relationships (Chou, 2012). The author reported, strengthening this strong relationship link could help reduce the job elements which clearly caused dissatisfaction.

Several extrinsic factors were also associated with increased staff satisfaction and the extent to whether staff enjoyed their job (Chenoweth et al, 2010). Whilst factors such as a high workload in conjunction with low staffing levels were found to negatively impact on job satisfaction in the workplace (Chenoweth et al, 2010).

2.6.1.2 Factors causing job dissatisfaction

Similar to influences on satisfaction levels within a work role, it was reported that a number of intrinsic and extrinsic factors caused dissatisfaction with staff employment (Brannon, Barry, Kemper, Schreiner & Vasey, 2007; Chou, 2012; Skills for Care, 2011; Stearns & D'Arcy, 2008). Dissatisfaction was found to be associated with level of workload and team care practices (Chou, 2012). Several studies reported dissatisfaction negatively impacted and appeared related to difficulties with management, existing staffing levels, intensity and level of workload, team care practices, which reduced the quality of care provided (Chou, 2012; Skills for Care, 2009). This confirmed Chou's (2012) study which reported a real sense of organisational injustice was likely to increase job dissatisfaction.

National nursing home datasets reported dissatisfaction was closely linked to the quality of the job itself, feelings of being valued, promotion opportunities, workload and team care practices

(Stearns & D'Arcy, 2008). Negative factors such as not feeling valued and not having work stability were reported to heighten job dissatisfaction. However, increasing satisfaction was not related to individual items of dissatisfaction, as it was far broader and often difficult to define (Brannon et al, 2007).

2.6.1.3 Strategies and approaches to improve job satisfaction / reduce dissatisfaction

Several studies reported that to increase job satisfaction or reduce dissatisfaction, was associated with offering positive improvements in both intrinsic and extrinsic workplace factors (Karsh et al, 2005). Intrinsic and extrinsic satisfaction factors were reported to be susceptible to organisational change, thus employers should take every opportunity to improve these issues (Chenoweth et al, 2010; Decker, et al, 2009).

Improvements in organisational extrinsic factors, such as supervisor behaviour, pay satisfaction and staff benefits, improved individual intrinsic factors, such as job tenure and education, were found to have a positive impact on overall job satisfaction (Karsh et al, 2005). Whilst, increasing staffing levels and by reviewing daily workload, encouraged and enhanced the variety of work approaches which were also reported to increase job satisfaction (Chenoweth et al, 2010).

A large number of studies reported individualised approaches to retaining staff, including mentoring and supervision, peer support, and positive staff support (Aaron, 2011; Choi & Johantgen, 2012; Chou, 2012; Hegeman et al, 2007; McConnell, 2000; Pillemer et al, 2008; Singh & Schwab, 2000). This was frequently reported in conjunction with improvements in education, training and empowerment, including effective leadership, culture of care and enhancing respect (Chenoweth et al, 2010; Choi & Johantgen, 2012; Decker et al, 2009; Ha et al, 2014; Mittal, Rosen & Leana, 2009). A primary exploratory study, through focus groups settings, raised explanations and provided reasons why staff either stayed or left an organisation (Mittal et al, 2009). The authors suggested organisational and managerial factors, which influenced role flexibility greatly impacted on staff satisfaction. They reported satisfaction was also linked to personal expectation, such as feelings of having patient advocacy, development of personal relationships with residents, integral feelings of being 'called' to the care service, ability to reflect religion or spirituality in role, while work time was seen as a personal haven from their home problems (Mittal et al, 2009).

The study by Karsh et al. (2005) reported a lack of certain factors resulted in job dissatisfaction, with suggestions that strategies to improve training, ongoing education and increasing staff competencies helped to reduce dissatisfaction. Well thought out supervision structure, motivation of staff and delegation were strategies which reported potential improvements in job satisfaction. Approaches which improved those factors altering job satisfaction, such as work autonomy and feelings of being valued, were required (Ha et al, 2014).

Certain factors appeared to have a greater effect on retention than others (Hunt et al, 2012). For example, low retention homes did not appear to provide many staff extrinsic factor rewards, whilst controlling and improving upon these variables were related to higher retention rates, such as improving rewards and recognition (Ha et al, 2014; Hegeman et al, 2007). Examples of rewards included additional pay increase, paid holidays, recognition programmes, conference reimbursements, attendance awards, tuition reimbursement, and career development (Hunt et al, 2012). Equally, low retention rates were linked to a lack of benefit packages (Hunt et al, 2012). Although no direct effects on turnover were seen to be predictors, there did appear to be a tipping point, whereby staff sought out new employment which increased their intention to leave (Karsh et al, 2005).

2.6.1.4 Job satisfaction factors associated with intention to leave the organisation

Measures of job satisfaction were associated with predictors of staff intentions to stay or leave their employment (Karsh et al, 2005; Brannon et al, 2007), however these factors did not appear to be consistent across the workforce. It was clear from the evidence that different personal and workplace factors influenced staff satisfaction. Personal concerns were considered one of the strongest influences on intention and likelihood to leave the premises (Stearns & D'Arcy, 2008). This study, using national nursing home survey data, proposed the quality of the job itself, feelings of being valued, along with promotion opportunities, workload and team care practices, were all related to potential reasons to not stay employed (Stearns & D'Arcy, 2008).

Increasing job satisfaction through a number of approaches was reported on, with suggestions that job dissatisfaction could in fact drive up a person's intention to leave, although it did not necessarily follow staff went on to leave their organisation, conveyed in Kemper et al's (2008a) study. The threshold for leaving thus appeared different across different individuals but did appear to be related to difficulties with management, existing staffing levels, intensity of work

and the quality of care provided (Skills for Care, 2009). Although reduced satisfaction was linked to earlier findings of pay, better working conditions, communication with management, and supervision, what is unclear was why not all staff went onto display dissatisfaction (Brannon et al, 2007). This showed it was either a single factor, or a combination of reasons which caused staff to remain in a job (Chou, 2012).

Job satisfaction was clearly linked with staff intentions to leave (Brannon et al, 2007). Whilst many influences on job satisfaction were reported previously, the study by Choi and Johantgen (2012) reported that residents' care was noticeably highest. It showed relationships and caring were key and although certain factors negatively impacted on staff, they did not necessarily cause them to leave. It was suggested that managers needed to better understand the work-related factors associated with increased dissatisfaction (Rosen et al, 2011). In Decker et al's (2009) study, telephone interviews from staff found that certain factors appeared to have a higher priority in mediating the decision to leave, such as receiving health insurance and pay rewards (Decker et al, 2009). The strongest predictor for reducing staff intending to leave was reported as improving overall intrinsic satisfaction factors (Decker et al, 2009). However even with this said, the authors also advocated that these work-related factors did not really have a direct effect on actual turnover, they influenced staff behaviour, which in turn effected their intentions (Rosen et al, 2011).

2.6.1.5 Job satisfaction factors associated with staff turnover from an organisation

The study by Karsh et al. (2005) reported on a variety of job characteristics, which supported many other studies in identifying predictors for staff turnover (Castle, 2013; Karsh et al, 2005; Decker et al, 2009). These characteristics focused on the provision of staff supervision, personal recognition, family/work conflict, job related communication, work patterns and shift working, work related stress, communication with supervisors/ peers and organisational commitment. Gaps in staffing were reported to influence staff turnover due to increases in workload (Castle, 2013). Several studies reported similar influences and features which impacted on staffing which added to their decision to leave an organisation (Decker et al, 2009).

Factors which influenced staff turnover were reported as being a lack of respect, inadequate management, work or family conflicts, difficulty of the work and a lack of job openings (Mittal et al, 2009). A mixed method study (Chou, 2012), within its qualitative exploration, reported

that using a resident centred approach to individual care promoted job satisfaction, which deterred staff from leaving. Whilst from its quantitative data, it reported no actual effect on turnover itself, but importantly staff were less likely to apply for another job in long-term care. This same study (Chou, 2012) reported that 42% of staff had seriously wanted to quit, whilst only 10% had gone on to apply for another job. This suggested there was a specific time point when staff could be brought back and stopped from leaving.

A primary research study, through a questionnaire survey, found the most important staff influences were linked to poor skill discretion, high job demand, little decision authority, low job security, low pay and a lack of relationships with other staff members (Nakanishi & Imai, 2012). It showed each separate factor negatively impacted on an individual. An accumulation of these factors resulted in an increased unhappiness and despondency within their role. These factors, along with overall job quality strongly promoted intentions to leave the organisation (Nakanishi & Imai, 2012), with reports that these negative factors were greatest in young females with low educational background and those having a long journey time into work.

The point at which staff intending to leave their organisations actually shifted to the next stage and resulted in actual staff turnover remained uncertain. Chou (2012) argued a tipping point for each person which reinforced a push / pull conceptual model. This suggested the desirability of the current post with its potential opportunities offset with its perceived challenges versus the ease of moving to another post, guided staff decisions to leave. Consequently, the exact trigger point for when staff actually left a job remains unclear.

The evidence demonstrated that a variety of factors impacted on whether staff left their current post, with Hsieh and Su's study (2007) suggested the need for separate strategies when looking at recruitment and retention. Similar findings were reported by Nakanishi & Imai's (2012) whereby their study compared staff reasons for intending to leave their current post with leaving the caring profession, which reinforced the need for different strategic approaches to workforce employment.

2.6.1.6 Factors associated with staff leaving the caring profession

One paper was unique in making the distinction between staff intention to leave their job with their intention to leave the caring profession itself (Nakanishi & Imai, 2012). However, the nursing staff's intention to leave the profession was linked more with pay, enhanced variety of work and the acquisition of skills, which supported the reasoning that strategies focused on improving staffing levels needed to be linked to different individual issues within the various care homes.

2.6.2   The care industry

Theme 2 relates to the care industry in its entirety and reports on recruitment and retention strategies encouraging a national perspective. This approach aimed to assist and manage the current workforce problems to promote sustainability across the whole care home sector, rather than on a home by home basis.

2.6.2.1 Encouraging a national approach

The study performed by Chenoweth et al. (2010) reported on an array of strategies which supported the long-term care sector with recruitment and retention issues. They argued the need to differentiate between recruitment and retention practices within these approaches. Whilst a Report from Care England (2015) suggested there were already plenty of strategies and policies currently in place which enabled the care industry as a whole to generate improvements and manage change, and accordingly argued against the development of further initiatives.

A national strategic approach to supporting and managing the care home market which focused on long term care services was reported as a priority in Department of Health's 2006 Report. Although Care England (2015) argued the need to value and recognise the care home sector in its entirety to support community health needs. The Report reinforced that the issues surrounding recruitment and retention was an industry-wide problem, not just the care organisations themselves (Paget & Wood, 2014). One suggestion was to shift the whole workforce staffing issue away from the individual provider towards being a common workforce issue, this was indicated as a key legacy (Kemper et al, 2008b). The project suggested those organisations facing significant challenges needed to focus on a clear vision and provide intensive action.

2.6.2.2 Improving the status of care homes

The care home sector is currently receiving adverse publicity and to reverse this requires the promotion of this care industry at a national level. Increasing public awareness and better explaining social care, could offer the public a broader understanding of the current care home position (Skills for Care, 2011). Raising the profile of this sector was a necessity, supported by existing staff acting as champions (Skills for Care, 2011). This Report stated that one of the most effective methods which improves the standing of social care work was through "word of mouth" and by positively marketing the "reputation of the organisation" (Skills for Care, 2009, p.1).

Strategies which improved the standing of care home employment were helpful in encouraging new staff into the sector (Rubery et al, 2011; Skills for Care, 2011). Several studies suggested this could be achieved through focused, consistent and dedicated interventions to attract new staff and affirm the professionalism of these careers (Skills for Care, 2009; Paget & Wood, 2014). The Skills for Care (2011) Report suggested uptake could be improved through attracting volunteers, older workers and more men into these caring roles.

Understanding the worth and reward generated from working in this sector could promote the longevity of a career in care (Rubery et al, 2011). It was suggested that older aged staff were more likely to stay in a post than younger staff, whilst more experienced staff with longer employment tenures were also more likely to stay in their jobs (Karsh et al, 2005). Skills for Care (2009) reported similar findings which proposed that if staff were retained for 12 months or more, the turnover trend was likely to be reduced.

2.6.2.3 Promotion of good practices

The promotion of specific good practices which countered negative publicity could improve the status of social care work (Paget & Wood, 2014). One approach was the endorsement of workforce resource tools which promoted improvements in staff working conditions to increase job satisfaction (DH, 2006). Various examples included the Skills for Care workforce tools, such as 'I Care' systems (which is a range of case studies available to download), career pathway e-tools, the care Ambassador Resource Pack, along with a range of work placement guides, supervision toolkit and supporting websites (Skills for Care, 2009).

National and local leadership could inspire a positive image of working within care homes (Skills for Care, 2009; Skills for Care, 2011). The development of high-level initiatives and practices aimed to add to the credibility and respect for this industry was recognised. Examples included the implementation of champions, care ambassadors and raising the status through a National Care Home Open Day (Care England, 2015). Other practice proposals were collaboration with NHS job recruitment agencies, NHS employers' website, careers advisors, counselling and support services along with local employer networks (DH, 2006).

2.6.3 Environmental

Theme 3 reports on strategies and approaches to help the nursing home setting and offers solutions to resolving the recruitment and retention of staff. This environmental approach makes recommendations focused on supporting organisational and managerial features.

2.6.3.1 Improving organisational systems

Riggs and Rantz (2001) study reiterated that organisations needed to recognise that human capital was vital and that their business and management systems were imperative to retain high levels of staffing (Chenoweth et al, 2010). Several studies suggested that no one approach responded to recruitment and retention shortages and thus taking a multi layered approach was required (Riggs & Rantz, 2001). Promoting a supportive open organisation was deemed as one approach to improving broad and sustainable organisational changes, with recruitment recommendations, aided through the development of a highly productive and healthy workforce, promoting mutual respect and the maintenance of health (Riggs & Rantz, 2001).

Interventions which built on and maintained staff relationships were recommended to reduce staff motivations to leave (McGilton, Boscart, Brown & Bowers, 2014), with this achieved through a greater understanding of leadership culture and personal growth, alongside the development and improvement of workplace and organisational factors. The Department of Health (2006) Report stated that staff simply wanted to be treated with fairness and quality, with this considered an achievable approach to retaining the current workforce.

Learning how to better manage staff facilitated healthier organisational structures which enhanced leadership skills (Chenoweth et al, 2010). Thus, effective targeting of organisations

focused on improved the quality of the facility structures was imperative. The achievement of goals through collaboration and working together was considered a preferred way to improve the service, rather than through the application of authority (Riggs & Rantz, 2001).

As mentioned previously, recruitment and retention were often viewed as different issues with differing countering approaches to their resolution. However, Stearns and D'Arcy (2008) also suggested 2 different reasons why staff left and so this warranted different solutions. They reported staff frequently left the establishment and moved on to what they perceived as a better job or employer, whilst some staff left the nursing profession itself, which was linked more to the skills and quality of the care role itself (Stearns & D'Arcy, 2008). This study reported two different retention policies or strategies needed to be applied, however confounding these arguments was the proposition that intention to leave did not always proceed actual leaving and turnover (Nakanishi & Imai, 2012).

Changes to an organisation's ownership was shown to have a significant impact on staff leaving (Skills for Care, 2009). Increased dissatisfaction and the likelihood of staff leaving was due to poor management, which was linked to management relationships, management styles and techniques, ineffective communication and a lack of management competence. These issues in themselves caused staff to have low job satisfaction but were subsequently compounded by the lack of quality supervision and the intensity of work practices (Skills for Care, 2009).

2.6.3.2 Improving organisational factors to improve workplace satisfaction

Difficulties were reported when addressing individual job satisfaction factors which required further exploration through an organisation's quality environment (Karsh et al, 2005). Many strategies reported a multi factorial approach was required when resolving recruitment shortfalls within care homes and reinforced the need for an effective systems approach to supporting staff in the workplace (Chenoweth et al, 2010). This proposed modification of a range of inter-relating factors, potentially achieved via training, rewards, facilitating teamwork amid many of the work-related factors (Chenoweth et al, 2010).

The McGilton et al. (2014) study reported that non-supportive managers, inadequate resources and staffing, a lack of full-time employment options and expectations of staying on after the

shift ended, along with excessive documentation, were all considered overwhelming influences on staff intentions to leave. Support and organisational commitment were critical in reducing turnover, which reinforced suggestions that investment in the workforce through training, promoting autonomy was essential to provide job stability. This was achievable through an employer's role in supporting and participating staff in decision making, which was reported to help retain staff (Ha et al, 2014). However, it's argued that although training could assist with staff commitment it may not necessarily enhance overall job satisfaction (Karsh et al, 2005).

2.6.3.3 Standardisation of management posts

Significant differences were reported in the roles and responsibilities, pay rates, terms and conditions of care home managers (Paget & Wood, 2014). The manager title and status did not always reflect the range of skills and abilities required for the post, with large role discrepancies across all organisations. These crucial differences were reported to directly impact on retention and turnover of staff (Paget & Wood, 2014). Changing this title was proposed, to reflect all the complexities involved in the post, whilst integral within this was the need to offer training and ongoing development, responding to the range of requirements needed for the post.

One suggestion to improve manager retention rates was the development of a new management role, accompanied by greater credibility and status (Skills for Care, 2011), such as the development of a general management post or senior practitioner roles, particularly recommended for larger organisations (Paget & Wood, 2014). The Care England (2015) Report suggested amalgamating a practical registered nursing role with a senior supervisor role which offered an alternative to current management roles.

The attraction of new staff, by raising the status of the care home manager, required further exploration to determine the post's suitability for change, and its value in responding to future workforce issues. Additionally, it required defined pay scales, training and support, and the ability to embrace the diversity of these new and changing roles (Skills for Care, 2011), all proposed to enhance positive job satisfaction (DH, 2006).

Understanding the pros and cons for staff working in large or small sized organisations required further exploration (Paget & Wood, 2014). Their study reported that recruitment was influenced

by several broad factors, which included the size of the care home, the complexity of residents' needs and the variations in the type and quality of support received by registered managers from their employers (Paget & Wood, 2014). Reducing these variances was considered as an option to reducing varying staff enticements, which potentially caused constant staff movement across organisations. Thus, reducing this shifting workforce facilitated better relationships with residents' relatives and friends, which was acknowledged to promote effective mutual respect (DH, 2006).

2.6.3.4 Increasing organisational commitment

Participative management promoted increased organisational commitment of staff, which promoted principles of respectful, open communication, enhancing value in their staff (Riggs & Rantz 2001). Several organisational and environmental issues were raised that caused inflexibility within the workplace, which then heightened staff intentions to leave (McGilton et al, 2014). Promoting a flexible structure of networks, people centre, teamwork centred leadership, offered improved decision making through problem solving, positive expectations, respectful communication and goal-oriented evaluation of employees (Riggs & Rantz, 2001).

Suggestions were made which encouraged a family-friendly learning environment, especially when care homes were family owned and staffed by family members (Chenoweth et al, 2010). This aimed to value and nurture its nursing staff which subsequently encouraged the nurses to value and care for their residents. It was argued that this approach was crucial to ensuring increased retention of staff (Chenoweth et al, 2010). The evidence from one study found the majority of homes (over half) were single owners or part of a small group, often managed and staffed by family members (Paget & Wood, 2014). All these homes were facing significant challenges due to high level of financial investment and current fee levels. However, large businesses were also reported to be going into administration or reducing their services, thus reinforcing the need for a market intelligence function across Wales (Paget & Wood, 2014).

Positive job satisfaction was linked to improving commitment of staff which promoted stability in the workplace (Brannon et al, 2007), and as discussed, this was achieved through several different methods and approaches. The study by McGilton et al. (2014) reminded us of the complex interplay between factors which influenced staff intention to either stay or leave a job, and they reiterated different reasons for why nurses leave or stay, with leaving frequently linked

to higher education and job tenure, above pay satisfaction (Decker et al, 2009). The inflexibility and inability to use professional judgement frequently caused nurses the greatest concern (McGilton et al, 2014), which influenced the balance between the many interlinking factors. It was these positive and negative feelings which ultimately affected their decision to stay or leave. A lack of commitment to the organisation was previously linked with poor performing staff (McGilton et al, 2014).

2.6.3.5 Increasing organisational values

The retention of staff was considered to link to an organisation which offered the right values, enabled staff to feel proud and fostered greater staff loyalty (Skills for Care, 2009). Factors such as the work atmosphere, teamwork, having flexible contracts, the drive for qualifications and promotion routes were all cited as approaches which help to retain staff. Job satisfaction was higher if staff were reported to work as part of a team (Skills for Care, 2009).

Building good working relationships within an organisation was needed, and involved a range of activities, such as high interpersonal processes of communication, increasing trust and reducing conflict (McConnell, 2000). Recruiting staff with compassion and commitment was suggested as key for promoting organisational commitment and loyalty of staff (Chou, 2012; Ha et al, 2014). Karsh et al's (2005) study reported that commitment to the organisation was a stronger predictor of turnover than job satisfaction. Top management turnover was strongly linked to the commitment of employees within the organisation, and indirectly to job satisfaction (Castle & Engberg, 2006). Commitment is arguably influenced by leadership (McGilton et al, 2014), thus all elements are crucial within an organisation to ensure improvements are seen.

Empowering carers within the decision-making process increased their dignity and feelings of respect amongst their peers, increasing job satisfaction and the desire of staff to come into work (McConnell, 2000). These improvements developed higher levels of team cohesiveness, greater co-operation and valuing each other, along with bonding outside of work, which all aided job satisfaction and retention. Flexibility of the job, social or esteem factors, such as building working relationship, while having a positive self-identify were considered important when supporting recruitment problems (Castle & Engberg, 2006).

As discussed earlier in relation to staff satisfaction levels, pay, work overload, adequate staffing levels, respected status amongst peers, healthy work-life balance all affected organisational commitment and supported staff retention (Riggs & Rantz, 2001). Castle and Engberg's (2006) study added to this, reporting further themes such as staffing levels, top management turnover, resident case mix, facility quality, ownership, chain membership, size and Medicaid census, were all reported to be associated with lower staff turnover rates.

Improving the organisation's environment required and included issues such as, promoting a positive ethos and philosophy of caring, improvements in managerial structures, better communication, development of a more positive culture of openness and job embeddedness, intrinsic rewards, respect, values and empowerment of staff (Karsh et al, 2005). Organisational work pressure with poor work schedules that did not meet the employee's needs were all indirectly linked to affecting nursing home turnover intentions through reduced employee job satisfaction and commitment (Karsh et al, 2005).

2.6.4   Education, training and development

Strategies and approaches to improving education, training and development can be seen within Theme 4. The evidence made recommendations to support the care homes with recruitment and retention practices. Well trained staff were shown to influence the quality of care, and as such, approaches to improve education and development are discussed in the next section.

2.6.4.1 Collaboration with educational providers

Close collaboration with higher education providers, supported by work at national levels, was considered a necessity to ensure staff felt confident and competent in their working practices (Aaron, 2011). Education, training and ongoing staff development was found to improve staff satisfaction through increasing feelings of being valued (Skills for Care, 2011). Inherent within this was the promotion of frameworks and continued programmes, which focused on the development of future leaders, aiming to driving change management within all care practices, for all organisations (Hegeman et al, 2007). The providers needed to offer cost effective training models, which supported flexible professional development programmes targeting increased attendances (Skills for Care, 2011). A clear educational framework was required, with providers needing to promote examples of good practice, such as embedding diplomas within more courses to encourage intrinsic job satisfaction factors (Skills for Care, 2011).

Hegeman et al. (2007) reported a real disconnect between management, leadership and communication training for registered nurses, and the training nurses truly received. There was a noticeable gap with staff reporting education packages currently focused on clinical skills and not management skills, which they considered as essential for the development of long-term relationships with staff (Hegeman et al, 2007). Changes to programmes also needed to incorporate learning to enable effective management of their work, to embody caring behaviour, while combining it with care planning and time management skills (Hegeman et al, 2007).

2.6.4.2 Introduction of new educational schemes

The promotion of new technologies and programmes such as apprenticeship and graduate schemes, helped urge new recruits into this sector, whilst rewarding existing staff with promotion helped to retain this workforce (Skills for Care, 2011). The need to review and improve upon training and professional development required a fresh look at current programmes and structures (Skills for Care, 2011). For example, improvements proposed increasing training resources, the introduction of possibly a national skills academy, development of an outcome and appraisal framework, remuneration system, with commissioners who reward quality services with quality premiums, and an endorsement from educational providers (Skills for Care, 2011).

2.6.4.3 Development of new career opportunities

Approaches to promote career pathways and the development of new roles required a consistent response and was considered a priority for social care (Skills for Care, 2009). Staff frequently reported a sense of injustice with a lack of career advancement and opportunities, adding to several other negative influences, all strongly linked with feeling unvalued in their roles (Chou, 2012). Retention programmes such as tuition reimbursement and career promotion opportunities were used more frequently in moderate to high retention homes (Hunt et al, 2012).

The development of career frameworks for all staffing roles was essential to drive forward career opportunities and advancements within their working environment (Hunt et al, 2012; McGilton et al, 2014). Improving employment opportunities and promotions were considered to support staff retention, in addition to assisting the recruitment of a wider social care workforce, than currently exists (Paget & Wood, 2014). For example, offering opportunities to

student nurses and clinical placements to a range of health care professionals was discussed earlier, and was reported to offer an early insight into this sector.

2.6.4.3 Increasing workplace opportunities

Due to the rising older persons population in Taiwan, this country has already commenced staff training programmes, through the identification of the care sector as a potential for new employment opportunities (Chenoweth et al, 2010). Hsieh and Su's (2007) study, reported on an original idea which aimed at addressing the future potential shortfall of staff, enabling the country to sufficiently respond to future care needs. Integral within this new initiative was the careful selection of student nurse clinical placements, which required clearly structured supervision and education, skills training, and the promotion of leadership and teamwork (Chenoweth et al, 2010). Championing education was another approach which not only proposed educating all team members but enabled greater facilitation and coaching to help take changes in practice forward (McConnell, 2000). Training was key to the effective transition of this role, which required commitment by the organisation's senior staff members, ensuring its successful implementation (McConnell, 2000).

Offering clinical student placements early in nursing careers promoted greater work opportunities to aid recruitment shortfalls. Care England's (2015) Report highlighted the need for students to support the shortfall gap, which would enable future workforce needs to be met. Retention of existing staff was also enhanced during the upskilling of these nursing placements, by the addition of staff training and development this presents. Nurturing of the new recruits was enhanced through mentorship, career development and rewarding achievements, which all aimed at promoting new staff uptake (Skills for Care, 2011; Castle, 2013). Highlighting the home as a workplace which values and appreciates staff, made it a potentially more appealing employment option for new recruits.

2.6.4.4 Introduction of staff supportive programmes

Various staff supportive programmes were reported to make positive inroads into addressing current workforce recruitment difficulties (Aaron, 2011). The introduction of preceptorship programmes, mentorship programmes and peer support roles empowered staff to meet the challenges of working within the long-term care sector (Aaron, 2011; Care England, 2015; Chenoweth et al, 2010). Key within these structured programmes was the ability to promote

personal and professional growth, facilitation of a competent and stable workforce with the prospect of a stronger bottom line (Aaron, 2011). The supervisor's positive behaviour achieved the strongest association with intrinsic job satisfaction (Decker et al, 2009).

The preceptor role was reported to support 7 domains of competencies within an organisation, which included the helping role, resident monitoring function, ability to handle non-nursing issues, increased regulation, effective management and interventions which ensured quality of practices and organisational work roles (Aaron, 2011). The uptake of this preceptor role was linked to positive improvements and staff competencies, whilst its introduction within a care home environment, suggested to prospective employees that the home understood their role needs and possible fears.

Peer mentoring programmes was another approach to improving feelings of being valued in the workplace (Choi & Johantgen, 2012). The introduction of supervisor training programmes and formal supervisor training as part of peer mentoring programmes, promoted greater enthusiasm in staff roles (Hegeman et al, 2007). A proposed 3-week programme encouraged the mentor and mentee to be 'joined at the hip' and work the same shifts with the same residents, which was thought to develop positive working attitudes.

Mentorship promoted warm compassionate care, encouraged good time management and helped to reduce frustrating work situations (Choi & Johantgen, 2012). Without the suggested mentor training it could negatively affect the management role, their leadership and communication skills (Choi & Johantgen, 2012). However, it was argued that many current programmes were not actually fit for purpose and did not meet the needs of care home staff, possibly as the development of these roles have not been generated from the long-term care setting.

2.6.4.5 Development of specific staff retention roles
The introduction of new roles such as the retention specialist was recommended as a mean to offer a continuous integrated approach to retaining staff within the organisation (Pillemer et al, 2008). This post was an original, innovative role designed to provide ongoing support, with the ability to effectively troubleshoot staff problems as they arose. The retention specialist role

made organisations more aware of the importance of addressing retention, helping them to respond to the immediate needs of staff, and encouraging them to want to stay in their posts (Pillemer et al, 2008).

The role focused on developing common strategies for staff to deal with personal problems and workload demands which enabled them to cope better (Pillemer et al, 2008). They advocated for, and implemented programmes to improve staff retention and commitment throughout the facility. This role required specialised expertise and human resource management to progress this new programme (Pillemer et al, 2008). Three components were reported to be essential for its success, which was an intensive 3-day training in retention leadership, ongoing technical assistance with an extensive portfolio of tested retention strategies, and lastly the ability to offer support and influence community resources and educational materials (Pillemer et al, 2008). This study noted that staff reported the programme successfully demonstrated improvements in the overall quality of their organisation. While the retention specialist stated "we have become more sympathetic to what the certified nursing assistants need. We are more flexible in meeting their scheduling needs" (Pillemer et al, 2008, p.88).

2.6.4.6 Increasing managerial skills

The study by McConnell (2000) argued that effective management strategies were not currently achieved within the care home sector and was unnecessarily impacting on recruitment. It was suggested that managers lack knowledge and have ineffective management practices, accompanied with excessive institutional policies. This all negatively influenced employee morale, with this lowered job satisfaction expected to result in high staff turnover, whilst also reducing the existing quality of care. The study by Hsieh and Su (2007) reinforced similar findings from other studies, which went a step further by suggesting there was a "person-job fit" (p.100), causing people to stay in a job because it fitted in with their personal interests and job characteristics (Hsieh & Su, 2007).

A range of approaches increased the delegation of roles, which helped managers, however this required input from the organisation's agreed Responsible Individual, the employers and acceptance from staff (Karsh et al, 2005; Paget & Wood, 2014). The development of well qualified and skilled nursing home administrators (NHAs) offered greater managerial support and assisted future recruitment, however this did require collaboration with universities and

local colleges to encourage enrolments into these programmes (McGilton et al, 2014). The development of good working relationship between managers and carers positively impacted on staff morale (Hegeman et al, 2007).

2.6.5 Partnership working and engagement

Theme 5 provides evidence on partnership working and engagement with various organisations. Collaboration between a multitude of commissioners and other key stakeholders which promoted partnership working is discussed in the next section, whilst highlighting how strategies and approaches can impact on staff recruitment and retention.

2.6.5.1 Collective strategic approach

The Department of Health (2006) Report reported a general shortage of staff across many NHS organisations and subsequently recognised the need for all NHS employers to revisit their workforce issue. They argued that the NHS needed to include and review the care home and independent sector within their workforce strategies, rather than seeing them as separate providers, as clearly a lack of care home services would impact on NHS delivery. As the NHS has a large workforce it is potentially better placed to redeploy staff to support the care home establishments, through turnover and its own natural wastage. This highlighted within the NHS's own organisations that the reasons why staff took up their initial job and then why they subsequently left these, were not the same (DH, 2006).

Improving policy and commissioning practices along with generating and improving upon national policies and procedures was required (Rubery et al, 2011). The focus needed to be on redesigning the workforce, whilst training and education was key within this to support the changes and new improvements, bringing the community together and developing strategies (Skills for Care, 2011). A diverse workforce needed core values and new skills and competences in order to support people and part of this was to raise public awareness to market careers in care in a fresh new positive way (Skills for Care, 2011, Paget & Wood, 2014). It was essential that future initiatives generated changes to workforce and management practices, however this was considered difficult, requiring policy initiatives and funding to address this. Better explaining of social care was reported as necessary with the Skills for Care (2011) Report which recommended greater intervention from the Department of Health.

2.6.5.2 Greater engagement with key stakeholders

It was suggested that workforce and management practices needed to change to ensure future recruitment and retention was better addressed for the care home sector (Kemper et al, 2008b). However, several studies recognised that as care homes were individual providers, the engagement of key stakeholders was difficult (Aaron, 2011). Effective partnership working with other employers and organisational groups aimed to promote a systems wide response with all partners (DH, 2006). The burden of staff shortages, in particular nurse practitioners and managers in care homes was highlighted as being everyone's concern (Paget & Wood, 2014).

Shared approaches between the care home providers and a whole range of commissioners and organisational partners was needed to meet future requirements (Rubery et al, 2011). This needed to include strategic partners such as national and local government, local Health Boards, education establishments and workforce development groups (Rubery et al, 2011), with the development of these key relationships being essential, to encourage the promotion of likeminded policies and common goals (Kemper et al, 2008b).

The study by Rubery et al. (2011) suggested that commissioners were pulled in different directions making the requirements for effective partnership working even greater, while finding solutions to successfully address the issues of recruitment very challenging. Working in collaboration with care inspectors and reviewing the balance of their current processes and systems was advocated (Paget & Wood, 2014). The range and consistency of regulation, monitoring and inspection activities to which registered managers and services were subject to, required reviewing (Paget & Wood, 2014). Longer term workforce requirements must be considered to avoid not only current but future staff shortages (DH, 2006), this issue is discussed later in this chapter.

2.6.5.3 Multi-agency approach

Local authorities were already adopting strategies focused on providing stability within the care home sector, however even after positive attempts, care home stability did not always appear to be the result (Rubery et al, 2011). A lack of coherent signals for independent providers was blamed, with some current approaches causing higher costs for Local Authorities whilst not always resulting in quality improvements of working time practices.

The value of introducing collective approaches across Health Boards with a need to meet responsibilities through collective actions, supported through the generation of national policies and initiatives was proposed (Brannon et al, 2007). Key within this was the suggestion of high-level strategic engagement to affirm strategic leadership roles, with a clear understanding of the current care home market. This included for example, staff vacancies, types of current provision, provider concerns and workforce issues. Driving improvements in policy and commissioning was essential to ensure a sustainable future, while pivotal within this was leadership (DH, 2006).

2.6.5.4 Development of strategic leadership

Leadership was identified in many studies as key within both the roles of strategic health authorities and in the care homes themselves, recognising that leadership styles affected employee autonomy (Ha et al, 2014). A priority was therefore to stabilize leadership especially within senior nursing positions (Singh & Schwab, 2000). The development of executive leadership and the involvement of other partners, such as trade unions and primary care employers, promoted strong collaborative working, encouraging stakeholders to respond to their collective responsibilities (DH, 2006; Skills for Care, 2011).

2.6.5.5 Meeting current expectations and challenges

Health and social care accounts for a huge proportion of the public expenditure budget and resources are a growing problem. Commissioners are under great pressure to meet the changes in public expectations, and long-term care is a challenge to all governments. Demographics are changing, people with long-term conditions are living longer and thus the need for social care is increasing (Skills for Care, 2011). Developing specialities across a continuum of care aided the impact of the care home industry (Skills for Care, 2011), which could be directed through community engagement, putting care services first and offering strategies for supporting, facilitating the growth of multi-disciplinary working (Skills for Care, 2011).

Supporting a community-based approach to care, to uniting the health and social care sector, was also on the national agenda (Skills for Care, 2011). The public were demanding changes to highly structured services, towards care packages which better moulded to their needs and lives. Bridging health and social care in residential homes was one approach recommended to support the wider care system, alongside the promotion of flexible staff, increasing the skills of care

workers, and the inclusion of personal assistants who can support relatives and residents (Skills for Care, 2011).

2.6.6 Financial features

Several financial features are discussed in Theme 6, which provides solutions to addressing recruitment and retention of care home staff. Many of the solutions reported on are closely linked with improving job satisfaction factors.

2.6.6.1 Financial stability

The promotion of stability of care services accompanied by financial viability was essential to foster sustainability of the long-term care sector (Ha et al, 2014). It appeared that formal and informal recruitment practices can impact on staff employment, whilst viewing the establishment from an employee perspective was very powerful (Rubery et al, 2011). For example, informal word of mouth and voicing their job satisfaction and commitment within their role was found to aid retention. Even with other dissatisfaction issues such as having low pay, care workers accepted this if certain HR bundles were present. On several occasions, it was reported that relationships with residents strongly influenced staff retention, alongside training. Several factors including terms and conditions, and pay rates clearly influenced a pull ethos towards the NHS sector, resulting in staff leaving the care industry (Chou, 2012).

2.6.6.2 Improving financial incentives

The development of financial incentives aided the retention of staff through additional rewards and contributions for their work practices (Brannon et al, 2007). Remuneration frameworks acknowledged care staff contributions and offered awards for high level performances with personal growth through continuous professional development programmes (CPD). Career progression was linked with this award process which encouraged staff to stay within the organisation (Hunt et al, 2012).

The study by Rosen et al. (2011) reported staff wages and salary as a key influencing factor when recruiting and retaining staff. Several studies (Ha et al, 2014; Paget & Wood, 2014) reported huge variances across staff pay, terms and conditions, bonuses and benefit packages, annual leave, sick pay, pension contributions, car allowances and mobile phones. However,

although a major recruitment factor, it appeared pay alone did not directly cause staff to leave (Rosen et al, 2011), while being valued and appreciated were found to compensate for a lack of financial reward (Chou, 2012). Consequently, increasing higher rates of pay, providing pay enhancements and rewarding high performance work practices were all found to contribute towards staff remaining in their current jobs (Care England, 2015).

2.6.6.3 Improving staff working conditions

Rewarding mentors which enhanced staff working conditions offered the organisation assurance of quality practices and supported efforts around retention (Hegeman et al, 2007). Individual salary increases, and the provision of training and development encouraged mentors to take up the role and drive change forward. Additional mentor training in areas such as interpersonal mentoring and communication skills, leadership and improving teams, stress and time management all supported improvements (Hegeman et al, 2007). Death and dying principles combined with increasing compassion and changing attitudes helped guide the staff towards greater working confidence (Hegeman et al, 2007). It appeared these additional rewards, in conjunction with enhancing staff satisfaction promoted better stability of the workforce.

Improving managers' work life balance and avoiding unnecessary nursing home pressures aided retention of this staff group (Paget & Wood, 2014) through the provision of a lower conflict between job demands and personal life, which was reported to help staff remain employed (Chou, 2012). Reducing work pressures on managers due to delays and confusion of current NHS processes which often impacted negatively on their work life balance was proposed, as it resulted in staff leaving the labour market (Paget & Wood, 2014; Karsh et al, 2005).

2.6.7   Staff roles and care practices

Theme 7 provides evidence on strategies and approaches to improve current role opportunities and changes within care practices which aims to have an impact on recruitment and retention issues. The evidence suggested a greater understanding of roles, challenges and appreciation of care home staff can support the retention of existing staff.

2.6.7.1 Promotion of standardised practice

Organisations need to promote standardisation of care practices, which was achieved through the introduction of high-performance care bundles. McConnell's (2000) study stated the effect of these changes enhanced nursing assistant's self-image, confidence, and promoted positive interactions between team members, increasing their desire to stay in their current post. Organising staff within hierarchical structured care teams arguably promoted better decision making and empowerment (McConnell, 2000), with this enhancing job satisfaction through the establishment of small integrated working teams (McConnell, 2000). Professional development, workplace learning and improving clinical skills were all reported to influence the quality of resident care (McGilton et al, 2014).

2.6.7.2 Improving care practices

Several studies reported that making improvements which improved the quality of care and care practices greatly impacted on staff morale and satisfaction (Ha et al, 2014; Rubery et al, 2011). Person-centred care was also reported to promote satisfaction in staff roles, and it was believed that not achieving a certain standard of care resulted in staff members feeling negative (Donoghue & Castle, 2009).

One strategy which reported potentially reducing staff turnover, focused on increasing staff organisational commitment with proposed changes making staff actively implement high performance work practices (Ha et al, 2014). The introduction of a range of high-performance work-based practices (official training, employment stability, autonomy, employee participation and group-based payment) were all reported to positively impact on job satisfaction (Ha et al, 2014). Reducing employee turnover due to increasing job satisfaction improved the desire of staff to come into work and was accompanied by increased feelings of dignity and self-respect (McConnell, 2000).

Resident activities encouraged a harmonious relationship and helped to build good working relationships, making staff enjoy their work more by feeling their employers valued the residents (Hsieh & Su, 2007). Staff who had no time to mourn when residents died, just having to move on quickly, reported the personal relationships they had built up were not recognised or appreciated (Mittal et al, 2009). This suggested a lack of respect for their caring role which did not acknowledge the staff's spiritual or faith needs; a consideration that organisations

needed to address. Staff who were unable to support the caring needs of residents and unable to provide person-centred care acknowledged this caused great dissatisfaction in their roles (McGilton et al, 2014).

2.6.7.3 Improving team working

High performing care home teams were found to contain registered nurses who delegated a range of healthcare responsibilities to carers (McConnell, 2000). Promoting a participatory and consensus approach to making decisions appeared to heighten staff self-esteem as staff appreciated being listened to. This was found to reduce job dissatisfaction, as it enabled the carers to drive some of the care decisions and raise care standards (McGilton et al, 2014). Traditional non-transformational nursing roles whereby carers were told what to do and had a lack of decision making was reportedly seen in low performing teams (McConnell, 2000). These teams were associated with a lack of staffing structure and was linked to staff being given much less opportunity to make decisions. A lack of decision making was frequently found to cause confusion in the workplace and reduced carer job satisfaction. The poorer systems reported lower levels of trust, a lack of team cohesion and staff feeling unsupported with a reduction of workplace enthusiasm (McConnell, 2000).

2.6.7.4 Improving staff relationships with residents

One key area which was recognised as an incentive for nursing staff to remain employed was the ability to sustain relationships with residents (Castle & Engberg, 2006). Staff reported those who connected to and related with residents, frequently experienced emotional reciprocity which was identified as the most important factor in remaining in the job. Relationships not just with residents but with colleagues also appeared to be a determinant of employment decision making. Within this, studies that found mutual understanding, sharing of workload and promoted helping each other were very influential when managing staff shortages (Castle & Engberg, 2006; Castle, 2013; McGilton et al, 2014).

The use of consistent assignment whereby staff cared for the same group of residents when they came in on their shift, was recommended as a means of addressing recruitment (Castle & Engberg, 2006; Castle, 2013). The role promoted greater staff enjoyment of their working practices through building valued resident-staff relationships. Individual pride and value in their activities when caring for their residents did deter staff from leaving (Castle & Engberg, 2006).

It was suggested that by knowing which residents they were caring for, not only meant staff enjoyed their activities more, but it also enhanced feeling respected during their care giver role (Castle, 2013). The findings reinforced personal relationship with residents and the quality of care they provided as important reasons to stay, with decisions not based just on payments and benefits (Hsieh & Su, 2007).

Although the evidence for consistent assignment was not directly linked to improvements in the quality of care given (Castle, 2013), there did appear to be a strong link between positive staff-resident relationships, feeling appreciated and improving job satisfaction (Castle & Engberg, 2006). To influence policy makers, government agencies and industry to advocate for and increase the use of consistent assignment required a large shift in work practices and a recognition of the need to change the culture within the care homes (Castle, 2013).

2.6.8   Workforce and labour market

Strategies and approaches which highlight the current workforce and labour market as requiring investment are discussed within this section. The development of these recommendations helped promote the care home sector to assist staff to take up post and remain within nursing home organisations.

2.6.8.1 Workforce planning and development

A strategic approach to workforce planning and development was identified to improve the recruitment and retention approaches currently being delivered within the care home sector (Skills for Care, 2011). Significant challenges are facing this sector and improvements in management and human resource practices may offer a solution (Rubery et al, 2011). Retaining and recruiting staff was reported to have a positive knock-on effect on workload and working conditions and thus offered greater staff opportunities to deliver quality nursing care (Castle, 2013). Arguably the best recruitment strategy of all, considered that having a high retention rate subsequently encouraged existing staff to stay, with a pull of new staff towards joining the establishment (Chenoweth et al, 2010). Staff turnover negatively impacted on the remaining staff and their attitudes to their workload, which resulted in gaps within the caring teams, whilst increasing staff workload (Castle, 2013).

A stable workforce improved job satisfaction by reducing staff stress accompanied by low employment within the organisation (Ha et al, 2014). A key area within this was reported as the introduction of training, education and the development of competencies, which promoted a positive staff outlook and was associated with staff organisational stability (Brannon et al, 2007).

2.6.8.2 Greater succession planning

Greater succession planning and a recognition of the wide level of skills required for care home posts, was reported to go some way in establishing an appropriate workforce (Paget & Wood, 2014). Currently there appeared to be recycling of the same pool of people, thus, longer term planning was required to address future staff shortages (Paget & Wood, 2014). A range of strategic approaches with larger and smarter investments to develop this workforce was recommended, particularly appreciating continuing education and the need to moderate the demand for long-term care personnel.

Workforce stability is essential within succession planning but needs to be more responsive to the changing environment and include cultural issues (Mittal et al, 2009). Instability in management and administrator roles was deemed to not only cause unrest amongst the remaining workforce but was reported to have a subsequent negative effect on the quality of resident care (Singh & Schwab, 2000). Consequently, supportive workplace practices heightened the nurses' commitment to the care home, emotionally, morally, and economically, and the intention to leave was reduced.

2.6.8.3 Increasing managerial business skills

The development of managers with business skills greatly aided the care industry, enhancing various organisational processes (Skills for Care, 2011). CSSIW reported care homes (nursing), are currently more likely to be without a registered manager, which subsequently impacts on the service delivery (Paget & Wood, 2014). A current obstacle in recruitment was the attainment of the level 5 qualification for prospective managers, which is a pre-requisite for the Care Council and CSSIW registration (Paget & Wood, 2014). The promotion of greater flexibility within the service was required accompanied with a passion to proactively drive organisational change. The ability to offer effective operational and managerial roles, care managers required a variety of skills, which included not only caring, supportive and enablement skills, but also

essential entrepreneurial skills and a heightened business sense in order to thrive (Skills for Care, 2011). Managers who had completed formal supervision training were recognised as having a greater ability to manage effective change (Skills for Care, 2009). Improved communication, clarity, assertiveness and an understanding to improve staff isolation issues were deemed to influence satisfaction and resulted in less staff leaving (Skills for Care, 2009).

2.6.8.4 Reducing variances in employment terms and conditions

Resolving variances across the sector in relation to employment terms and conditions helped to avoid staff being headhunted (Paget & Wood, 2014). The study by Stearns and D'Arcy (2008) suggested various changes which could potentially encourage more personnel into the long-term care industry. For example, the improvement of working conditions and quality of the jobs along with increased wages and benefits made the jobs more competitive. Rubery et al. (2011) study suggested that providers need to try and respond to the labour forces and improve their own working and management practices, so as to address the wide-ranging recruitment issues. Clearly identified have been poor HR policies, poor employment conditions, low rates of pay, and a variance of contractual arrangements. Retaining staff undoubtedly drives ongoing retention, whilst Decker et al. (2009) argued the need for longer staff tenure as those with the longest experience of the organisation were associated with lower intentions to leave.

During 2014, Paget and Wood's study reported the lack of a common set of workforce data accompanied by a lack of recruitment figures, as having a strong impact on recruitment (Paget & Wood, 2014). Workforce data is currently limited with a need to streamline and introduce a common national minimum data set for the social care workforce (Paget & Wood, 2014; Skills for Care, 2011). Recommendations suggested employers need to start to use processes which plan, anticipate and target workforce shortfalls so early gaps in service needs are identified (Skills for Care, 2011). The processes to support these activities focused on improving upon current workforce data needed to be reviewed nationally. The development of a national workforce strategy to support and manage the care home market in Wales, with a focus on providing accurate and accessible workforce data, was considered essential for the development of the wider workforce (Paget & Wood, 2014). It was suggested that the age profile of staffing has increased but a lack of robust data for this sector has made this assessment difficult (Paget & Wood, 2014).

Undesirable job characteristics undoubtedly caused a sense of organisational injustice (Chou, 2012), with a need to investigate workload structuring, time allocation and assigned work roles (Brannon et al, 2007). The intention to leave was associated with changing roles and workload pace and pressures (Brannon et al, 2007), thus the honest involvement of staff in resolving these factors was considered significant in positively encouraging staff to stay (Karsh et al, 2005). Improving on and developing working time arrangements was another approach to increasing staffing level (Rubery et al, 2011). Rosen et al. (2011) suggested the employment of fewer part-timers and more full-timers would help reduce staff numbers leaving and add stability to this industry. The level and type of workload by carers appeared to impact negatively on job satisfaction, however it was not perceived as a single reason in itself for leaving an employment but did go some way in contributing to dissatisfaction of their roles (Castle & Engberg, 2006). Resolving the current negativity surrounding the care home sector was reported to help reduce the current level of staff being headhunted from one establishment to another (Paget & Wood, 2014).

2.6.8.5 Acknowledging UK recruitment

Recruitment into the UK nursing profession has been supported over recent years by the employment of overseas nurses. There was a need to understand the recruitment, movement and support processes needed for migrant workers currently being recruited (Paget & Wood, 2014), with suggestions that the UK labour market needed to be fully tested before overseas recruitment was considered (DH, 2006).

2.6.9   Recruitment and employment practices

Theme 9 relates to recruitment and employment practices and the effects of these practices and procedures on the uptake of employment. The evidence included employment stability and improving hiring practices, and these issues are discussed in the next section.

2.6.9.1 Factors which influence employment stability

Employment stability was one of most critical factors for the care sector and was very influential in responding to recruitment issues (Ha et al, 2014). Singh and Schwab's, (2000) study found that staff with previous job stability was a predictor of future organisational stability and reported that short staff tenures of employment produced workplace instability within an organisation (McGilton et al, 2014). One study reported 56% of leavers' reason for

leaving was promotion (Singh & Schwab, 2000), whilst Decker et al. (2009) study attributed it to higher pay rewards.

2.6.9.2 Strategies and approach to improve employment stability

Several studies suggested that to secure employment stability several factors needed to be readdressed as a matter of priority (Hunt et al, 2012; Singh & Schwab, 2000). An evaluation of this workforce wage system to promote competitive rates, to reward staff for their work practices and to offer some combination of retention programmes were some of these approaches (Decker et al, 2009; Hunt et al, 2012). However, most of these strategies did not find a significant association with the registered nursing retention rates, although they did report the relationship between extrinsic factors and the director of nursing tenure were strongly associated with staff retention (Hunt et al, 2012).

2.6.9.3 Improving hiring practices

Improving hiring practices was reported as essential if increased numbers of staff employed was to occur (Castle 2013). A suggestion made was that hiring practices should focus their attention on the recruitment stage of employment rather than concentrating on retaining staff already employed (Singh & Schwab, 2000). This approach starts at the hiring process, with an attempt to draw out potential leavers during the interview process even before staff have been employed. It was suggested that the interview process was used as an opportunity to ensure the job was compatible with the staff's own personal lifestyle.

An alternative strategy within the recruitment process was to understand the personal and professional needs of people at the hiring and pre-employment stages (Chou, 2012). Staff were considered to have their own personal and professional needs which influenced job satisfaction (Chou, 2012). This change in recruitment practices supported the view that having certain staff values, attitudes and their own quality of life prior to employment all determined future staff job satisfaction (Singh & Schwab, 2000). Staff with compassion, commitment and loyalty could be predicted from previous job patterns and number of previous employers which could highlight their suitability for a caring role (McGilton et al, 2014). Thus, recruiting staff who desired a caring role was shown to increase job satisfaction and consequently improved retention rates (Chou, 2012). These practices reflected the need to look wider than skills and

abilities for the job, but to explore the potential to support overall job stability within the establishment.

Another strategy was to target and capture staff when they were in-between employment posts (Skills for Care, 2011), considered an opportunity not to be missed. Supporting this process by offering clear pathways for advancement, training and an induction framework was reported whilst Chou (2012) noted that feeling valued and appreciated compensated for a lack of financial reward and reduced dissatisfaction in the workplace.

Temporary staff contracts have an added consequence of driving up recruitment costs which impacts on the financial stability of the organisation (Castle, 2013). The cost of temporary staff and supporting gaps in staffing was reported to influence staff turnover (Castle, 2013). The development of an effective teamwork approach which supports individual staff needs was proposed as an approach to delivering high quality care, which was linked to improvements in staff satisfaction.

2.6.9.4 Promotion of safer recruitment practices

The promotion of good recruitment practices aimed to improve the uptake of staff (DH, 2006). Examples to support recruitment processes included reviewing and improving work contracts, the use of internal pools of staff, increasing secondment opportunities, reviewing current staff vacancies and early identification of staff at potential risk of redundancy (DH, 2006). An innovative recommendation for NHS Health Boards was to retain and manage a dedicated talent pool of staff who could respond to staffing gaps (DH, 2006). An emphasis on the total organisational packages available may enhance the overall employment rewards, bonus rewards for recruiting colleagues, access to training and development, transport schemes, and childcare vouchers for new recruits (Skills for Care, 2009).

It is vital that the care industry follows robust recruitment policies and practices, similar to those already in place in Scotland from the Care Commission (2008). The Scottish *Safer recruitment through better recruitment* guidance (2007) helped support the use and development of recruitment and selection processes. This included existing practices such as national care standards, regulations, the adherence to Social Care Acts, codes of practice and good practice

guidance. Improving organisational systems for recruiting staff ensured service users were safeguarded and reaffirmed that legal requirements had been met. Several Reports (n=3) suggested good employment practices went wider than the organisation itself and that service users should also be familiar with current practices.

The Care Commission (2008) suggested key within recruitment processes was for providers to adopt and implement safer systems when recruiting their employees. This Report stated that the quality of existing recruitment practices varies across services, with 225 services having at least one requirement following inspection visits. Organisations needed to follow robust recruitment policies and practice, including involving the right people in the recruitment processes to ensure good recruitment practices were adhered to. Employment failings were frequently reported as failing to take up and check references, carry out DBS checks, confirm applicants' fitness to do the job (mental and physical) as well as checking staff skills, qualifications and experience. Generally poor practices were not being adhered to by organisations. A Scottish survey confirmed that follow up inspections did in fact promote safer working practices (Care Commission, 2008).

2.6.9.5 Improving Local Authority practices

Local Authorities needed to promote better and reasonable employment to manage staffing (Paget & Wood, 2014). Local Authorities had clear policies about recruiting staff and checking documentation and the use of these were encouraged (Care Commission, 2008). Tools such as the 'preparing for practice' toolkit should be promoted, these were practical guidance documents to support managers on staff induction and codes of practice. Reviewing the standards on management and staffing was also needed.

Another approach suggested that relatives should get involved more and could ask about the last inspection report, recruitment practices, explore the organisations standards and codes of practice. Discussions with managers needed to be sought if concerns were raised about any staff member. A new process was to get relatives involved in all steps of the recruiting stages, so they felt assured and this would potentially drive up quality and working practices within the organisation.

The Care Commission (2008) report suggested that as part of good employment practices organisations should promote care staff to ensure that their references had been taken up. They should challenge providers if inappropriate practices did not occur. When staff left, the need for managers to offer replacements, the time and energy to recruit along with additional hiring costs was considered a negative factor within the organisations (Castle, 2013). Low staffing levels resulted in the increased use of temporary staff which negatively impacted on the permanent staff. There was a great need to improve working conditions and to improve working practices which directly increased job satisfaction, which was proposed to reduce staff turnover (Castle, 2013).

2.7 Summary of findings

Through the scoping review process, different approaches to aiding care homes recruitment issues were uncovered, with many appearing very similar for both retention and recruitment (Chenoweth et al, 2010). The 9 themes reflected these factors and was represented in a model (page 49). The evidence showed most of the individual themes were all inter-linked and influenced by job satisfaction. For example, Theme 2 reported that education, training and ongoing staff development could support recruitment practices. These elements were also influential in improving staff job satisfaction through feelings of being valued (Skills for Care, 2011).

Quality improvement practices that focus on both staff and resident outcomes were shown to be the most effective at addressing factors that negatively impact on staff satisfaction and commitment (Karsh et al, 2005). Looking at the evidence of factors that influence job satisfaction, it reinforced the need for a major shift in resolving the serious problem of staff turnover, whilst reiterating that performing isolated changes remain ineffective across the wider sector (Riggs & Rantz, 2001). Whilst job satisfaction and dissatisfaction has been widely studied, the consensus was, that understanding how to better manage the issues remains limited (Squires et al, 2015). Numerous initiatives were found to be already in existence which focused on improvements and changes to supporting the workforce, with several suggestions against the development of further initiatives (Care England, 2015).

Phase 1 of the study, has so far explored management strategies, approaches and tools which assist care home workforce practices, helping to support employment stability of the workforce.

The data has added to the current evidence base for the care home workforce, and through its contribution has demonstrated that staff issues were very complex, signifying the very individual nature and threshold for satisfaction and dissatisfaction across the workforce. The evidence noted that job satisfaction and its influence on attracting staff into the care profession was evident. However, making clear links between those staff intending to leave and those that went on to leave, was very difficult.

Consequently, the intention of Phase 2 of the study was to build on this knowledge and to further empirically understand the perceptions of this workforce. Investment in this workforce is a priority for the future (Imison et al, 2016), particularly with the rising need for more complex healthcare provision (RCN, 2014). Reducing the current evidence gap is essential (Stow, 2016), while further inquiry into employment practices can strengthen the individual perspectives of the various workforce groups working in this sector (Bostrom et al, 2012). Thus, better understanding the influences and impact of job satisfaction within this context and understanding reasons why staff stay or leave their employment, can help to assist the recruitment and retention of staff (Public Health England et al, 2017).

2.8 Strengths and limitations of the scoping review

2.8.1 Strengths

This scoping review, as far as the researcher is aware, is the first scoping review to explore management practices within a care home setting. This has provided a unique insight into the strategies, approaches and tools which are used within this contextual environment and greatly enhances the knowledge base around care home workforce practices.

The scoping review methodology was deemed appropriate to meet the study aims, through providing a vast array of data which supported the generation of the 9 themes; this adding to the care home sector evidence base.

The scoping review design, through its iterative processes enabled an overview to be taken of the topic, with the subsequent stages such as the preliminary searching and stakeholder discussions, helping to narrow down and focus the research question. This step by step approach was clearly defined with the structured framework of Arksey and O'Malley (2005) providing

methodological rigour and transparency to the study (Mays et al, 2001). This facilitated a greater understanding of management practices within the care home context, which adds to, and expands on the under researched literature base for the care home workforce.

2.8.2   Limitations

The objectives of Phase 1 of the study focused on exploring workforce practices and approaches which may influence job satisfaction in the care home workforce. A worldwide approach to reviewing the literature was taken, which reflected the international context and variances of care homes and was incorporated into the search strategy, with terms such as 'long-term care establishment' and 'rehabilitation homes'. The delivery of care and workforce issues may differ from country to country, thus it is acknowledged that these settings may not be fully reflective to UK care homes and their workforce practices, with a possibility of limiting the transferability of the findings.

A quality appraisal stage may be considered to be lacking from the literature review, as it was not performed in the scoping review. However, one of the aims of the scoping review was to "map rapidly the key concepts" underpinning a research area (Mays et al, 2001, p.194), particularly when exploring a complex topic area (Anderson et al, 2008). Thus, this enabled quicker search techniques to be undertaken which permitted a more in-depth overview of the subject area (Mays et al, 2001), and as such, was considered suitable for this study. However, adding weight to the quality and transferability of the findings, an evidence table permitting an assessment of the strength of the evidence from the included studies, was included.

The topics of staffing shortages and variances in skill mix were excluded from the search strategy, as following the preliminary searches it was considered that much of this evidence related to the quality and safety of care being delivered, and less to employment stability of the workforce itself. In hindsight, this subject matter may have offered a different perspective on job satisfaction.

Researcher inexperience when undertaking the literature review may have impacted on the findings, particularly during the search strategy and data extraction processes (Booth, 2015). However, process refinement and consistency were promoted with the assistance of an

information scientist, whilst the scoping review framework added structure to these processes, supporting methodological rigor (Valaitis et al, 2012) and transparency (Mays et al, 2001). Potential bias was reduced further through the inclusion of several databases when searching the evidence base, whilst the inclusion of the stakeholder discussions reinforced the direction and scope of the study, while highlighting gaps in the evidence (Straus et al, 2009). Regular supervisory team discussions throughout the process also served to maintain reliability of the search findings.

2.9   Summary of Chapter

This chapter has reported the literature review which generated 9 overarching themes associated with multi-factorial approaches to supporting recruitment and retirement of staff. Job satisfaction was found to be a significant factor interlinking all the themes and influenced staff to stay or leave the care home organisation. The contribution of these findings to the current literature evidence base surrounding care homes and its workforce has been demonstrated. This key finding was selected for the next phase of the research study, which led onto reviewing, and determining, the most appropriate methodology for the subsequent research study. The report of the methodology used to guide the empirical phase of the research study is provided in the next chapter

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CHAPTER THREE:
METHODOLOGY

3.1 Introduction

In this chapter, the methodological approach used in Phase 2 of this study is presented, building on the findings generated from the earlier scoping review. Consideration was given to several approaches in order to find the suitable methodology for this study. An appreciation of the contextual environment and the need for improvement, as articulated in Chapter 1, was also important to consider at this stage of the research process.

3.2 Philosophical position

Philosophical beliefs relating to the nature of the world and how we develop knowledge, has led to many differing schools of thought used within research. On a continuum, from positivism to interpretivism or pragmatism which provides different means of research investigation.

3.2.1 Ontology and epistemology

The "nature of reality" and how the social world is constructed relates to ontology (Ormston, Spencer, Bernard & Snape, 2014, p.4). It refers to how social reality exists, whether it is a shared reality with a viewpoint that reality exists independently of individual understandings and beliefs, a position of realism. Where social reality is shaped by individual contexts and as such does not exist independent to individual beliefs, this is known as idealism. It is important to understand what individuals know and how they learn about the social world, which provides the basis of our knowledge or truth, known as epistemology (Ormston et al, 2014). Ormston et al. (2014) reports knowledge as being either inductively generated through observation of the world, a "bottom-up" process, or deductively acquired from existing evidence and tested, this being a "top-down" process (p.6). An appreciation of these factors helped position this study and helped guide the direction and decision-making process.

A positivist position argues knowledge is generated through observations (Willis, 2007) whilst affirming that "reality is unaffected by the research process" (Ormston et al, 2014, p.10). This view assumes the researcher plays no part within the researcher's natural world, which

reinforces the objectivity of the research findings reflected by having no effect on the facts of the investigation (Ormston et al, 2014). However, Blaikie (2007) reported that research investigation is always composed and influenced by the researcher's assumptions of the world, whether this is derived from previous experience, actions, thoughts or learned knowledge.

The interpretive perspective reinforces the paradigm that "reality is socially constructed" (Mertens, 2005, p.12). Mackenzie and Knipe (2006) identified qualitative research as exploratory research and is used to understand the underlying reasons, opinions and motivations of individuals which provides an insight into a specific problem. Qualitative research recognises the role and perspective of the researcher and the openness required to enable inductive development of new theories (Ormston et al, 2014).

3.2.2   Qualitative methodology

Qualitative methodology comprises naturalistic, interpretative approaches to exploring phenomena within research (Ormston et al, 2014) and its approach facilitates the application of meaning from a personal stance so that the issue being studied can be understood (Baxter & Jack, 2008). Burns (2000) defined research as a systematic investigation or inquiry, with the research paradigm (or theoretical framework) helping to guide the philosophical intent, research design and overarching direction of the study (Mackenzie & Knipe, 2006).

Through the research process, generating patterns or meaning to the evidence, whilst inductively building on previous knowledge and learning can be achieved (Creswell, 2003). The key focus is to explore the views and experiences of humans within their own environments, as it is the views of their own reality that appeals to the researcher. This is deemed one of its advantages as through a qualitative methodology, participants can tell their own stories within their own context and appreciate why certain actions were performed (Merriam, 2009). Charmaz (2006) reports that research participants construct their individual and shared meaning of the phenomenon and therefore construct the realities in which they participate.

Research investigation of a specific context so that multiple features of a phenomena can be interpreted and understood is a key feature within qualitative research (Clarke, Reed, & Keyes,

2015). Uncovering meaning through the subjective voice of the participants adds greater understanding of the phenomena and would offer a valuable insight into the subject area within this thesis. Ritchie and Ormston (2014) proposed that contextual research enables the researcher to "unpack issues" associated with the phenomena and explore how they are understood by the study participants (p.31).

3.2.3 Constructivism

The epistemology which frames this qualitative research study is based on constructivism, a philosophical approach which has the intention of understanding "the world of human experience" (Cohen & Manion, 1994, p.36). It has been suggested that constructivism is a middle ground between rationalist and interpretivist approaches and provides a foundation for the development of new theories (Adler, 1997). This approach acknowledges that meaning is constructed from individual experiences, so the same event could be interpreted in differing ways by different people (Crotty, 1998). Implicit within this school of thought is that knowledge is "actively constructed by human beings rather than being passively received by them" (Ormston et al, 2014, p.13). This research poses to "understand phenomena through accessing the meanings that participants assign to them" (Orlikowski & Baroudi, 1991, p.5), which strengthens the ontological perspective that reality is subjective, hence reflecting the constructivist perspective.

Understanding and exploring what makes staff remain content within their role, what influences this from an organisational stance and, if full potential was not achieved, the effects of staff dissatisfaction, was demonstrated as an area for further investigation. With the research study required to gain an understanding of the care home workforce within a local context, the decision was made to use case study approach. Recognising the value of this approach, through its ability to construct knowledge within a specific context (i.e. the case), was regarded as most fitting to understanding the experiences of staff. Based on the belief that reality is 'real' (Yin, 1994), exploring and building on knowledge in this setting strengthens the philosophical relationship between the constructivist perspective and the case study approach.

3.3   Review of alternative perspectives

Grounded theory focuses on the development of theories through the identification of categories from the data and drawing relationships between them (Ormston et al, 2014). Constructivism is similar to grounded theory in that it constructs relationships between the constructed data, however it goes further in its approach by looking at meaning and explanations for the themes, whilst in a particular context (Orlikowski & Baroudi, 1991). Narrative analysis research on the other hand is more focused on studying the way individuals tell their stories and how they construct these stories, rather than just the meanings placed within the narrative themselves (Ormston et al, 2014). Lastly ethnography situates the researcher within the community itself in order to understand the individual's or group's social world, which provides descriptions of their individual cultures and beliefs (Reeves, Kuper & Hodges, 2008).

Several approaches were deemed suitable for use within this study; however, criticism has been voiced towards many of them, thus it was imperative to consider alternative stances within this thesis (MacNaughton, Rolfe & Siraj-Blatchford, 2001). Following deliberation, the alternative approaches of grounded theory, ethnography and narrative analysis research were not considered sufficient to meet the Phase 2 study objectives. For instance, the study aimed to explore and understand the meaning behind the study data, and was less about developing theory, thus grounded theory approach was not chosen. Narrative analysis research pays more attention to the way the stories are constructed, and less to the meaning underpinning the individual narratives, while central within the ethnography approach is exploration of the social world, its cultures and beliefs (Reeves et al, 2008). Consequently, these approaches were not selected for use.

For this study, the methodological approach was influenced by the scoping review findings (chapter 2) and underpinned the study's research intentions. Based on the research question presented in chapter 1, the constructivist perspective was considered to be the most appropriate approach to exploring and explaining workforce practices within a care home setting.

3.4   Case Study Approach

Case study research methodology is considered a valuable approach within health care research (Baxter & Jack, 2008), with a benefit of its design being its capacity to test developed theory

or assist the development of new theories by adding to the evidence base (George & Bennett, 2005). It offers the ability to explore a phenomenon in its context, (that of job satisfaction in care homes), whilst assuming the context is significant to understanding the phenomenon (Clarke et al, 2015). Integral in its primary design facilitates "a holistic understanding of research participants' views and actions in the context of their lives" (Ormston et al, 2014, p.13), which permits real-life issues embedded within complex clinical environments to inform professional practice and policy decisions (Baxter & Jack, 2008).

Bromley (1990) described case study methodology as "a systematic inquiry into an event or a set of related events which aims to describe and explain the phenomenon of interest" (p.302), thus enabling "in-depth, multi-faceted explorations of complex issues in their real-life settings" (Crowe et al, 2011, p.1). The design is particularly useful when focusing on patient perspectives and experiences, personal accounts and diaries, which provide a wealth of information (Zucker, 2001). A case can be defined as "an individual, a community, an organisation, a nation-state, an empire, or a civilization" (Sjoberg, Williams, Vaughan & Sjoberg, 1991, p.36). It is for this reason sometimes referred to as a "naturalistic" design (Crowe et al, 2011, p.1). This method of research enables contemporary researchers to obtain rich subjective data underpinned by experience and meaning, thereby providing a full and complete description and understanding of the case (Zucker, 2001). As the focus of this study was to explore staff perspectives within the care home setting, the suitability of the case study approach in understanding an issue in context, was reinforced.

3.4.1 Case study approach underpinning the research design

The *next step* was to determine the most suitable case study approach to underpin its design and data collection methods, whilst ensuring the constructivist viewpoint was followed. This required a review of case study approaches.

3.4.2 Case study approaches

The viewpoints of two eminent case study founders Robert Yin (1984) and Robert Stake (1995) were examined to determine the most fitting framework approach to guide this research study. The two approaches have many similarities which recognise "the importance of subjective human creation of meaning", with both supporting theory development and intervention within

healthcare research (Baxter & Jack, 2008, p.544). Although both viewpoints had many similarities, (and acknowledging some differences), an in-depth review of both theoretical frameworks was required. This enabled the best fitting approach to be selected which was central to the success of the study's aims and objectives (Baxter & Jack, 2008).

Yin (1984) and Stake (1995) have imparted clear direction for case study approaches, having developed robust conceptual frameworks to support its methodology. Both Yin (2003) and Stake (1995) reinforced the importance of positioning the case study approach within a philosophical framework, which subsequently aids the clarity and structure of data collection methods (Lauckner, Paterson & Krupa, 2012). Tellis (1997) claimed if these scientific procedures were followed, the design would accomplish its study aims.

Yin (2009) describes the case study as an approach to empirical enquiry, with his highly-quoted definition that it "investigates a contemporary phenomenon within its real-life context, when the boundaries between phenomenon and context are not clearly evident" (Yin 2009, p.13). Stake meanwhile suggested "a case study is both the process of learning about the case and the product of our learning" (Stake, 1995, p.237), recommending a step by step approach. Stake clearly advocated a more naturalistic approach, underpinned by a grounded theory philosophy within contextual descriptions.

Stake's interpretation specifically links to the exploration of the different perspectives of those involved in the case, which takes a different stance to Yin (Lauckner et al, 2012). The importance of knowing and understanding the phenomenon in its context and how this occurs in practice is key to case study research. Stake's approach offers the opportunity of learning in a specific context to explore the phenomenon. It assumes the need to understand the impact of the context on the establishment, processes and outcomes of the phenomenon (Clarke et al, 2015). Stake (1995) reported a "naturalistic generalisation" which facilitated a greater understanding of the phenomenon (p.86).

Both researchers position their case study approaches within a constructivism paradigm, one that reflects the "truth is relative and that it is dependent on one's perspective" (Baxter & Jack, 2008, p.545). However, a clear distinction between their designs is the definition of the type of

case study undertaken. For instance, Yin (1994) supports a study design based on exploration and description of the phenomenon and is aligned towards the positivist paradigm with an assumption that the reality is 'real'. Yin (1993) reported 3 theoretical designs, exploratory, descriptive or explanatory and distinguishes between single, holistic, and multiple-case studies within a study. Whereas Stake (1995) acknowledged the researcher intent and proposed 3 designs, intrinsic, instrumental and collective. Kozma and Anderson (2002) suggested the uniqueness of instrumental case studies was not the 'case' but on the underlying issues, relationships and causes that generalises beyond the case.

3.4.3   Rationale for Yin's approach

Both Yin and Stake's approaches to performing case study research is reflective of the constructivist approach to the research investigation. However, it was Yin's definition that resonated for this thesis, distinguishing the case study as a process of scientific investigation, as opposed to Stake defining it as the unit of study (Yin, 2009; Stake, 1995). The purpose of performing case study research highlighted the differences between the two researchers, whilst overall, the study appeared allied to Yin's perspective.

What is evident within Yin's case study approach (Yin, 1984) is how this methodology fits in well with exploring and answering a specific type of research question, that of exploring and understanding job satisfaction / dissatisfaction. This reinforced the approach that "the all-encompassing feature of a case study is its intense focus on a single phenomenon within its real-life context" (Yin 1999 p.1211). Yin's approach supports the contemporary nature of the phenomenon, responding to the importance of real-life situations, with the setting being influential to the phenomenon, this making it difficult to successfully study one element without the other (Clarke et al, 2015).

Difficulties currently faced within the care home context have been raised and discussed earlier within Chapter 1, which clearly demonstrated the value of further exploration within this complex contextual environment. The generation of unanswered questions explaining what makes staff experiences positive or not, what impacts on them personally and its effect on the organisation, reflected the case as a means of "examining the various facets of a causal argument" (Yin, 2003, p.154). With the desire to understand and interpret experiences, attitudes and behaviours within context led to an alignment to Yin's approach.

3.5 Case Study Design

The design of the case study enabled exploration of individuals or organisations through understanding relationships, communities and interventions (Yin, 2003). The design investigated the phenomenon and context which are intertwined, and accordingly the sampling ensured it reflected the context drawing effective findings from the analysis. The value of theory which underpins the design, selection, conduct and interpretation of the case study was considered important (Keen & Packwood, 1995). Case study design enabled the research to be inductively developed and did suit the constructivism approach of building on data, although many believe it's often a criticism of case study design (van Thiel, 2014). These decisions were very individual to the care home context chosen and required careful thought, whilst continually referring to the aims of the research question.

Design imitations is a criticism of case study research, particularly relating to the theoretical and methodological elements (Clarke et al, 2015). Thus, integral within this approach was the use of a formal protocol which ensured the study's reliability (Yin, 1994), which aided the logical planning around data collection and its measurements, which helped to shape the overall processes and procedures (Yin, 2003). (The case study methods, reflective of Yin's approach, are expanded on in the next chapter). Rigour was essential with a focus to provide "research that is well-designed and well-conducted and to generate well-funded and trustworthy evidence" (Ormston et al, 2014, p.23). The protocol therefore enhanced the study's methodological rigour as the transparency of the methods and design were explicit from the outset (Kitto, Chesters & Grbich, 2008). Rigour and trustworthiness are discussed in more depth in chapter 4, page 111.

3.6 Defining the case

Yin (1994) suggests a need to bind the case to ensure a reasonable topic scope, which avoids the research question being too broad or extensive (Baxter & Jack, 2008). Defining the case and its boundaries was vital to address the research question (focusing on job satisfaction) and its impact on sampling, thus an iterative process was recommended in the design of the case study, which required several modifications (George & Bennett, 2005).

Clarke et al. (2015) suggested treating the phenomenon to be researched as the 'case' and as a single distinct entity is required, alongside exploration of its contextual environment. However, the fact the phenomenon and the context are closely interlinked, makes the identification of a 'case' not as clear cut and easy to perform as one would anticipate. The very nature that the phenomenon and its context are inextricably entwined, makes determining the boundary around the case difficult, a factor recognised within Yin's approach.

3.6.1 Definition of the 'case' for this study

Defining the case was a crucial process of addressing the research question. The research question aimed to understand the views and attitudes of the care home workforce in relation to job satisfaction / dissatisfaction, their knowledge of current strategies and approaches to promoting job satisfaction, identification of whether these practices were being employed in the workplace and what staff believed the effect of these practices had on them. As such, the appropriate 'case' for this research question was identified as the organisation and for this study, i.e. *the care home*.

3.7 Summary of Chapter

This chapter determined the philosophical, epistemology and ontological approach for the study alongside the contextual environment. The rationale for the case study design was justified and reflected the thesis's overarching aims and objectives, with the case study design explained in detail. In the next chapter, the report of the undertaking of the case study research with case study methods is presented.

CHAPTER FOUR:
CASE STUDY

4.1 Introduction

Thus far in this thesis, the need to explore recruitment and retention within this care home sector has been presented, while the earlier scoping review findings have demonstrated that, highlighted across all nine themes, the concept of job satisfaction warrants further investigation. A gap in the literature has been shown, reflected in a limited understanding about factors which influence job satisfaction in the care home workforce, thus a principal aim of this research study was to explore staff experiences and management practices which influence and impact on job satisfaction.

In this chapter, the case study phase is reported which includes an explanation of the selection of the case, recruitment sampling, data collection and data analysis methods. The ethical considerations necessary to undertake the proposed case study are reported. The case study findings are presented in Chapter 5 of the thesis.

4.2 Methods

The *following sections* report the case study methods, including selection of the case, recruitment of participants, data collection and data analysis.

4.3 The 'case'

In Chapter 3, defining the care home as the 'case' has already been established. Establishing boundaries and defining the 'case' was crucial to ensure answering the 'how' and 'why' questions, influenced by the context, within which the phenomena of job satisfaction was situated (Baxter & Jack, 2008). Inappropriate selection of the case could potentially have impacted on the overall study preventing it responding to the research question and meeting its anticipated aims. As the intention of this study was to explore staff experiences across various organisational contexts, this subsequently reiterated the value of Yin's structured transparent protocol and multiple case approach was used (Yin, 2009).

4.3.1 Selection of the case

Purposive sampling was performed with the specific intention of selecting cases which aimed to add to the richness of the collected data (Patton, 2002). This pragmatic approach ensured the phenomena of interest was central to the study's design (Teddie & Yu, 2007). For this study, a purposeful sample of four care homes was undertaken utilising sampling criteria, explained below, which promoted a wide breadth of data, whilst appreciating timescales and availability to undertake data collection.

4.3.2 Criteria for sampling

Within the chosen Health Board, there were nearly 80 care homes which provide placements for residents requiring nursing care. In chapter 1 the focus of this study as care homes which provided nursing care, has been established, thus care homes (without nursing provision) were excluded. Of the 80 care homes (with nursing) identified, it was clear there were variations in size, type, location, ownership and workforce employed within each of these organisations. Consideration was given to various contextual factors when determining selection, with a view to sampling care homes with different case characteristics, see Appendix 6 for care home details. This would offer the potential for comparisons and similarities across cases to be made, enabling one of the study's objectives to be achieved. The following sampling criteria helped guide the selection process of cases:

- geographical location – wide ranging coverage across the Health Board locality

- size – selection of both small (bed capacity below 25) and larger care homes

- rurality – selection of rural and urban settings

- type of care home – care homes providing different types of care provision were selected.

The final selection decision was based on judgement of weighing up how well potential homes matched the purposive criteria, including discussion with the supervisory team. A list of care homes was organised by the above characteristics, with each individual home selected randomly from the list. While, if a care home declined to participate (n=2) the next home on the list was chosen. Two care homes were selected which were providing general nursing care and two care homes selected which were providing care for residents with mental health conditions. Full details of the cases selected, and their individual characteristics are provided in

Chapter 5. An anonymised code was attached to each care home ensuring all data was non-identifiable (further details are presented later in this methods chapter, alongside ethical principles and data management processes).

4.4   Recruitment of participants

Following selection of the care homes, telephone contact was made with each care home manager. Recruitment of the participants was undertaken, as follows:

4.4.1   Local collaborator

An initial meeting was organized in each care home, which enabled the study and research methods to be discussed and allow the manager time to ask questions of the researcher. The managers agreed to be the local collaborator within the care home. This individual was crucial to the research process as it was through contact with the local collaborator that access to the site and to all potential participants was initiated and negotiated (NHS Health Research Authority, 2016). A Memorandum of Understanding (explained later in the chapter, page 113) was completed by each care home manager, signed prior to commencement of the study and securely stored.

4.4.2   Process of sampling participants

Potential participants invited to take part in the study, were outlined within the study aims and Phase 2 objectives (see chapter 1, page 21). Consideration was given to the study size and overall number of study participants, based on practical reasons which included an appreciation of timescales and resources, combined with researcher and staff availability to undertake data collection (Malterud, Siersma, & Guassora, 2015). It was anticipated that a total of 10 participants would be included within each case (n=40); the care home manager and a mixture of the remaining clinical staff, which would be dependent on the current workforce within the care home. As the unregulated care staff tended to be the largest workforce within a care home, it was considered appropriate to have a sample mix of one third registered nurses to two-thirds unregulated staff (maximum of 9 clinical staff). The participant sampling guide assisted this selection process, see Table 8 below.

Participants included	Participants excluded
Care Home Staff:	Care Home Staff:
Care home manager from each care home	All non-clinical staff excluded, except for the care home manager.
All clinical staff including registered nurses & unregulated care staff.	Any staff employed directly by NHS organisations.
All staff employed by the care home provider, whether permanent, regularly employed temporary or agency workers.	Individuals under the age of 18 years
Individuals over the age of 18 years	

Table 8: Participant sampling criteria

4.4.3   Selection of participants

The opportunity to participate in the study was given to each care home manager, all registered nurses and unregulated staff within each care home (n=4). Prior to participant selection, it was made clear that participation was voluntary and any decision to participate remained confidential. Researcher and academic supervisors' contact details were provided on all participant facing documentation. All participant facing documents were provided through the medium of both English and Welsh, in line with the Welsh Language Act (1993).

The participant invitation letter (Appendix 8) and project summary form (Appendix 9) were given to the local collaborator who distributed these documents to the potential participants. Participants indicated if they wanted to take part in the study by contacting the researcher via email, telephone or returning the reply slip, in the pre-paid, addressed envelope provided. Once the participant had agreed to participate in the study, they were further provided with a participant information sheet and consent form (Appendix 10 and 11). The completed consent form hard copy was subsequently collected by the researcher at the time of interview, and securely stored.

Arrangements were made with the participants for a suitable time within the work environment for data collection to take place. Interview schedules were occasionally amended according to the availability of staff, presenting challenges when co-ordinating with the participant work

schedules and the researcher's own employment. Staff shortages on the day, workload changes and maintaining continuity of resident care were influences, which resulted in additional visits. Limited to the time allotted for data collection, convenience sampling was also undertaken, this approach was not considered to impact on the reliability of the study, as a participant group exhibiting similar characteristics was investigated (Saunders, Lewis & Thornhill, 2012). All participants received a signed hard copy of the completed consent form prior to the interview. A total of 40 participants were included in the study, with full details presented later in Figure 14.

4.5   Data collection methods

Key within case study methodology was to ensure data collection addressed the research question and importantly the transferability of the learning from this data set to enrich and contribute to research beyond the 'case' and its contextual setting. Intrinsic within the constructivist approach of studying "a contemporary phenomenon in its real-life context", was the possibility of researcher bias which could influence the overall findings (Yin, 2009, p.73), with every effort made to mediate this from the outset (detailed later in the rigour section of this chapter).

Yin (1994) suggests using a range of data sources as a means of reducing this, such as documentation, archival records, interviews, direct observations, participant observation and physical artefacts. Thus, multiple sources of data collection were an essential component of the design which also offered an additional ability to capture a richness of data from the 'case' (Yin, 1994). The quality and trustworthiness of data collection methods and the subsequent findings is paramount, with further explanations of how this was achieved, presented on page 111.

Data collection was performed in 2 stages:

1. Semi-structured interviews

2. Documentation collection

4.6 Semi-structured interviews

Interviews are considered to be one of the most important methods for data collection in a case study approach (Yin, 2009) and was the main method used within this case study. The constructivist approach was the basis for this study, and as such the building of knowledge was enhanced by using semi-structured rather than open or structured interviews (Ormston et al, 2014). Semi-structured interviews allow for specific issues to be investigated whilst allowing the participant the opportunity to expand on and add information they feel is relevant. They also allow the investigator to probe further into issues raised by participants. Interviews were considered appropriate to explore personal attitudes, behaviour and views of the care home workforce.

4.6.1 Interview guide

Interview questions were drawn from the themes and the gaps identified from the scoping review findings, (chapter 2, page 36). The 9 themes were key to the structure of the interviews and formed the basis of the interview questions. An interview guide was devised (Appendix 12) without restraining the questioning, to enable exploration of the participants' views and experiences.

The interview questions were piloted with 3 colleagues prior to commencement of the study, to determine their suitability. Minor amendments followed which helped streamline the questions, which made them more user friendly and promoted "guided conversations" (Yin, 2009, p.106). All interviews were audio taped and fully transcribed, as close in timeline to the interview as possible, with all personal data stored and disposed of securely in line with University data management policy (see page 113).

4.6.2 Face to face interviews

The interviews were arranged within the participants' area of work and during their working hours, at a time convenient to the individual. Discussion with the local collaborator helped co-ordinate the interviews within quieter work periods and lessen the disruption to care services. 40 interviews were conducted, which included care home managers (n=4), registered nurses (n=9), unregulated staff (n=27). Full details are presented in chapter 5, page 120.

Completion of all interviews required the researcher to visit on numerous occasions, during day hours, evenings and at weekends. On occasions, several interviews had to be rescheduled due to workload and staff shortages, resulting in additional visits until data collection had been completed. Participants were informed of intended digital audio- recording and transcription by the researcher.

The interview timings varied, with each interview taking approximately 15-45 minutes. Occasionally, interviews were interrupted and stopped, to permit the participants to respond to colleagues' requests of assistance with residents' needs. All interviews were subsequently recommenced, although a few interviews had to be shortened due to staff needing to return to their duties.

4.6.3   Transcribing the data

Following the interviews and in readiness for the transcribing of data, each participant was allocated an individual code, to preserve anonymity (see Figure 7 below). This enabled the care home, and the role of the participant to be identifiable to the researcher only, i.e. Site A, third care assistant was recorded as SACA3.

Participants
Sites A, B, C, D
Manager
Nurse Manager (Matron)
Registered Nurse
Care assistant (unregulated staff)

Code
SA /SB /SC /SD
MA
NM
RN
CA
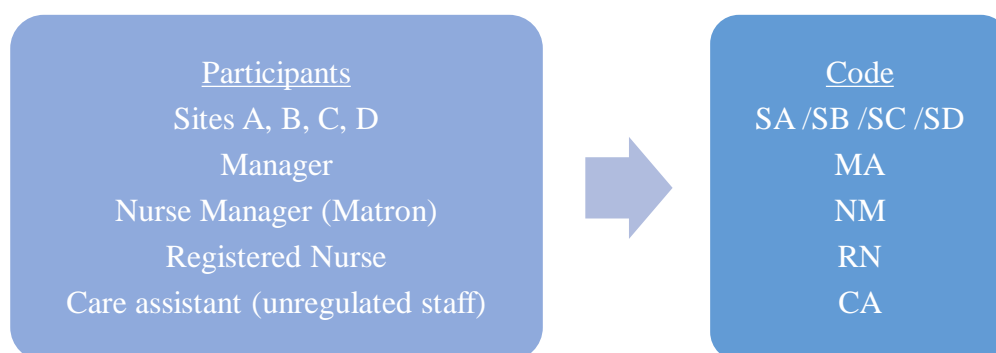
Figure 7: Participant codes

Transcribing the interview data from audiotape to a written record allowed early familiarisation of the data. All data were managed according to University data management processes (see page 113), whereby all personal identifying data were destroyed immediately after this stage had been completed.

4.7   Documentation review

Multiple sources of data is a characteristic of case study research (Baxter & Jack, 2008), with documented data adding to the context backdrop within the study (Yin, 2009). The inclusion of documented evidence was significant to corroborate other forms of data verification, a benefit deemed essential within Yin's approach (2009). The documentation review provided additional data to support the interview data. Yin (2009) determines this stage as "insightful", although he does recognise a possible weakness if accessibility is reduced due to privacy reasons (p.102). Documentation was requested from the care home manager at the time of their interview, either on-line or hard copy (all documents were publicly available).

A document evidence summary form (Appendix 13) was used to determine their relevance to the study, with the number and type of documents collected recorded. The documents included HR policies, guidance, care home mission statement, statement of staff wellbeing and internal memos. Each document was subsequently aligned to an individual code to preserve anonymity (see Figure 8 below). This enabled the documented data to be identifiable to the researcher only, i.e. Site C, document 4 was recorded as DSA4. Full details of the types and number of documents collected are detailed later in the chapter.

Figure 8: Document codes

4.8   Data analysis methods

Data analysis can use a combination of both inductive and deductive approaches, aligning it to the purpose of the research study (Elo & Kyngäs, 2008). An inductive approach derives the themes or categories from the data, which is useful when there is limited available knowledge about the phenomena in question (Lauri & Kyngäs, 2005, cited in Elo & Kyngäs, 2008). Whilst a deductive approach is used to test an earlier theory or model (Burns & Grove, 2005). Grouping the main themes helped guide the data which enabled valid inferences to be made with the

purpose of providing a new insight from the initial documented data (Krippendorff, 2004), although Vimal and Subramani (2017) suggested a multi-dimensional approach should be taken.

In this study, a coding framework was used, which facilitated a deductive approach to the data analysis, whilst also enabling inductive codes to be created. An illustration of the data analysis stages (Figure 12) is presented at the end of this section.

Data analysis was completed in 3 separate stages:

1. Analysis of the participant data, within sites and then across sites

2. Analysis of the documents

3. Integration of the datasets

4.9   Analysis of the participant data

Thematic analysis is a flexible, useful approach to identifying, analysing and reporting the patterns and themes within the data and is frequently used within qualitative research (Braun & Clarke, 2006). The 5 key stages of analysis included familiarisation, coding and sorting, data summary and display, and forms the basis for this analysis stage. McLeod (2001) supports this method of analysis within qualitative research as it can provide in-depth detail and an understanding of experiences based on reality, enabling the researcher to gain an understanding of the investigated phenomena.

4.9.1   Familiarisation of the data

The identification of themes within the datasets, which represented meaning or patterns, were captured through a process of coding (Braun & Clarke, 2006). The initial stage of the data analysis required familiarization of the transcribed data and this was achieved by thorough reading and re-reading. Gaining an overall impression and understanding of the participant responses was extremely important, both individually and across all care homes. The transcribed data (reflecting the participant responses) were studied one by one, as a large volume of data was generated from the interviewing process.

4.9.2   Coding

Coding provided a means to represent the qualitative data in words or phrases, with the intention of uncovering emerging themes (Lacey & Luff, 2009). A coding framework was developed based on the nine themes from the scoping review findings (Chapter 2). The nine themes identified different approaches and strategies when responding to recruitment and retention and was a useful starting point for this next stage of data analysis. The themes (n=9) provided an initial structure for the coding framework, helping to organise and build up the codes.

Organization of the transcribed data was achieved, using open coding and data abstraction processes (Elo & Kyngäs, 2008). Open coding occurred which enabled the text to be read, enabling descriptions of the content to be recorded in the margins (Hsieh & Shannon, 2005). The preliminary codes were collected with many being modified and re-coded, as they were brought together according to their similarities (Burnard, 1991). Grouping these codes rendered them intelligible and more useful for the researcher, with Dey (2004) recommending continually revisiting the original evidence to ensure it was accurately reflected in the codes. Cavanagh (1997) suggested these processes enabled the phenomena in question to be understood, generating new knowledge (Dey, 2004). This stage was slow and meticulous which ensured no data was missed, thus assuring all relevant participant data was captured within the codes. Refining the large volume of codes helped with sorting and streamlining the data later.

4.9.3   Sorting

Interpretation of the codes was important to enable them to be developed into themes. For example, the 'training' code was pertinent to both individual' job satisfaction' (Theme 1) and 'staff roles and care practices' (Theme 7), thus reinforcing the need for good description and interpretation of the individual code. This sorting stage enabled the identification of deductive codes (n=92) alongside new inductive codes (n=23), which provided new data not previously identified in the scoping review findings. Data mapping against the coding framework was undertaken, with all the codes finally aligned to the nine themes. During the drafting and refining process during this stage, one theme was removed as no corresponding codes were identified, and no additional new themes emerged from the data.

4.9.4   Data summary

The final coding framework included 115 individual codes, which comprised reverse codes (n=23), indicating both positive and negative participant associations to the code and in vivo codes (n=17), formed from participant verbatim quotes. Appendix 14 provides a fuller summary of all final codes, whilst a brief overview is illustrated below:
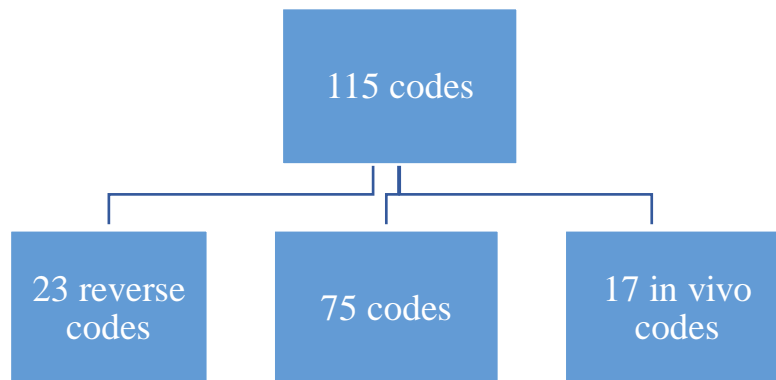
Figure 9: Types of codes identified

4.9.5   Display

The final step was the visual arrangement of the findings from the 40 participant interviews, which is seen in the final coding framework (Appendix 15). The coding framework portrayed a visual representation of the participant data, making the data more obvious and distinctive, thus aiding interpretation and subsequent integration of the data later in the analysis process. Further explanation of the final codes is reported in the next chapter.

4.10   Analysis of the documents

Documentation review is "a data collection method for evaluation" (Evaluation Research Team, 2009, p.1). This method reviews the documented evidence which helps to understand the organisation it operates in, whilst bringing large amounts of textual data together, which reflects the same meanings (Cavanagh, 1997). This stage enabled the documented data to be reviewed; whereby all documentation was examined for additional information to support or refute the interview data.

4.10.1   Undertaking the documentation review

The documentation review was undertaken on completion of the participant interviews, with Yin (2009) recommending documents be included. Relevance to the phenomena in question was established and determined according to the aims and objectives of the study (identified earlier in chapter 1). Each document (n=20) was read and absorbed by the researcher several times, which encouraged a fuller understanding of the document content and its meaning. Analysis of each document required observations of similar phrases or wording relating to job satisfaction and workforce practices. This stage was fairly time consuming due to the number and length of documents collected. All documents were reviewed in parallel which promoted consistency of the documented data.

As with the interview data, robust data management processes were adhered to. A total of 20 documents were collected from the cases, with details reported in Chapter 5, along with a brief outline providing an overall impression of each document, which helped with organisation and analysis of the data (Evaluation Research Team, 2009).

4.11   Integration of the datasets

The purpose of this stage was to amalgamate datasets with the aim of generating overarching themes, initially to represent each case and thereafter the entire case study. Integration and merging data added depth and richness to the findings (Murphy & Casey, 2009) and promoted a greater understanding of the issues and experiences that staff encountered in relation to job satisfaction.

The processes of integrating the data were lengthy and undertaken in separate stages, which initially involved synthesis of the two data sources to reflect the date for each case. Further synthesis was then performed across cases, which presented the main themes across all cases. More detailed explanation of these data analysis stages is reported below, whilst the findings are presented in Chapter 5.

4.11.1 Data integration per individual cases

During the analysis stage earlier, the data (codes and document summary) were aligned to each individual case in readiness for the next phase, the merging of the two sets together. The codes were combined with the documentation data in an inductive manner. Although often limited in relation to job satisfaction and workforce practices, the documented data was found to corroborate the participant responses (Yin, 2009). The integration of these codes provided a greater awareness and understanding of each individual case.

From this, new themes started to be inductively created, which were grouped together, generating several categories. The newly formed categories (n=30) gave a greater synopsis of factors influencing job satisfaction for each case (see Appendix 16). This comprehensive new knowledge and understanding per case enabled similarities and differences across cases to be studied. This process fulfilled one of the research aims (set out in chapter 1), with these findings reported in the next chapter.

4.11.2 Cross – case integration of data

Following analysis of the data per individual cases, the next step was cross-case analysis, which combined all the individual categories (n=30) enabling integration of the data across all four cases. This merging reflected the entire case study data, which permitted an overarching perspective on job satisfaction in the workplace, within a local context.

The formation of the cross-case categories was achieved by bringing all the individual categories together. For example, all cases reported a category of training which fundamentally influenced job satisfaction. This was reported through attendance on the training itself which provided better levels of care, along with learning through peer support to improve care practices.

The above process generated 10 cross-case categories representative of all the case study findings. These cross-case categories illustrated below, demonstrate the factors which impact on staff job satisfaction.
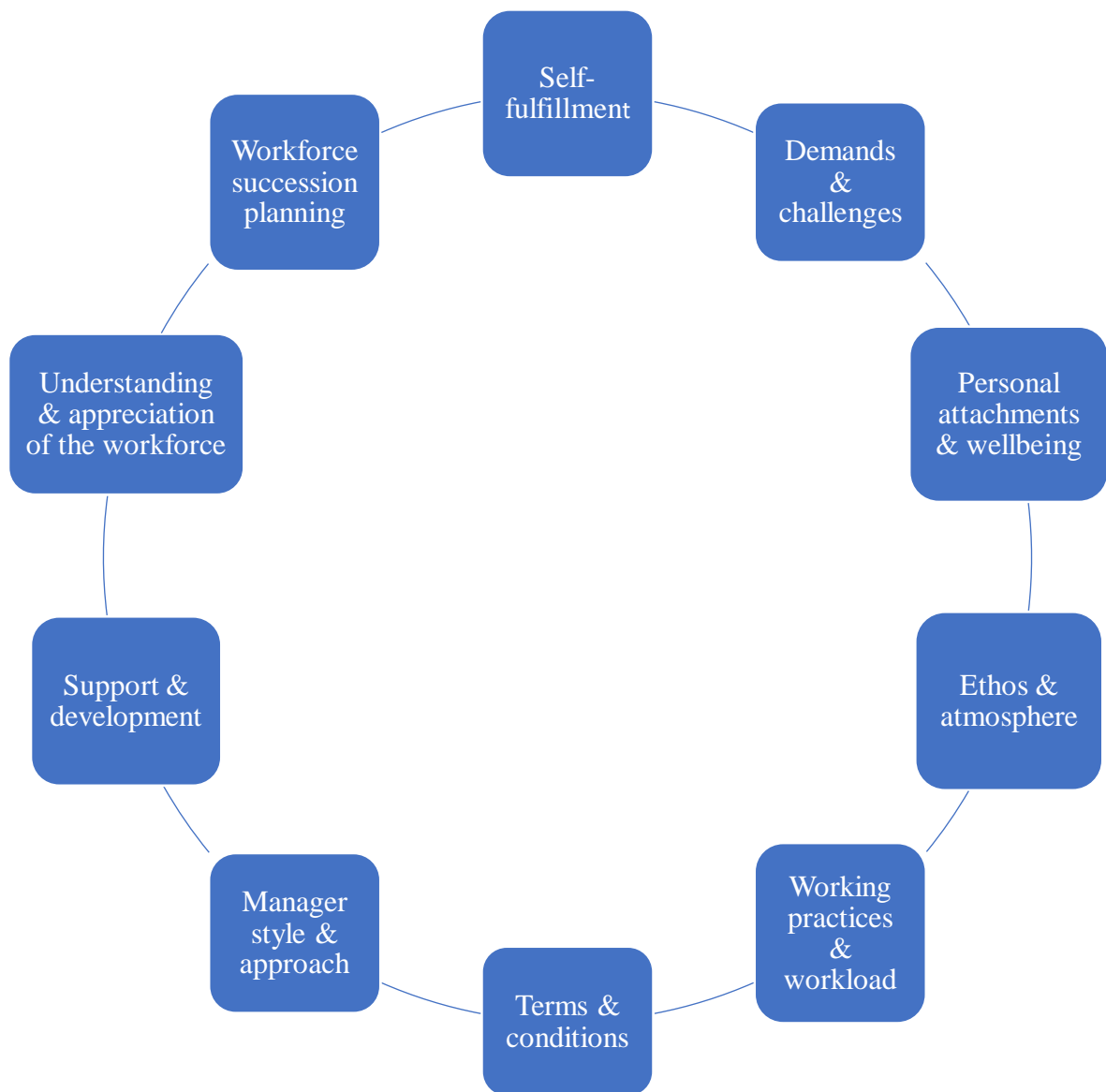
Figure 10: Cross-case categories

The last step in the data analysis process was achieved through grouping the above cross-case categories which provided 3 overarching final themes (see Figure 11 below). These themes are representative of the case study data in its entirety, with detailed findings presented in the next chapter of this thesis.

Figure 11: Final case study themes

Figure 12: Data analysis stages
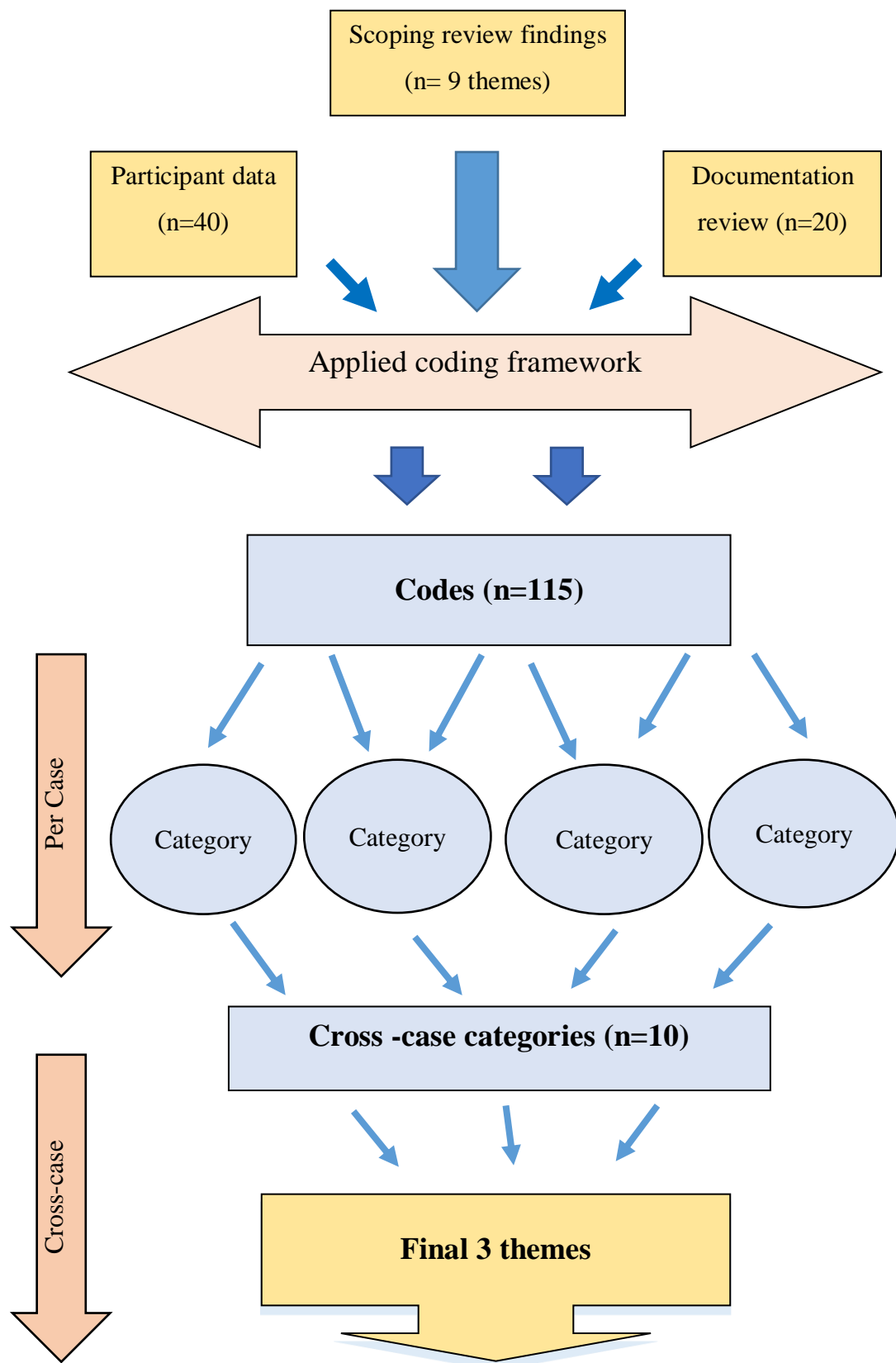
4.12　　　Ensuring rigour within the study

The rigour of this qualitative research study was enhanced through trustworthiness, dependability, confirmability and transferability of the findings (Lincoln & Guba, 1985). Trustworthiness of the data, often posed as a critical element within case study research, was assured through accurately describing the phenomena being studied (Lauckner et al, 2012). Accurately capturing the phenomena, that of job satisfaction, was achieved which was essential to affirm the credibility and transferability of the findings to other similar settings.

The intention of this study was to explore and recognise local findings which could add to the wider knowledge base, thus, transferability to other settings was an important aspect of this applied research (Lacey, 2010). "Thick descriptions" ensured the data was adequately described (Houghton et al, 2013, p.16), and achieved using a case study approach, to gain an insight into job satisfaction issues and experiences within their local setting. Findings from this type of qualitative design are sometimes perceived to be too unique and thought to reduce the likelihood of generalizability, however, the findings from this study were considered highly valuable, with the transferability of this data enhancing "their own intrinsic worth" (O'Leary, 2004, p.7).

Confirmability is concerned with ensuring the findings "are clearly derived from the data" (Tobin & Begley, 2004, p.392), and its application is enhanced through multiple case study design, where greater replicability and confidence in the findings can be achieved (Miles & Huberman, 1994), although a single case approach remains suitable when examining existing theory (Yin, 2009). A balanced approach is therefore required when determining limitations and benefits of both methods. Four cases were explored within this study as multiple case design was considered helpful through offering the ability to make case comparisons. Arguably, the benefits of case study research diminish with fewer cases, thought to not fully demonstrate the interactivity and the complexity of the situation (Stake, 2006), with his suggestion of between 4 and 15 cases. The research inquiry took into consideration the similarities and differences of the phenomenon being investigated within the cases. Critics of case study research argue cases are often unrelated and thus have limited impact on wider healthcare settings (Holloway & Wheeler, 2010). Consequently, homogenous cases are frequently promoted enhancing transferability of the findings, whilst heterogeneous participant sampling is undertaken to capture the diversity of data.

Transparency can be considered a shortcoming of case study methods, however in this study, logical planning around data collection guided the methods, which endorsed a fuller methodical and transparent approach (Yin, 2003). Dependability (or reliability) refers to the accuracy, consistency and repeatability of processes (Tobin & Begley, 2004), whereby in this study, using a formal protocol increased the dependability of the findings (Yin, 2003). Underpinning these processes were clear audit trails which elicited reliability during data collection and from interpretation of the findings (Crowe et al, 2011). Whilst reflexivity adds to transparency of the processes, through demonstrating an awareness by the researcher (Houghton et al, 2013), and is explained later in this thesis. Flexibility is often viewed as a criticism; however, an element of flexibility was necessary, specifically during the recruitment phase until the cases and participants had been established. It also helped facilitate a constructivist approach, appropriate for this study which enabled the process of building upon data (Ormston et al, 2014).

Credibility refers to the believability of the research findings (Houghton et al, 2013) while multiple data sources improved the confirmation and completeness of the data (Murphy & Casey, 2009). Rigour was enhanced through gathering data from different sources through the "development of converging lines of inquiry" (Yin, 2009, p.115), which subsequently provided a more convincing case study (Casey & Houghton, 2010). This method of data collection was used to increase construct validity (Yin, 1994), which promoted greater consistency and accuracy of the data collected (Lacey & Luff, 2009). Orum, Feagin and Sjoberg (1991) disagreed with this approach, arguing multiple cases potentially diluted the meaning from a single case.

Triangulation of the data from various data collection methods was considered to enhance credibility of the findings (Houghton et al, 2013). For this study, the integration of the two data sources permitted greater exploration of the phenomena from multiple perspectives (Clarke et al, 2015). While combining both organisational documentation and participant data enhanced the study's reliability and quality, through processes of comparing and confirming findings (Krefting, 1991).

4.13 Ethical considerations

Clear guidance supports researchers to uphold ethical considerations when conducting research (Johnson & Long, 2010). Ethical principles ensured the safety of the participants, which was imperative during all research planning and its following implementation (RCN), 2009). All ethical considerations were adhered to, in accordance with the University Ethics Policy (Bangor University, 2016). For this study, ethical approval was sought, as the study explored staff experiences and management practices within a care home setting. The proposal was reviewed by the Health and Medical Sciences Research Ethics Committee and approval was granted (2015-15602). Research skills training was undertaken which enhanced the researcher's competence (Appendix 17).

4.13.1 Memorandum of Understanding

Permission to access the sites was not required by NHS Research & Development department (see Appendix 18). Instead, an agreement, known as a Memorandum of Understanding, although not legally binding, enabled parties to reach a decision which recognized the intention of the parties involved (WG, 2014a). Prior to commencement of the study each care home manager agreed and signed the Memorandum of Understanding, which was stored securely (Appendix 19).

4.13.2 Data management

University data management policies were adhered to throughout the study, and participants were made aware of this in advance of any data collection processes. Data were managed in compliance with the Data Protection Act (1998) and the University Research Management Data Policy (Bangor University, 2015a). This included the safe storage of hard data (all documented data, consent forms, anonymised data), secured in locked filing cabinets. Hard copies of personal data were destroyed 3 months after the analysis stage had been completed. All audio recordings and electronic files were stored on the password protected secure University U drive, as per the University Code of Practice Guidance (Bangor University, 2014). Participants were informed that data could be retained for 10 years, with access limited to the researcher and academic supervisors only.

4.13.3 Maintaining anonymity

All care homes and individual participant data were anonymised, with the use of a unique identifier, ensuring that no names and personal information were identifiable. Personal data such as staff names, roles and place of work were removed from the data and subsequently destroyed, 3 months after the analysis stage had been completed. Anonymity of the participants remained throughout the study, together with any reporting and dissemination of results (including verbatim quotes). Only the researcher had access to un-anonymised data and assurance was provided to the participants.

4.13.4 Consent

Gaining written informed consent was an imperative and the issue of consent was revisited at the time of the interview which ensured individual understanding and consent was achieved. Staff were guided towards the participant information sheet and were advised that participation was voluntary, and the interviews could be stopped at any point. All participants signed a consent form and 3 copies were made; one returned to the participant, one kept by the researcher, and the other scanned and securely stored in the University drive study folder.

There was no financial cost incurred by any participant during the research study. The researcher emphasized that the study intended to contribute towards a Doctoral thesis and to the evidence base for improving job satisfaction within the workplace. Consideration was given to any participant choosing to withdraw from the study and the management of this data. No participant withdrew. Additionally, participants were informed that any complaints or concerns about the study should be reported to the Director of Postgraduate Studies, in the first instance. Contact details were provided on all participant facing documentation for the participants.

4.13.5 Confidentiality

Confidentiality was upheld during all aspects of the research study, as outlined above within the University Research Data Management policy (Bangor University, 2015a). All care home and participant personal details remained confidential and were not disclosed to any participating colleagues. All personal data was anonymised and access to the data was limited.

4.13.6　　Burden to participants

For the participants, all time spent away from their practice was minimised (between 15-45 minutes each). Minimal risks had been anticipated for the participants whilst taking part in this study. However, the researcher had considered that during the data collection, participants may highlight issues which could give cause for concern, such as unacceptable service quality. Registrant duty of care to protect the health and wellbeing of the residents and act in accordance with the Nursing and Midwifery Council (NMC) Guidance on Raising Concerns (NMC, 2013) were ensured. Depending on the nature of the disclosure the researcher was to respond and take appropriate action (see Appendix 20). No issues were raised during any part of the investigation.

4.13.7　　Researcher safety

The safety of the researcher was considered in accordance with the University Fieldwork Handbook (Bangor University, 2015b). A system was adhered to which notified the researcher's academic supervisors of all planned visits. This was especially pertinent for out of hours or weekend data collection visits, with supervisors notified of the researcher's safe return.

4.14　　Summary of Chapter

In this chapter, case study methods, site selection, and data collection and analysis methods have been described. Maintaining the trustworthiness and integrity of the study was important which ensured the robustness of the findings. Adherence to ethical principles was maintained throughout the study. The following chapter presents the findings from the research.

CHAPTER FIVE:
CASE STUDY FINDINGS

5.1 Introduction

In this chapter, the findings from the case study are presented in two sections for ease of explanation, as follows:

1. Description of the cases and participants

2. Reporting of the themes

3. Limitations of the study

5.2 Description of cases and participants

The *following section* offers a comprehensive report of the case study characteristics, including the individual cases and the study participants. This provides an insight into the demographics and characteristics of the workforce studied.

5.2.1 Characteristics of individual cases

Four care homes were sampled from across the Health Board. Two care homes provided adult nursing care and two care homes provided nursing care for residents with mental health conditions. The case selection process considered variations in care home size, ownership and location. The size of the care homes varied with bed occupancy ranging from 18 - 52 residents. Case A had the largest capacity (n=52) and case C had the lowest (n=18). See Table 9 below:

Cases	Type of care home	Location	Bed occupancy (total)	Number of residential beds (inclusive)
A	General care	Town	52	up to 10
B	General care	Rural	27	no specified number
C	Mental health	Town	18	0
D	Mental health	Rural	23	0

Table 9: Case characteristics

The *following section* reports on demographic data and characteristics of the cases and then moves onto describe the participants and documents included in the study. Of the cases selected the following characteristics were recorded.

Case A
- Type — Offers nursing and residential care for older adults.
- Ownership — Private, family owned care home which is located near a small town.
- Registration — Accommodates up to a maximum of fifty-two
- — people who require general nursing and personal care.
- Facilities — Offers a range of facilities and services such as day care and respite care.
- Workforce — Employs a workforce of 61 staff.

Case B
- Type — Offers nursing and residential care for older adults.
- Ownership — Privately-owned care home which is located within a rural setting.
- Registration — Provides general nursing care and personal care for twenty-seven people over 65 years.
- Facilities — Offers a range of facilities and services such as day care.
- Workforce — Employs a workforce of 45 staff.

Case C	• Type	Offers nursing care for residents with mental health conditions.
	• Ownership	Private, family owned home which is located within a small-town setting.
	• Registration	Provides personal and nursing care for eighteen people, over the age of 65 years, living with dementia.
	• Facilities	Offers a range of facilities and services such as day care.
	• Workforce	Employs a workforce of 31 staff.

Case D	• Type	Offers nursing care for residents with mental health conditions.
	• Ownership	Privately owned and is located within a rural setting.
	• Registration	Provides personal and nursing care for twenty-three people, over the age of 50 years, living with dementia.
	• Facilities	Offers a range of facilities and services such as day care.
	• Workforce	Employs a workforce of 42 staff.

5.2.2   Care home workforce

All four cases employed a mixture of professional and ancillary staff. This included maintenance staff, kitchen assistants and chefs/cooks, laundry assistants and cleaning staff. Three of the four cases had nurse managers in charge, with the remaining case having a non-nurse manager plus an additional nurse lead. There were many staff supporting the homes, such as administrative and accounting staff. The number of nursing staff (RNs and unregulated staff) varied across each home from n= 21-44, with the higher bed occupancy rates reflecting larger care staff numbers. See Appendix 21 for a selection of workforce characteristics.

5.2.3   Staff turnover data

The staff turnover data is provided for the last three years (2014-2017), which shows a change of workforce, with staff leaving and taking up new posts within all four organisations. Many reasons were reported as to why staff left their jobs (n=39), relating to personal, professional and employment related factors.

Case A was found to have the highest staff turnover per case (n=14) and was the largest care home studied. From those leavers, it was the only case to have staff leave to undertake nurse training (n=3), move to domiciliary care work (n=2), and manage their own residential care home (n=1). Case A likewise, had the greatest uptake of new employees (n=12) in comparison to the other cases. Appendix 21 reports turnover data per case. A summary of the reasons for staff leaving is shown in Figure 13 below:

Figure 13: Reasons for staff leaving 2014-2017

It was noted there were differences between the different staff groups in terms of workforce changes (see Appendix 21 for a breakdown). Fewer staff overall were recruited (n=32) into new jobs than the numbers that left (n=39). No managers had either left or taken up employment within the last 3 years. Registered nurse flow, although with some leavers and starters, remained reasonably constant throughout. Unregulated staff had the highest turnover from all the staff

groups and across all the cases. Changing job roles, retirement and ill-health were the leading reasons for staff leaving. Several unregulated staff posts remained empty and still required filling. A couple of existing staff (both registered and unregulated staff) were reported to take on additional shifts, which added to their overall number of hours employed. Even with this uptake, some care homes were still left with several vacant posts, with ongoing recruitment taking place.

5.2.4　　　　Characteristics of participants recruited

The study participants recruited included nurse managers (n=3) and non-nurse managers (n=1), registered nurses (n=9) and unregulated staff (n=27), with a total of 10 recruits per case. See Figure 14 below for details of the participants recruited (n=40).

Cases	Manager	Nurse manager	Registered Nurses	Unregulated staff	TOTAL
A	1	-	3	6	10
B	-	1	2	7	10
C	-	1	2	7	10
D	-	1	2	7	10

Figure 14: Participants recruited

5.2.4.1 Length of employment
Employment within the organisations varied across all cases with staff employed from under a year's employment (n=7) to over 30 years in one instance. Appendix 21 provides a summary of this information.

5.2.4.2 Unregulated staff qualifications
All unregulated staff were required to undertake NVQ qualifications within all four care home settings, a CIW requisite. The level of NVQ varied amongst the staff (n=27) ranging from no qualification (n=3) to level 3 achievement (n=16). Staff qualifications are reported in Appendix 21.

5.2.5 Characteristics of documents collected

The documents collected (n=20) focused mainly on the provision and services within the care home, the philosophy and core values, expectations and standards expected by the resident and their family, along with formal contractual agreements and guidance. A summary of overall findings, with details for each documented collected, detailed in Appendix 22 and 23. The documents collected are shown below:

Case A
- CSSIW Report 2016   Staff induction booklet
- Statement of purpose (service user guide) Health & Safety handbook
- Care assistant training pack 2007   Employee handbook
- Care assistant schedule of tasks 2008   Company policy 1
- Induction programme (nursing staff) 2007 Company policy 2

Case B
- CSSIW Report 2016

Case C
- CSSIW Report 2016
- Induction training manual
- Service user guide 2015
- Daily staff rota checklist

Case D
- CSSIW Report 2016
- Induction document
- Statement of purpose booklet
- Social care induction framework for Wales (2015)
- Social care induction framework progress pack

Table 10: Summary of the documented data

5.3   Reporting of the case study themes

As described earlier, cross-case data analysis resulted in the development of three overarching themes.

Figure 15: Final 3 themes

The 3 themes are presented below using the 10 categories identified earlier (Chapter 4, Figure 10). Many of the issues raised were not mutually exclusive, however for ease of reporting the categories are used to best represent the themed data across the cases.

5.3.1   Personal satisfaction

Theme 1 incorporates factors associated with personal satisfaction which promoted greater staff enjoyment within their role, influencing their decision to remain in employment in their respective organisations. The categories highlighted within this theme are:

Figure 16: Personal satisfaction

The data that formed this theme showed interlinking factors which improved job enjoyment at a personal level, through the positive resident relationships and making improvements in care practices. Key findings related to a personal sense of pride and accomplishment, accompanied by feelings of being valued and recognised for their contribution in the workplace. Dissatisfaction was linked to increasing challenges and demands of the role.

5.3.1.1 Self-fulfilment

Across all cases, key for staff at all levels was feeling a sense of pride and accomplishment in their role, and feeling recognised for their actions, which helped support retention of staff. Many staff linked motivation and a sense of achievement to enjoying their role, and reported it strongly influenced their attendance record in the workplace. Many staff perceived the care home setting as exciting and interesting which added to their job enjoyment and never considered leaving this environment. One participant reported:

"I think from the staff that we've got here, they've got a lot of pride from the fact that they're doing a really good job. We've always got good reports you know we don't let it slide, ... we're proud of what we do, ... they are they're all really proud of what they do".

Nurse Manager 1, Case D

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Participants reported feeling a sense of personal achievement and job satisfaction through getting to know the residents and providing the care they need, and knowing they were helping somebody else. Albeit, occasionally it meant staff accepted some negative factors associated with the role, as it was not always easy and often demanding. Generally, most staff felt a real sense of pride in their role, especially when they felt they could make a difference to the residents' lives, for example:

"Just being proud to work somewhere …. you do get attached to the people which is a shame sometimes, you know if they are end of life …. I don't get any more enjoyment, than seeing them smiling or having a little giggle with them, because you're making their day, that's just one minute out of your day".

Registered Nurse 1, Case A

Evident within many participant responses across all cases, was staff feeling valued in their role and likewise valuing colleagues, which reinforced their sense of pride and happiness in their workplace and was closely linked with feeling they had provided good standards of care to the residents. In contrast, many staff felt dissatisfied when they perceived they had not provided enough time or completed all care activities for the residents. Excessive workload volume and its demands reduced their sense of accomplishment and achievement, with staff reporting they often left work feeling disappointed and sad:

"There's always something that hasn't been done properly…. it can be quite deflating at times really …. if you've got somebody poorly or a palliative patient, you feel like you haven't even seen the rest of your patients, …. you've sort of neglected the rest of them …. it's a bit disheartening really".

Registered Nurse 3, Case A

The CSSIW Annual Report confirmed the above participant data, which was recorded within document 1, Case A. In this documentation review the data identified the residents' responses of: "*the staff are fantastic*" and: "*they'll do anything for you*".

Self-fulfillment and role contentment were enhanced for many staff through building relationships with fellow colleagues. This was reported to improve job satisfaction by the development of better communication channels between staff members, which was considered important. Good working relationships had a positive impact on job satisfaction, along with its subsequent influence on resident care. Managers and registered nurses reported building strong teams at all levels of the organisation, helped to increase communication networks. Effective communication with unregulated staff, across the cases, was central within management duties, and promoted feelings of appreciation, respect and helped reduce the perceived difficulties of the role, which directly improved resident care:

"Appreciation, we are appreciated as nurses, um, and I appreciate the work that the carers do …. I've never seen anything quite like what they do here, 'cos they are so dedicated, and I do feel that people are appreciated".

Registered Nurse 1, Case A

However, in contrast, several staff reported staff relationships sometimes caused annoyance and unhappiness within the workplace. Colleagues who appeared lazy and did not perform effectively resulted in poor morale and staff avoided working with these colleagues. Staff feared poor actions of others reflected badly on them and can cause negativity amongst certain teams. When asked what made staff unhappy in their work this participant reported:

"If you get a lazy partner. That winds me up, I get so angry".

Care Assistant 2, Case A

Many registered nurses reported a reluctance to change as a real barrier to the development of new initiatives within the home, as it reduced their own role gratification or self-fulfillment. This resulted in discontentment and frustrations with staff reporting the ability to develop new projects as difficult and challenging. They reported unregulated staff often disliked change within the workplace and put up barriers making improvements in care practices harder to introduce, with one participant acknowledging:

"There's always barriers always, ... some carers have the attitude that I don't get paid to do some of the roles that they see that nurses should be doing, 'cos we don't get the wage for it. Those types of attitudes don't bode well with me ... some attitudes could do with changing, that's one of the biggest barriers here".

Registered Nurse 2, Case A

5.3.1.2 Personal attachments and wellbeing

Staff reported gaining greater enjoyment in their role through the development of personal attachments with the residents. Most staff, across all levels and in all cases, reported feeling real concern for the residents' day-to-day wellbeing and wanting to provide the best care possible. Maintaining high standards and improving the quality of care was important as it increased feelings of self-worth, pride and accomplishment in the role. At all levels, staff felt rewarded with a sense of acknowledgment and appreciation when residents responded well to them, all linked to greater job contentment:

"Self-satisfaction as well, that you are doing something to help somebody and you know if I go in and apply care in the morning, I like to when I leave the room, turn around and see they are clean and tidy, I know then I've done my job".

Care Assistant 2, Case A

The development of genuine personal attachments, feelings of affection and building close, positive relationships seemed to be extremely important for most staff and impacted on their enjoyment of their work. All levels of staff reported feeling a closeness to the residents, following spending long hours caring for them. Of these staff, many appeared to show real concern for the residents and expressed in interviews that they felt like a surrogate family to them, believing themselves to be providing an essential supportive role. According to this participant:

"I enjoy the people that I work with and my residents, I feel like I've been here such a long time that they are my second family .... they do feel a bit closer than my family at home, ... I think that's what it is, the closeness".

Registered Nurse 2, Case A

This was also supported in the documentation review of the CSSIW Reports which explored the compliance of national standards. Document 1, Case B reported this achievement through: "*people experience warmth, attachment and belonging*".

Staff reported gaining greater job enjoyment through enhancing the residents' quality of lives, which raised their feelings of self-satisfaction and a sense of achievement within their role. Feelings of wanting to support residents and making time for them which helped to improve their well-being was an important factor for increasing morale levels within their role. Most registered nurses and unregistered staff reported that caring for the residents was associated with intrinsic factors, such as being valued and appreciated by residents and their families:

"Because I care, I love working here, I love each, and every resident, I get so much satisfaction coming here and making a single person smile. If I can make one person's day better, I will".

Care Assistant 5, Case B

The CSSIW Report produced by the care home inspectors confirmed these findings, with document 1, Case D reporting: "*people enjoy being cared for by motivated staff who appreciate and want to make a difference to people's lives*". This finding was supported by the Document 5, Case D (Statement of Purpose) which reported the need for service users to fulfill and realise their own aims, which promoted the delivery of the highest standards of care. Prioritizing each resident's needs was reinforced across all the care homes, with this participant stating:

"I say it's like toilet and hoist city here…. if they think they can't sit down with the ladies, you sit with them, part of your job, as much as toileting, as much as feeding, you sit and talk to them, read the paper with them have a jangle do their nails anything but do never feel guilty, this is our job".

Registered Nurse 2, Case C

Spending time with the residents greatly enhanced the role satisfaction of staff across all cases, through enabling residents to reminisce about their younger days. This promoted real fondness and warmth towards the residents, from all levels of participants, with many reporting the residents were like family to them. Staff enjoyed helping with activities as they reported its positive influence on residents' behaviours. For example, singing and dancing helped increase appetite, an area which was strongly linked to staff morale and greater enjoyment of the role:

"I think making them happy and playing music and having a dance with them and you know just getting them active and it's nice to see them smile, …. you can tell the difference in them, they eat much better when they sing, its lovely".

Care Assistant 1, Case D

This above point showed how staff prioritised the resident's needs, a finding that was supported within several care home Service User Guides (Document 2, Case A and Document 3, Case C) which strongly encouraged bringing residents and staff together through activities.

The finding that participants felt close to residents was exemplified with participants across the cases reported feeling a great deal of distress and unhappiness when residents became ill or were deteriorating, especially if they had known them for a long time. Some unregistered staff found bereavement difficult to come to terms with and considered it an emotional time when residents died:

"We have a lot of deaths that some of the staff find very difficult, ... that's one of the main things that they have problems with, is accepting the residents dying, they find it very difficult, they need a lot of support around death and bereavement".

Nurse Manager 1, Case C

Many registered staff interviewed, across all the cases, considered the care home environment to be a more rewarding setting than a hospital setting because of being able to establish closer relationships with those they were caring for. They reported it facilitated the development of more comprehensive relationships with residents through the longer-term placements, with all levels of staff reported it helped gain a greater understanding of the residents and an awareness of their needs. Providing more consistent care made them feel they were making a positive difference to the lives of the residents, which increased their role enjoyment. In addition, unregulated staff reported making a difference through providing the extra little things which they believed made residents happy, which had a positive personal effect giving them a sense of self-worth and appreciation for their actions:

"It's the little things really that make the difference, that makes you feel you've gone the extra mile .... they appreciate so many little things .... like one lady today didn't get a newspaper yesterday, so today I stopped and picked up 2 newspapers, ... she was so chuffed this morning".

Registered Nurse 1, Case B

All levels of staff felt a sense of pride and personal satisfaction when able to deliver high quality care, promoting greater self-fulfilment for their efforts and hard work. Several work-based activities helped to heighten their job satisfaction, through delivering of person-centred care. For example, the allocation of key workers to specific residents helped improve care practices and relationships which resulted in more holistic care, which occurred in most of the cases. In fact, some registered nurses thought the unregulated staff should take more responsibility for their residents and having a key worker system would assist with this. However, some unregulated staff preferred the variety of caring for different residents, so they had a greater awareness of all their ongoing needs:

"You get to know the residents, you get to know the family and you also, yes I think you can give better care, really, because you know them, you know what they like, you know what they don't like, you know how, you know what their normal is compared to if they are acutely ill".

Registered Nurse 3, Case A

In the documentation review, the care home Statement of Purpose also recognised the need for ongoing improvements. Document 5, Case D reported that key workers could contribute to improvements in resident care, through the need: "*to provide and sustain high quality services through the skills and dedication of the staff, enhanced by training and career development*".

5.3.1.3 Demands and challenges

Registered nurses reported the environment frequently promoted a range of professional challenges which enhanced their job satisfaction. They reported that due to the lack of colleagues and medical teams present in the building, this promoted greater flexibility and autonomy within their role. They considered working in a hospital setting, staff had a range of professionals on hand to ask for advice and guidance. They felt this mainly motivated them, although, they did report feelings of anxiety and isolation particularly during night shifts, for example:

"There's the responsibility that you have here on your own, ... people that work in hospitals they've got a complete medical support, they've got everything, and I don't think that an

awful lot of people have got the skills really to take the responsibility to do it all on their own .... we're very multi skilled to be perfectly honest".

Nurse Manager 1, Case D

However, this was not the response from all staff. Several unregulated staff reported taking on greater responsibilities for the residents. As the registered nurses were frequently working away from direct resident care, the unregulated staff were concerned that if they missed a change in a resident's condition that they would be held responsible. Many staff felt a lack of recognition and understanding of their role, occasionally fearful of their actions, resulting in that they often felt pressured to report every item to the senior nurses in charge. Likewise, a few newly qualified registered nurses also perceived the care home setting as quite daunting due to their inexperience and the complexity of residents' care. This was reported particularly on night shifts when there were lower staffing numbers and a lack of medical cover:

"I've got the carers with me on nights, but we're on our own as nurses here .... and it's quite frightening, thinking that the paramedics have just left the building and then, if you've tried your best and something happened to that patient, you'd feel responsible even though you've tried to escalate".

Registered Nurse 3, Case A

Although staff clearly reported enjoying their role, many staff across the care homes also reflected on how residents' needs were increasing in complexity, which added to their workload pressures, occasionally causing them distress and concern for their own safety. The impact of these issues was a reduction in personal job satisfaction, which showed a different side to the earlier participant responses. Many staff believed some residents were too aggressive and were often physically difficult to manage, made more difficult with some residents not wanting to be there:

"I think it's some of the strains that are put on you, um dealing with clients that probably shouldn't be here. Wrongly placed, aggressive and um nowhere else for them to go, and you're left trying to deal with that, ... its stressful really because you feel you're not able to offer the care that you should be able to offer .... it feels that you don't do your job properly".

<div align="right">Care Assistant 1, Case B</div>

Additionally, staff within the care homes with mental health specialty reported that the role was much more physically demanding than in previous years, not only due to the nature of the resident illnesses, but also due to the increasing size and weight of the residents. These extra demands impacted on the staff's own health with some staff reporting it had resulted in being off work with sickness and ill-health. In this instance, the data reflected that staff considered leaving their employment:

"It's just hard work, it doesn't matter how you look at it's just hard work .... I think it is getting heavier for us .... we've had quite a, more violent ones in of late, ... people are getting bigger as well which is, it is harder work, ... I'm 34 .... I've had the doctors write me off sick because of my back, it's so bad, purely from my job, ... Leave? yes it would, you do have to think of your own health in the end don't you".

<div align="right">Care Assistant 6, Case D</div>

However, in varying amounts, many registered and unregulated staff across all the cases, reported feeling unappreciated around families. A few staff reported difficult relationships with residents' relatives and considered them too demanding with unrealistically high expectations. Likewise, registered nurses reported feeling annoyed by the way they were spoken to and believed relatives' disrespectful manner should not be tolerated. They often reported feeling cautious when relatives were hostile, which resulted in increased anxiety. Although these responses would not necessarily trigger their leaving the care home, it did make some staff antagonistic towards relatives. According to this participant:

"Being spoken to like a piece of dirt from families, ... we used to be respected as a nurse, and now it's more of a mentality of looking for what you are doing wrong, and looking to complain ...., the lack of, I would say appreciation. .... the pressure and the abuse we get off relatives and families is quite appalling, ... it's so overpowering and it's disheartening .... it really gets to you".

Registered Nurse 2, Case A

In the documentation review, the CSSIW Annual Report acknowledged these feelings, with Document 1, Case A reporting the need for: "*relaxed staff who are able to cope with more complex demands without becoming stressed or resentful*". Whilst, the care home induction programme (Document 8, Case A) also attempted to adopt this position, reporting the need to support staff when dealing with conflict in the workplace.

The data showed how staff reported accepting the added emotional and physical demands placed on them and the daily tiredness when leaving their shift. Several staff, (mainly unregulated staff), reported actual physical injuries due to residents' behaviours, particularly heightened in the care homes supporting residents with dementia and mental health issues. Even taking into consideration these difficulties, staff continued to report how much they enjoyed their role and working with the residents. This was reinforced by the fact that most remained in their workplace suggesting the positives of the role far outweighed the job negativities:

"We're doing a lot more mental health work now, a lot, 70% challenging behaviour .... we always used to have ladies thinking it's Christmas Day every day and the world was lovely .... to now people wanting to kill us .... we're getting hurt a lot now. I've had 3 teeth knocked out, it's very much it's part of your job .... it's very complex, challenging, noisy".

Care Assistant 5, Case D

5.3.1.4 Summary

The personal job satisfaction theme demonstrates the positive influences on staff through personal fulfilment, feeing valued, recognised and appreciated in their role within a care home setting. The development of close relationships with both staff and relatives was important which enhanced personal intrinsic factors. The satisfaction gained from delivering high standards of care was also a positive influence. Job dissatisfaction was linked to varying workload challenges such as increased responsibility, the growing demands of the role associated with complex resident care. Poor relationships with relatives, and sometimes other colleagues, was also reported as negatively influencing job enjoyment.

5.3.2 Organisational and management influences

Theme 2 relates to organisation and management structures and systems within the care home which influenced and impacted on staff satisfaction. The categories within this theme are:

Figure 17: Organisational & management influences

Crucial within this theme was the atmosphere within the care home and the approach of the manager, which promoted an allegiance for the organisation. This positive outlook influenced behaviours and attitudes of staff, encouraging better working relationships and working practices, which was seen to encourage loyalty, commitment and positivity. Satisfaction was mostly related to organisational support, financial rewards, staff shortages and workload

demands. Staffing shortages and the effect of these levels on working practices, along with organisational terms and conditions, were significant influences on dissatisfaction.

5.3.2.1 Ethos and atmosphere

The ethos of the home had a strong influence on moral and job satisfaction particularly through promoting greater contact with residents and comfortable relationships with colleagues and senior staff. The proactive, family-friendly approach to care encouraged staff within all care homes to spend time with residents, which enhanced their satisfaction, provided a relaxed workplace and impacted on the overall quality of care, with this participant reporting:

"Everyone's happy families here, everyone's got a smile on their face and they are always chatting, having good banter with the clients, …. it's important to the clients as well, it makes everybody happy and happy to work with in those surroundings".

Registered Nurse 1, Case C

In the documentation review, the CSSIW Report annotated in Document 1, Case B confirmed the philosophy of the home as: "*a relaxed homely atmosphere for people to live in*". The Statement of Purpose within Document 5, Case D also confirmed this.

Managers believed if the care home ethos was supportive, it would help retain staff for longer. This was reflected within participant interviews, whereby many staff across all levels, perceived their care home environment was better than many others. They opted to stay rather than move on, to what could potentially be a worse workplace. Staff reported this was related to being able to accomplish their duties and keep the residents happy, which in itself promoted greater enjoyment amongst the staff. The ethos was also associated with the care home reputation, which was reported to be very influential when recruiting new staff to the organisation. Many staff felt proud of their care home which promoted organisational commitment, with new job starters frequently influenced by family and friends already working there. A good reputation and knowing their care home provided good standards of resident care enhanced their self-respect, with this participant acknowledging:

"Most of them have come, most of the staff are local or know somebody, word of mouth ....
and the ones that have left have either moved or retired, so we haven't had a great turnover
of staff really".

Nurse Manager 1, Case B

Managers reported enhancing job satisfaction through promoting warmth and friendliness in the workplace, as it encouraged a sense of belonging and increased staff commitment. This welcoming ethos was reported to promote greater affection for their individual managers, encouraging greater job contentment. The employment of local staff was another factor which added to feeling valued and needed by the wider community. Rural locations meant many staff lived close to their employment. This had a positive influence on staff staying due to the convenience and proximity of their employer. Being viewed as part of the community helped promote wider help for the care home, with additional support offered during times of need. For example, the local council supported one care home by storing safety blankets in the local theatre in case an evacuation was required.

Another perceived benefit reported by many unregulated staff who lived close to their organisation, was the practice of informal agreements with managers. This permitted staff to leave early in times of urgency, if they then returned the favour and helped during times of low staffing, this in fact promoted feelings of strong loyalty with staff feeling supported. On the other hand, some managers reported the location of the care home strongly influenced staff employment, often making it more difficult to attract new staff. Additional issues which impacted on their decision to join or remain in the home, were associated with travelling to work costs. This caused some staff to consider leaving due to added time and fuel expenses:

"Our location, a lot of them live in the outskirts of the villages so we're convenient, it's easy
to get to, they don't have to travel all the way down to the coast. So, in a way we provide
employment for the local community and we are a community for the local community 'cos
that's where they all come from".

Nurse Manager 1, Case B

This community spirit was recognised during the documentation review which explored the compliance of national standards in the CSSIW Reports. Document 1, Case D stated that the care home: "*valued the involvement of family and friends in care planning*" and actualized this by inviting the family to be part of the care planning process.

Staff reported the positives of working in a smaller sized home, often associated with rural settings, as they believe it enables them to spend time and chat more with the residents. Staff reported smaller staff teams promoted better working relationships reflecting more of a family approach to working: They considered larger homes would be busier and mean less time with the residents. The size of the home appeared to be linked with job satisfaction and retention of staff, with the smaller homes reporting a lower turnover rate, this was also reflected in the workforce turnover data (Appendix 21), and this participant detailed:

"I suppose because we're so small as well, we very rarely, we rarely have new staff, rarely, we've got hardly any turnover at all really."

Registered Nurse 1, Case D

In contrast however, some staff felt smaller homes were unable to offer competitive wages and so were more difficult to recruit to. While a few staff believed that larger homes had a heavier workload and less of a friendly atmosphere, one registered nurse considered smaller homes lacked organisational and management structures which would be more obvious in the larger homes. The employment options for staff living in rural settings were more limited, with one participant reporting:

"You'd like a little more support, whereas I know in a larger company there's a lot more support, ... we do have a manager and she's lovely but sometimes you just think, do something .... as much as I love the small .... I miss the structure of a larger home and the more structured management level, I miss that".

Registered Nurse 2, Case D

The ethos within the care home was reported to enhance working relationships across all staff groups which made roles more enjoyable. Staff reported the value and importance of teamwork, with the development of a team approach helping to improve staff relationships. Positive working relationships and feeling supported by colleagues promoted feelings of resilience, confidence and enabled staff to better respond to challenging situations. The rotation of unregulated staff across different teams, promoted greater variety in the role helping to reduce boredom, increasing job satisfaction. In contrast, frequent role and team changes occasionally caused unhappiness particularly, with many older unregulated staff reporting the familiar routine made them feel safe and content. They enjoyed the consistency and found change to be unsettling, with this participant reporting:

"Knowing what you are doing, where you're going, how you are going to plan the day, is a big thing .... who's working with who, who's going where, ... some days, it's not possible to do that, like today, we do normally work 2 and 2 but there's 3 of us on, so it's not possible".

Care Assistant 3, Case C

Although most staff reported the promotion of teamwork across all the care homes helped lessen daily stresses, occasionally staff disagreements did occur, and resulted in an unhappy team. With close working necessary during long busy shifts, this sporadically resulted in an unsettled workforce. Although, for the main, most staff accepted the likelihood that their views and opinions would differ from colleagues and frequently attempted to resolve these issues quickly themselves:

"I mean, I've had my disagreements with people, and we have our say and then we move on, we forget about it. You know .... don't bear grudges let's just move on. Carry on and its fine, well that's how it works here".

Care Assistant 3, Case C

From the documentation review, the Statement of Purpose (Document 2, Case A) acknowledged the: "*importance of professional and friendly staff*", thus reinforcing the need for staff to work well with each other.

5.3.2.2 Manager style and approach

The style of the manager was reported as pivotal in shaping the workplace conditions and making the care home a nicer place to work, leading to greater job satisfaction. Their approach was important in building positive staff relationships within the care home, not only amongst the teams on the ground but with the senior staff also. This was seen by all levels of staff as extremely valuable in the workplace. Approachable senior staff increased the family feel of the workplace and encouraged staff loyalty and to go that extra mile, for example, when the home encountered staffing difficulties. Unregulated staff viewed managers as real team players who would assist them with any aspect of their care role. They believed managers often viewed them as friends rather than employees, with one participant reporting:

"It's the people skills as well isn't it, it's just treating your staff as though you want to be treated as well. I'm not willing to ask my staff to do anything unless I'm willing to do it myself, ... I'll clean carpets, I'll take people to the toilet, I was here till 8 o'clock the other night. If they see you doing things they are willing to help you out".

Manager 1, Case A

Many managers reported the importance of demonstrating value in their workforce, so staff really felt part of the care home team. Recognising their worth and standing helped managers to promote loyalty and commitment in their role. Registered nurses and unregulated staff felt appreciative of managers who had these traits and were flexible and supportive in their approach. Prominent influences of staff happiness, for registered nurses and unregulated staff, across all the cases, were working patterns and shift allocations (discussed earlier) and staff acknowledged this was clearly connected to the manager's style. Thus, all care home staff confirmed the need for managers to appreciate their difficult home lives and personal situations, recognising them as individuals rather than just employees. Staff valued a greater level of reasonableness in the manager's approach to managing staff needs. For example, allowing

unscheduled time off, last minute rota changes and paying time back rather than losing out financially:

"I think job satisfaction, ... I think they enjoy that there's a reasonableness, so if someone says can I go for a quick cigarette .... or can I go for a doctor's appointment .... if people come to me and say I need this day off, I can count on one hand how many times I have not".

Nurse Manager, Case C

In the review of the documentation the CSSIW Report found in Document 1, Case A, found: "*staff interacting with each other and the people who use the service in a respectful manner*".

Managers reported feeling a real sense of wanting to support their staff as they considered the carer role as a difficult one and so reported that listening to staff was crucial. This was reflected by participants reporting the importance of both personal and work-related issues being discussed in a non-judgmental manner. Equally, staff greatly valued colleagues and managers taking time to hear their concerns, even if the response was not what they hoped for, it was still perceived as very positive and extremely important. Regular discussions, staff meetings and getting to know staff helped empower staff in their roles, with one participant acknowledging:

"We have regular team meetings, ... it's maintaining continuous care for the clients as well isn't it, you know keeping on board of how the ladies have changed 'cos with dementia what we deal with, they change it's a progressive illness".

Registered Nurse 1, Case C

The effect of managers' listening to staff's views and opinions was reported across all the cases as a means of encouraging a happier environment. Although the extent to how this was implemented varied from case to case. Additionally, a few unregulated staff were concerned about the extent of the openness from managers in the workplace and felt there was sometimes

a lack of confidentiality with certain information being shared amongst other staff and not kept private. This caused some dissatisfaction with one participant reporting:

"I think management things should stay more confidentiality, if you know what I mean, a lot more. Because we're so open here, that's why we all get on so well, but certain things should be kept, it's a bit too open".

<div align="right">Care Assistant 5, Case C</div>

Following the documentation review of CSSIW Reports, Document 1, Case D, reiterated the need for formal 1 to 1 supervision to take place within the care home sector. Although some managers acknowledged that supervision was often difficult to achieve due to time constraints.

However, in contrast, a few registered nurses reported some managers were not strong enough and did not take appropriate action when required, perceiving it as a lack of leadership. They related this to the lack of organisational structures within the home, which caused delays in making changes or responding to difficult staff. Nurses felt this lack of professional support undermined many of their decisions, whereby some staff reported considering leaving if managers continued to inadequately address their concerns. Lenient managers also caused annoyance and negativity for many unregulated staff who believed they were unfairly reprimanded, in an attempt to keep the peace across all staff groups:

"She's probably a little bit too soft, …. she doesn't come down on places that she needs to, the people that she needs to, she'd just do it as a whole, and then some of the staff feel like, …. we are getting told off for something that actually, we are doing perfectly fine …. singling out things would be better".

<div align="right">Care Assistant 1, Case B</div>

5.3.2.3 Working practices and workload

Many staff, across all the care homes, reported excessive paperwork reduced their time with the residents, which was the component of the job they enjoyed. Managers reported this growing amount of paperwork constrained their daily duties and kept them more office bound, which reduced their morale. Excessive paperwork was not confined to registered nurses and managers, with unregulated staff reporting increasing record keeping which frequently reduced time with the residents:

"The policies are harder and harder, and you have to abide by all the policies and there is a lot more red tape, and things you have to do, and the paperwork wastes time when you could be at the patient".

Care Assistant 3, Case A

Providing work rotas in advance was reported for all levels of staff as a real priority, as it enabled them to plan their home life with family and friends. This work-life balance was considered very important across all the cases. Many staff had ongoing anxieties over childcare or responding to personal emergency situations when at work, particularly for those that stated they were single parents. As such staff needed to advance plan as much as they could, which was sometimes made more difficult with staff shortages, as this became more challenging for example, when children were taken ill unexpectedly. Thus, the ability to have flexible but planned rotas which acknowledged and supported their personal needs was deemed significant. So much so, that staff reported frequently choosing new employment based on the accommodating working practices, as supportive systems helped make them feel empowered, treated fairly and valued within the organisation. This approach was reported to help retain staff in their jobs, with one participant stating:

"I'm about to become a grandmother next year for the first time and I was hoping to take some annual leave, 'cos my son and my daughter in law want me at the hospital but she has said that I can take it from the year after, next year's, if I have to take a couple of days".

Care Assistant 3, Case C

Staff enjoyed the variety of their daily workload, across all the cases, as this kept them motivated and promoted greater enjoyment, which they reported enabled them to better deal with daily challenges more readily. Having an element of structured daily tasks was reported as making the flow of the day run smoother and easier, and ensured all activities were shared equally. Added to this, some staff gained further satisfaction from the unpredictability within each shift, with one participant acknowledging:

"I love my job, when I don't love my job I'll leave, ... I think for me no day's ever the same, I never know what I'm coming in to, ... it's very rewarding it's just lovely and it's just so different. And as well I think things have changed so much over the years, and it's something I have just embraced, and it's just, I just love it. I still like it".

Care Assistant 5, Case D

Within the review of the documents, the daily staff rota checklist confirmed the above. Document 4, Case C identified the need for structured daily tasks, which helped support staff activities and encouraged their completion.

Staff reported varied working practices existed across the wider care home sector, with some care staff tending to laundry and cooking, whilst others undertook caring duties only. Across the cases studied, unregulated staff reported performing caring duties with additional specific staff employed and dedicated for achieving the non-caring duties, this being a preferred option for most. Registered nurses also reported some variances with less clinical input into resident care in some homes more than others, which for many was the most enjoyable part of the role:

"This person that started this weekend .... where she's come from, it was a very much harder job than us, as they had to do all the laundry and half the cooking, and god knows what by the sound of it. She was amazed that we are just here solely to care for the residents .... we've got laundry staff, we've got more time, you sit down and chat with them".

Care Assistant 4, Case D

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Many managers felt they had to prioritise their own working duties to respond to sudden staff changes. They reported reducing their admin time, which often added to their own workload, but prioritised the staff on the ground, in an attempt to help during times of need. For example, frequently personal circumstances impacted on their role and was a real concern for many staff particularly with their childcare arrangements, (discussed earlier), often needing to request rota changes. Unregulated staff particularly recognised and valued the added help with the growing workload, with this manager stating:

"Because that's why I'm so much on the floor, because I'm a trained nurse at the end of the day, I'm a nurse first. I mean your manager work, that has to stay over there if you haven't got a nurse".

Nurse Manager 1, Case D

Staff believed many policies existed within the care home and were probably there to support them, although many staff were unaware as to what they were or what they covered. Even if they did not always agree with these policies and processes in the organisation, most staff were loyal to their employers and believed they were trying their best for them:

"The management is really good actually, like they've come in today, to talk to us and have been really open about what's going on and stuff like that, and so yes, nothing I can fault them with really".

Care Assistant 7, Case B

In the documentation review, document 1, Case C supported the above. The CSSIW inspection report suggested that: "*staff are clear on individual roles and responsibilities, working together and sharing information*".

5.3.2.4 Terms and conditions

Pay rate was an influential factor which caused dissatisfaction and frustration in the workplace as staff believed the rates did not reflect the difficult, heavy workload. Low wages meant staff had to work increasingly more hours and longer shift patterns to earn sufficient wages, resulting in staff feeling of weary and tired, and as such had a huge impact on staff enjoyment. Many staff believed they had far too much responsibility within their role, again not reflected by their wages. Even so, most staff still did not consider leaving the workplace. This was representative across all types of care homes, with staff maintaining the collective positives of working in a care home continued to outweigh the negativity of reduced financial rewards. With this participant acknowledging:

"I say to him (her husband) I wish I could get just a slap on the wrist for dropping a tin of beans, …. I work with people and any harm came to them, well bloody hell. We've got a lot of responsibilities we really have, not just with the ladies …. but the relatives, social workers …. you come in and you think what the hell am I doing? But then again you go back to the ladies and you think that's why I do it".

Care Assistant 5, Case C

Some of the more junior nurses in the general care homes felt they were actually paid higher rates than health board nurse colleagues, which encouraged them to take up employment within the care home sector. Although, for many staff across all the homes, financial benefits were often seen as contradictory. Staff considered they may sometimes receive higher hourly rates, but this was regrettably compromised by lower sickness and annual leave benefits. This participant reporting:

"Another part of the reason why I came back here, the pay was better for me in the private sector than in the NHS. The difference …. is £3 an hour, which is a lot of difference when you're doing 12 hours shifts at the end of your month … you don't get paid for sick days …. you get more benefits in the NHS, but it still made me sway more on this way".

Registered Nurse 3, Case A

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In contrast, although many unregulated staff confirmed the wages were lower than they believed they should be. Several staff did acknowledge that they were still better paid than some colleagues in other care homes, and so felt appreciative which encouraged a greater loyalty towards their own organisation. Acknowledging the shortfall and variances in wages across all homes and at all staffing levels, it was reported by many staff, that the love of the job and helping the residents were key influential factors which mitigated this:

"The pay is not brilliant, but there again, if you are going to be a carer, you aren't in it for the money, it's got to be the job satisfaction and knowing you are helping somebody else".

Care Assistant 1, Case A

Some staff looking to retire were conscious of their previous pension payments and considered this as a possible reason to return to the NHS, knowing it would potentially increase their overall pension pot. Several more senior registered nurses reported already receiving their NHS pension and so although they acknowledged the wages were low, as it was not their main income they accepted the pay terms as they enjoyed the job. However, another participant agreed and reported similar findings, although he suggested that had he been younger, the current wages would be a pivotal issue and may have caused him to leave the job:

"I've got my pension as well from the NHS, so it's not a big issue. If I was to go back 20 years in time and I'd got, my 2 children were small and my wife wasn't able to work and I was the sole wage earner, then no, I couldn't stay in a nursing home".

Registered Nurse 2, Case B

Many unregulated staff reported difficulties managing their personal budgets, requiring them to increase their working hours. One manager recognised this and provided weekly wages, which was appreciated. This increased the home's own financial costs, but the manager considered it a necessity to maintain employment stability through addressing employees' needs. To supplement the low wages, staff were provided with paid breaks and all meals, whilst

they were working their shift. This helped to ensure staff felt valued and appreciated, although this was not the case in all the care homes. Additional insurance schemes which provided some financial benefits for staff was another way some care homes enhanced staff wages, whilst also promoting better individual health:

"We've got a health insurance …. it means they get £60 towards a pair of glasses, they can have acupuncture, …. they can have confidential counselling if they want".

Nurse Manager 1, Case C

One manager offered additional personal help and resources, which appeared above and beyond what was anticipated as an employer, which staff found extremely valuable and appreciated. For example, this manager offered money in lieu and even small loans to staff that were struggling financially, promoting great loyalty amongst the workforce. Whilst this same manager also helped to reduce staff outgoings in other ways by offering free assistance where she could, for example this participant reported:

"Another example of what you can do to help staff is, my husband has got a van, so say if they are moving house, I'll lend them the van …. my son's an electrician say …. a socket's gone off he'll pop, he'll go for 5 minutes. I've had people who've come to me and they can't pay the council tax, I've loaned them the money, they've paid me back bit by bit".

Nurse Manager 1, Case C

Reduced staffing levels was reported by most staff, across all the care homes as a cause of unhappiness and dissatisfaction in the workplace. Several different reasons were indicated, such as the increased workload pressures and demands making the role even more difficult than usual, the reduced time spent with residents, having insufficient time to complete their work with a perceived lack of quality care. Many staff felt disappointed when reduced staffing levels impacted on their time caring for the residents or entertaining them, feeling less rewarded in their role. With the extra work pressures and needing to finish task, safety of the residents and

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themselves was reported as a worry during shifts of low staffing numbers. Whilst staff readily reported this impacted on their job satisfaction, most staff appeared to accept this as part of working in healthcare. Although, for a small minority, low staffing was considered problematic and would influence their decision whether to stay or leave their job, with one participant reporting:

"You've got a lot of responsibility, um you know things like short staffed, being short staffed things like that puts extra pressure on you and it's just, it's not the easiest of jobs anyway so just, I think those things really would make me want to leave".

Care Assistant 6, Case D

During the documentation review, the CSSIW Report identified compliance of standards in the care home whilst Document 1, Case D confirmed the care home had reported inadequate staffing levels on occasions. Staff shortages were acknowledged as a factor impacting on resident care with the same document also reporting the need to review staffing levels to ensure the provision of consistent quality of care.

During times of staff shortages, increasing demands on the unregulated staff and the need for more care staff puts added pressures on the senior staff. This may have been due to sudden sickness or just lower staff numbers due to planned annual leave. Staff were required to change shifts and work extra hours which resulted in a great deal of unhappiness. Many staff already work many hours and this required them to be on call even more, often feeling they were never off duty. Staff sickness immediately impacted on staffing numbers and caused frustration and feelings of anger as staff believed many sickness episodes were not always genuine, often weakening relationships with colleagues, with this participant reporting:

"It's annoying when people phone in sick, 'cos…. some girls will have to stay, stay on till probably 8 o'clock, when the other day another girl she had plans but she had to cancel them".

During staff shortages, many registered nurses believed they took the brunt of this, feeling unable to leave work as they recognised there would most probably not be a replacement nurse to take charge of the home, adding to their dilemma. This demonstrated commitment to the role and the organisation, however many felt they really had no option but to stay on longer:

"You can't really ring in sick, you've got to sort of pre-empt it, even a couple of days, um, yes it's just, …. it's not that you want to ring in sick, but you feel like, oh god I can't ring in".

Registered Nurse 1, Case A

Additionally, the pressures of staff shortages added to staff stresses, at all levels, as they did not get their full wages when off sick. Their pay was reduced to statutory payments only which added to their financial worries, with many staff reporting it often forced them back to work before they were better. This often made them feel they were in a hopeless position but also increased their concerns for the residents as they feared they were putting them at risk. Many staff of all levels reported annoyance when only receiving other statutory payments, such as maternity pay. Again, they felt this did not reflect the difficult challenges they encountered and made it harder to manage their own personal finances, occasionally resulting in staff returning to NHS employment. This participant reported:

"We don't get sick pay, we only get statutory sick pay, so as an example in a few weeks I've got to have a cataracts operation and I've had to take 3 weeks' annual leave, 'cos I can't afford £64 on statutory sick pay because I pay all the bills".

Care Assistant 3, Case C

Many staff offered advice for responding to staff shortages, and reported valuing pay incentives, such as increases in hourly rates of pay, along with additional night and weekend payments during these times. However, some senior staff voiced concerns that unregulated staff may chose these shifts for additional pay, which could consequently have a negative impact on routine shift patterns. Many staff, across all the cases, reported supporting the home by working many additional hours without extra payments. They frequently went into the care home on their days off to support social functions and staff believed this was not widely recognised or appreciated:

"You come in, you support things, like bonfire night, we do the bonfire, Christmas fairs you do unpaid, I was in yesterday, a couple of hours of unpaid work. You know I bring things in, the things you do all the time that people don't see it, they just see the horror stories, the people left, um but nobody reports on the good things, do they?".

Care Assistant 1, Case B

Unregulated staff acknowledged the difficulties the managers faced in continuing to deliver high standards of care during times of staff shortages, but they felt they suffered the consequence of poor staff numbers. As such, they were appreciative of the managers responding to staff shortages and increasing staff numbers through employing agency staff, making them feel staff had considered their needs. This meant workloads were not increased, which kept staff more contented:

"If we are short staffed she will bring in agency in, they are quite good to be fair".

Care Assistant 2, Case A

The concern over payments and financial worries was reported to relate to the organisation itself not just the individual staff. It has been widely acknowledged for the care homes, that staffing, utility bills and equipment costs have increased, particularly after the higher minimum wage level, which have added to financial pressures for the home. The resident payments have

not raised to reflect increasing costs, and this increased managers' anxiety when there was an empty bed on the premises. Understanding the requirements of the home and increasing Local Authority payments was suggested by many staff as a solution to improving wages and staff retention:

"The local authorities need to pay a damn sight more money in order for the carers .... to have the money they're worth .... we haven't got the finances to be able to give them an on-call pay .... but the money's not there, the money's not there it's because the local authorities don't pay enough basically".

Care Assistant 5, Case D

5.3.2.5 Support and development

Training was associated with several positive benefits and was found to raise staff satisfaction for a number of reasons. Training improved organisational factors such as care practices. Perceived improvements in resident care was another factor which staff considered important as it added to the care home reputation, and thus reflected well on them also. Nearly all staff believed training facilitated a skilled workforce which encouraged them to generate new ideas and broaden their knowledge which directly improved resident care. Enhancing the development of knowledge and individual skills, promoted feelings of confidence, respect and self-worth. One participant stated:

"I've done NVQ 2 and 3, um it's nice that I've achieved something for myself, yes, um' cos I left school without any GCSEs, so to do them, yes it was an achievement for me".

Care Assistant 2, Case C

The Statement of Purpose reported within Document 5, Case D affirmed the need for a skilled workforce and recommended continuous staff training was implemented.

The unregulated staff felt that investing time to undertake training away from the caring role and paying for courses and training showed commitment in them, reinforcing their individual value and worth. They appreciated the paid time to attend which increased their loyalty towards their employers. A lack of training opportunities was reported to negatively impact on staff as it didn't acknowledge the complexities of the role. However, although most staff recognised the importance of training, many staff across all the cases, reported learning on the job as the best way to gain their knowledge:

"Learning hands on is essential obviously, it's far different from learning in a classroom .... we are learning every day, you learn something different every day".

Care Assistant 3, Case C

Several unregulated staff reported feeling nervous when attending training as they had to attend on their own, particularly if it was provided externally. Staff appreciated managers acknowledging this and attempting to provide alternative opportunities, such as in-house training or local providers. Staff valued this as it reduced their anxieties. Opportunities to undertake online training was appreciated by staff, particularly part-time workers, who frequently had other commitments which reduced the possibility of attending:

"Doing these online courses really helps, 'cos I'm part time here and a full-time mum and so I couldn't really go out and do the training".

Care Assistant 1, Case C

In some cases, attendance on training was associated with pay increases, which encouraged staff loyalty through feeling valued and recognised for their efforts. Some mangers provided incremental pay whilst others provided a lump sum after completion of NVQ training. However, not all staff were happy with this approach, reported by a few participants who had not yet achieved an NVQ award. Some unregulated staff considered they undertook the same duties as colleagues but were on lower rates of pay, and so did not judge this as fair:

"I'm NVQ 3, as far as I know this is the only home that offer, a lot of homes give you a hundred quid or two hundred quid if you pass your NVQ, and everybody else is on the same wage, but not here, your wage goes up with your NVQ, that's an initiative in itself, it's better than being on minimum wage".

Care Assistant 2, Case A

Managers reported that some of the younger carers were often more eager to develop their learning. They felt this supported being valued which would help staff retention and so strongly encouraged ongoing development. Staff recognised the managers who provided learning opportunities above and beyond the minimum requirements of mandatory training. Training kept staff personally motivated and inspired them to achieve beyond their potential to help them progress in different directions in the future, such as offering broader job opportunities or undertaking nurse training. Staff appreciated managers were investing in them individually and felt a sense of pride in their accomplishments, which encouraged them to achieve additional higher qualifications:

"I think it just makes me more confident .... the phlebotomy course, it gives me an extra something to do that I can take away from here, if I did ever come to leave, so it's about furthering myself, as much as it is putting it into here".

Care Assistant 6, Case D

Although training was generally accepted as crucial within role development, several staff felt it still did not live up to its expectations. For example, to become a senior carer, staff completed NVQ level 3 but also needed to be working at a senior carer level. Not all homes provided this role thus reducing development opportunities for staff, which disappointment due to a lack of promotion opportunities:

"I can't go any further, 'cos I've got to, to do the NVQ3 I've got to be in a senior role so that's not going to happen, um, yes disappointed".

<div align="right">Care Assistant 3, Case C</div>

Unregulated staff reported a variance in clinical skills across the cases. The development of new and advancing clinical skills was viewed as extremely positive and boosted morale, with staff reporting it greatly enhanced their daily skills which impacted on the variety and scope of their role, recognised earlier as strongly influencing job satisfaction. Learning and development was reported to increase confidence in the worker's own abilities, which helped the unregulated staff feel better prepared for their caring role. However, in contrast, many senior nurses, particularly within the general care homes, felt they were prevented from extending their roles which caused frustration and reduced job satisfaction. They believed it reduced the holistic care they were providing and often felt they had to transfer residents to acute setting through a lack of skills rather than in their best interests:

"We can't do IV antibiotics which would change, you know sending people in, that I don't think should be sent in …. it would ease off on the hospital as well. I mean we put sub cuts up, we do the syringe drivers, have the just in case boxes, …. if the family want them to have antibiotics, IV antibiotics, we can't do it here, so we have to send them in".

<div align="right">Registered Nurse 1, Case A</div>

Document 1, Case D reported staff were competent and confident in meeting the needs of residents, acknowledged from the feedback in the CSSIW Inspection Report.

Peer support was reported to be extremely important both for job satisfaction and for understanding of the care home practices, across all care homes. Senior staff reported a positive benefit from providing a structured induction and mentorship programme as it promoted good practice and raised awareness of the homes policies and procedures. The induction stage encouraged new working relationships, enabled them to familiarise themselves with working

practices and helped them settle in and adjust to a new workplace. Unregulated staff completed formal written assignments as part of the induction programmes within Wales. Most staff reported this induction programmes as positive, informative and worthwhile, although, occasionally staff perceived no value in receiving the induction package and just wanted to get on with their job. Most unregulated staff preferred shadowing and observing colleagues, as this promoted greater self-confidence. One participant acknowledged:

"Yes, I can act as a mentor, yes. Oh, gosh, yes it keeps them all up to date with everything as well isn't it and then informing them of anything new that's coming into place …. keeping them informed and how to do it properly".

Registered Nurse 1, Case C

Structured inductions with learning outcomes were promoted within the social care induction framework for Wales. Document 2, Case D identified the need for a: "*confident and competent workforce".* This document also recognised the need to raise awareness of policies, procedures, along with the need for staff orientations and ongoing training.

Managers were keen to promote positivity and motivation within their staff and used appraisal and supervision processes to encourage them to get more out of their role. Working alongside the unregulated staff was reported by managers as essential, as it facilitated informal supervision. This provided managers with greater assurance of care practices and standards. Staff appraisals were offered across all the cases, with all workers valuing them as it provided an opportunity to discuss their development and progress in the care home. Staff of all levels considered the appraisals important, however they were often not completed on an annual basis as intended due to workload:

"I do always ask them in supervision if there's anything that I can do better and usually the best thing they come up with is get the rotas out earlier, ... 'cos we're using bank staff, they're all working elsewhere, for the trained staff, so it's really difficult to put a rota out".

Nurse Manager 1, Case D

Managers and registered nurses across all care homes, valued the opportunity for external professional support and the ability to network with colleagues, through attendance at manager forums and link meetings. Networking was considered extremely valuable as it not only broadened their awareness of changes to current practice or care home legislation and policies, but also enabled staff them to support their NMC revalidation requirements, which lightened their worries. One participant stated:

"Going to management meetings with other homes, that was a good source, that was a support thing and we work with (name care home), and if we have a problem there we all counteract each other".

Nurse Manager 1, Case C

5.3.2.6 Summary

Organisation and management structures were shown to impact on care home staff's job satisfaction. Key is the positive ethos and atmosphere within the home which was enhanced by the supportive and responsive style of the manager. Supporting staff through training and development promoted greater confidence of their skills and abilities, through greater role enjoyment. Networking, appraisals and supervision added to staff commitment and loyalty for the organisation. Negative influences and changes to working practices were clearly increased following time of sickness and staff shortages, which in conjunction with low staff wages resulted in job dissatisfaction.

5.3.3   Sustainability of the workforce

Theme 3 relates to the sustainability of the care home workforce, with public recognition of the role influencing staff recruitment into this healthcare sector. The categories within this theme are:
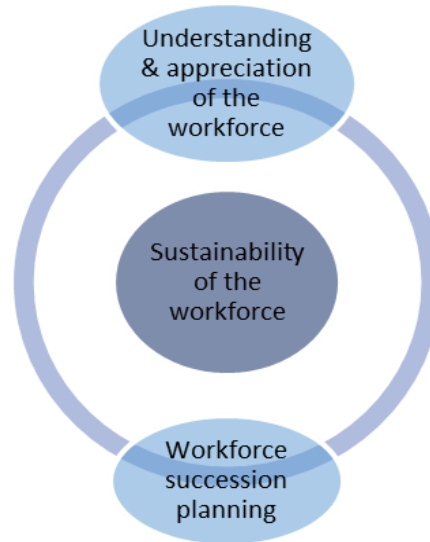
Figure 18: Sustainability of the workforce

Sustainability of the workforce was an important issue for both staff and managers, with concerns over ongoing resident care. With a lack of recognition, media negativity and public misconceptions of the role, many staff were fearful for the future viability of the care home sector. Encouraging a wider acknowledgement, understanding and respect for the role, along with improvements in employment practices for both recruiting and retaining staff, were considered options to help address some of the negative factors associated with the care home sector and their workforce.

5.3.3.1 Understanding and appreciation of the workforce

Many staff felt that the public did not recognise the carer role or understand its responsibilities, so consequently did not value their skills or efforts. At all levels, staff reported a lack of respect for those working in the care home sector. The unregulated staff however felt they were the least valued of the workforce and occasionally lacked validation from the public, senior nurses and relatives alike. Additionally, many staff across all cases believed this media negativity intensified resident and family reactions with a lack of acknowledgement for their knowledge, hard work and efforts. They believed they were regularly scrutinised by residents' relatives which occasionally resulted in verbal abuse towards them. This backlash made them angry,

frustrated and upset, which added to their workload challenges. This impacted on staff retention through feelings of bitterness and worthlessness:

"The care sector is a dicey one and I genuinely don't think people want to come into the care sector like they used to, … it's a hard job to come into and I don't think you get the recognition, the right recognition that you deserve, from the public".

Care Assistant 3, Case A

Company policy documents found that care homes recognised the need to prevent resident abuse and advised staff to report all genuine concerns to the managers, as reported within Document 10, Case A.

Faced with these additional public and media perception challenges many staff felt undervalued, frustrated and unappreciated in their roles. Many unregulated staff across all cases reporting feeling public perception of them was that they were uneducated, low skilled and worked in a care role due to their limited employment options. They believed nurses had a certain credibility and kudos but felt this was not replicated for the unregulated staff. As such, attracting new recruits into the sectors was frequently negatively influenced by public misconceptions, with caring roles generally perceived as boring and unattractive, for example:

"They're not respected, …. I think nurses are respected, 'cos we've got, we've professional status but I don't think carers in general are. They're not respected by society, or the government, otherwise they wouldn't expect them to work on this level of pay. There's no respect, you know, they do a heavy job".

Nurse Manager 1, Case C

Whilst many staff felt it was important to acknowledge the difficulties they faced, they judged the positives out-weighed the negatives of the job. This meant the overall enjoyment of the role encouraged staff to stay in their workplace. however, the unregulated staff perceived a lack of respect and insight into their role, believing it needed to be better promoted, and presented as a worthwhile career option. This participant reported:

"People seem to think caring is for people that haven't got much more going for them. It's totally the opposite. People who haven't got much going for them go and do a 9 to 5, ... People that do need that excitement, ... that different thing every day, come here. We've got such a low turnover of staff, of care staff, it's fabulous you know".

Care Assistant 5, Case D

Staff felt under constant pressure following media reports of poor care practices. They believed care staff worked extremely hard and long hours, were conscientious and provided excellent care, but this was never conveyed. Staff were concerned by the negativity that care homes received and reported this sometimes puts added pressure on the workforce, thinking they had to consistently protect themselves. They believed that media stories reported on bad practices and generally did not recognise the good staff, leaving them deflated. The negativity did impact on staff with some considering leaving the sector, with this participant acknowledging:

"Terrible, yes it would make me leave nursing, and it crossed my mind so many times and even last year I was moments away from calling up my friend in Australia and saying I'm coming to stay with you for a few weeks, with a view to moving over there".

Registered Nurse 2, Case A

Conversely, staff also reported this widespread negativity made them even more determined to provide a higher standard of care. They believed they needed to dispel these rumours and did their utmost to improve their own care practices. Although acknowledging this positive impact on their care practices, many unregulated staff did feel it was associated with added anxieties

and over-reporting of concerns. When asked about the negativity of the media one participant stated:

"I know some of the stories you hear, it's quite daunting.... so, if there's anything, I'm straight to the office, ... you know the slightest mark or anything, 'cos you've got to cover your back and then you can't do any more, I know what I can do, I've reported it".

<div align="right">Care Assistant 4, Case C</div>

5.3.3.2 Workforce succession planning

Succession planning and the development of future managers within the home for sustainability was perceived to be crucial. Managers invested in their teams through the promotion of training and new learning experiences. Managers reported upskilling staff was strongly related to staff staying within the home through improving job satisfaction. This made them feel recognised and valued through offering them possible options for the future, with this participant acknowledging:

"I've done it for me .... at the moment I wouldn't want to run a nursing home, I'm quite happy being second in command.... I've chosen the units that would be as a manager .... they have recognised me now and I suppose it is in their interest".

<div align="right">Registered Nurse 1, Case D</div>

All staff, across all the cases, recognised the need to encourage new recruits into this sector and were keen to inspire a younger workforce through offering work experience, trial periods and student nurse placements. Managers reported, although they needed staff numbers to increase, they wanted the right recruits coming into their organisation. Staff working across all the care homes worried about the sustainability of care homes as they were concerned for the future care provision of their residents. Staff considered they propped up this sector with many coming in to help without pay, and without this help care homes would be in an even more difficult situation, with one participant stating:

"The major problem I see for the future of homes, is that we're not going to be here unless .... they increase the amount they pay us .... small homes are not going to be around… you can't expect a workforce for doing a most important job .... to do this for minimum wage".

Nurse Manager 1, Case C

Several staff reported the promotion of safer recruitment practices such as a carer register, would help protect them whilst reducing their own anxieties. They believed poor carers would not be approved onto the register and consequently would reduce existing unregulated staff being tainted with the bad staff:

"I think the idea of carers on a register .... I think people are prepared to put themselves forward and be on a register then, they've got nothing, that's what I think anyway".

Registered Nurse 1, Case D

The Statement of Purpose booklet, found within Document 5, Case D also reiterated the need for safer processes to be undertaken when recruiting staff.

Staff considered a stable workforce helped reduce workloads, making their own roles easier and less stressful, whilst having a knock-on effect of stopping staff leaving. Ensuring existing staff were well looked after and not overburdened would help with retention of the workforce and encourage in new recruits. Staff felt the public lacked awareness of their role whilst management needed to ensure openness and honesty of the working conditions. They believed financial rewards such as improving wages, offering additional payments following training and on-call retainers, were all proposals which may reduce staff leaving:

"I think it's just playing fair you know, not over working, not overloading work, ... make sure there's plenty of staff, you're not stressed in any way .... and that people enjoy their work, ... it will make them want to stay, which is how it should be".

External agencies provide assistance and support to care homes, such as the local health board, social services and CSSIW. The care homes generally worked well with these colleagues and valued their advice and guidance. However, a few staff reported specific instances where organisations had a lack of understanding of the challenges posed when working within a care home setting. This often resulted in a perceived reduced provision of support. Some managers reported that occasionally they received conflicting information from CSSIW or the health board, which made it difficult to know what tasks and skills their carers can do, which impacts on the training they can offer and their development:

"It's difficult to know what you can allocate to carers, …. then with CSSIW and the health board, …. you allocate or give them tasks to do, then the health board says it's not CHC anymore, if you delegate and give tasks to carers, it's a fine line at the moment, your hands are tied".

Manager 1, Case A

5.3.3.3 Summary

This theme demonstrated the wider influences on the care home sector and its effect on individual staff working in this environment, recognising the high levels of disapproval this workforce faces. Lack of public recognition, understanding and limited respect and recognition for this workforce, along with heightened media negativity was an influential factor in staff leaving this sector. Addressing issues such as, safer working practices, recognition of national nursing shortages amid improved succession planning could help retain more existing staff, whilst encouraging a greater number of new recruits into this sector, overall promoting greater sustainability of this workforce.

5.4 Difference and similarities across and between the cases

Following on from the reporting of the final 3 themes, the *following section* summarises the similarities and differences between each case.

The similarities across the cases were apparent and are seen in Chapter 5, Table 9. It was evident from the findings that most of the staff issues and concerns, were broadly similar and reflective across all the cases, whether positively or negatively impacting on job satisfaction. The care home environment, organisational and management structures along with personal satisfaction held many similarities in their approaches when supporting the workforce. Recognition, appreciation and a sense of pride in their workplace, were key factors which influenced job satisfaction across all levels of staff, across all care homes. The influences of the manager and the atmosphere within the care home strongly impacted on job enjoyment and whether staff felt a sense of belonging. Wider care home workforce concerns were reported amongst all staff groups, across all four cases.

Differences between the cases were few with findings showing that the same issues impacted on job satisfaction, such as increasing workload demands and staff shortages. However, supportive mechanisms and how the issues were addressed was found to vary slightly from case to case. This was often influenced and directed by the individual attitudes, behaviours and responses of the staff themselves. Care homes appeared to address specific issues and concerns based on the impact of these issues on staff job satisfaction, rather than on the type and severity of the issue itself. For example, managers appeared supportive across all the cases, whilst in one particular case the extent and depth of this was far greater than the others. Rurality, geography and size of the care home were recognised to offer different levels of job satisfaction across the cases, with some staff acknowledging a preference for one type of home other another.

5.5 Transferability of findings

The transferability of findings is key within any qualitative study and concerns the extent of its applicability to other contexts (Lincoln & Guba, 1985), with attempts consistently made throughout this thesis to facilitate this (Lacey, 2010). For example, the stakeholder discussions not only ensured the subject matter's relevance to the local workforce, whilst broader

consultation and literature searching using international evidence, promoted the utility of the scoping review findings to be transferred more widely. The "thick description" of data generated from both participant and documentation evidence helped to describe the views, attitudes and experiences of the workforce within their local setting (Houghton et al, 2013, p.16). This description helped gain a greater insight into job satisfaction issues, while helping others to see if relevant or potentially transferable to their own context (Anney, 2015). Whilst, the pragmatic selection of cases promoting the wide-ranging care home characteristics within the case study, and permitting the inclusion of different geographical locations, rurality, size and type of care home, offers the opportunity to more readily assess the findings and whether they are transferable to the researcher's own context (Korstjens & Moser, 2018).

5.6   Limitations of the case study

As a novice researcher and aware of potential research limitations, every effort was made to recognise and mediate the impact of these factors from the outset, which are considered below.

As the study was designed to explore the how and why of the phenomenon, consideration was given to several constructivist research approaches, such as histories and surveys. The availability of researcher time and resources in data collection was recognised and influenced decision making processes. Ideally practical restrictions should not hamper any study developments (Ellis, 2003), however, a multiple case approach was considered appropriate (Yin, 2009). Using four cases, enabled the construction of data permitting comparisons across cases, with replication of data promoting robustness and diversity of the findings (Yin, 2009).

A pragmatic approach to case sampling was used (Teddie & Yu, 2007), although consideration was given to a random selection of cases. As the investigation of different case characteristics was deemed important, random sampling could have prevented this, by excluding one type of care home in preference over another. A sampling criterion was used which helped reduce the likelihood of selection bias, and consequently this sampling approach was considered appropriate to provide a "rich, theoretical framework" (Yin, 2009, p.54).

Although a pragmatic approach was used to select the cases, this may have excluded selection of the least well managed or lowest staffed homes, which may have generated a broader dataset

on job dissatisfaction. Utilising the CSSIW Reports may have supported this process through the selection of cases based on the poorest reports, with the possibility of generating a more varied understanding of these cases, and the consequence of a poorer working environment on the attitudes and behaviours of the staff working within these care homes. Although it is recognised that these homes may have declined to take part in the study or may have been disinclined to allow staff to be released for the interviews; it is acknowledged that these care homes may have added to the diversity and richness of the data.

Interviews were the main method for data collection, which encouraged a richness in the participants' responses (Patton, 2002), Researcher bias was a concern, however a number of elements were included in the study design, reducing the likelihood of this occurrence (Yin, 2009). For example, an interview guide was developed and piloted which helped to focus the questioning, along with drawing on the supervisory team for regular checking of techniques, processes and approaches undertaken. This also added to consistency and reliability of the data collection method and promoted transferability of the findings to other similar settings (O'Leary, 2004).

Direct observation of the managers may have provided additional findings, through understanding their approach and style to their leadership role. This was not the study's main question but did raise this as a future area for research. However, the use of documentation data did add rigour to the study findings, through the ability to integrate several different sources of data (Houghton et al, 2013) which provided greater consistency and accuracy of the collected data (Lacey & Luff, 2009).

Multiple data sources increase the trustworthiness of the findings (Krefting, 1991). The study incorporated two data sources, with the documentation data providing the ability to corroborate the participant data (Yin, 2009). A greater number may have enhanced this further, however due to practical reasons of time and resource constraints, additional data sources were considered unreasonable within this study (Ellis, 2003).

5.7   Summary of Chapter

This chapter has reported the findings from the four case studies. The demographic data, participant and case characteristics, along with the themes per case, have enabled similarities and differences across and between the cases to be reported. Workforce and turnover data were also introduced which added to the contextual setting, while limitations of the study have been acknowledged.

Whilst many factors influenced participants' perceptions of job satisfaction in the care home setting, they were framed around three main themes; that of personal satisfaction, organisational and management influences, and sustainability of the workforce.

The data that formed the personal satisfaction theme showed interlinking factors which improved job enjoyment through building positive resident and staff relationships, accompanied with a personal sense of accomplishment, feeling valued and recognised for their contribution in the workplace. While the increasing challenges and demands of the role was linked to reduced care practices and job dissatisfaction.

The ethos and atmosphere within the care home was shown to promote an allegiance for the organisation, which was guided mainly by the approach and leadership style of the manager. The positive philosophy enhanced staff behaviours and attitudes, which developed greater loyalty and commitment through improved working practices and better working relationships. Ongoing support, workload demands, financial rewards and deficiencies in staffing, impacted on organisational satisfaction, often resulting in dissatisfaction.

Both staff and managers reported workforce sustainability as important, with worries over meeting resident care needs and viability of the future care home sector. Media negativity, public misconceptions combined with a lack of recognition and respect of their role, resulted in job dissatisfaction. With suggestions for greater acknowledgement and understanding for the role, with improvements in employment practices to retain existing staff and encourage new recruits into this sector proposed to address the negative factors associated with the care home sector and their workforce.

The case study findings have built on the early scoping review findings and demonstrate a clear contribution to the care home evidence base, through greater understanding of the issues influencing job satisfaction in the care home setting, with the next Chapter advancing the discussions around the care home workforce further.

CHAPTER SIX:
DISCUSSION

6.1　　Introduction

This chapter presents a discussion of the case study findings.

Following on from the three themes identified in chapter 5 (personal satisfaction, organisational and management influences, and sustainability of the workforce), in this chapter a discussion of the key individual and organisational factors, which influenced job satisfaction and fostered a workplace where staff wished to remain is presented. The factors included the manager's philosophy and approach, alongside the ethos and atmosphere of the organisation, which subsequently guides the interactions, behaviours and attitudes of staff. The benefits and drawbacks for staff when working within a care home are discussed. An awareness of the balancing of these factors by staff, providing the basis for determining whether they remained in their employment. These key findings are discussed in the context of literature, theories and models.

6.2　　Development of the study's framework

This new framework builds on the contribution of the initial scoping review findings (and the previous job satisfaction framework, seen on page 49), by incorporating the case study findings. These findings show that the influences for whether staff find their working conditions conducive to staying is a function of a balancing act. Care home staff appeared to, not only consider factors which enhanced their job satisfaction, but also weighed up the pros and cons of their effect on their work-life balance, with the subsequent outcome determining whether to leave (or not) their care home employment.

A diagrammatic representation of balancing the factors which enhance care home staff job satisfaction is illustrated below (and expanded on further within this chapter). This is an addition to the current evidence base and provided the underpinning for the development of the implementation plan, which can be found in Chapter 7, page 203.

Figure 19: Framework for influencing job satisfaction in care home staff
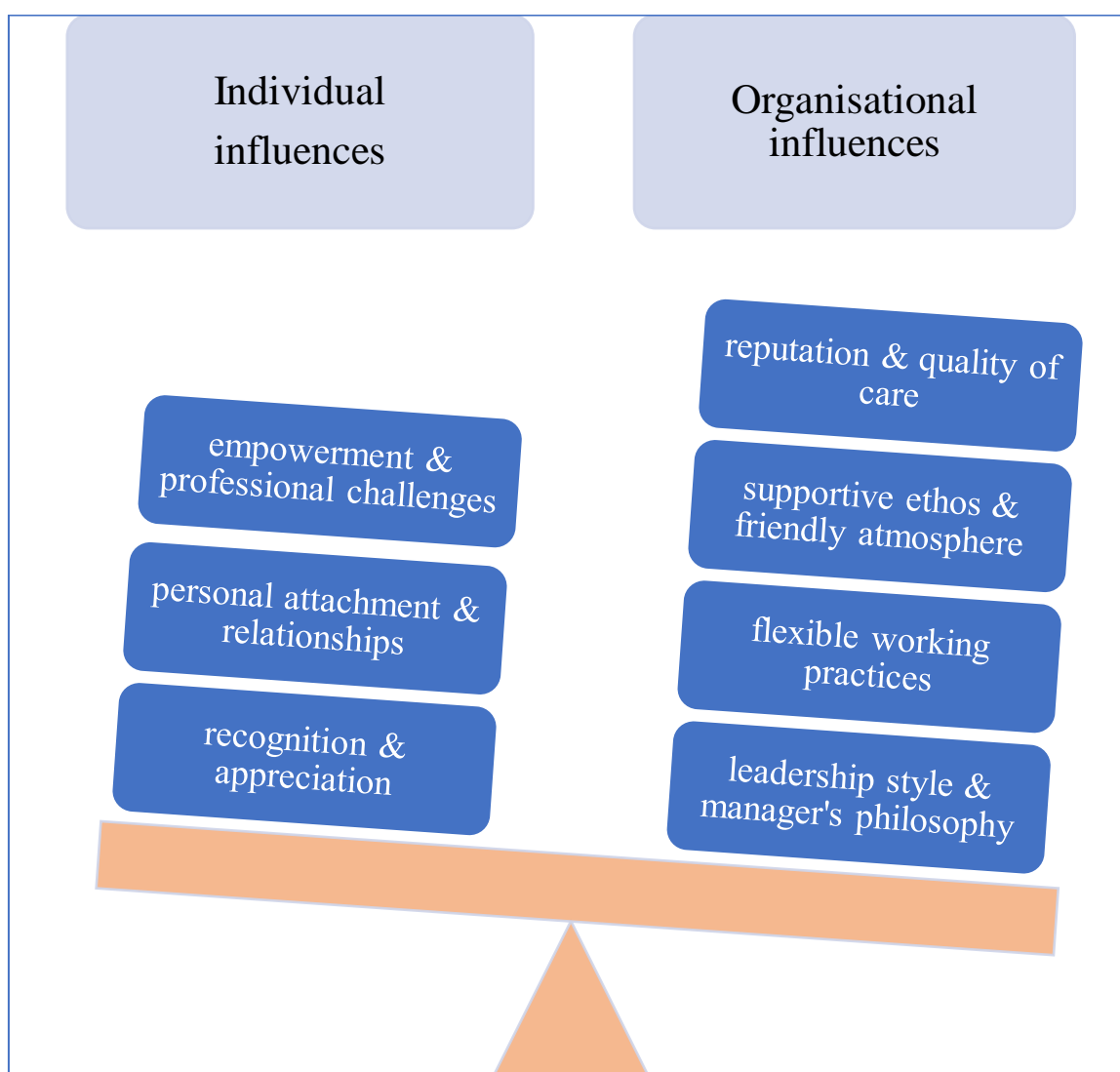
The *next section* discusses the key influential factors enhancing job satisfaction, and framed by the new framework, explores the effect of these factors on the function of balancing job satisfaction in their workplace, which ultimately guides decisions whether to stay or leave the care home employment. Although discussed separately for ease of reporting, these influences were shown to overlap and were not mutually exclusive.

6.3 Individual influences

The *first section* focuses on the key individual influences which enhanced staff job satisfaction, from the case study findings. Key within these influences were the development of genuine relationships with the residents and their colleagues, the professional development and

autonomy within staff roles, accompanied by the value and appreciation placed on this contribution in the workplace.

6.3.1 Personal attachment and relationships

Many staff across the cases, reported the development of strong relationships with resident and genuine attachments as important influences to enjoying their role. For example, staff reported feeling a sense of warmth, strong friendships with both colleagues and residents, and a commitment to their care home. This is reflected in the work of McCormack et al. (2018), which advocated "trusting, personal relationships" as key elements of person-centred care (p.2), which can facilitate a culture of "human flourishing" (p.1). Personal expectations and the development of close resident relationships are key predictors of increasing a sense of pride in their job, whilst Brannon et al. (2007) reflected that negative personal factors heightened job dissatisfaction.

Consistent assignment was reported by Choi and Johantgen (2012) as key to improving job satisfaction through enhancing feelings of accomplishment, recognition and appreciation (Chou, 2012), with reduced satisfaction when care delivery was compromised (Donoghue & Castle, 2009). Farrell and Frank (2007), within their study also reported the benefits of consistent assignment was such that staff took less absences and turnover was reduced. Delivering high quality resident care encouraged staff to feel they were positively contributing to residents' well-being, greatly enriching the satisfaction within their role, while the RCN (2012) reported effective leadership as a crucial component to optimise patient care. Consequently, reduced quality of care which heightened staff stresses was viewed as a predictor of staff turnover (Spence Laschinger & Fida, 2015). Thus, developing working practices to foster real affection between carers and residents, as reported in this study to support resident-centred care, adds to the work of Chou (2012), with suggestions that it could deter staff from leaving their job.

Kemper et al. (2008a) proposed work relationships as one of the greatest influences on making job improvements, with positive and effective working relations also reported within the data of the current study. A strong sense of belonging and feeling part of a team, greatly adding to enjoyment in the care role. Belongingness has a strong effect on emotional patterns of behaviour making the care role more enjoyable (Gibson, Ivancevich, Donnelly & Konopaske, 2009).

Social attachments were often formed willingly, reported with a powerful drive to belong as a "fundamental and extremely persuasive motivation" (Baumeister & Leary, 1995, p.497), whilst a lack of attachment had a direct impact on staff health and well-being,

Dissatisfaction, within this study, was often linked to staff feeling unvalued and under developed, with the manager's vision and interaction being key in reducing these negative staff feelings, and dispelling thoughts of wanting to leave their job. For example, the development of personal friendships with fellow colleagues, were noted to impact on working activities and workload, and markedly boosted personal satisfaction in the workplace (chapter 5, page 125). This finding adds to the current evidence, reinforcing that improving staff relationships enhances staff development and personal growth, which helps with workforce retention (McGilton et al, 2014). Thus, building genuine personal attachments was reported as central in both the study data, seen across all the cases, and reflected widely amongst the scoping review literature (Chenoweth et al, 2010; Kemper et al, 2008a).

Feeling part of a team and the development of positive working partnerships were reflected in the data and echoed in a study by McGilton et al. (2014), which recognised that strong supportive teams helped to reduce motivations to leave the organisation. The promotion of self-managed working teams was a means to increase staff decision making and autonomy, while also suggested as a strategy to raise care standards (Hill & Bartol, 2015). This was echoed by McGilton et al. (2014) with this study portraying small close-knit teams as a way to heighten self-esteem and self-worth, whilst a lack of team working can magnify staff workloads (Kalisch, Weaver & Salas, 2009). McSherry and Warr (2006) proposed practice development is achieved through a "facilitative approach to team working, collaboration and partnership building" (p.55). This suggests human behaviour, attitudes and the interaction between staff (and residents) is key to facilitating change, emphasising the need to offer practical support to assist care home managers in shaping motivational factors, to improve job satisfaction in their workforce. Furthermore, recognising the importance of research evidence as a key component of improvement interventions, although often complex, this can enhance the success of implementing the findings into practice (Kitson et al, 2008; Seers et al, 2012).

Within the study data, a lack of close working relationships, seen at all levels of an organisation, often resulted in poor performing staff with a reluctance to generate workplace changes.

Gaining satisfaction through attaining psychological needs, was reflected by Maslow's (1943) theory, whereby feelings of belonging, and building team relationships were important within the hierarchy of needs, which were seen from many of the participants' comments. West et al. (2015) reported similar findings with strong team working encouraging active involvement of staff, which promoted a more positive and enjoyable work climate. The effect of positive emotions and mood has been recognised to influence behaviour, and thus job satisfaction (Isen & Reeve, 2006). For many staff, additional feelings of esteem and fulfilment were realised, although for some staff their higher-level needs were not always met, suggesting the attainment of satisfaction was multi-factorial and thus requires greater understanding of the workforce needs (Imison, et al, 2016).

A lack of recognition of the complexity of resident needs associated with physically abusive situations, heightened staff concerns for their safety causing, in this study's data, an upsetting and troubled workplace. A positive relationship, albeit weak, has been found between the intention to leave an organisation and workload stress, reported in a study by Gaudenz et al. (2017). Low levels of job satisfaction were frequently associated with emotional exhaustion (Karsh et al, 2005), potentially leading to work-related burnout, often seen to be higher in the nursing workforce, reported in a study by Khamisa Peltzer Ilic and Oldenburg (2016). While Clausen, Tufte and Borg, (2014) suggested emotional exhaustion, combined with poor relationships with residents' families and fellow colleagues, had consistently been linked to staff intentions to leave. Cohen, Blake and Goodman (2015) suggested the factors influencing dissatisfaction needed to be addressed, rather than the focus being on whether they were good predictors of a person's intention to leave, whilst Armstrong, Atkin-Plunk and Wells (2015) highlighted structured organisational initiatives, such as staff supervision, as key to workforce retention. This reinforces the need to repeatedly enhance "meaningful engaged relationships" (McCormack et al, 2007 p.78), whilst stressing the importance of interventions and approaches focused on cultivating healthier workplace environments, whilst promoting "modernisation and development of effective services" (McCormack et al, 2007, p.79).

Weak levels of trust are more likely to generate disharmony in the workplace, with consequently lower performing staff (Forbes-Thompson, Leiker & Bleich, 2007), thus the need to build trusting, honest working relationships across all levels of staff within an organisation is reinforced. Authentic leadership traits focus on higher levels of honesty, character and integrity, with this style of leadership linked to improved leader-follower relationships (Wong

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& Cummings, 2009), with Chan and Mak (2014) suggesting this encourages pride and greater commitment in their role. The work of Clegg (2001) suggested high performing staff felt trusted and more enabled, reducing feelings of dissatisfaction whilst helping to decrease staff turnover, combined with increasing staff knowledge, which is reported to be influential within close knit working environments, such as within care homes (Rogoff, Paradise, Mejía Arauz, Correa-Chávez & Angelillo, 2003). Fairness and dependability of the manager, as shown in this study, have been shown to influence staff attitudes and behaviours through increased loyalty and job satisfaction, with the work of Dirks and Ferrin (2002) supporting engendering this behaviour within leadership development reporting a significant relationship between trust and staff commitment, performance and their intention to leave the organisation.

6.3.2   Empowerment and professional challenges

Bandura (2001) suggested the "essence of humanness" is the ability to take control over one's life in terms of its nature and quality, hence feeling in control of their personal situation is imperative for job satisfaction to be fully achieved (p.1). Empowering staff in their daily activities was crucial to ensuring they felt in charge of their actions and had confidence in their abilities, similarly reported by the work of Deci and Ryan (2008). Gaining added responsibilities made staff feel proud and confident in the workplace, however occasionally if deemed excessive in nature, this randomly tipped the balance of satisfaction towards negative feelings of being unvalued and overwhelmed. The manager was essential to enabling staff to reduce these negative workplace influences, largely through increasing staff feelings of being in control, which were reported to strongly shape and enhance their work-life balance.

The empowerment of carers was seen within the case study data, with staff reporting positive self-identities, evidence of dignity and self-esteem, which have all been linked to staff commitment and job satisfaction (Sturm & Dellert, 2016). Nurturing pride and self-worth in their role, for example during times of staff shortages, increased the staff's commitment to the organisation, which was reflected widely in the study data and supported by McGilton et al. (2014). While recognising that trusting teams are more likely to work together to resolve internal conflict issues (Pellerin, 2009), the development of an honest and empowered workforce is crucial. Features seen through the power of team-working and within effective philosophies of care can be promoted (Wong & Cummings, 2009), which strengthens the need

for management training programmes to develop managers with the necessary skills to facilitate active staff involvement.

The study data reported staff enjoying their work more when they could influence and take actions to improve resident care, activities guided through the managers' ethos to inspiring staff behaviours. For example, many registered nurses found the professional challenges developed feelings of independence and confidence, empowering them in their decision making and increasing their feelings of personal credibility. The staff reported feeling better able to deal with added responsibilities, through knowing they had the back-up, support and co-operation of their managers. Nakanisho and Imai (2012) supported these findings, suggesting a lack of decision-making skills within the caring workforce resulted in unhappy and despondent staff. However, this is not always the case, particularly for the unregulated staff in the study, who reported additional responsibility left them feeling overwhelmed, under pressure, and unhappy (page 131). This finding adds to the work of Brannon et al. (2007), which reported a lack of skills development, being overloaded and feelings of isolation, were all related to staff intentions to leave their job. For the main, the negativity associated with a lack of control, largely due to restrictive working practices (explored later in this chapter), strongly intensified staff intentions to leave, hence, reflecting the importance of establishing interventions to increase staff autonomy and decision-making skills. Improving staff opportunities with the acquisition of the necessary tools to help them feel empowered, can better enable them to manage and fulfil their increasing role demands (Ha et al, 2014). Hegeman et al. (2007) reported strengthening an individual's internal locus of control and leadership skills could assist with wider change management interventions and greater satisfaction in their role.

Effective persuasion techniques can also empower individuals to better promote self-belief in their own abilities (Schunk & Pajaras, 2009). Whilst Jones et al. (2015) recognises the Health Belief Model when modifying behavioural change when focusing on variables such as "perceived barriers, benefits, self-efficacy, and threat" (p.566). Professionally supporting staff to drive change and lead quality improvement projects in the organisation was promoted through effective leadership behaviours. For example, staff reported the value of being guided, directed and encouraged to affect change whilst knowing they would continue to be supported in a non-judgemental manner. Role modelling is a method also apparent in the study data with the managers supporting, nurturing and influencing more junior staff (Rippon & James, 2015), whist Spilsbury et al. (2015) stated care home nurses had many expectations placed on them,

encompassing role modelling and patient advocacy (Mittal et al, 2009). Practice development is considered to offer "complex social intervention" based on the various methods involved in focusing on people and processes, while offering the opportunity to promote effective change (Department of Health and Children, 2010, p.18).

Although the data showed the value of being listened to, with the ability for staff to voice their individual issues shown as important, their perception of the manager having genuine concern for them was key to cultivating stronger trusting and rewarding relationships, with allegiances to both the manager and the organisation, also reflected in the study by Stearns and D'Arcy (2008). Rubery et al. (2011) confirmed this, suggesting an employee's inability to speak up caused dissatisfaction, reinforced by the work of Chen and Silverthorne (2008), which suggested a high internal locus of control generated higher job satisfaction, lower job stress and consequently greater levels of performance, all motivating job satisfaction. Transformational leadership through promoting greater job autonomy was associated with higher levels of internal locus of control in staff (Wu, Griffin & Parker, 2015), and suggesting that leaders can clearly influence staff behaviours towards taking control of their own actions. This underlines the need to help guide managers towards interventions which promote self-efficacy and empowerment thus improving satisfaction in the workplace.

The ability to use professional judgement with structured support networks, found in a study by McGilton et al. (2014), often resulted in less staff leaving an organisation and was similarly reflected in the local data (chapter 5, page 130), with staff reporting greater autonomy and responsibility heightened their self-fulfilment in their role. From the data, this style of management was seen and was recognised as boosting commitment to the organisation through staff feeling valued and respected and was also supported by the work of Riggs and Rantz (2001). The Department of Health (2006) report *Securing and retaining staff for health and social care: a partnership approach* reinforced this, adding that a culture of collaboration, fairness and quality would positively influence the retention of staff, and is reflected by a transformational approach to leadership (McCutcheon; Doran, Evans, McGillis-Hall & Pringle, 2009). Thus, a manager who has the necessary skills of creativity and innovation, with the ability to drive an organisation's vision forward, is one means to improving organisational and management structures, and is reflected in the work of Jeon, Merlyn and Chenoweth (2010). Whilst this study's data has demonstrated that unstable management structures, recognised by,

for example, delays in responding to staff difficulties or implementing changes, can contribute to dissatisfaction in the workplace (Skills for Care, 2009).

Reported across all the cases, the managers' approach of encouraging educational achievements was associated with empowerment of staff, which considerably enhanced satisfaction in the care role (Skills for Care, 2011). Gazioglu and Tansel (2006) reported higher levels of satisfaction for those that received job training opportunities, which reflected the study's findings which reported learning as promoting confidence, feelings of reward and self-worth (page 151). This supports the work of Skills for Care (2011), reporting its value in promoting greater feelings of commitment and job enjoyment, with Haggstrom, Skovdahlk, Flackman and Kihlgren (2005) advocating the involvement of staff in educational activities to help reduce workplace pressures. Also revealed in the study data, was the opportunity to advance staff prospects through offering development opportunities, which helped to improve self-image and cohesiveness of staff (Skills for Care, 2011). Increasing the value of the workforce through the development of a structured career framework is one recommendation to achieving this (Spilsbury et al, 2015). Mainly directed by forward thinking managers, learning new skills increased feelings of self-worth and respect, generating a more positive outlook which motivated staff even further, whilst Donoghue and Castle (2009) reported a lack of these feelings was linked to workplace negativity. Similar findings were also reflected in the study of Help the Aged (2006), which reported reduced confidence in the work role was found to negatively affect job satisfaction. However, Cooper et al. (2017) reported this workforce faces challenges when accessing training programmes, also reflected in the study data, however the managers did report doing their utmost to reduce the current barriers, while offering managers a practical solution to overcoming potential obstacles could be considered helpful.

6.3.3   Recognition and appreciation

The case study findings reported an association between personal satisfaction being increased through enhancing intrinsic and extrinsic factors of job satisfaction. Recognition of staff as individuals rather than just as a workforce helped positively promote factors associated with greater job enjoyment. For example, intrinsic factors such as motivation, esteem, commitment and achieving one's potential were strongly associated with increased job satisfaction, while positively influencing motivation is linked with reduced staff turnover intentions (Bonenberger,

Aikins, Akweongo, & Wyss, 2014). These factors, whilst reported within the case study findings, were also reflected in the scoping review findings (chapter 2, page 36).

In this study, some staff reported working mainly for money, security and as a means to an end, whereas other staff were clearly seeking a greater accomplishment in their role. The employee's desire to stay in the role was seen as a positive influence on job satisfaction (Pathak & Srivastava, 2017), with some staff striving to fulfil their maximum potential, with sights on continual development and progression. The findings support the work of Gilley, Gilley, McConnell and Veliquette (2010) reinforced that growth and development act as "a powerful human motivator" (p.33). The motivational theory of Maslow (1943) is useful to contextualise this data, reiterating the requirement for lower level tiers to be satisfied, such as survival needs, before staff ascend the levels to successfully achieve their full personal development in the workplace, thus demonstrating the tiered approach to motivating behaviour, with some needs taking precedent over others (Taylor et al, 2014). The theory of self-determination (SDT) highlights the different types of motivation, rather than focusing on the amount of motivation, which enhances outcome predictors such as performance and well-being (Deci & Ryan, 2008). The study's findings demonstrated staff were at different stages of this process, thus various job satisfaction interventions are required to address these needs. Therefore, interventions such as practice development must appreciate and target these lower tiered activities for successful implementation and change to occur.

The findings showed, that for many staff, feeling supported about their personal concerns was a significant factor influencing job satisfaction (Ellenbecker, Boylan & Sarnia, 2006), reflecting several studies recognising a strong link between personal factors and intentions to leave employment (Parsons, Simmons, Penn & Furlong, 2003; Armstrong-Stassen & Cameron, 2005; Tourangeau, Patterson, Saari, Thomson & Cranley, 2017). Self-actualisation, defined within Maslow's framework and integral within the Herzberg theory of job satisfaction is considered an important constituent of a role (Decker et al, 2009). This underpins Maslow's hierarchy of needs, reflecting that staff may be less motivated to develop the higher order needs of belonging and developing friendships, until for instance, the lower tiered need of affording job security, has been satisfied. Through this study, this finding was strengthened by the participant data which recognised the value of both intrinsic and extrinsic factors as predictors of job satisfaction, particularly increasing responsibility, self-satisfaction, accomplishment and self-development. Whilst dissatisfaction was associated with poor workplace communication, lack

of quality supervision and increasing demands of the role (Skills for Care, 2009). Hunt et al. (2012) studied intrinsic factors in relation to registered nurse retention and reported that although behaviour was enriched by both intrinsic and extrinsic factors for this group, it did not appear to be the sole answer in addressing retention of staff.

In the study data, staff reported valuing the opportunity to discuss issues and concerns, through team meetings and one-to-ones which gave them a greater voice and feelings of empowerment. For example, being able to make some decisions and feeling they had contributed to improving care standards enhanced staff feelings of accomplishment and self-worth (page 124). This finding reinforces the work of McGilton et al. (2014) and promotes the importance of empowering staff to change behaviours to encourage high performing care teams (Williams, Graham & Baker, 2003). Participatory management offers staff the opportunity to be more involved in decision making processes (Alharbi, 2017), and combined with building greater staff harmonies, fosters feelings of appreciation and one of collective identity (West et al, 2015). Transformational leaders vary their styles which can include directive, participatory, authoritarian or democratic behaviours, with a participatory approach promoting active support and engagement through open discussions (Alharbi, 2017). This report suggests collective leadership is considered a more effective way of empowering front-line staff, rather than focusing on managers alone, although they reiterate the importance of context and its contribution towards positive organisational development (West et al, 2015).

Clearly within the case studies, encouraging staff to feel appreciated and recognised greatly enhanced the enjoyment of their role, which was further enhanced through a positive happy working environment. For example, the managers in the study were found to offer nurturing, rewarding, calming and co-operative behaviours, all recognised as key personality traits for influencing organisational and management processes, with these findings supporting the work of West et al. (2015), which reported the importance of developing a shared, collaborative integrated leadership culture. The importance of collaborative working has already been established in fostering greater staff recognition and job enjoyment (Körner, Wirtz, Bengel & Göritz, 2015), while inter-professional teamworking can also strengthen team effectiveness (Clarke, 2010). This recognises the need to develop an organisational culture conducive to promoting positive staff interactions, attitudes and behaviours (Rycroft-Malone, 2010), which supports and strengthens factors that impact on job satisfaction, while encouraging retention of the workforce.

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Drawing conclusion from this evidence, it appears that development opportunities aimed at the top of Maslow's hierarchy are almost destined to fail unless more basic needs have been attained first. Ha et al. (2014) reinforced feeling valued, appreciated, respected and being listened to, were all crucial influences of improving job satisfaction. Thus, negative factors which frequently reduce intrinsic factors, accompanied with the challenges of negative and angry residents and relatives, all heighten job dissatisfaction and increase the likelihood of staff leaving.

6.4   Organisational influences

The *next section* focuses on the organisational influences which improve the conditions for staff within the care home setting. These include the ethos and atmosphere within the workplace, together with the philosophy and style of the manager, which impacts on the interaction and behaviours of staff. The importance of this role in promoting stability through several approaches, such as developing flexible working practices, endorsing high standards of care, and enhancing a positive reputation, is acknowledged.

6.4.1   Supportive ethos and friendly atmosphere

Within the study data, and reported across all cases, the development of a positive cultural environment was closely linked to job satisfaction, while also impacting on the provision of quality, patient centred care, which acknowledges the need to appreciate the contextual environment when improving staff working conditions (Kitson et al, 2008). For example, staff reported working in an exciting, challenging and interesting environment, which encouraged a sense of achievement and motivated them to make a real difference to resident care. This was clearly reflected in the work of Schein (1984) who believed "organizational culture is the key to organizational excellence" (p.3), with Chamberlain, Hoben, Squires and Estabrooks (2016) suggesting features of the working environment in long term care establishments could be modified, helping to enhance job satisfaction.

Loyalty and commitment are shaped by the culture of the organisation, with effective leadership seen as essential to inspiring a positive working philosophy (Cummings et al, 2017). Bandura (1977) argued learning was generated through observation, imitation and copying, thus a friendly happy environment fosters further positive staff relationships of this nature (Karsh et

al, 2005). Later known as the social cognitive theory (Rosenstock, Strecher, & Becker, 1988), this belief focused on behavioural changes learned through expectancies and incentives (Grol & Wensing, 2004). If the culture of an organisation is perceived "as correct and valid" new staff will follow this, whilst bringing new ideas themselves to produce cultural change (Schein, 1984, p.10), while facilitating organisational development and cohesiveness (Kroth, 2007). Bass (1999) suggested successful managers are those who can influence others, with West et al. (2015) reporting the requirement for effective leaders to ensure "priorities are communicated" to successfully drive forward their vision (p.5). Whilst Cable and Judge (2003) reinforced the viewpoint that managers who used "pressure and persistence" developed a different workforce culture to those that supported and encouraged their staff (p.197), which echoes the study data which showed calm and open managers, through recognising and valuing their staff, offered a more positive working environment.

Mittal et al. (2009) suggested resident advocacy was affected by the organisational culture within the home, also acknowledged by Hsieh and Su (2007), suggesting that advocacy was strengthened by the promotion of positive demeanours and performance. This builds on the earlier study data, which identified that providing good standards of care were strongly associated with staff raising their self-worth and pride in their achievements. This warming ethos promoted within the home, combined with the promotion of positive relationships with both staff and residents, helped staff to perform even better, while stimulating far greater job enjoyment, clearly known to deter staff from leaving (Castle & Engberg, 2006). Practice development can be a means to support these processes, as "a continuous process of improvement towards increased effectiveness in patient centred care" (Department of Health and Children, 2010, p.11). Context is recognised as fundamental for the uptake of evidence into practice (McCormack et al, 2002), whilst a multi layered construct acknowledges the crucial elements of culture, leadership, behaviours and relationships (Brown & McCormack, 2011).

Organisational culture can clearly be seen to play a large role in inspiring and stimulating staff, with Karsh et al. (2005) suggesting these behaviours can breed similar behaviours, aiding the growth and progression of the organisation. These findings were reflected in the study data, with staff feeling happy and relaxed from working with caring and helpful staff, in a friendly, supportive environment. Shaping organisational culture can help motive staff through the facilitation of goals, which is suggested to positively influence staff performance (Alvesson, 2012). However, the opposite may also be the case, with negativity and a lack of enthusiasm in

the workplace breeding an unhappy and dissatisfied environment, with staff participants reporting feeling disrespected and unvalued when this occurred. Thus, it is essential that any negativity and poor behaviours are stamped out early, with regular supervision and team meetings offering a mechanism to address this. Jones and Kelly (2014) highlight the vulnerability of people in care settings and the importance of staff and manager communication, whilst McCormack, Wright, Dewar, Harvey and Ballantine (2007) and McCormack et al. (2018) recommended embedding practice development activities within learning and development strategies if sustainable outcomes were to be achieved. Engaging staff in work-based learning is one approach to achieving this (Chenoweth, et al, 2010), combined with greater facilitation and coaching in the workplace (Cummings et al, 2017). As such, further interventions focusing on improving workplace opportunities, with an emphasis on improving the organisation's culture (Rycroft-Malone, 2010), may help to better motivate staff and encourage higher rates of retention.

Peer support was another important influence on shaping job satisfaction, demonstrated in the case study findings and in the scoping review findings (Aaron, 2011; Hegeman et al, 2007; Singh & Schwab, 2000). Associated with this was the need for clear structured supervision strategies, influenced by the manager's approach to autonomy, delegation and the development of work-based competences, supporting the nursing home studies of Karsh et al. (2005) and Ha et al. (2014). In the study findings, a sense of pride in their own abilities was reported to enhance job enjoyment, for example, through staff feeling they had provided good standards of resident care. The data also reflected the growing responsibility within the role, which positively impacted on feelings of self-worth, advancement and self-fulfilment, while respect and being well-regarded was linked to being treated fairly, all found to be crucial if staff retention was to be achieved (Skills for Care, 2011).

Positive supervisor behaviour was strongly linked to enhancing personal intrinsic factors to enhance job enjoyment. The findings reported that supervision provided by the senior care home staff, promoted staff perceptions of being invested in as individuals and enhanced feelings of being valued and of self-worth, and reinforced the findings in the work of Decker et al. (2009). Staff participants appreciated the opportunity to openly discuss their own concerns which made them feel in control of their activities, while increasing an individual's internal locus of control and self-esteem is associated with high performance, emotional stability and greater job satisfaction (Chen & Silverthorne, 2008). This was reflected in the findings, with

many registered staff reporting independence and flexibility in their role which gave them greater professional and personal satisfaction (page 130), and it was recognised that these factors were guided and directed by the organisational and management approach towards the workforce.

6.4.2   Leadership style and the manager's philosophy

A healthy workforce is enhanced through effective leadership (Skills for Care, 2009) which promotes mutual respect within the organisation, aiding staff retention (Sethuraman & Suresh, 2014). In this study, it was found that the approach and style of the manager was a key thread in enhancing positive working relationships with individual staff and across staff groups within the care home. Participants reported that managers were seen to encourage positive behaviour and proactive attitudes, which were developed through a culture of helpfulness, confidence and tolerance. Staff function better when able to contribute to overall decision making (Alharbi, 2017), thus crucial to heightening staff enjoyment and happiness in the workplace was the manager's personality and practices which steered staff interactions, whilst cultivating an environment they wished to remain in.

The ethos and philosophy of the care home was noticeable in promoting a warm, friendly working environment with a caring culture, with the case study findings showing the approach of the manager as influential in enhancing this ambiance. The ability to influence the atmosphere of the environment was considered important, improved through organisational structures combined with effective leadership within the care home. This supports the work of Cascio and Boudreau (2008) which suggests managers play a significant role in encouraging team building within their organisations, known to boost job satisfaction. In the data, for example, staff participants appreciated the responsive and approachability of their managers and those who appeared to take a genuine interest in supporting them. This reinforced the work of Ha et al. (2014) which showed a compassionate workplace could generate greater loyalty in the workforce and reduce staff turnover (Castle & Engberg, 2006). A culture of openness, mutual respect and empowerment were all recognised in a nursing home study by Karsh et al. (2005) as influencing job satisfaction, steered by the behaviour and temperament of the managers. Acknowledging the important role of organisational context within care home change interventions and strategies can better aid the development of workforce improvement

projects (Estabrooks et al, 2009), while also an understanding of the organisation's "readiness for change" can influence a more successful outcome (Weiner, 2009, p.1).

Personality traits are regularly classified according to the Five Factor Model suggested by Goldberg (1990), that of extraversion, agreeableness, conscientiousness, emotional stability and openness. The study findings showed the managers' friendly, warm and co-operative demeanour helped to guide staff behaviours and attitudes and were seen to be aligned to the agreeable measures in the personality trait model (Kim, Shin, & Umbreit, 2007). Agreeable traits help to foster greater staff engagement, enhanced team working and engendering professional efficacy, reported as having positive effects on job satisfaction (Akhtar, Boustani, Tsivrikos & Chamorro-Premuzic, 2015). Staff participants reported seeing these positive traits in their managers, through their affable nature, which encouraged flexibility and willingness of their staff, whilst also encouraging greater contentment and fulfilment in their care home role (Chapter 5, page 135). Similarly, these findings were reflected in the study by Mittal et al. (2009) which reported a lack of respect from senior staff greatly influenced staff turnover. Alvesson (2012) suggested the approach of managers and their management techniques can guide the workforce culture within their organisation, thus interventions to help steer these processes are considered valuable.

The manager's organisational and management style of supporting their workforce, was also revealed within this case study, and was strongly linked to the managers' leadership standpoint (chapter 5, page 139). For example, adaptability and good communication skills influenced their organisational approach taken, and clearly impacted on the staffs' personal expectations, echoed in the work of Mittal et al. (2009). Effective leadership is crucial in promoting a supportive environment and reducing staff intentions to leave the organisation (Gaudenz, De Geest, Schwendimann & Zuniga, 2017), and was reflected in the local data, with managers shown to adapt and respond to difficult situations, such as working closely with unregulated staff to care for residents during times of workforce shortages. Fair and accommodating leadership fostered greater commitment and loyalty to their organisation, with staff less likely to leave their workplace (Cowden, Cummings & Profetto-McGrath, 2011), underlining the need for approaches to enhance this style of leadership.

Successful leadership embodies personal traits such as charisma, creativity and flexibility to "elicit effective performance from others" (Giltinane, 2013, p.35), whilst the contribution of characteristics of inspiration, intellectual stimulation, idealised and individualised influence, can further enhance transformational leadership success (Boamah, Spence Laschinger, Wong & Clarke, 2018). Enhancing emotional intelligence, through learning and self-leadership, has been reported to positively influence staff retention (Smith, Profetto-McGrath & Cummings, 2009), although its effectiveness has been questioned with this quality being difficult to measure (Cavazotte, Moreno & Hickmann, 2012). Clearly deemed influential for effective leadership, these skills and traits should be afforded to management training programmes to encourage professional growth of the managers, with the bonus of promoting a more stable workforce (Rippon & James, 2015). Manager's leadership styles varied, with transformational approaches shown to positively influence staff retention, mainly through inspiring organisational commitment and feelings of well-being (Cummings et al, 2010), with this style aiding staff development through promoting shared goals (Rippon & James, 2015), with the appreciation of clinical leadership also influencing the uptake of evidence-based practice (Kitson et al, 2008). Motivation and self-confident managers are required to successfully drive this forward with Joseph, Jin, Newman, and O'Boyle (2015) recognising the need for emotional stability, cognitive ability and organisational knowledge as central contributions to effective leadership styles.

Whilst in contrast, staff participants reported feeling frustrated and annoyed, when managers' natures were perceived to lack momentum and drive, were not quick enough to respond to workplace disagreements, and combined with ineffective reporting structures, were all reported to add to feelings of negativity and despondency (page 141). Skogstad, Hetland, Glasø and Einarsen (2014) argued laissez-faire leaders displayed low levels of leadership activity and were associated with reduced leadership effectiveness. Forbes-Thompson et al. (2007) recommended "values-based leadership behaviors" to effectively contribute to a strong cohesive organisation (p.341), with a strong correlation between inspirational motivation and effective leadership reported (Jeon et al, 2010), thus reinforcing the value of strong leaders to encourage sustainability of the workforce. Peus, Braun and Knipfer (2015) reported women tend to be less autocratic, being more participatory and democratic in their approach, supported by Eagly, Johannesen-Schmidt and van Engen (2003), suggesting this leadership style offered a greater level of job satisfaction, for both men and women.

Managers' leadership style seemed to influence the stability and strength of the organisation's culture, through the generation of shared experiences (Schein, 1984). Based on the Stages of Change Model, DiClemente and Prochaska (1982) recognised different stages of readiness for change, with the importance of identifying the individual's position in the change process. Prochaska and Velicer (1997) reported improvements in recruitment and retention were increased following "stage-matched interventions" (p.38). Transactional leaders tended to be task orientated and did not generally promote a culture of contribution and involvement from all, while data from a systematic review reported that task-focused leadership styles heightened job dissatisfaction (Cummings et al, 2010). Strategies which affect individual behavioural change which generates positive staff relationships, should adequately appreciate these stages otherwise success may not occur. This reinforces that culture is "always in the process of formation and change" (Schein, 1984, p.14). A study by Spilsbury et al. (2015) reported wide variations in managers' leadership styles, with engagement and enthusiasm key traits for promoting fulfilment on staff roles. Although combining elements of both transformational and transactional styles has previously offered a solution to the development of effective leadership (Aarons, 2006), Cummings et al (2010) suggests "relationally focused leadership styles" can further enhance job satisfaction, through demonstrating an understanding of the needs of others, motivating staff to reach their full potential, while also inspiring and coaching them through complex situations (p.364).

In the study, staff participants reported communication as being key to helping them feel an integral part of the care home team, making them feel fully involved and self-fulfilled in their role. The managers' approachability, reflected in the study data, affected the strength of interaction with their staff, also considered important in the work of West and Dawson (2012) who reported high levels of staff engagement encouraged positive staff attitudes, job satisfaction and lower turnover intentions, similarly supporting reduced sickness rates (Guzmán, Wenborn, Swinson & Orrell, 2017). Staff reported being kept informed helped improve team working, which upholds the sustainability of compassionate cultures while helping staff foster greater job enjoyment. Clearly identified role expectations amid recognition for their activities, increased staff motivation through a sense of "organizational justice" (Deschamps, Rinfret, Lagacé, & Privé, 2016, p.194). While, ineffective channels of communication were found to cause frustration and negativity, and were linked to poor performing and unhappy staff, also echoed in the work of McGilton et al. (2014) reporting these staff were more likely to leave the organisation.

Understanding staff's personal and family difficulties, shown in the data through the friendliness and accessibility of the manager, was another element that helped staff feel valued and respected. This appeared over and above the role assumed of a care home manager, which did not emerge strongly in the scoping review. For example, most staff participants reported feeling managers had real concern for their well-being, which promoted greater staff bonding and feelings of trust, and encouraged stronger working relationships. Staff participants reported believing their manager had their best interests in mind, which reduced their level of conflict, and was supported by the work of Simons, Leroy, Collewaert and Masschelein (2015), which showed behavioural consistency, integrity and good communication promoted greater trust in the workplace. In the study, the managers' recognition of their staff's personal concerns and difficulties provoked genuine feelings of friendship and loyalty by staff, promoting greater motivation and contentment in their job (Chapter 5, page 140). This was further enhanced through the managers offering every means of rewards and support they could, seen by their implementation of flexible working practices, development of learning and education opportunities and the extra personal touch, of providing additional individual rewards and help (page 147). In contrast, for hospital nurses, Terera and Ngirande (2014) suggested that although increased rewards led to staff retention, it did not necessarily result in greater job satisfaction, hence reflecting the complexities and challenges posed when supporting the care home workforce.

6.4.3 Flexible working practices

Findings from both phases of this study showed poor working practices heightened staff negativity, with these factors reducing overall job enjoyment. Negative influences were reported as including both intrinsic and extrinsic factors, for instance workload and team care practices, also reflected in the earlier scoping review findings (Chou, 2012; Stearns & D'Arcy, 2008). Kacel, Millar and Norris (2005) used the Herzberg's theory to explore job satisfaction amongst nurse practitioners and found that although both hygiene and motivation factors contributed to overall job satisfaction, it was reported that making improvements to the hygiene factors (such as care practices) often made the greatest impact (Kacel et al, 2005). Extrinsic factors such as financial rewards, paid holidays, terms and conditions, were also reported to influence retention of staff, which were directed by organisational processes, reported in a study by Hunt et al. (2012). Daily working practices and variety of work were also reported to influence job satisfaction in terms of extrinsic factors of motivation (Deci & Ryan, 2008), thus highlighting the need to consider intrinsic and extrinsic factors within organisational change

processes, if greater job satisfaction was to be achieved (Karsh et al, 2005). The findings were reflected in the work of Squires et al. (2015) with carers in both hospital and community care settings reporting working conditions as one of the biggest influences on job satisfaction, whereas pay and benefits were not considered as important. Strategies focused on understanding the factors which influence the attraction and retention of staff were considered most valuable, with an emphasis on "job-related (intrinsic) and non-job related (extrinsic) issues" (Scanlan, Still, Stewart & Croaker, 2010, p.120), thus reflecting the need for targeted approaches to improving job satisfaction in the care home setting.

On the whole, the negative feelings towards poor pay rates reported by participants, along with issues with general terms and conditions of employment, did not appear to impact on the staff's day to day enjoyment of working with the residents. Many staff participants across all care homes, reporting this dissatisfaction was more frequently linked to personal feelings of being unrecognised and unvalued in their role, as opposed to the financial reward itself (Chapter 5, page 145). Many participants acknowledged feeling a lack of acknowledgement, appreciation and respect, which were often linked to people's lack of awareness and understanding of the complexity of the role, similarly reported in a study by Stearns and D'Arcy (2008). Findings reinforced the importance of staff endeavours being recognised, also reflected in the work of Franco, Bennett and Kanfer (2002), which suggested Herzberg's higher-order motivating factors stimulated "worker motivation in the absence of extrinsic rewards" (p.1258). The findings suggest staff considered all these factors, with positive motivational factors outweighing the negative hygiene influences, although a possibility was that limited better options were available to them, and hence they tolerated the factors causing disappointment and dissatisfaction and remained in their employment.

Findings show that low staffing levels were considered a negative influence on job dissatisfaction, with poor staff numbers linked to various challenges, such as increasing workload and responsibilities, changes to shift patterns, reduced levels of care and more time spent away from the residents. Staff participants reported valuing their managers employing agency and locum nurses to bolster the permanent workforce, although sometimes inadvertently adding to staffing inconsistencies, it calmed them thorough easing their workload demands. Staff greatly valued the managers' team spirit by them also helping with the residents' care needs, which allowed the carers more time to fully accomplish their own duties. These findings were similarly reported in studies by Chenoweth et al. (2010), Chou (2012) and Skills for Care

(2009). Rosen et al. (2011) reported physical health problems and emotional exhaustion, were also consequences of lower staffing numbers, and reported it increased the intention of staff to leave their employment. Although Gaudenz et al. (2017) argued this association was often based on studies set in hospital settings rather than care home environments.

Staff reported reluctantly accepting the difficulties and challenges whilst at work, with Lehmann, Dieleman and Martineau (2008) acknowledging poor working conditions through a lack of supervision, low wages and a lack of equipment as possible reasons for staff leaving, particularly within remote rural areas. Squires et al. (2015) found that where staff in long-term care establishments identified workload and availability of equipment /resources as central to causing annoyance, with this was not similarly seen within the hospital environment. While practices such as allocation of tasks, work-based variety, and the option to alter shift patterns were helpful solutions in this study, which alleviated staff difficulties whilst enhancing feelings of worth and contribution (West et al, 2015).

6.4.4   Reputation and quality of care

Findings show a concern about the sustainability of the future workforce, for example, several staff reported limited numbers of student nurses accessing care home placements and those that did, had a limited awareness and understanding for this sector (Chapter 5, page 160). This was also documented in a scoping review study by Spilsbury et al. (2015) which recognised current undergraduate nurse training programmes did not suitably prepare nurses to work in care homes. Whilst Cooper et al. (2017) reported that although the care homes provide rich supportive learning environments, the lack of a career structure greatly impacts on the stability of staff. Several national documents reported the need for care industry wide strategies to address the shortfall in recruitment levels (Rubery et al, 2011; Paget & Wood, 2014). Van Hooft and De Jong (2009) examined the theory of planned behaviour, in the context of staff seeking temporary employment, and found behavioural beliefs, sense of security, status and work-life balance as strong factors related to their work intentions. Ajzen (2011) similarly reported "past behavior is the best predictor of future behavior" (p.1120), reinforcing the strong association between preceding behaviour and subsequent future actions (Wieber, Thürmer & Gollwitzer, 2015). Beauregard and Henry (2009) make the link between work-life balance practices and organizational performance, suggesting it can also reduce staff turnover. As such, further

exploration of this potential workforce may help to develop interventions to promote greater recruitment into care homes.

Both these study findings and previous literature reviews reported adverse negativity as influencing employment uptake into the care home sector (Skills for Care, 2011). Findings suggested this was very much linked to media negativity and reputation of the care homes, supporting the work of Skills for Care (2009). Attracting new staff needs concerted interventions and nationally, and a better understanding of the care home sector (Skills for Care, 2011). The study data however, suggested each care home was responding to their workforce needs individually, and although recognising the wider workforce crisis, each organisation appeared to consider their recruitment and retention difficulties in relation to themselves. This reinforces the need to resolve wider workforce issues through greater local workforce planning, as high staff turnover is extremely costly for organisations not only from a financial perspective (RCN, 2012) but also in terms of workforce disruptions and continuity of resident care (Castle & Engberg, 2006).

In the study data, the staff reported remaining in their organisation due to the home's positive reputation, with many staff selecting their post following word of mouth reviews, feedback from family or friends already working for the organisation, as well as choosing a job close to their home and according to their preferred hours of work. This was upheld by the welcoming friendly ambiance reported to champion existing staff whilst encouraging new recruits into the care home. These findings reflect those of Spilsbury et al. (2016), which suggest care home staff selected their employer based on personal circumstances and their commitments rather than based on career aspirations.

6.5   Balance between benefits and drawbacks of the job

This *final section* explores the decisions which influence the perceived benefits and drawbacks of staff employment in care homes, alongside their need for a stable work-life balance, which shapes staff decisions as to whether they stay or leave their job.

Work-life balance is an extremely important factor, contributing to the growing decision to leave the care home (Chou, 2012), with the causes and consequences of this balancing function

significantly influencing job satisfaction and staff retention (Lee, Dai & McCreary, 2013). The importance of free time away from work, the value of leisure activity, reducing mental health through fitness and well-being issues are factored in this (Beauregard & Henry, 2009). Nohe, Meier, Sonntag and Michel (2015). suggested family responsibilities can interfere with employment duties, resulting in work-family conflict due to this imbalance of demands (Michel, Kotrba, Mitchelson, Clark & Baltes, 2011).

Acceptance of the negative influences of the workplace, reported in Hertzberg motivational theory, was a key finding within this study's workforce. Found in the study's data and detailed earlier, motivational factors (e.g. the need for personal development) along with workplace influences (e.g. working practices, terms and conditions, and organisational policies), and according to Alshmemri, Shahwan-Akl and Maude (2017) increased job contentment. Although acknowledging all these influences, the importance of addressing personal satisfaction is highlighted which ensures overall job satisfaction is achieved and staff remain in their jobs (Decker et al, 2009). Case study findings show staff were very accepting of certain negative situations across a range of issues. For example, individual home circumstances, location and length of their employment, personal motivation and drive, individual views on their own abilities, amid positive organisational factors such as the flexibility of the manager and ability to change working shifts (chapter 5, page 142). Job dissatisfaction was not solely a reflection of personal negative factors but multi levelled and multi factorial, therefore organisational and management influences cannot be excluded.

In relation to weighing up the benefits and drawbacks of the workplace, what was significant within the study, was that one particular issue was seen to be a positive influential factor, that of staff relationships with the residents. Although discussed earlier it cannot be underestimated as to the importance of this in retaining staff, with the emphasis of the manager along with the organisational focus, being an important condition for this. It is evident across many studies that positive relationships with residents, and being able to provide high levels of care, is directly associated with feeling valued as a carer (Skills for Care, 2011), and from the study data, building close resident relationships clearly aids job satisfaction, which is reported to reduce absenteeism and staff leaving their job (Castle, 2013).

What was evident, was that the impact of continued negativity, could eventually reach a point where the shift of this balance resulted in staff leaving. For example, within the local data, continued physical abuse or prolonged heavy workloads would make staff consider leaving the care home (chapter 5, page 132). The tipping point for dissatisfaction appeared variable amongst the different staff groups, with the subsequent decision to leave the job identified as multifactorial. This was aligned with Chou's suggestion of a push/pull model whereby potential opportunities were offset with perceived challenges in the workplace, which guided their subsequent movement from one organisation to another (Chou, 2012). The self-determination theory demonstrates the changing relationships of intrinsic motivation and its impact on job satisfaction, with regular disputes or challenges producing dissatisfaction (Deci & Ryan, 2008). Interventions therefore must offer multiple approaches to successfully addressing possible negative factors within the care home sector (Department of Health and Children, 2010).

Individual change behaviour is influenced by personal belief or perceptions, which are offset against the likelihood and severity of the occurrence, based on the health belief model originated in the 1950s (Green & Murphy, 2014). Also recognising the incorporation of motivating factors, cues to action and self-efficacy, alongside the perceived benefits of taking action (Janz & Becker, 1984). Considered similar to Bandura's self-efficacy model, this approach suggests that through modifying the negative barriers to job dissatisfaction, this could influence positive behavioural actions resulting in employment stability (Jones et al, 2015). Supported in a study by Kor and Mullan (2011) which reported that intentions to leave, were often seen as poor predictors of behaviour change, also shown in the earlier scoping studies, when intentions to leave an employment did not come to fruition (Kemper et al, 2008a). This consequently emphasises the strength of the culture alongside an effective manager with excellent leadership skills, to overcoming barriers and resolving challenges within the organisation.

6.6   Summary of Chapter

As demonstrated in chapter 5, uncovering the three themes, that of personal satisfaction, organisational and management influences, and sustainability of the workforce, the case study findings have demonstrated the influence of these factors on job satisfaction. Fundamental across these themes was the extent to which individual and organisational factors played and influencing whether staff found their working conditions conducive to staying in their job. The

positive perceptions and drawbacks to the role presented a balancing act, which this function clearly underpinned and contributed to a workplace staff wished to remain in.

Findings from both phases of the study show the multifactorial nature of factors that influence staff's perceptions about their workplace, illustrated in Figure 20 below.

Findings from this study have contributed to the evidence base, through greater understanding of the factors that influence care home staff's perceptions about their workplace and subsequent decisions about whether to stay or leave. Aided by the development of a new framework (shown earlier in Figure 19), the added contribution of these influences on job satisfaction were more evident. Identifying these influential factors, with an ability to respond and improve job satisfaction in the care home workforce, has played a significant role in determining a practical solution to assist the care home managers. Consequently, an implementation plan (detailed later in the next chapter) was developed, which recognises the need for practical support and a resource tool to assist the managers, in helping to improve staff working conditions in this sector.

Figure 20: Summary of findings influencing job satisfaction
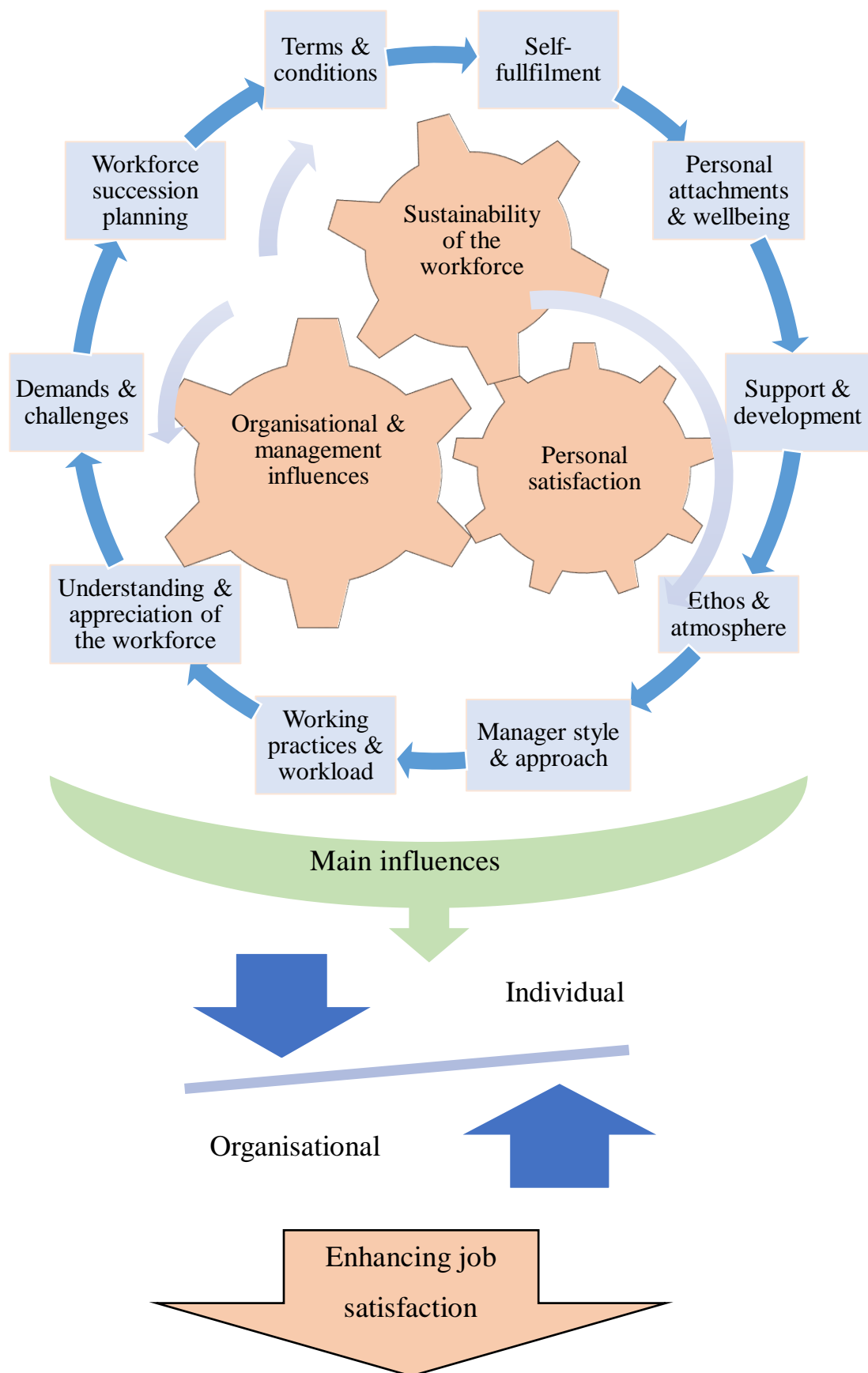
CHAPTER SEVEN:
CONCLUSIONS AND RECOMMENDATIONS

7.1   Introduction

In this final chapter, the thesis is drawn to a close. The suitability and utility of the study approach and processes are reflected upon. The contribution of the thesis findings to the evidence base is outlined, and recommendations for practice, policy and research are made. The development of an implementation plan to assist care home managers to enhance job satisfaction in the workplace is also presented. A reflexive account of the researcher's journey is also presented.

7.2   Summary of study

This study has focused on the experience of the home care sector workforce, a neglected area of research, in order to learn more about what approaches could be used to improve conditions and job satisfaction.

The case study findings, presented in chapter 5 uncovered three themes which influenced and impacted on job satisfaction; that of personal satisfaction, organisational and management influences, and sustainability of the workforce. Emerging from these 3 themes, was the importance of staff balancing job satisfaction factors to determine whether to remain or leave their organisation. Crucial within their decision-making processes were several influential individual and organisational factors, which helped staff decide whether to stay or leave their job (discussed in chapter 6).

Recommendations are presented, with an implementation plan designed around leadership and management practices in the care home sector, believed to be particular to this setting. This plan is a new resource suitable for care home managers, which offers practical solutions to helping with employment stability of staff, through enhancing staff job satisfaction.

7.3 Study's Contribution

This research study has contributed in the following ways:

1. Added to the current body of research evidence, including the first scoping review of management and workforce practices in a care home setting
2. Provided new framing of the issues influencing job satisfaction in the care home workforce, with the development of a new framework
3. Developed a new resource tool, which can assist care home managers to enhance staff satisfaction.

7.3.1 Balancing job satisfaction

Findings show that there is a balancing act between the factors that influence staff perceptions about how satisfied they are in their role. This is a balancing act between individual factors and organisational factors. Staff considered the benefits and drawbacks of their role, their workplace plus their work-life balance, and evaluated whether overall, their working conditions were conducive to staying in their employment. The ability of the manager to help influence the staff's position whether to stay or leave their employment was seen as important in the care home setting. These important findings contribute to the current knowledge relating to this care home sector workforce. Thus, the importance of developing a practical solution to support the care home managers promoting overall contentment in the role is recognised.

From these findings, alongside recognising the value of the managers role, an implementation plan was developed and is discussed in detail later in this chapter. The plan synthesises the key findings from across the study evidence (scoping review and case study) and can help to support care home managers when addressing job satisfaction in their workforce.

7.4 Reflections and Implications

Cousins et al. (2016) reported that "the {care} sector is often disadvantaged and overlooked by commissioners, policymakers and researchers" (p.18), thus reaffirming the urgency required in addressing the escalating challenges this healthcare sector faces. The findings from this study advance the current knowledge of the care home setting, highlighting influential factors which

help to improve job satisfaction, which play a significant role in responding to recruitment and retention issues in this workforce.

Implications for future research, policy and practice are considered within *this next section*.

7.4.1 **Implications for research**

The study's findings contribute to and inform care home research, offering ways which can help managers to keep staff satisfied in their roles. Qualitative research has been recognised to offer a significant contribution to academic knowledge through increasing the current evidence base (Ormston et al, 2014). Job satisfaction has important implications for the care home workforce and the wider care sector (Castle, 2006b), whilst Chen and Silverthorne (2008) showed strong links between job satisfaction, job performance and the delivery of quality care.

For this study, the use of the case study approach to exploring a different contextual environment has proved successful. Context has been recognised as a dominant factor influencing the uptake of evidence into practice (Rycroft-Malone et al, 2004), with the recognition of a multi layered construct including culture, leadership, behaviours and relationships (Brown & McCormack, 2011). This study was positioned in the care home setting, thus reinforcing the relevance of context within this study. Case study research is sometimes considered to lack methodological elements (Clarke et al, 2015), however the value of this approach in investigating the intertwining phenomena and context is thus evident (Yin, 2003).

In comparison to acute healthcare settings, the care home sector is by far, a much less studied context, in terms of both the employees and the residents (Stow, 2016). Consequently, workforce data is far less readily available for this sector (Spilsbury et al, 2015), which has given rise to an under-representation within research studies (Stow, 2016). A lack of conceptual clarity makes reviewing a specific context within a study difficult (Holloway & Galvin, 2016), thus using a case study approach has been beneficial.

7.4.2   Implications for policy and commissioners

Care home settings are a crucial part of healthcare services (WG, 2010), providing care for residents with increasingly more complex health and social care needs (Cooper et al, 2017). Current demands facing NHS hospitals with increasing bed shortages (WG, 2018a), has resulted in a growing reliance on the independent care home sector (Knapp et al, 2001). The ability to sustain the care home workforce to meet the challenges of an ageing population is thus a priority (RCN, 2014). The study findings, and the resultant implementation plan, offer areas which if addressed, could ease the current burden on care home organisations and thus help to support improvements in the delivery of healthcare.

Local authority payments to care home providers to deliver high quality care has been highlighted as being insufficient (Rubery et al, 2011). Commissioners need to invest in higher resident payments to support the sustainability of care home services. Occupancy is a concern, and this will help alleviate owner concerns when occupancy is not full, also encouraging new owners to take on care home establishments. This would potentially offer wider recognition and investment in the care home workforce and facilitating greater staff development, known to enhance role satisfaction. Additional funds could enable managers to provide higher wages and provide additional rewards such as on-call and weekend payments, all known to increase personal satisfaction which is key to both employment and financial stability (Ha et al, 2014).

Another area of interest is the development of improved collaborative working practices which could offer a means to support managerial and organisational processes for organisations (Kemper et al, 2008b). The costs associated with delivering and maintaining high standards of healthcare are immense, with a shared approach between the providers needed to meet the future social care requirements (Rubery et al, 2011). Improvements in partnership working across care homes could help in several ways, from procurement, servicing contracts, HR processes and for example administrative processes, all helping to reduce costs in line with economies of scale. Releasing funds could be used to support training and development of staff, known to increase job satisfaction, along with ensuring sustainability of the organisation.

Individual organisations considered their recruitment and retention difficulties in isolation, which did not promote a unified approach to responding to the workforce needs of this sector. Approaches to offer collective practices to help recruit and retain staff are recommended (Spilsbury et al, 2015). Developing strategies and approaches which integrate recruitment and retention practices and processes, could aid the ongoing recruitment dilemma. For example, combining interview selection panels, rotation of staff, and providing greater internal development opportunities may offer quicker, more efficient employment processes helping to recruit the right staff with the right skills into this care sector.

Many registered nurses have limited understanding of this healthcare sector, often reinforced by negative media reports, which clearly reduces the likelihood of nurses taking up employment in a care home environment. Approaches to promote this sector as an exciting and professionally challenging workplace is needed at the pre-registration education stage. Policy to assist care homes to increase student nurse placements, along with other allied health professionals could encourage staff to return to this setting when qualified. The study has highlighted the ongoing issues of sustainability of the workforce, thus strategies which focus on improving the career pathway opportunities for this workforce can help address this. This could also help with the reputation of this sector through staff understanding and appreciating the demands and rewards these roles can offer.

7.4.3   Implications for practice

The findings provide a basis to understanding key factors which influence satisfaction stressing the importance of personal satisfaction, organisational and management influences, and sustainability of the workforce. Significant across all the themes, and a key thread within the study, was the managers' role in inspiring and enhancing job satisfaction, which provides the focus for improvements at a practice level.

The managers' role was shown to be central to enhancing individual feelings of accomplishment and appreciation, thus reinforcing the value of this role in promoting and recognising the worth of this workforce. Education, support and ongoing development above the organisation's requirements, can help to motivate staff and reduce negativity, and is directly

influenced by the care home manager. The findings from this study found that as staff were at different stages of motivation, various job satisfaction interventions are therefore required and is an area for further development. Responsibilities and challenges need to be recognised early and responded to, thus listening to staff is key to avoid dissatisfaction which may influence them leaving. This links to greater empowerment in their role and improving opportunities to discuss and allay staff concerns. Increased benefits and supportive, approachable managers can reduce overall negative factors of the role and promotes loyalty and commitment to the employer. Thus, further development of these leadership qualities and skills, through education and supportive networks, are recommended, which can greater advance the positive personal influences affecting job satisfaction.

Managers' approach to enhancing the organisational influences through developing a friendly warm atmosphere, along with flexible working practices, enables staff to feel a work-life balance is achieved. Embedding practice development activities within learning and development strategies, such as through work-based learning may help the manager to keep staff better engaged and promote a more confident and happier environment. Developing staff decision making, autonomy and empowering them in their roles through participatory delegation will help increase their locus of control, promoting a more confident workforce. The outlook of the manager and their actions has the added benefit of improving the quality of resident care. Team working and building supportive relationships is guided by the style of the manager, thus leadership development is key, which can be improved upon through networking with colleagues and management training programmes. The findings thus reinforce the value of developing a practical resource, i.e. the implementation plan, to assist the care home managers to improving recruitment, job satisfaction and retention in this setting.

7.5   Recommendations for research, policy and practice

The integration of research evidence into working practice can improve the quality of care within healthcare services (Stetler, Ritchie, Rycroft-Malone, Schultz & Charns, 2007), although it is recognised that the uptake and transferring of this evidence is often complex (Rycroft-Malone et al, 2004). This has resulted in a clear focus on improving its implementation which has helped to narrow the research - practice gap (Seers et al, 2012).

The findings from this study corroborate current academic findings on job satisfaction, detailed in Chapter 6, page 168. The contribution of individual and organisational influences was shown to support better job satisfaction. Balancing the benefits and drawbacks was pivotal to influence staff decisions to remain (or not) in their care home role. This advances the growing body of care sector evidence through providing new framing of the issues influencing job satisfaction, particularly through improving individual and organisational factors. The inclusion of this new knowledge helps to uncover and broaden the understanding of this sector, whilst providing recommendations for future research, policy and practice.

The *following section* demonstrates this contribution to the key areas of enquiry.

7.5.1   Recommendations for research

From the findings of this study, potential new research areas were generated, building on the current context and the new knowledge. Future inquiry could build on the following research questions:

- How does the care home context differ from other healthcare settings in relation to job satisfaction?

- Which recruitment practices could be developed further to assist care home managers?

- What job satisfaction strategies are effective in supporting managers during their recruitment practices and processes?

- How can managers ensure staff job satisfaction is sustained, whilst continuing to achieve the current demands of delivering high quality care?

- How can behaviours of the temporary workforce (i.e. locums / agency staff) be better understood and influenced to promote employment stability?

- Could increasing student placements within care homes increase employment uptake, and if so why?

7.5.2 Recommendations for policy and commissioners

Current key policy drivers influencing the care home sector include *Health and Care Standards Framework – Health in Wales* (WG, 2015), *Our plan for a primary care service for Wales up to March 2018 (*WG, 2014b) and the *Parliamentary Review of Health and Social Care in Wales.* (WG, 2018a). This study adds to policy makers and commissioners decision-making processes through recommendations which could contribute to the development of strategies and approaches which can enhance job satisfaction in the workplace.

- To review current provider resident placement payments, with a view to increasing these payments, encouraging financial stability, employment stability and sustainability of the care home sector

- To drive the development of strong clinical leaders and leadership programmes with an emphasis on supporting the workforce through increasing job satisfaction

- To support a national drive to increase the reputation and value of this sector, whilst reducing the wider negativity, to encourage greater opportunities for staff

- An acceptance and acknowledgement of the challenges and barriers facing this sector and to offer practical solutions to addressing these

- To support the development of key employment practices, to help to streamline these processes and aid the stability of the care home workforce

- To respond to national nurse shortages through greater collaboration with educational providers to promote this sector and offer positive placement experiences

- To promote greater collaborative and partnerships working with a range of healthcare establishments, promoting sustainability of this sector

- To induce a greater focus on the development of this workforce, with a drive towards redesigning and advancing roles, enhancing positive cultures and encouraging greater employment stability

- To encourage and assist overseas nursing staff into this sector, whilst reducing current employment barriers and delays to respond to nurse shortages nationally.

7.5.3   Recommendations for practice

Recommendations for practice include interventions which can directly impact on job satisfaction and offer an immediate response to the current workforce issues. Affecting change and ensuring sustainable improvements at a practice level is vital and can be achieved through practice development programmes and change interventions. Following on from the earlier reflections on the effectiveness and importance of the managers' role (page 198), recommendations for practice are highlighted below, with a more detailed implementation plan presented in the following section:

- Consistent recognition and appreciation of this workforce, raising awareness and understanding of the role, ongoing challenges and barriers within the sector

- Reinforcing the value and worth of the workforce through education, support and ongoing development activities.

- Reviewing the workforce on a regular basis, with the development of job satisfaction interventions

- Responding to issues and concerns quickly and promoting a culture of openness, transparency and positivity

- Promoting a workforce who actively engages with residents, building trusting, genuine relationships

- Recognition of rising responsibility and challenges, responding to these early to reduce job dissatisfaction

- Promoting participatory leadership with active involvement of staff to develop greater autonomy, decision-making and empowerment in the role

- Promoting 'safe havens' where staff can speak freely and openly about their concerns

- Exploring ways to improve financial benefits, working practices, terms and conditions making a work-life balance easier to attain

- Ensuring the manager is approachable and accessible to staff, and developing this within their daily working activities

- Promoting greater team working and positive staff relationships.

7.6   Implementation of findings

Implementing change interventions and improvements at a practice level is influenced by the contextual setting (Dopson & Fitzgerald, 2009). The PARIHS (Promoting Action on Research Implementation) framework was used as a mechanism for implementing the findings into practice (Seers et al, 2012), reinforcing the importance of the relationships between context, facilitation and the nature of evidence, in determining implementation success (Kitson et al, 1998, 2008). Transferability and wider inference are a consideration for the research findings and can be achieved following reasonable judgements based on contextual features (Lewis, Ritchie, Ormston & Morrell, 2014). Therefore, whilst the role of the manager has been established as crucial to influencing job satisfaction within the care home sector, similarly, the managers' role could be assumed central to a range of alternative healthcare settings.

7.6.1   Implementation plan

Drawing from the scoping review and case study findings, current academic literature and above recommendations, an implementation plan was developed. Proposed interventions and expected outcomes focused on improving job satisfaction in the care home workforce, whilst the sources of suggested evaluation were guided by the PARIHS framework (Kitson et al, 1998, 2008).

The significance of the manager role has been repeatedly highlighted as a key influence in improving job satisfaction in the workforce. As such this stakeholder perspective was considered extremely important and included in the development stage of the implementation plan. Discussion and reflection on the study findings, with the care home managers who participated in the case study research was undertaken. This provided the managers with the opportunity to evaluate its content and suitability to affect change within their organisation, whilst commenting on its potential value to improving job satisfaction across their staffing groups. The final implementation plan is presented below in Table 11.

Table 11: Implementation Plan

Interventions to improve job satisfaction in the care home workforce

Finding	Intervention	Staff group targeted	Expected outcome		Suggested approaches to evaluate the intervention
			Tangible	**Desired**	
1. LEADERSHIP					
To support the manager's leadership role within the organisation	• Clear organisational and managerial structures to support the care home leadership • Reinforcing authority of senior staff when manager off shift • Clear role of senior RNs, so reducing amount of manager on-calls	All staff	• Clear lines of responsibility and processes • Reduction in manager on-call shifts • Reduction in workplace negativity and conflict situations • Manager and senior staff better able to respond to issues	• Staff feeling more supported • Reduction in turnover rates • Less conflict with residents / families • Greater awareness of internal escalation processes	audit and feedback • Staff feedback • Staff satisfaction questionnaires resident narratives • resident feedback organisational data • Retention rates • Turnover rates

| To improve ethos and atmosphere in the home | • Develop a philosophy within the care home which recognises the value and supportive needs of staff

• Generate positive culture amongst staff groups, through induction programmes, training, annual appraisals

• Promote approachable, flexible and accessible manager

• Promotions through marketing, events, walkarounds / meet and greets

• Build sustainable good reputation encouraging new recruits | All staff
Stakeholders | • Improved partnership working and responses from wider stakeholders

• Greater retention of existing staff

• Increased attainment of training, inductions and appraisals

• Improvement in reputation

• Less conflict in the home between staff groups and residents / relatives

• Improved relationship with manager

• Greater uptake of new staff | • Positive working practices, culture and support

• Promote warm friendly atmosphere

• Greater promotion of a positive care home service to wider community and stakeholders

• More contented workforce | research (empirical data)

• Case studies

audit and feedback

• Reflective discussions

• New recruit feedback

service evaluation

• Stakeholder feedback

resident narratives

• Resident & relative feedback

organisational data

• Training and induction rates

• Completion of appraisals

• Staff attendance /sickness rates |

					• Turnover rates
To develop and enhance individual leadership styles	• Recognise the need to shift styles of leadership towards participatory and involve staff groups within decisions • Develop training and shadowing programmes for senior nurses and carers • Attendance at networking events, leadership courses, cross care home contact to build up leadership skills • Promote a culture of collaborative working through a willingness to listen • To continue to an outlook, style and	Managers /Senior RNs	• Staff who are involved in decision making across all levels of the organisation • Increased role development • Increased autonomy and responsibility of staff • Improved succession planning • Increased supportive style of leadership and enhanced skills • Improved relationships with fellow colleagues	• Staff feeling more motivated in role • More confident, self-aware and resilient staff • Greater empowerment and decision making of staff • Greater opportunities to discuss issues and concerns • Positive staff attitudes, actions and behaviours from managers • Increased staff satisfaction	audit and feedback • Staff feedback • Staff questionnaires service evaluation • CSSIW inspection reports resident narratives • Resident feedback organisational data • Turnover rates

	approach to working which promotes better staff interactions		• Quicker response time when dealing with staff conflict / concerns • Improved interactions across staff groups		
To support staff working practices	• Promote flexible working practices, daily practices and greater awareness of pressures on staff • Offer improved working practices, such as time back, ability to swap shift patterns/ hours when required, rotation of staffing to avoid staff cliques, support junior staff with experienced staff working	All staff	• Less staff leaving the organisation or going off-sick • Improved consistency and quality of care practices • Improved work-life balance for staff • More enjoyable working environment with less conflict • Staff able to speak out with fear of reprisals	• Staff feeling more valued and appreciated • Staff feel recognised and supported when high demands • Staff feeling in greater control of their work-life balance • More job satisfaction	audit and feedback • Schwartz rounds • Debriefing and reflections • Staff feedback • Staff satisfaction questionnaires organisational data • Staff sickness / absence rates

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	• Acknowledge when rising pressures and respond appropriately i.e. additional staffing numbers • Allow to request holidays in advance, weekends off, night duties, in line with service requirements		• Stable workforce with sufficient staff numbers		
To encourage accessibility to manager & improve the flow of communication	• More effective communication and regular contact/ meetings with staff • Greater number, variety and frequency of both team meetings and 1 to 1 discussion –i.e. via huddles, handover meetings, clinical supervision, 1 to 1s	RNs and carers	• Improved flow of communication • Private and confidential discussions • Informed when new policy / guidance within the home • Opportunity for on the day requested meeting	• Greater awareness when issues or concerns • Staff openly able to discuss personal and work-related issues, ensuring confidentiality. • Staff feel valued	<u>audit and feedback</u> • Staff feedback • Staff satisfaction questionnaires <u>resident narratives</u> • Resident & relative feedback

	• Increase manager's opportunities to speak to and develop staff • Promote accessibility of manager to enable • Maintain confidentiality so staff able to be open and honest		• All staff have sight of and informed of new developments or improvements • Improved staff, resident and relative relationships • Open and honest culture, maintaining confidentiality • Approachable & accessible	• Staff able to voice their views which may add to and improve care delivery • Staff more informed and aware of changes in care home • Staff fully informed of availability of manager	
2. STAFF AND RESIDENT RELATIONSHIPS					
To improve better working relationships	• Involvement in resident care planning, i.e. development of key workers, training and on-going development • Include staff in assessments of	Carers	• All staff involved in care delivery of ill and deteriorating residents • Recognition of staff distress during time of	• Staff feel involved in resident care, building relationships and caring ethos	<u>audit and feedback</u> • Staff feedback <u>service evaluation</u> • Resident outcomes <u>resident narratives</u>

	placements and relative meetings • Offer support and increased awareness of distress when dying and ill residents		dying, death and bereavement • Less staff leaving or reducing hours	• Staff feel they have a voice • Staff feel their role and activities are valued • Staff better able to cope with upsetting situations	• Resident feedback organisational data • Turnover rates
To develop strong resident attachments	• Staff to build genuine trusting relationships with the residents • Staff to spend more time with residents, i.e. dancing, chatting, getting to know them	All staff	• Improved working practices and team working • Improved quality of resident care • Improved working relationships	• Greater understanding of resident's needs and for welfare • Enhance work role satisfaction	audit and feedback • Staff feedback • Staff satisfaction questionnaires service evaluation • Resident outcomes resident narratives • Resident feedback

3. PERSONAL GROWTH AND EMPOWERMENT				
To develop and enhance personal fulfilment	• Encourage greater role fulfilment, feel valued, appreciated and respected • Encourage values-based approach to care home philosophy • Invest in staff through training, development • Encourage wider and advancing development • Offer staff the opportunities and exposure to wider clinical care i.e. specialist services/ nurses • Encourage greater vision i.e. student nursing,	All staff	• Clear understanding and adherence to care home philosophy • Improved quality of care • Able to positively support student nurses, work experience staff and placements • Lower sickness rates • Attainment of higher qualifications • Better able to promote the care home sector and its reputation • Increased recruitment • Better able to respond to role challenges /	• Able to take on more challenging and advancing roles • Encourage confident, resilient and empowered workforce • Staff feel better able to guide more junior and inexperienced staff • Staff feel valued and invested in • Staff are encouraged to further develop themselves	<u>audit and feedback</u> • Staff feedback • Staff satisfaction questionnaires <u>service evaluation</u> • Home reputation • Resident outcomes <u>resident narratives</u> • Resident feedback <u>organisational data</u> • Retention rates • Sickness rates • Qualification rates

	work towards being a care home provider		difficult situations / media negativity	• Promotion of high standards of care	
4. EDUCATION AND DEVELOPMENT					
To continually develop and improve skills, learning and competences	• Ensure ongoing training and education, accompanied by an ethos of learning, quality and safety • Encourage in-house, access to journal, e-learning, short regular events, conferences session, link nurse meetings • Develop improved working with education providers and access to Health Board events • Enable Health Board practice development	All staff Education providers	• Improved working with university / education providers • Regular attendance on clinical supervision, opportunity to discuss concerns, development and learning • Lower complaints / conflict • Greater uptake of training	• More satisfied staff • Access to training made easier • Improved working with other colleagues	audit and feedback • Staff feedback • Staff satisfaction questionnaires service evaluation • Professional colleague feedback organisational data • Attendance rates for supervisions, inductions, appraisals and mentorship • Complaints / concerns rates

	teams to provide support with clinical knowledge i.e. specialist nurses, therapists, GPs • Regular 1to 1s, peer support, ensuring appraisals, induction programmes, clinical supervision and mentorship			
5. CARE PRACTICES AND ROLE DEVELOPMENT				
To improve individual development	• Develop internal career structure i.e. senior roles and clinical advancement • Work towards formalising career pathways, such as attaining higher NVQ level qualifications, specific modules i.e.	Carers / RNs Education providers	• Regular, allotted time with mentor • Clear career development options • Greater number of qualified staff with higher awards	• Ability to continually develop and expand staff • Promote more positive working and recognition of advancing roles	audit and feedback • Staff feedback • Staff satisfaction questionnaires service evaluation • CSSIW/Health board reports resident narratives

	• palliative care / dementia learning • Ensure national HEE frameworks used to support ongoing development			• More fulfilled and satisfied staff • Improvements in care practices	• Resident feedback <u>organisational data</u> • Retention rates • Sickness rates • Qualification rates
To feel rewarded when have increased responsibility	• Rotation and sharing or workload across all carers, reducing pressures on same staff • Offering pay rewards when achieved and reflected in changing role	Carers / RNs	• Standardised care practices • Less conflict amongst staff • Improved staff working relationships	• More valued and appreciated in the job • Greater trust amongst colleagues with less conflict	<u>audit and feedback</u> • Staff feedback • Staff satisfaction questionnaires <u>service evaluation</u> • Resident outcomes <u>resident narratives</u> • Resident feedback <u>organisational data</u> • Retention rates

To deliver high standards of care	• Access to and discussion around guidelines and care processes promoting greater consistency of care • Identified lead RN for each carer to link with and who aware off specific training and development needs • Reduction of non- caring activities (such as undertaking laundry or kitchen duties)	All staff	• Good quality care with less incidents reported • Improved care practices • Reduced concerns/ complaints rate • More knowledgeable staff • Greater retention of staff	• Less insecure staff • Staff better able to take on challenges and more responsible roles • Staff feeling more informed • Feel supported and part of the wider team • Staff feeling less disruptions to caring role and more time spent with residents	<u>audit and feedback</u> • Staff feedback • Staff satisfaction questionnaires <u>service evaluation</u> • CSSIW inspection reports • Resident outcomes <u>resident narratives</u> • Resident feedback
6. WORKFORCE SUSTAINABILITY					
To develop improved staff	• Regular staffing reviews	All staff	• Greater workforce stability – less	• Staff feel pressures/ demands are	<u>audit and feedback</u> • Staff feedback

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contingency planning	• Develop agreed contingency plans when staff shortages / sickness • Agreed minimum staffing numbers and act quickly when reduced • Explore role changes to support future care needs and focus on ways to reduce daily workload and pressures		sickness, last minute shortages • Less inconsistent care due to staff shortages • Less staff injuries associated with workload pressures • Lower sickness rates • Less staff considering leaving • Reduced short notice changes to shift patterns and staying over shift end • Less complaints	being addressed and less demoralised • Staff feeling more empowered • Staff feel more supported and content	service evaluation • CSSIW reports • Resident outcomes resident narratives • Resident feedback organisational data • Turnover rates • Retention rates • Complaints rates
To reduce negativity associated with sector	• Reduce external negativity by promoting openness, transparency with residents and relatives	Stakeholders Education providers	• Less conflict in the workplace with residents and families • Improved reputation • Increased number of new recruits	• Feel proud and confident of their workplace • Greater appreciation of the workforce	audit and feedback • Staff feedback • Staff satisfaction questionnaires organisational data

	• Greater engagement with Local Authority / Health Board / General Practices etc • Wider engagement with schools, education providers, apprenticeship and employer schemes		• Open, transparent and positive culture • Improved communication and working practices with stakeholders	• Greater understanding of care home service and staff roles / potential challenges • More contented workforce	• Recruitment rates • Retention rates
To build more robust employment practices	• Develop robust polices for recruiting staff / develop across localities to support workforce • Ensure staff aware of role demands to reduce inappropriate hiring of staff • Ensure the suitability of staff prior to employment and DBS checks	Managers	• Shorter employment processes • Reduced costs associated with unnecessary employment screening • Easier and quicker uptake of staff • Regular meetings / networking with	• To promote the right staff for the role • Reduced pressures and demands from recruitment delays • More satisfied staff	<u>audit and feedback</u> • Staff feedback <u>service evaluation</u> • CSSIW reports <u>organisational data</u> • Employment and retention data • Financial expenditure costs

	• Liaise with other care home managers to explore staffing issues, rotation of staff, locum systems at times of shortages		fellow care home colleagues • Improved relationships across the sector • Lower sickness rates		
To promote wider workplace opportunities	• Offer greater number of employment opportunities i.e. placements, shadow shifts and work experience • Increase student nurse placements	Managers	• Increased placement opportunities to raise care home reputation • Improved reputation of the home • Greater uptake and retention of staff	• More contented workforce	audit and feedback • Staff feedback organisational data • Work placement data
7. FINANCIAL REWARDS AND BENEFITS					
To offer greater rewards	• Aim to offer equivalent Agenda for Change rates of pay • Promote system of incremental / pay awards	All staff	• Greater staff retention with fewer staff leaving the job • Improved staff relationships	• More contented workforce • Staff feeling more valued and appreciated	audit and feedback • Staff feedback • Staff satisfaction questionnaires organisational data

	• Explore ways to increase staff rewards – look at other non-financial offers i.e. time in lieu /on call payments		• Higher pay rates	• Greater recognition of role, skills and responsibility of the job	• Working practices • Sickness rates
To enhance terms and conditions	• Explore ways to offer improved terms and conditions of employment • Aim to increase additional benefits such as annual leave, for all staff	All staff	• Increased retention of staff • Improved terms and conditions of employment • Increased benefits	• More satisfied and valued staff • Improved work-life balance	audit and feedback • Staff satisfaction feedback organisational data • Turnover rates • Sickness rates

7.6.2   Care home manager feedback

Feedback from the care home managers on the implementation plan was very positive, with all managers agreeing with the issues and interventions identified and the appropriateness of the expected outcomes in helping to improve job satisfaction. They valued the implementation plan in clearly identifying all the inter-linking factors which impact on job satisfaction, and helpful as contained within one document, advising this could help to organise their interventions in a staged targeted manner. Although each intervention was in principle achievable, they suggested the plan helped them to appreciate and reflect on the range and number of interventions needed to promote greater job satisfaction.

The managers recognised the need to influence the factors affecting satisfaction in the workplace, and agreed with the interventions and their expected outcomes, as a means to supporting and helping with staff retention. Particularly the need for democratic styles of working, engagement and openness with staff and the desire to develop better working relationships with staff was discussed. They considered that the amount of time spent with staff, was frequently made more difficult due to the increasing non-clinical demands being placed on the care home manager, for example, implementing new government legislation such as information governance systems.

The managers were familiar with many of the findings and interventions, considering them all important factors in increasing job satisfaction, with some managers less familiar with the employment and sustainability findings. In all cases, the managers were already undertaking a selection of these interventions, and overall were very supportive of the different elements contained within the plan. They considered personal growth to be key for staff retention and promoting empowerment through activities such as training and supervision which helps to recognise staff concerns early. However, they also felt that for long-serving staff the training became very repetitive and monotonous and new ways of working were needed to keep them motivated. They highlighted the need for continual development, even greater than the role required, as a means to keep staff happy, valued and respected, and to hopefully reduce the likelihood of staff turnover and sickness rates.

Several of the managers had not considered ways of evaluating the success of their interventions and so felt this measure was extremely helpful. One manager stated she had already decided to develop and implement a staff satisfaction questionnaire as this was not currently being undertaken. She intends to introduce this on a regular basis to provide staff with the opportunity to feedback on workplace issues and concerns, believing staff would value being more involved in making changes and improvements in the care home.

Whilst emphasising the complexity of implementing and affecting change across the workforce, the managers reflected that the plan highlighted the additional time and investment needed to enhance job satisfaction, potentially making implementation more challenging. Another barrier to implementation was the gap in registered managers currently employed in adult care homes, with vacancy figures in 2016 at 7% and 13% for Wales and England respectively (Moultrie & Rattle, 2015).

7.7   Reflexivity

Reflexivity provides an insight into the researcher's role whilst undertaking the practice of research, its processes and outcomes (Haynes, 2012). This enables the researcher to position themselves within the research whilst examining the researcher influences within this relationship and is deemed a continually mutual process (Alvesson & Skoldberg, 2000). Ormston et al. (2014) suggest "empathic neutrality" is needed when conducting research (p.22), thus reflexivity strengthened the researcher's perspective during decision-making processes, and helped to underpin a transparent approach (Booth, 2015).

Reflexivity is considered to include both reflection and interpretation, suggesting it is far more complex than reflecting on the research processes alone (Haynes, 2012). Reflexive practice involves thinking about experiences and questioning the ways things are carried out (Alvesson & Skoldburg, 2000). They argue reality is not based on the facts alone but is interpreted and adapted according to the researcher's behaviour and attitudes. Whilst Haynes (2012) reported that "interpretation is influenced by the assumptions of the researcher doing the research, their values, political position, use of language" (p.73).

As a novice researcher, the challenges of the insider/ outsider perspective were recognised at the outset, with a conscious attempt to position myself as an outsider within the research process, believing this to promote greater researcher objectivity. I was conscious not to attach too many pre-conceived assumptions to my work, although I was cognisant that prior learning and experience could be influencing factors. Regular reflexivity and supervisory discussions helped to mediate the potential for me to take an insider role, aided by the use of formal protocols, semi-structured questioning and the use of field notes, particularly during the study design and data collection processes. However, on reflection, this was challenging at times, as I was perceived by the workforce as both a nurse and a researcher, and as they knew I worked for the local Health Board they also considered me to be a fellow colleague. However, it no doubt influenced how they received me into the home and how they perceived my activities, seen by their willingness to participate during my questioning and to assist my research investigation.

Limitations and strengths are apparent for both perspectives, with the insider role providing membership into the group, offered through an openness and trusting relationship with the participants (Corbin Dwyer & Buckle, 2009). This was helpful as it added greater insight and understanding into the phenomena in question which enabled me to explore job satisfaction in this workforce (Milligan, 2016). Whilst the outsider role offered a greater ability to investigate the phenomena in its own context without influencing participant responses. However, it is now clear that the insider/ outsider roles are difficult to fully maintain, with the boundaries often becoming blurred (Hayfield & Huxley, 2015). Corbin Dwyer and Buckle (2009, p.61) supports this stance, suggesting "the intimacy of qualitative research" prevents us from fully occupying one or the other of these positions.

Qualitative research is complex and demanding (Mann, 2016) with reflexive practice providing an important means to ensuring rigour and quality in qualitative research (Darawsheh, 2014). Strategies to ensure reflexivity was achieved included the use of handwritten field notes documenting processes, ideas and designs, which were recorded throughout the study's journey (Haynes, 2012).

7.7.1   Reflexivity and the Doctorate journey

The research study was the culmination of my journey through the Professional Doctorate in Healthcare. The selection of the taught modules has been guided by my personal experiences and views, reflected in my learning and development, reflecting the views of Alvesson & Skoldburg (2000) who suggest decisions and actions are adapted following the researcher's interpretation of the events, with the reality of these events based on, and influenced by the researcher's own beliefs and expectations (Haynes, 2012).

Throughout the doctorate programme my knowledge has broadened immensely, and this has impacted on both my personal and professional development. In relation to my professional role, a more in-depth understanding of workforce management and employment issues now supports my current role within a primary care setting. A greater awareness, appreciation and insight into factors influencing job satisfaction and its impact on the stability of the workforce has guided my leadership and critical thinking. This has been valuable and has supported my current role through helping to focus my decisions in the development of interventions and improvement projects which focus on improving the working conditions, care standards and sustainability of the workforce.

Through achieving the taught element of the professional doctorate programme, and successfully undertaking the research study, has helped to refine my organisational, presentation and networking skills, which have not only added to my toolkit of transferable skills for use within my current professional role, but has also enhanced my personal development through building upon my confidence, self-assurance, adaptability and assertiveness. This has manifested in feeling more comfortable with my own abilities and knowledge, which has contributed to my perseverance and attainment of a job promotion during this doctorate process.

7.8   Personal reflection

Reflection is a key element within health improvements (Lucer & Nacer, 2015), and was an extremely valuable tool used throughout the study process (Gustafsson, 2004). The development of evidence-based practice facilitated learning skills such as, critical thinking,

problem-finding and questioning, which were central to my development as a novice researcher (Lucas & Nacer, 2015), which helped facilitate greater understanding of the study processes and methods required.

The professional doctoral study has embedded my professional role within learning, development and change processes, with the aim of successfully implementing new knowledge into healthcare practice (Rycroft-Malone et al, 2002). My professional background helped focus my research topic and influenced my decision to explore the care home workforce. I believed the study could identify factors which could provide a greater understanding of this often-overlooked staff group, with the potential to make health improvements. As a clinician, it was important for me to ensure that my study would make an important contribution to practice. I realised that potential workforce improvements, through aiding recruitment and retention of staff, would have a positive knock-on effect on the quality of resident care (Park & Stearns, 2009).

As a registered nurse, I found my background enabled me to build relationships with the stakeholders and the participants, through encouraging them to be honest and open, continually expanding on their accounts of job satisfaction. I was cognisant of generating bias, although working to semi-structured questions helped reduce this. The engagement of staff can enhance learning and advance quality initiatives in healthcare (1000 Lives, 2011), whilst highlighting the gaps in current knowledge. During a previous role, I supported clinical development within this sector and had visited care homes often, I was therefore extremely aware of the staff's co-operation and contribution to my research study, when taking time off their shift pattern to assist me. The staff's belief in my genuine desire to help their fellow workers, helped make access to them easier, through their willingness to contribute and support my development. Although a downside to this, was the possibility of staff altering their responses in a way they considered helpful to my study, with a potential to reduce the credibility of the findings. This was considered to be limited, as the accuracy and honesty of participant replies was evident in interview discussions.

The study was the final step in my professional doctorate journey, and my development and learning were continuous from start to finish of this process, from the scoping review to

undertaking the case study itself. Improving my confidence, research abilities and understanding was ongoing and enhanced through each stage of this thought-provoking journey (Burton, Duxbury, French, Monks & Carter, 2008). It was a real challenge, which took me out of my comfort zone, particularly during learning new analytical techniques and understanding how to operationalise processes. Over this process I have continually reflected upon my progress and adapted my style and approach, adhering to best research practices. A sense of accomplishment followed completion of the study, knowing the findings have established new knowledge which can contribute to the development of the care home workforce. My Professional Doctorate programme permitted an opportunity to make a "change and improvement" in healthcare practice (Rolfe & Davies, 2009, p.1266).

7.9   Conclusion

This final chapter has provided the conclusion to this thesis. The study findings have both corroborated and advanced knowledge into factors which influence job satisfaction in the care home workforce, whilst contributing to the care home evidence base through a new job satisfaction framework and resource. Interventions which enhance these issues can help encourage new staff into this sector, whilst reducing staff leaving. Reflections have enabled implications to be made focusing on areas requiring further development, with the inclusion of clear recommendations within key areas of healthcare research, policy and practice. The findings have highlighted potential areas for local improvement and the managers' implementation plan goes some way to support this.

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APPENDIX ONE: SEARCH STRATEGIES

Boolean search strategy

Population	Concept	Context
• workforce or staff* or personnel or matron or "nurse manager" or manager* or nurs* or "clinical lead" or "ancillary staff" or "support staff" or "support worker*" or HCSW or "healthcare assistant" or HCA or "agency staff" or "bank staff"or locum*	• AND recruitment or retention or "retaining staff" or employment or "staff shortage*" or rota* or roster* or staffing	• AND "nursing home*" or "care home*" or "rehabilitation home*"

Limits set: Date: 2000–current date (Oct 2015) / Language: English only

Keyword and subject heading search (e.g. EMERALD database)

274
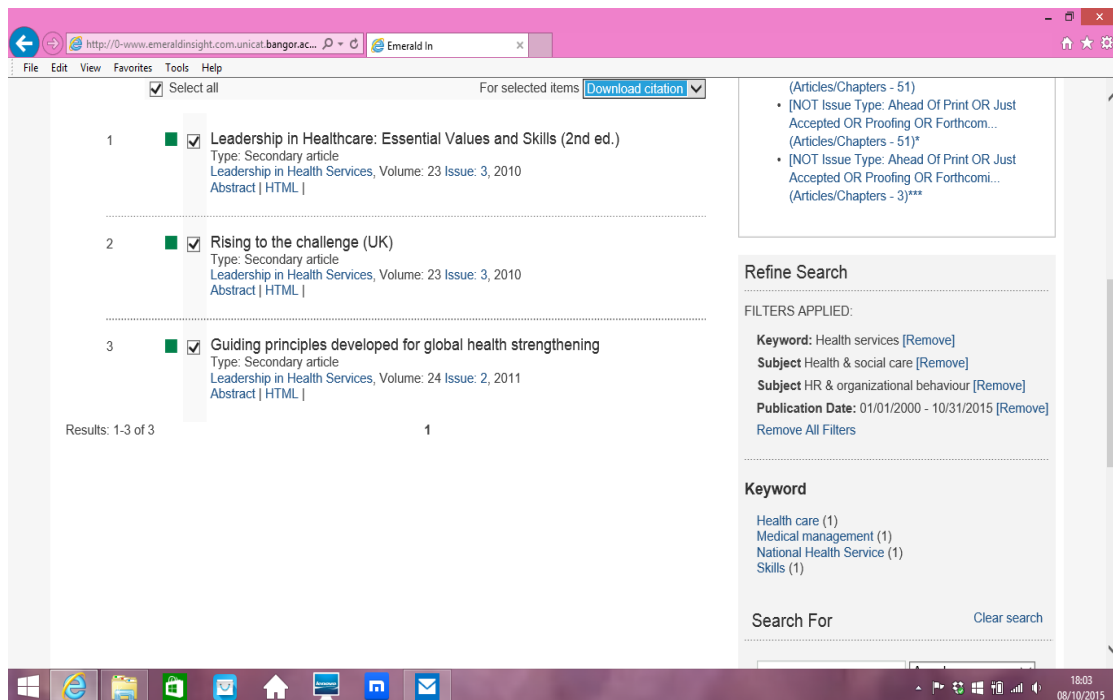
APPENDIX TWO: REASONS FOR EXCLUDED ARTICLES

Excluded	Excluded
• Not empirical primary study nor policy • Nursing home summaries / overview / current status and situation • Regulations and policies • Intervention into clinical care • Resident outcomes and indictors • Family caregivers • Infection control • Safety, fire issues • Pressure ulcer care / monitoring • Fractured hips / prevention of falls • Medication uptake / effects in dementia residents • Pain management • Intervention scales / tools • Medication and use of psychotropic and anti-depressant drugs • Palliative care • Resident end of life care needs • Symptom management and improving quality of care	• Staff quality of care and patient outcomes • Staffing – minimum standards and skill mix • Admission and discharge processes / improvements • Care planning and procedures / interventions • Dementia and aggressive behaviour • Use of physical restraints • Memory intervention • As hoc – vaccination programmes, staffing tools, clinical deficiencies • Assisted living / domiciliary care • Rehabilitation needs and interventions • Clinical trials and resident / staff uptake • Incontinence • Malnutrition and feeding interventions • Mistreatment and elder abuse • Dementia and maintaining cognitive function / resident's identity

Reasons for excluded articles

APPENDIX THREE: SCOPING REVIEW ARTICLES

Article Code (n=32)	Article Details
1	Aaron, C.S. (2011). The positive impact of preceptors on recruitment and retention of RNs in long-term care: A pilot project. *Journal of Gerontological Nursing,* 37(4), 48-54
2	Brannon, D., Barry, T., Kemper, P., Schreiner, A., Vasey, J. (2007). Job perceptions and intent to leave among direct care workers: Evidence from the better jobs better care demonstration. *The Gerontologist*, 47(6), 820-829
3	Care Commission (2008). *Safer recruitment for safer services: A report on the quality of recruitment practices in registered care services*. Dundee: Care Commission
4	Care England (2015). *Sustainability, innovation and empowerment: A five-year vision for the independent social care sector*. London: Care England
7	Castle, N.G., & Engberg, J. (2006). Organizational characteristics associated with staff turnover in nursing homes. *The Gerontologist,* 46(1), 62-73
8	Castle, N.G. (2013). Consistent assignment of nurse aides: Association with turnover and absenteeism. *Journal of Aging & Social Policy*, 25(1), 48-64
9	Chenoweth, L., Jeon, Y., Merlyn, T., & Brodaty, H. (2010). A systematic review of what factors attract and retain nurses in aged and dementia care. *Journal of Clinical Nursing,* 19(1-2), 156-167
10	Choi, J., & Johantgen, M. (2012). The importance of supervision in retention of CNAs. *Research in Nursing & Health*, 35(2), 187-199
11	Chou, R. J. (2012). Resident-centered job satisfaction and turnover intent among direct care workers in assisted living: A mixed-methods study. *Research on Aging,* 34(3), 337-364
12	Decker, F.H., Harris-Kojetin, L., & Bercovitz, A. (2009). Intrinsic job satisfaction, overall satisfaction, and intention to leave the job among nursing assistants in nursing homes. *The Gerontologist,* 49(5), 596-610
13	Department of Health (2006). *Securing and retaining staff for health and social care: a partnership approach*. London: HMSO
14	Donoghue, C., & Castle, N.G. (2009). Leadership styles of nursing home administrators and their association with staff turnover. *The Gerontologist,* 49(2), 166-174

15	Ha, J.G., Man Kim, J., Hwang, W.J., & Lee, S.G. (2014). Impact of organisational characteristics on turnover intention among care workers in nursing homes in Korea: A structural equation model. *Australian Health Review: A Publication of the Australian Hospital Association*, 38(4), 425-431
17	Hegeman, C., Hoskinson, D., Munro, H., Maiden, P., & Pillemer, K. (2007). Peer mentoring in long-term care: Rationale, design, and retention. *Gerontology & Geriatrics Education,* 28(2), 77-90
18	Hsieh, P., & Su, H. (2007). Retention and attrition of certified care assistants in the long-term care industry from the Taipei area: An interview survey. *International Journal of Nursing Studies,* 44(1), 93-104
19	Hunt, S.R., Probst, J.C., Haddock, K.S., Moran, R., Baker, S.L., Anderson, R.A., & Corazzini, K. (2012). Registered nurse retention strategies in nursing homes: A two-factor perspective. Health Care *Management Review,* 37(3), 246-256
20	Karsh, B., Booske, B.C., & Sainfort, F. (2005). Job and organizational determinants of nursing home employee commitment, job satisfaction and intent to turnover. *Ergonomics,* 48(10), 1260-1281
21	Kemper, P., Brannon, D., Barry, T., Stott, A., & Heier, B. (2008b). Implementation of the better jobs better care demonstration: Lessons for long-term care workforce initiatives. *The Gerontologist*, 48, 26-35
22	Kemper, P., Heier, B., Barry, T., Brannon, D., Angelelli, J., Vasey, J., & Anderson-Knott, M. (2008a). What do direct care workers say would improve their jobs? Differences across settings. *The Gerontologist,* 48, 17-25
23	McConnell, E.S. (2000). Reducing turnover and improving health care in nursing homes: The potential effects of self-managed work teams. *The Gerontologist*, 40(3), 358-363
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APPENDIX FOUR: EVIDENCE TABLE OF INCLUDED STUDIES

a)   Empirical evidence (n=25)

Author	Study type	Setting	Study location	Characteristics of population	Number of participants	Interventions	Main findings
Pillemer et al (2008)	Randomised controlled intervention -data collected 3 times over 1-year period, and interviews	Nursing homes	USA – New York State & Connecticut	32 nursing homes randomly selected from 4 stratified groups (from 847 total)– randomly assigned to treatment or control conditions.	Certified nursing assistants (CNAs) - interviews	Randomised controlled intervention designed to reduce employee turnover by creating a retention specialist position. This person received intensive 3-day training in retention leadership & retention programmes.	Significant declines in turnover rates compared to control facilities. Positive effects on CNAs – quality of retention efforts and of care provided, but no effects for job satisfaction or stress. Study provides evidence for the effectiveness of the retention specialist model, but evaluation suggest modifications of the programme may increase effects- mostly a retention team approach rather than focusing on an individual.
Aaron (2011)	Descriptive design with semi-structured focus groups - feasibility study	Long term care environment	USA - Illinois	4 nursing homes (all the Expanding Teaching-Nursing Home Project)	12 staff including administrator and directors of nursing (response rate not recorded)	To identify the strengths and weaknesses of current recruitment and retention.	Structured preceptor programme allows nurses to meet challenges and has a positive impact on long term staffing, due to greater interest in employment, as feeling they are better meeting residents' needs, and offering continuity of care.

Brannon et al (2007)	Cross sectional survey – paper survey, logistic regression analysis	Provider organisations participating in Better Job Better Care demonstrations	USA - 5 states	50 skilled nursing facilities, 39 home care agencies, 40 assisted living facilities and 10 adult day services	3468 Direct care workers (DCWs) (54.4% response rate) – all employed in the BJBC organisations	To assess how perceived rewards and problems with care giving work and supervision, relate to intent to leave among DCWs	Suggests changes to management practices are needed to mitigate negative factors. Improvement strategies link to job satisfaction and increasing opportunities in roles which reduces intention to leave. Certain factors correlate to intent to leave (work overload and dead-end job). Rewards positively link to feeling stable and reduce likelihood to quit
Goon et al (2014)	Survey – April 2010 - Structured questionnaire	Nursing homes	Korea – 2 Regions studied	14 nursing homes (no response rate)	504 care workers (response rate 76.8%)	Explore the impact of organisational characteristics on turnover intention among care workers	Organisational characteristics impact on staff turnover, a high staff turnover had direct negative effect on the continuity of nursing services as well as quality of care. Employee turnover leads to additional costs - recruitment and training of new employees, contributing to inefficiencies in management. Increasing staff organisational commitment by actively implementing high performance work practices, potentially reduce staff turnover. Also has indirect effect by mediating organisational support/ commitment. Potential for professional growth, involvement in work related decisions & supervision, influences turnover intention or actual turnover
Hegeman et al (2008)	Descriptive study of 2 LTC peer-mentoring programmes.1) Growing Strong Roots 2) Peer mentoring for long term care charge nurses	Nursing homes	USA - New York State	Nursing homes - all part of the Foundation for Long Term care project 1)31 homes, 2)13 homes (100% rate)	1) CNAs 2) licensed practical nurses and RNs (no rates recorded)	To explore peer mentoring in long-term care, rationale, design and retention	Outcome of programmes were positive with 1) greater retention after peer mentoring. Future mentoring could maybe have longer peer support to see if this effected retention rates. 2nd programme suggest improving RN retention will have direct impact on CNA retention rates. 2) 3mth retention reinforces mentoring as key component of 1). Formal supervisor training & peer mentoring to develop enthusiasm and develop positive attitude.

Hsieh & Su (2005)	Descriptive survey and - telephone interview (Jan-July 2002)	LTC	Taipei, Taiwan	826 certified care assistants (CCAs) who had trained in 1999	313 interviewed (38% response rate)	To identify employment status of CCAs and to understand, why post training, they have either stayed or left	Greater number of CCAs stayed in LTC. Stayers-main reasons were personal interest in caring for the elderly, good financial benefits, supportive leadership. Leavers – low wages, heavy workload, long working hours, high level of stress, poor financial benefits. Also, personal factors, work related factors, the welfare system, managerial system, leadership style and environment.
Karsh et al (2007)	Survey - self-administered questionnaire	Nursing homes	USA	76 nursing homes (70% response rate).	6,584 care and non-care staff and RNs. (response rate 44%) -	To examine whether job characteristics, the work environment, participation in quality improvement activities and facility quality improvement environment predicted employee commitment & job satisfaction, & whether it predicts turnover intention	Results support the hypothesis that job and organisational factors predicted commitment and satisfaction. Commitment was a stronger pedictor of turnover than satisfaction. Older aged staff and those with longer tenure are more likely to stay. Job satisfaction related to – supervision, personal recognition, family/work conflict, communication, day shift, stress, commitment, communication with supevisors, routinization and communication with peers. Although no direct effects on turnover they are predictors to leave. Difficult to address the factors individually, need to be tackled though organisations quality environment, ie training, teamwork.
Kemper et al (2008a)	National survey BJBC (2002) data – BJBC is a long-term care workforce initiative	LTC	USA – 5 States	All 5 BJBC initiative sites	Direct care workers (3,468) – baseline survey	To understand what changes in management practices would most improve the jobs of frontline workers and to analyse differences across settings	Across settings, DCWs low pay affects high turnover. Improved training for staff and supervisors had potential to improve jobs and thus turnover. Other influences were management systems, training, education, work schedules, work relationships and greater intensity of personal concern. Not all staff were dissatisfied with their jobs. Feeling valued and respected and increasing job satisfactions, along with pay.

McConnell (2000)	Qualitative study of the SMWT Observer completed a questionnaire of 75 questions.	1 nursing home using SMWT	USA - Wisconsin	3 SMWT teams (self-managed work teams)	14 staff (response rate not recorded)	To provide rationale for SMWTs, examine major factors found to affect theory performance and describes steps on how to implement SMWTs	SMWT were found to reduce employee turnover as job satisfaction increases desire to come to work, dignity & self-respect. High performing teams had RNs who handed over day-to-day responsibility, enhancing CNA self-image, and confidence, promoting more positive interactions, decision making & listening. Traditional RN role of decision making was seen in low performing teams, whereby CNAs told what to do, & not showing same enthusiasm, with lower levels of trust and team cohesion, feeling on their own & not supported. Management support is crucial to SMWTs success.
McGilton et al (2013)	Qualitative descriptive study / focus groups at each home and content analysis of primary data	LTC settings	Canada - Ontario	7 nursing homes (response rate not recorded)	41 licensed LTC nurses (response rate not recorded)	To understand factors that influence nurse's intentions to remain employed at their current job	A range of work and personal factors influence retention or intentions to leave, based on multiple factors and not the same ones why staff stay or leave. Key here is therefore trade-offs between intention to leave and work-related factors. Work conditions affected nurses' intentions to stay - included impact of regulations on their role, flexibility and professional judgement, an underfunded system contributing to insufficient resources /staffing, a lack of supportive leadership. Poor work conditions result in reduced level and quality of care. Willingness to stay influenced by the development of meaningful relationships with residents/staff, opportunities for learning and professional development, and personal and life circumstances.
Mittal et al (2009)	Exploratory – interpretive study -7 focus groups	Pennsylvania Registry of health workers	Usa - Pensylvannia	DCWs– all working in senior positions for at least 3 years	47 DCWs were eligible (response rate not recorded)	To understand the factors associated with turnover and retention of direct care workers (DCWs)	It identified difference between why people stay and why they leave , 5 main themes– and werent the same issues, reiterates like other papers issues are multifactorial. Turnover mainly assooicated with work and organisational issues, whilst intention to leave what cam up again was advocacy and

							relationships with residents. Reinforces the driver that make people stay are different to dissatisfaction and thus what makes them leave. Suggests organisational or managerial factors such as flexibility of the job and social or esteem factors, relationship with each other. Suggests culture change and need spiritual /faith perspective. Choice – a feeling of perceived choice, future motivator and includes lack of respect. Person centred care vital. Workforce and stability, & culture change need to be addressed.
Nakanishi & Imai (2010)	Cross sectional data from employees over a 1-month period Oct 2009 – paper questionnaire	Elderly residential facilities including special nursing homes, geriatric intermediate care facilities & group homes	Japan – 3 regions studies	746 facilities (46% of all homes)	6,428 DCWs (46% responses collected with complete information provided by 20.9%). (25 participants per home)	To examine job role quality relating to intention to leave current facility and to leave profession among direct care workers in residential facilities	Factors of schedule control, supervisor relationships and job security were negatively correlated with decision authority, pay adequacy, job demand and skill discretion. Same factors were positively loaded to rewards and linked to DCWs sense of interference. It provided findings on not only intention to leave job but also intention to leave profession - which were different factors. Intention to leave the facility was due to job role quality, lack of feeling valued and little opportunity for promotion. Intention to leave profession - linked to less career development and lifelong learning activities compared to RNs.
Paget & Wood (2014)	2 staged review. (May - Oct 2014) Desk research and fieldwork of semi-structured interviews & Focus groups	Care homes (with and without nursing)	UK - 8 different locations in Wales	Managers, employers and commissioners and workforce development managers	1)All CSSIW data 2) 40 participants at interviews and 20 at focus groups	To investigate key factors influencing recruitment and retention of managers in care homes for older adults	Majority facing significant challenges due to high level of financial investment & current fee levels. Need a market intelligence function across Wales to provide accurate & accessible workforce data. Greater health board collaborations, & concerns over nurse shortages. Need to understand the employment needs of migrant workers and succession planning. Variances in pay, terms & conditions, bonuses, annual leave, sick pay, pension contributions, car allowances, mobile phones etc. Recycling same pool

							of people, same staff being headhunted. Bad publicilty needs to be countered at a national level. Pressures on managers due to NHS processes, delays, confusions-negative impact on worklife balance. Various levels of different support for managers.
Rosen et al (2011)	Longitudinal investigation – phone survey, baseline & 1 year later	Department of Health CNA Registry	USA - Pennsylvania	620 nursing homes (76.1% response rate)	814 CNAs / DCWs (59.8%) 1,360 (57.5% of Registry eligible at screening (working 30hr/week)	To evaluate the job factors and work attitudes associated with just full-time stayers or leaving	Reiterates that job satisfaction and emotional well-being mediated the intention to leave to actual turnover. Stayers were significantly less likely to report any intention to leave. Many suggested factors such as pay does not directly cause staff to leave. Leavers reported higher turnover intentions, greater emotional distress, less job satisfaction and lower supervisor respect than stayers and differed from switchers. It appears although work related factors increased intentions it didnt really have direct effect on actual turnover, while it did affect behaviour .
Rubery et al (2011)	3Staged Research Project 1) local authority postal survey 2008 2) telephone survey 3) case study	Local Authorities and social care providers	UK	1) 92 local authorities (62% response rate) 2) 52 care homes & 52 domiciliary care providers (from14 LAs) 3) 4 LA case studies	1) 92 LA leads returned survey 2) 115 providers - telephone interviews 3)98 staff interviews	To explore recruitment and retention of the social care workforce	Commissioners were pulled in different directions. Las did not necessarily provide stable and coherent signals for independent providers. LA did affect the quality of working time practices. Poor HR policies, poor employment conditions, low rates of pay, contractual arrangements differ – did suggest that providers to try and respond to labour forces and improve their practices. Employee perspective – informal word of mouth, job satisfaction and committment aided retention, care workers accepted low pay if certain HR bundles were present. Relationships with ptients influenced retention. Training, pull of NHS oftenmade staff leave with better pay and conditions.

Singh & Schwab (2000)	Survey (mailed questionnaire)	Nursing homes	USA – 2 states, Michigan & Indiana	Nursing home administrators (52.8% Michigan and 53.2% Indiana)	552 NHAs (Response rate 53.3%)	To determine what factors, attitudes and personal characteristics of NHAs are associated with tenure in the administrator position To construct a predictive model that can help decision makers	Shows range of factors influence NHA stayers and leavers. This looked at recruitment stage of employment rather than looking at retention whilst employed. This goes back to the hiring process and looking at potential leavers here. Confirms that a short tenure of staff causes instability within the facility. Also, negative impact on quality of care. Committment to the organisation has been found to improve retention and ths poor performing staff and instability should be avoided. Committment is influenced by leadership. Loyalty and committment could be predicted from previous job patterns and possible frequent leavers / number if jobs.
Skills for Care (2009)	Case study approach – interviews	Long term care (with and without nursing)	UK - 7 skills for care regions in England	18 CSCI registered care homes selected (6 domiciliary care, 6 care only homes and 6 care homes with nursing)	67 interviews - care staff, nurses and managers (response rate not recorded)	To explore the development of preceptor programme	Reinforces that different issues need to be addressed and different strategies for recruitment and retention. Reasons why staff take up a job and then why they leave are not the same. Again mainly, job satisfaction, teamwork and perceived quality of care. Management (or lack of) clearly influences supervision, workload, teamwork and thus subsequent decisions to leave. Pay is important but not the key to attract or retain staff. Need to retain staff with the right values, feeling proud, increased loyalty. Change of owner & org factors have significant impact on staff leaving, along with difficulties with management, staffing levels, intensity of work and reduced quality of care.
Castle (2012)	Survey and online survey certification and secondary reporting data (OSCAR), Area	National nursing home sector	USA	3,941 nursing homes	NHAs (survey) Nurse aides (NA) studied-	To examine the association of nurse aide consistent assignment with	Advocates suggest staffing and scheduling improves quality of care - with proposed benefits of reducing turnover and absenteeism. Homes with higher levels of consistent assignment (85%) were found to have

	resource File. (secondary data analysis)				on-line data & resource file	turnover and absenteeism.	significantly lower rates of turnover and absenteeism (p<0.01)
Choi & Johantgen (2012)	Survey (2004 national nursing home) & 2004 National Nursing Assistant Survey (secondary data analysis)	National nursing home sector	USA - Kansas	582 nursing homes (75.7% response rate).	certified nursing assistants (CNAs) (Response rate 53%)	To test a conceptual model of direct relationship of work related and personal factors to job satisfaction and intent to leave	Job satisfaction was considered a predictor of intent to leave. By increasing supervision staff were less likely to intend to leave, thus employers should provide better training and support for RNs to develop their supervisory skills. Suggestions that employers should investigators motivators of employment to enhance job satisfaction and retention.
Castle & Engberg (2006)	Mailed survey in 2003 and 2004 online survey (OSCAR), 2004 Area Resource File (secondary data analysis)	National nursing home sector	Usa- 6 states,	854 nursing homes	Nursing home administrators (NHAs), nursing staff and CNAs (Response rate 77%)	To examine the association between certified nurse aides (CNAs), licensed practical nurse and registered turnover and organisational characteristics	Various reasons why staff turnover is higher, although consistent with other studies findings, and makes suggestions how to tackle these issues. All themes impacted on all caregivers - in particular low staffing, lower quality, for-profit ownership, and higher bed size
Chou (2012)	Mixed methods - Preintervention Mailed survey & WETA Program survey 2000 – (secondary data analysis)	Assisted living setting	USA	108 assisted living facilities selected (73.4%)	722 DCWs (73.4% response rate)	To examine the effects of resident-centred job satisfaction on DCW turnover intent, a proven predictor of actual turnover	Qualitative data shows DCW resident centred job satisfaction deters turnover intent, whilst quantitative data shows there is no actual effect on turnover intent, only that they are less likely to apply for another job in long term care. Job satisfaction influences decision to leave employment. Although 10 categories identified job satisfaction, it was noticable that residents care was highest, and often

							the only reason for staff staying in the job.it shows relationships and caring are key.
Decker et al (2009)	Survey - cross sectional data 2004 National Nursing Assistant Survey (NNAS) - (secondary data analysis)	Nursing home	USA	Nursing homes (NNAS 53.4% response rate)	2,146 NAs - interviewed (eligible if worked 30hr per week)	To examine predictors of intrinsic job satisfaction and intention to leave among nursing assistants	It suggests intrinsic satisfaction may be pivotal in the job behaviour of NAs in nursing home. Positive assessment of the supervisor's behaviour had the strongest association with intrinsic satisfaction. Intent to leave does not necessarily mean staff turnover. The paper reinforces job satisfaction and intirnsic factors influence intentions to leave and are not necessarily the same reasons for what brought them into the job intially.
Donoghue & Castle (2009)	Survey carried out in 2005 - National Nursing Home Turnover Study. (secondary data analysis)	Nursing home	USA -all regions	1,333 nursing homes	2,900 Nursing home administrators (72% response rate)	To examine the association between NHA leadership style and staff turnover	High administrator turnover is associated with high nurse aide turnover. Organisational and environmental factors were related to turnover of all caregivers. Requirement to change organisational culture and look at leadership styles. Job satisfaction as central to staff turnover. Suggests leadership styles are associated with staff turnover. Consensus leaders are associated with lowest turnover levels. Shareholder managers are associated with the highest turnover levels. Leadership strategies could aid policies for lowering staff turnover.
Hunt et al (2012)	Survey - 2005 National Nursing Home Survey (secondary data analysis)	Nursing homes	USA - national	Nursing homes – 1500 selected for inclusion (from 16,600)	1,174 nursing homes (78.2% response rate)	To explore the relationships between retention strategies, employee benefits, features of the practice	Almost all homes offered some combination of retention programmes; however, were not significantly associated with the level of RN retention. Extrinsic motivators and workplace factors are related to increased RN retention. Retention programmes - tuition reimbursement and career promotion opportunities were better. Intrinsic factors such as offering attendance awards were

						environment and RN retention.	more like to fall in mod/high retention homes. Other intrinsic factors – recognition programmes, conference reimbursement, attendance awards, career ladders, tuition reimbursement, career development – linked to higher retention.
Steams & D'arcy (2008)	National nursing assistant survey NNAS 2004- (secondary data analysis)	National Nursing Homes	USA	582 nursing homes (76% response rate)	2,328 NAs (71% eligible) with facility & response rate of 53%)	To assess the extent to which the same factors are associated with NAs intent to leave a particular job versus the NA profession	Substantially different factors affected facility versus profession retention. Facility characteristics mainly affected facility retention, whilst NA professional retention was influenced by income & education. What it showed was clearly that reasons for intending to leave their current employment was significantly different to those wanting to leave the profession. Retaining NAs –focused on facility led initiatives, whilst career and promotion opportunities for professional retention.

b)   Secondary data studies (n=3)

Author	Study type	Setting	Study location	Characteristics of population	Number of participants	Interventions	Main findings
Chenoweth (2010)	Systematic literature review	Adult and mental health organisations	Worldwide papers	International studies 1990-2008– 25 papers included, if quality rated as level 2++ to 3 (NICE 2006)	NA	To present evidence-based factors for the recruitment and retention of licensed nurses caring for older people and	Different strategies association with either recruitment or retention, whereas multi factorial strategies are required – recruitment appears to relate to effective systems approaches such as positive philosophy of caring, managerial structures, communication, culture of openness and job 'embeddedness', intrinsic rewards, respect, values and empowerment of staff. For retention - more individualised approaches such as mentoring,

						persons with dementia	supervision, peer support, positive staff support, education, training and empowerment, including effective leadership, culture of care and respect. Pay, work overload, adequate staffing levels, respected status amongst peers, healthy work-life balance, lead to affective committment.
Kemper et al (2008b)	Analysed project work data – BJBC (2002) is a long-term care workforce initiative	LTC	USA – 5 states	All 5 BJBC initiative sites	All 148 providers from the 5 project sites	Assess the implementation of the BJBC initiatives, analyse these factors, and draw lessons from it for other long-term care initiatives.	An important legacy from the project is to reinforce the need to shift the staffing issue away from indiviudal providers towards a common workforce interestis required. Reinforced recruitment/retention is a long term care industry wide problem, not just nursing home itself. Future initiatives need to recognise changes to workforce and management practices is difficult and takes time. Policy and funding is required, also need to engage key stakeholders and develop key relationships.
Riggs & Rantz (2001)	Literature review - concept analysis using evolutionary approach	Nursing home literature	USA	Nursing home workforce	Nursing assistants (not stated)	To propose a model of staff support which conceptualises the nursing home as a supportive social system in which the needs of both staff and residents can be met better.	The importance of a supportive organisational climate and effective interpersonal relationships emerges as a prevalent theme. Reinforces no one way to solve recruitment and retention strategies, therefore multi approach needed to target effective organisations and manage people. Review focus from technical system to social system. Isolated changes are not sufficient to deal with serious problem of staff turnover. Homes need to openly and consistently value its staff, implement organisational committment and principles of respectful open communication and participative management. Working environment is key and to promote an 'open' organisation.

c) Policy reports (n=4)

Author	Study type	Setting	Study location	Characteristics of population	Number of participants	Interventions	Main findings
Department of Health (2006)	Briefing paper – providing a framework for NHS organisations	Care homes	UK	Local government and social care employers	NA	To provide a framework for NHS organisations to manage stable and effective workforce during a time of change	A critical factor is to look at solutions across the wider system. NHS to consider independent sector within its workforce strategies. Reiterates the need to include care homes in workforce planning, but goes further by acknowledging the need to help staff care homes.
Care Commission (2008)	Report – reviewing the quality of recruitment practices	LTC	Scotland	Registered care services	4434 (sample about 60%)	To review the adoption of and implementation of safe systems to recruit their employees	Safer recruitment through better recruitment guidance (2007) can help support use and development of recruitment and selection processes. Report focuses on legal governance and regulation, codes and Acts and best practice to encourage safer recruitment, including family and staff voices
Care England (2015)	Report – outlining work programmes	Social care sector	UK	All care sector	-	A report outlining work programmes to ensure continuous improvements can be achieved	Suggests plenty of initiatives currently in place for us to see changes. Reinforces the need to value the sector in its delivery as essential to community health needs. Potential to improve positive image, by national and local leaders, and programmes driving new models of care, all impacting on recruitment and reducing turnover of staff. Pay is an influence. Development of new roles, improved carer progression and need for students to experience care home placements can all help.
Skills for care (2011)	Report – a recruitment and retention strategy framework	Adult social care workforce	UK	Social care workforce	NA	To offer a practical tool which sets out the issues, proposes the responses and shows examples of	Need high level engagement, ministers have pivotal role in leadership. Focus of this paper is very much about redesigning the workforce and training and education to support the improvements, bringing the community together and developing strategies. Need to raise public

						good practice. To move towards a framework for delivery and outcomes.	awareness and careers in care need to be marketed in a new fresh positive way. Attitudes and expectations of the public is changing from highly structured services its better mould their lives, while the diverse workforce needs core values, new skills and competences.

APPENDIX FIVE: DATA EXTRACTION FORM TEMPLATE

Data extraction date:	Article Code:
Title of study:	
Author(s):	Year of publication:
Aims of the study:	
Study geography:	
Type of study design / methods:	
Underpinning Theory:	
Characteristics of study populations i.e. ownership/ management / size etc:	
Types of tools, resources / approaches used and duration:	
Outcome impacts / effects:	
Main results:	
Features & issues /what does this mean for my aims and objectives?	
Ongoing reflection: (relevant info page numbers /build up commentary /extract quotes /text from studies)	

(adapted from Arksey & O'Malley, 2005)

APPENDIX SIX: CARE HOME CHARACTERISTICS

Type of care home	Adult care home (n=49)				Mental health care home (n=28)			
Size (small under 25 beds)	33 large		16 small		20 large		8 small	
Location	29 town	4 rural	14 town	2 rural	19 town	1 rural	6 town	2 rural

APPENDIX SEVEN: GROUPING OF RECRUITMENT AND RETENTION THEMES

9 Themes (Generated from the scoping review strategies and approaches)
1. Increasing job satisfaction   - Introduce training, education and competencies   - Develop resident relationships and assignment   - Increase staffing levels and daily workload   - Improve rewards and recognition (pay, holidays, etc.)   - Increase job satisfaction / dissatisfaction (intrinsic and extrinsic reasons)   - Encourage an enhanced variety of work   - Improved supervisor behaviour and satisfaction   - Offer peer support amongst managers
2. Care industry as a whole   - National focus on long term care delivery (not just nursing home)   - National strategic approach to supporting and managing the care home market   - Collective approaches across NHS Health Boards to meet collective responsibilities   - Generate national policy and procedure initiatives   - Address bad publicilty at a national level promoting good practice, using care ambassadors – raising the profile and act as champions   - Strategic health authorities to have leadership role   - To stabilize nursing home leadership, especially the director of nursing position   - Promote specific good practices, including the use of workforce tools   - Improving public awareness and better explaining social care   - Bridging health and social care in residential homes   - Developing specialities across a continuum of care   - Improving policy and commissioning practices   - Affirming the professionalism of careers & improving the status of social care work   - NHS to retain and manage talent pool and support care homes
3. Environmental   - Improving the quality of the facility   - Promote supportive open organisation by improving broad and sustainable organisational changes   - Encourage family approach to staffing   - Improve the sense of organisational injustice (high physical & emotional demands)   - Including employee's voice to increase job satisfaction   - Increase organisational commitment   - Increase number of full-time workers   - Increase staff commitment & loyalty   - Improve managerial effectiveness and develop business skills   - Develop quality improvement organisational practices   - Alternatives to management – develop senior practitioner roles to support, address pay scales, training and support, embrace diversity of roles   - Offer peer support amongst managers

- Improve leadership skills and team working
- Better communication,
- Value, support and empowerment of staff
- Address and change the culture and develop ethos and philosophy
- Encourage credibility and respect of roles, ensuring quality and fairness for staff

4. Education, training and development
- Close collaboration with higher education supported by work at national levels
- Promote frameworks and continued programmes to develop leaders
- Support CPD, flexible and cost effective training models, new technologies, apprenticeships and graduate schemes
- Promote career opportunities and the development of potential career pathways
- Targetting staff during career transitions
- Introduce core competencies, values training, induction framework with clear pathways
- Introduce preceptorship programmes, mentorship programmes Introduce manager / administrator training
- Develop supervisor training programmes and introduce supervision
- Review and improve upon training and professional development- training resources, national skills academy, outcome and appraisal framework, remuneration system, commissioners who reward quality services, endorsement of educational providers

5. Partnership working and engagement
- Chief executive leadership and involvement in systems wide responses and strong collaboration with partners, including primary care employers
- Greater collaboration and shared approaches between providers, health boards, WEDS and WG and local government
- Provision of support and intensive action for homes facing significant challenges
- Review regulation, monitoring and inspection systems
- Innovative partership working – i.e. jobcentre, government offices, trade unions
- Supporting a community based approach to care and support – community engagement, putting care services first, offer strategies for supporting, promote growth of multi displainary working.
- Stronger partnership working with providers
- Working with relatives and friends – mutual respect, acknowledgement, incentivised payments, staff training

6. Financial
- Promote stability of services and financial viability
- Promote job stability and evaluation of wages
- Local Authorities to promote better and reasonable employment
- Develop incentives for retention and career progression
- Improve staff pay – higher rates, pay enhancements, reward high performance work practices

7. Staff roles and care practices
- Improve upon quality and care practices
- Development of new roles / models of care
- Introduce retention specialist staff programmes
- Need to understand pros and cons of working for large / small orgs
- Increase resident consignment and value working relationships

- Organisation and standardisation of care practices and pace of work
- Greater understanding of roles, challenges and appreciation of care home sector
- Introduce high performance bundles
- Investigate workload structuring and time allocation
- Advise staff of expected and assigned work role

8. Workforce and labour market
- Greater succession planning and recognitition of skills to ensure an appropriate workforce
- Strategic approach to workforce planning and development
- Nurture new recruits and selling the longevity of a career in care
- Offer clinical student placements early to promote work opportunities
- Longer term workforce requirements to avoid staff shortages
- Improve workforce data, develop workforce strategy, streamline and review current data and introduce a common national minimum data set
- Developing new career pathways – management role, with status,
- Home labour market fully tested before overseas recruitment considered
- Addressing structured barriers to recruitment- Improving interface, including job centre, consider strategic approaches
- Improving labour market conditions
- Improving management and human resources practices
- Developing working time arrangements
- Introduction and development of new roles and of specialist services

9. Recruitment and employment practices
- Recruiting staff with compassion and committment as a strategy
- Improve managers worklife balance and avoid unnecessary NHs pressures
- Development of career framework
- To understand the recruitment, movement and support needs of migrant workers
- Understand staff needs at hiring/ pre-employment strategies
- Formal / informal recruitment practices
- Improve employment opportunities and advancement
- Providers to adopt and implement local authority safe systems, when recruiting employees
- Follow robust recruitment policies and practice, including involving the right people in the recruitment processes
- Encourage staff to provide appropriate references etc and to challenge providers
- Promote 'preparing for practice' tool – practical guidance for employers on staff induction, promote its codes of practice
- Review standards on management and staffing
- For care users– to review last inspection report, recruitment practices, check standards, codes etc, talk to managers if concerned about any staff member and get involved in recruiting stages
- remuneration framework awards for high level performance, inventivise CPD, acknowledge care staff contributions and offer awards
- The nature of the job

APPENDIX EIGHT: PARTICIPANT INVITATION LETTER

(Version1 / 17 May 2016)

Participant invitation letter

Title of study: Exploration of staff experiences and management practices focusing on improving job satisfaction, within care home settings.

Dear colleague,

I would like to invite you to take part in a research study. The study aims to explore staff experiences and management practices focusing on improving job satisfaction, within a North Wales care home setting. Please see the attached project summary form for further details. Does this impact on anonymity?

I would like to invite you to take part because of your current work in the care home setting. This will involve a short interview carried out in your place of work at a date and time convenient for you. It is hoped that the findings from this study will help care home staff and managers understand the potential benefits of developing new ways to support job satisfaction, and help to guide future developments in this area.

If you are interested in taking part, please can you contact me via email at hspe3f@bangor.ac.uk or telephone 07798 853126. Alternatively, if you prefer, you can complete the slip below, and post it in the pre-paid envelope provided.

Many thanks in advance for your time

Yours

Angela Roberts

Bangor University

Participation slip

I would like to / not like to participate in the research study.

Name …………………………………………………………………

Job Title ………………………………………………………………

Care home …………………………………………………………..

Date ………………………………………………………………….

I can be contacted via hspe3f@bangor.ac.uk or on 07798 853126.

APPENDIX NINE: PROJECT SUMMARY FORM

(Version1 / 17 May 2016)

Project Summary Form

Title of study: Exploration of staff experiences and management practices focusing on improving job satisfaction, within care home settings.

The study aims to explore staff experiences and management practices focusing on improving job satisfaction, within a North Wales care home setting. This part of the study follows on from a scoping review of evidence which explored current strategies and approaches to support recruitment and retention practices in care homes. Does this impact on anonymity?

This phase of the study will involve a short interview with a number of clinical staff and care home managers. Care home documents will also be reviewed with managers' permission (for example, policies and guidance that explore current management practices). Data will be analysed, and it is hoped that the findings will offer an important perspective on the views and experiences of staff in relation to job satisfaction.

The final stage of the study will be to use the findings to develop a programme of work with local care home managers to help improve staff experiences and job satisfaction in the workplace. Findings will be shared widely and with the care homes following. It is hoped that the study will help understand the potential benefits of developing new ways to support job satisfaction and help to guide future developments in this area.

APPENDIX TEN: PARTICIPANT INFORMATION SHEET

(Version1 / 17 May 2016)

Participant information sheet

Title of study: Exploration of staff experiences and management practices focusing on improving job satisfaction, within care home settings.

You are being invited to take part in this study. Before you decide to take part, please read the following information about why the research is being carried out and what it will involve.

What is the aim of the study?

The study aims to explore staff experiences and management practices focusing on improving job satisfaction, within care home settings. Interviews and the review of documents will be used to understand job satisfaction from a local perspective. It is hoped that the findings from this study will help understand the potential benefits of developing new ways to support job satisfaction and help to guide future developments in this area.

What is the purpose of the study?

I am interested in understanding the experiences of staff in care home settings in relation to job satisfaction. I would like to explore what factors help staff to enjoy their jobs and what could be done to help make this better. Research will be conducted within different care home settings to understand individual staff experiences, views and attitudes and workplace practices.

Why have I been invited to participate?

You have been asked to participate as you are part of the care team within your workplace, and I am interested in the views and experiences of care home staff. I would like to understand, from your perspective, issues related to job satisfaction in your place of work.

What would taking part involve?

I would like to invite you to participate through a face to face short interview, conducted at a date and time convenient for you. I will ask you to sign a consent form before the interview. The interview should take no more than approximately 30 minutes. The interviews will be audio-taped and transcribed. Participation is entirely voluntary, and you can withdraw from the study at any point.

What are the possible benefits of taking part?

The findings from the interviews will be used to inform care home managers and staff about the best ways to develop action plans / guidance to assist them to improve their management of job satisfaction. You may find it interesting to discuss your views of factors which influence job satisfaction. The findings will contribute to a better understanding of staff experiences and will also help to inform a future programme of work with care homes managers.

What are the possible disadvantages and risks of taking part?

Whilst I cannot foresee any possible disadvantages or risks to you to taking part., I do appreciate the pressures on your time. I will ensure there is time at the end of the interview should you wish to further discuss/be provided with contact details for any issues related to the study.

What will happen if I don't want to carry on with the study?

Taking part in the study is entirely voluntary. You can withdraw from the study at any point without giving a reason. If you wish to withdraw, any data that relates to you will be destroyed. If you wish to withdraw from the study please contact Angela Roberts (hspe3f@bangor.ac.uk / 07798 853126) in the first instance, or academic supervisor Dr Lynne Williams (hsse11@bangor.ac.uk / 01248 383170). If you prefer, you can contact the Director of Postgraduate Studies, SHCS (Dr Sion Williams, hss042@bangor.ac.uk /01248 388451).

How will my information be kept confidential?

Your personal data will remain strictly confidential throughout the study. Individual participants will be allocated codes so that no name or personal information is identifiable. Any reference to workplace, location, names of individuals will be removed from the interview transcripts. Any quotes used in study publications will not identify individuals or locations.

What will happen to the results of this study?

The project forms part of a Professional Doctorate in Healthcare, concluding in the production of an academic thesis. The findings will be used to build on existing workplace practices in a local setting and will help to inform a future programme of work with care homes managers within North Wales. The findings will also be shared widely through conferences and publications in professional and academic journals.

What do I do if I have any complaints or concerns about the study?

If you are concerned about any aspect of the study, please contact Angela Roberts, in the first instance (hspe3f@bangor.ac.uk /07798 853126). If there remain unresolved issues, you can contact my academic supervisors Professor Jo Rycroft-Malone (j.rycroft-malone@bangor.ac.uk /01248 383119) or Dr Lynne Williams (hsse11@bangor.ac.uk /01248 383170), or in writing to the Director of Postgraduate Studies, SHCS (Dr Sion Williams, hss042@bangor.ac.uk /01248 388451)

Who is organising and funding this study?

Bangor University is the sponsor of the study. Data collection will be undertaken by researcher Angela Roberts (hspe3f@bangor.ac.uk or 07798 853126).

Who has approved this study?

This study has been reviewed through Bangor University School of Healthcare Sciences Ethics Committee.

What do I do now?

If you would like to be part of my study, please complete the attached consent form and contact me via email or telephone and I will organise an interview in your workplace. You will be given the signed consent form to keep alongside this information sheet and the researcher will also retain a copy along with a copy for the University file.

Thank you for taking time to read this information.

APPENDIX ELEVEN: PARTICIPANT CONSENT FORM

(Version1 / 17 May 2016)

Participant Consent Form

Title of study: Exploration of staff experiences and management practices focusing on improving job satisfaction, within care home settings.

Please read the following and **initial** all the boxes.

- I confirm that I have read and understand the participant information sheet dated <u>17 May 2016</u> for the above study. I have had an opportunity to consider this information, ask questions and have had these answered satisfactorily.

- I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason.

- I agree to a take part in a face to face interview and I agree to the interview being recorded and transcribed for the purposes of analysis.

- I agree to the use of **anonymous** quotes in the thesis, in written reports, conference presentations and/or publications in professional or academic journals.

- I understand and agree that data will be anonymised and stored on a secure computer and that anonymised data may be used again in the future in secondary analysis.

- I agree to take part in the above study

Name of participant…………………………………………………………….

Signature…………………………………………………………………….

Date………………………………………………………………………..

Name of researcher……………………………………………………………

Signature……………………………………………………………………..

Date…………………………………………………………………………..

APPENDIX TWELVE: INTERVIEW GUIDE

(Version2 / 11 July 2016)

Interview Guide

PRIFYSGOL
BANGOR
UNIVERSITY

Title of study: Exploration of staff experiences and management practices focusing on improving job satisfaction, within care home settings.

Introduction
- Recheck consent
- Interviewer biography
- Orientation to interview topic
- Explanations on questioning outline
- Identify position/role / length employed in the organisation

The interview
1 Outline of questions for care home managers
Aim:
- To explore the care home manager's knowledge and awareness of strategies and approaches which may promote job satisfaction
- To explore what is currently being utilised by managers to improve job satisfaction

Improving job satisfaction
1 Why is improving job satisfaction important to you a manager? And as an employee? To your organisation?
2 What factors do you think appears to make a difference to job satisfaction? Why do you think these actions, if any, improves staff experiences and their enjoyment in their work?
3 How does job satisfaction affect/impact on your role as a manager? What could be done to help support you further in this? **
The care industry
4 Are you aware of any national or local strategies to support workforce practices, particularly linking it to improving job satisfaction? Which? **
5 Does your organisation implement any of these strategies? Have you used them elsewhere in another role or organisation?
6 Is there anything else you could do to improve staff experiences? If so, why are these not currently being used? Are there any barriers to their use?
Environmental
7 Does this care home have a specific policy or strategy to improving the workforce job satisfaction? **
8 Are there any documents the home uses which supports this? (retain) **
9 How do you prioritise your workload and daily demands to ensure these strategies are undertaken?
Education, training & development

10 Can you tell me how you developed your manager skills and knowledge, in particular when responding to workforce issues? **
11 Is there any education, training or development that helps to improve staff job satisfaction? What have you been on recently which has helped this?
Partnership working & engagement
12 Do you think there is a link with other organisations / agencies which either may limit, or could improve job satisfaction?
Financial features
13 How does finance / money influence job satisfaction?
Staff roles & care practices*
14 How does your manager role influence staff job satisfaction? In what ways? How do you think this can be improved?
Workforce & labour market
15 What do you think is the effect of not having a happy workforce? What are your strategies for managing this?
Recruitment & employment practices
16 How can job satisfaction be increased during the recruitment process and prior to staff starting a job? And also, then when employed?
Other
17 Do you have any suggestions or other thoughts about job satisfaction within your workplace?

2   Outline of questions for all clinical staff

Aim:

- To explore the views and attitudes of clinical staff (registered nurses and unregulated staff) of what would promote their job satisfaction.
- To explore the experiences and views on whether staff consider strategies and approaches are being employed in their workplace and the effect of these on their job satisfaction
- To explore what staff consider to be key issues relating to dissatisfaction and what would improve this for them personally
- To explore the effects of dissatisfaction in the workplace

Improving job satisfaction
1 What do you feel about the organisation supporting your job satisfaction and keeping you happy in your role? Does this fit with what you would want and expect and if so how?
2 What makes you happy and gives you job satisfaction in your role? What could make it better for you?
3 What has your employer done to make this happen? What would you like to happen differently?
4 If you feel unhappy in your role at all, why? How does it make you feel? What effect does it have on you?
The care industry
5 What do you think would help all care homes to improve workers job satisfaction? What do think prevents care homes from doing this?
Environmental
6 Do you know of any policies or documents to keep staff happy in their workplace?
7 How does your employer help improve your job satisfaction and keep you happy?

8 What does your home offer i.e. team meetings or forums, that enables you to share both your positive and negative concerns?
9 Do your managers listen to your suggestions? What do you think are the barriers to improvements in your organisation?
Education, training & development
10 Do you think education, training and development in your workplace could improve your enjoyment or satisfaction in work?
11 Which of these items would increase your job satisfaction?
12 What more could the home offer?
Partnership working & engagement
13 What other organisations/ agencies do you think could help improve your workplace and your satisfaction? Why and how?
Financial features
14 How does finance/money impact on your job satisfaction? What more, in relation to finance, could improve job satisfaction?
Staff roles & care practices
15 What clinical/ care practices could improve your current workplace/ role enjoyment? How?
Workforce & labour market
16 How do you manage yourself at work? What strategies do you use? What could improve your job satisfaction?
Recruitment & employment practices
17 In what ways do you think managers can help to improve job satisfaction for staff during induction/employment process?
Other
18 Do you have any suggestions or other thoughts about job satisfaction within your workplace?

Interview Closure
- Opportunities for additional questions from the participant.
- Opportunity to retain any specific organisational documents relating to improving staff experiences and job satisfaction
- Thanks and termination of the interview.

APPENDIX THIRTEEN: DOCUMENT SUMMARY FORM

Title of study: Exploration of staff experiences and management practices focusing on improving job satisfaction, within care home settings.

Data description	Reason for collection	Findings	Code
HR policies	To gather information on whether the care home supports the workforce in terms of job satisfaction. This may demonstrate how the organisation develops its policies with this in mind, how it links with other stakeholder and its aims and focus when recruiting and employing staff.		
Care home guidance	To explore different guidance documents which may demonstrate how the care home intends to support staff on a daily basis, to fulfil their roles, opportunities and development needs.		
Care home mission statement	To gather information which may reflect the aims and focus of the intention of the care home, which may include how they intend to support and develop their staff.		
Statement of staff wellbeing	To gather information on the values and aims of the home and whether this includes improving the lives of their staff.		
Internal memos	This information may reflect how the care home may assist staff in increasing their job satisfaction.		
Other			

APPENDIX FOURTEEN: DATA CODES

Reverse codes (n=23)	In vivo codes (n=17)	Inductive codes (n=23)
• Perception that their home is better than others • rurality of the home • appreciated &valued • better rates of pay • career opportunities • current media negativity • extended clinical roles • approachable managers • higher rates of pay • incentive schemes • lack of recognition / under-valued • Environment & equipment • making changes • management courses • Management not acting • more time with residents • Peer support/ staff induction • Staff meetings • Statutory sickness pay • support from other agencies • Training • unhappiness with colleagues • wages too low	• consistency of care • better rates of pay • homely environment • issues not resolved • low wages • more time with residents • providing a homely home • too much paperwork • accepting the residents dying • exposure to residential care environments first • key workers • reasonableness • register for carers • residents wanting to leave • responding quickly to applicants • rurality of the home • wrongly placed residents	• accepting the residents dying • additional perks & help • difficult relationships with resident relatives • exposure to residential care environments first • impact of negativity on staff & residents • Key workers • lack of applicants • lack of confidentiality • national shortage of nurses • no desire to work in care industry • opportunities to trial the work • Perception that their home is better than others • promoting the Welsh language • reasonableness • Recruitment of younger workforce • register for carers • residents wanting to leave • responding quickly to applicants • rurality of the home • travel to work costs • upward movement of staff • weekly pay • wrongly placed residents

APPENDIX FIFTEEN: CODING FRAMEWORK

Framework Codes		Description
a. Job satisfaction		
a.1 Factors promoting job satisfaction	a.1.1 resident wellbeing	Feeling that staff are caring for residents and doing their best by them.
	a.1.2 resident relationships	Feeling closeness with the residents & building positive relationships
	a.1.3 feel supported both work and personal nature	Feeling managers are genuinely supportive of staff for both external & personal issues
	a.1.4 *'consistency of care'*	Long term residents help consistency of care & offers greater job satisfaction
	a.1.5 variety within the role	Variety in roles and daily patterns, shift patterns
	a.1.6 positive staff relationships / team working	Building of good positive working relationships & good team working with fellow colleagues
	a.1.7 Motivation / challenge/	Feeling motivated within the workplace helps drive them forward, with recognition of isolated RN role but it adds challenges to their post
	a.1.8 Self-satisfaction / achievement / pride	Feeling that you have achieved the best you can, proud to work in the home and keeping high standards
	a.1.9 attendance on training	Able to attend regular training
	a.1.10 Confidence	Increasing confidence
	a.1.11 location and size of the home	Location of the care home is close to their home. Size of the home impacts on satisfaction
	a.1.12'better rates of pay'	Better rates of pay in care home than NHS
	a.1.12appreciated &valued	Staff feel appreciated themselves & value the care staff role also
a.2 Factors causing job dissatisfaction	a.2.1 staff shortages	Lack of staff in the workplace causing workload demands and unhappiness
	a.2.2 Staff sickness	Staff sickness impacting on workload, feeling that sickness is not always genuine
	a.2.3 wages too low	Staff feel wages are too low & they must work long hours to get a decent wage
	a.2.4 lack of recognition / under-valued	Lack of recognition, understanding of the role & a lack of valuing the role and the additional hours they put in

	a.2.5 difficult relationships with resident relatives	High expectation from relatives & lack of recognition/ value of the staff roles
	a.2.6 unhappiness with colleagues	Colleagues which don't perform as expected by other colleagues
	a.2.7 changes to the role	Frequent role changes cause unhappiness within the workplace
	a.2.8 increasing workload demands on staff	Additional demands increasing, & are impacting on the role, making it harder
	a.2.9 *'accepting the residents dying'*	Ill or deteriorating residents can cause distress & unhappiness in role
	a.2.10 *'wrongly placed residents'*	Staff feel some residents are wrongly placed (maybe aggressive) & so feel they shouldn't be in the home
	a.2.11 Manager not taking action	The manager is too easy going and doesn't respond to the issues & difficulties often viewed as not strong enough and do not act when required
	a.2.12 *'residents wanting to leave'*	Some residents wish to leave the home
	a.2.13 environment and equipment	Difficulties and challenges with the local environment or equipment that may impact on job satisfaction
	a.2.14 lack of promotion opportunities	Lack of promotion opportunities
	a.2.15 responsibility of the role	Role responsibility can result in dissatisfaction, especially for the payments they receive
	a.2.16 manager on duty	Staff feel the job runs smoother when there is no manager on duty
	a.2.17 lack of confidentiality	Staff concerns over lack of confidentiality within the home
	a.2.18 reduced sense of achievement	Staff feel dissatisfied when they feel they haven't given sufficient care or done enough for their residents
	a.2.19 *'too much paperwork'*	Staff don't enjoy the large amount of paperwork involved with their post
a.3 Approaches to influence satisfaction	a.3.1 Training	Providing training for staff to motivate & develop along with essential requirements
	a.3.2 staff support	Opportunities for staff to have open door access to them for support to raise any issue home or work related

	a.3.3 staff working patterns	Improving staff working relationships & staff patterns of working to reduce dissatisfaction
a.4 Factors associated with staff intention to leave	a.4.1 current media negativity	Negativity reflecting staff & perception of them being part of the bad staffing - even this staff wouldn't leave the home or profession
	a.4.2 improving NHS pension	Some staff looking to retire are conscious of their pension input
	a.4.3 travel to work costs	Costs associated with traveling to work could cause staff to consider leaving
	a.4.4 'issues not resolved'	Staff would consider leaving if the managers did not sufficiently respond to their issues and concerns
	a.4.5 increasing demands & responsibility of the role	Responsibility of the role daily can add pressures to the role
b. Environmental		
b.1 Improving organisational systems	b.1.1 management processes and policies	Supportive organisation and management systems
	b.1.2 'reasonableness'	Managers are reasonable in terms of rotas, time off, meals, etc. which helps them keep staff – staff respond & offer extra help at times of needs.
	b.1.3 Approachable managers	Value of a flexible & approachable manager in helping to support job satisfaction
	b.1.4 developing strong teams	Developing team working will improve staff relationships & resident care. Develop a feeling of importance & strong team
	b.1.5 improving the managerial structures	Staff feel better structure is required to ensure changes are implemented
	b.1.6 being listened to	Staff feel being listened to is very important, even if they don't get their wanted answer
b.2 Improving organisational factors	b.2.1 Staff meetings	Effective communication and opportunities to raise and discuss issues
	b.2.2 working pattern s and workload	Develop rota/pattern systems to ensure fairness of workload & skill mix
	b.2.3 additional health benefits -	Some paid benefits - health insurance /other advice to external support i.e. counsellor
	b.2.4 appreciating and valuing staff	Staff feel valued and appreciated

	b.2.5 appraisals / supervisions	Staff feel an appraisal offers them an opportunity to progress.
b.3 Increasing organisational commitment	b.3.1 good reputation	Having a positive reputation encourages staff to stay in the care home
	b.3.2 'homely environment'	Keeping staff committed through a friendly and happy working environment
	b.3.3 happy & relaxed workforce	Relaxed, happy staff influence the care being provided & improving residents care, makes staff want to give something back to the home and stay
	b.3.4 additional perks & help	Managers often support their staff in other ways above & beyond routine expectations
	b.3.5 weekly pay	Providing weekly pay to enable staff to better manage their finances
c. Education, training and development		
c.1 Collaboration with educational providers	c.1.1 increasing training opportunities	Increasing access to all staff by introducing in-house training opportunities
	c.1.2 difficulties accessing providers	Delays and difficulties meaning collaboration is not as effective
c.2 Development of new career opportunities	c.2.1 career opportunities	New career opportunities for staff I
c.3 Introduction of staff supportive programmes	c.3.1 Peer support/ staff induction	Provided alongside mentorship/ supportive / shadowing opportunities
d. Partnership working and engagement		
d.1 Collective strategic approach	d.1.1 increasing LA care home payments	Increasing payments to the care home so that it impacts positively on the staffing financial rewards
d.2 Multi-agency approach	d.2.1 support from other agencies	Sufficient external networks which add support to the roles
e. Financial features		
e.1 Improving financial incentives	*e.1.1 'low wages'*	The need to increase wages to reflect the workload
	e.1.2 acceptance of wages	Acceptance that wages are low what they should be but don't leave
	e.1.3 Statutory sickness pay	Would prefer to get formal sick pay not just statutory benefit
	e.1.4 additional rewards	Extra wage increased following attainment of NVQs

	e.1.5 incentive schemes	Offering additional bonuses and incentives for staff
f. Staff roles and care practices		
f.1 Promotion of standardised practice	f.1.1 daily work rotas	Patterns & daily practices more formalised through rotas and daily actions
	f.1.2 extended clinical roles	Developing & performing clinical skills at more advanced levels than the norm
	f.1.3 '*key workers*'	Allocating key workers to residents may help improve care practices
	f.1.4 making changes	Ability to make changes and improvements to resident care/ Barriers to change improvements
f.2 Improving care practices	f.2.1 improving good practice	Ensuring good practice is shared & staff don't do what they've always done. Enabling different staff relationships to be built
	f.2.2 Training	Increasing knowledge through training which will improve care practices
	f.2.3 variety and skill mix	Extra staff would enable a greater skill mix which would promote improved care practices
	f.2.4 increasing resilience	Feeling that staff are able to cope better with training
	f.2.5 higher staffing	Staff feel that to increase resident activities can improve care practices
	f.2.6 '*more time with residents*'	Staff feel they often require more times with residents to enable them to improve care practices which gives them greater job satisfaction
f.3 Improving staff relationships with residents	f.3.1 awareness of their religious beliefs	awareness of their religious beliefs
g. Workforce and labour market		
g.1 Workforce planning and development	g.1.1 promoting the welsh language	Supporting staff in speaking Welsh & providing opportunities to learn the language
	g.1.2 Upward movement of staff	Staff will gain experience & skills and be ready to move onto better roles – need to capture these staff
	g.1.3 higher rates of pay	Higher rates of pay
	g.1.4 career pathway	Opportunities to develop with a formal career pathway
	g.1.5 developing the right workforce	Inherent desire to care for & look after residents

	g.1.6 recruitment of younger workforce	Promotion of younger staff into the care workforce
g.2 Increasing managerial support	g.2.1 developing new managerial skills	Opportunities to develop managerial skills for succession planning & to develop individual careers, especially inexperienced RNs
	g.2.2 attending manager's forums	Getting together, whereby other managers offer support
	g.2.3 management courses	Some courses valuable, some waste of time. Experience is essential.
g.3 Acknowledging UK recruitment	g.3.1 Lack of applicants	Insufficient care applications into the sector
	g.3.2 No desire to work in care industry	People who just either do not want to get a job or don't want to work in the caring sector
	g.3.3 national shortage of nurses	Lack of nurses nationally
g.4 Encouraging a national approach	g.4.1 reduce negative perception of the home	Offering a more positive insight into working in the care home sector
	g.4.2 acknowledgement of responsibility of the role	Improving the public's acknowledgement of the responsibility & difficulty of the role
	g.4.3 sustainability of the sector	Sustainability of the sector is a real concern
	g.4.4 lack of respect for staff	Lack of respect for carers & nurses, but mostly carers
g.5 Improving the status of care homes	g.5.1 positively promoting the sector	The need to reduce negativity of this sector to influence staff joining & reduce staff leaving/ To improve individual perception of roles /care industry
	g.5.2 Impact of negativity on staff & residents	The effect of the media attention, causing negativity & impacting on the role & how staff care for residents
h. Recruitment & employment practices		
h.1 Factors which influence existing staff stability	h.1.1 public negativity / perceptions	Negativity from public or media or in relation to the care sector.
	h.1.2 'rurality of the home'	Location of the home impacts on recruitment / job availability
	h.1.3 acceptance of the current situation	Staff just accept the flaws & issues of working within a home. Staff do not report any negative feelings towards the role

	h.1.4 Perception that their home is better than others	Staff believe that their care home may be better than others
	h.1.5 other offers of better terms / money	Potential locum / agency offers with better wages
h.2 Approaches to improving employment stability	h.2.1 additional payments	additional payments following training / on call retainer
	h.2.2 better wages	Improving wages would impact on recruitment into the care sector. Increasing the wages could increase recruitment
	h.2.3 *'providing a homely home'*	Providing an environment whereby staff do not want to leave
	h.2.4 supporting staff	Recognising staff difficulties & adapting their workload /shifts to support or offer advice
h.3 Improving hiring practices of new staff	h.3.1 Understanding of difficult role and workload	Understanding & appreciation of the hard role & the expected workload prior to starting
	h.3.2 family/ friends already in the care industry	Easier transition into the role as family already working in care home job
	h.3.3 work experience	Undertaking work experience often promotes staff to return to seek employment
	h.3.4 Actively promoting the role	Increasing the use of advertising & social media to recruit new staff
	h.3.5 clinical student placements	Offering student nurse placements can promote staff to seek future employment
	h.3.6 opportunities to trial the work	Positive opportunities to trial the work may encourage new staff
	h.3.7 *'exposure to residential care environments first'*	Exposure to non-nursing care environment to gain experience & knowledge.
	h.3.8 'responding quickly to applicants'	Staff need quick replies to applications otherwise they will move onto another care home
	h.3.9 overseas nurses	Recruiting overseas RNs
h.4 Promotion of safer recruitment practices	h.4.1 *'register for carers '*	Developing registers for care staff

APPENDIX SIXTEEN: CATEGORIES PER CASE

Case A	Case B	Case C	Case D
• Flexible, responsive managers • Treat residents as part of their own family • Motivated by training • Good working environment • Feel valued and appreciated • Increasing challenges of role • Need for better wages • Promoting future workforce	• Effective management systems • Part of the local community • Increasing challenges of the role • Improving wages • Feel supported • Developing the workforce • Awareness of negative public perceptions	• Positive staff and resident relationship • Need for better wages • Increasing demands of the role • Media negativity • Developing staff • Job enjoyment • Helpful managers • Good organisational structures	• Good teamwork • Developing local workforce • Need for better wages • Increasing challenges • Supportive managers • Poor understanding of the sector • Supportive structures and processes

APPENDIX SEVENTEEN: GOOD CLINICAL PRACTICE RESEARCH

NIHR CRN Workforce Development
Enabling learning and development in the Clinical Research Network

Certificate of Attendance

Angela Roberts

attended

Introduction to Good Clinical Practice (GCP): A practical guide to ethical and scientific quality standards in clinical research

on 13ᵗʰ September 2017

Sessions include:
1. The Value of Clinical Research and the role of NIHR CRN & Health and Care Research Wales
2. Introduction to research and the GCP standards
3. Preparing to deliver your study
4. Identifying and recruiting participants: Eligibility & Informed Consent
5. Data collection and ongoing study delivery
6. Safety reporting and Study closure

Including EU Directives, Medicines for Human Use (Clinical Trials) Regulations and the Department of Health Research Governance Framework for Health and Social Care, as applied to the conduct of Clinical Trials and other studies conducted in the NHS

This course is accredited by the CPD Certification Service (6.5 Hours) and the Royal College of Physicians (6 CPD points) *CPD Code: 112212*

Lynette Lane
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APPENDIX EIGHTEEN: NHS RESEARCH & DEVELOPMENT

**Email advising that NHS Research & Development permission
is not required for the study.**

Title of study: Exploration of staff experiences and management practices focusing on improving job satisfaction, within care home settings.

Hi Angela

If these staff are being recruited only through the care home (<u>which is independent</u> and not run by xHB) and your research is taking place on their premises (not xHB premises) then I think you can avoid obtaining R&D NHS permission (as XXX also concurred that day you were here in our office). However, if you want to use any of the services or premises of xHB or want to recruit through xHB channels/departments then you will need to obtain R&D NHS permission.

Kind regards

XXX XXX
Research Governance Officer
xHB

Appendix Nineteen: Memorandum of Understanding

(Version1 / 17 May 2016 / C002584)

THIS MEMORANDUM OF UNDERSTANDING is dated [insert] 2016

PARTIES: -

(1) **BANGOR UNIVERSITY** (registered charity number 1141565) of College Road, Bangor, Gwynedd, LL57 2DG ("Bangor"); and

(2) [INSERT].

EXCEPT FOR PARAGRAPHS 2 (CONFIDENTIALITY) AND 3 (FREEDOM OF INFORMATION), THE PROVISIONS OF THIS MEMORANDUM OF UNDERSTANDING ("MOU") SHALL NOT BE CONSIDERED A LEGAL AND BINDING DOCUMENT

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1. MAIN PROVISIONS

A study to explore staff experiences and management practices focusing on improving job satisfaction within care home settings

1.1 Both parties agree to co-operate in a research study exploring job satisfaction within the care home setting and what approaches support staff to keep them satisfied in their role.

1.2 Each party will share information with the other to help promote mutual understanding, and each will respect the confidentiality and intellectual ownership of this information.

1.3 Each party will seek to promote co-operation to mutual benefit, and will be responsible for its own actions and its own costs.

1.4 Each party will respect the name and high reputation of the other, and will consult with the other regarding any publicity or external reference to this programme of work.

1.5 If either party has concerns about any aspect of the research study, then they will raise it with the researcher Angela Roberts, the study supervisors Professor Jo Rycroft-Malone [j.rycroft-malone@bangor.ac.uk / 01248 383119], Dr Lynne Williams [hsse11@bangor.ac.uk /01248 383170], or in writing with the Head of School, Professor Christopher R. Burton [c.burton@bangor.ac.uk / 01248 382556].

1.6 Within the research, a range of study information or research data may be collected or held by either party. Both parties will ensure that all data collected will be securely stored in line with the Data Protection Act (1998). Confidentiality and anonymity for all participants is assured in all written reports and publications, and individual written consent will be sought prior to data collection.

1.7 Both parties will endeavour to exploit any commercial or scientific opportunities that emerge from this study. The intellectual property is as follows:

1.7.1 Any clinical, organisational or educational tools developed will become the academic property of Bangor University but will remain in use in the care home setting and subject to updating amendment as required.

1.7.2 The interpretation and any new products which emerge from the analysed data will become the property of the Bangor University research team.

1.7.3 Where the study has the potential for academic or professional publication during and after the lifetime of the programme of work, then publications will be pursued jointly by all parties. All parties have a right to veto publication where there is a **direct risk** that publication of descriptions of company products may be commercially disadvantageous.

2. CONFIDENTIALITY

2.1 The parties to this MOU agree that during the continuance of the negotiations for any future agreement and for a period of five (5) years thereafter it shall use all reasonable endeavours to ensure that any confidential information ("Confidential Information") received shall be treated with at least the same degree of care and discretion to avoid disclosure as the receiving party uses with its own confidential information, which it does not wish to disclose and shall not disclose the Confidential Information to any third party without the other party's prior consent.

2.2 Confidential Information shall mean all information in whatever form (being written, oral, visual, or electronic) relating to any party and its business, including, but not limited to material, whether technical, commercial, financial, or information relating to intellectual property or otherwise.

2.3 The undertaking above shall not apply to Confidential Information:

> (a) which, at the time of disclosure, has already been published or is otherwise in the public domain other than through breach of the terms of this MOU;

> (b) which, after disclosure to any party, is subsequently published or comes into the public domain by means other than an action or omission on the part of any of such party;

> (c) which a party can demonstrate was known to him or subsequently independently developed by him and not acquired as a result of this MOU;

> (d) is lawfully acquired from third parties who had a right to disclose it with no obligations of confidentiality to the other party; or

> (e) is required to be disclosed by applicable law or court order or by any party's regulatory body, which is empowered by Statute or Statutory Instrument, but only to the extent of such disclosure and the receiving party shall notify the disclosing party promptly of any such request.

2.4 Employees, agents, consultants, sub-contractors or otherwise engaged to work on or in relation to this MOU shall be subject to the principles of confidentiality no less than those as set out in this MOU.

2.5 No party to this MOU shall use the name of the other party in relation to any publicity without the prior written approval of the other party.

3. FREEDOM OF INFORMATION

3.1 The parties acknowledge that Bangor is subject to requirements under the Freedom of Information Act 2000 as amended from time to time ("FOIA") and Environmental Information Regulations 2004 ("EIR") and shall assist and cooperate with Bangor to enable Bangor to comply with any such information disclosure requirements.

3.2 Where Bangor receives a request to disclose any information that, under this MOU, is the other party's Confidential Information, it will notify the party and will consult with them. Such party shall respond to Bangor within 5 working days after receiving Bangor's notice of the request. In the event that the party fails to respond within the requisite period, Bangor reserves the right to disclose any such information it deems appropriate.

3.3 Bangor shall be responsible for determining at its absolute discretion whether the information is: -

☐ exempt from disclosure in accordance with the FOIA or EIR;

☐ to be disclosed in response to a request for information under the FOIA or EIR and in no event, shall the parties respond directly to a request for information unless expressly authorised to do so by Bangor;

3.4 The parties acknowledge that Bangor may be obliged under the FOIA or EIR to disclose information following consultation with them and having taken their views into account.

4. GENERAL

4.1 The provisions of this MOU shall be governed by the laws of England and Wales and the parties submit to the [exclusive/non-exclusive] jurisdiction of the English and Welsh courts.

4.2 Clauses 2 and 3 shall survive termination howsoever caused.

4.3 If any provision of this MOU shall be found by any court or administrative body of competent jurisdiction to be invalid or unenforceable in whole or part, such invalidity or unenforceability shall not affect the other part of the provision or the other provisions of this Agreement which shall remain in full force and effect.

4.4 The parties to this MOU do not intend that any of its terms will be enforceable by virtue of the Contracts (Rights of Third Parties) Act 1999 by any person not a party to it.

(1) Signed:

Print Name:

Title:

Date:

For and behalf of Bangor University

(2) Signed:

Print Name:

Title:

Date:

For and behalf of [insert]:

APPENDIX TWENTY: ESCALATION OF CONCERNS FLOWCHART

This framework is a procedure for the PhD student Angela Roberts to manage the escalation of concerns in the care homes.

```
┌─────────────────────────────────────┐
│ Identification of issue which        │
│ violates professional codes or care  │
│ home guidelines / policies. i.e.     │
│ unsafe practice                      │
└─────────────────────────────────────┘
                 │
          Suspend data collection
                 ↓
┌─────────────────────────────────────┐
│ Report concerns immediately to       │
│ the care home manager. Ensure        │
│ safety of the patients.              │
└─────────────────────────────────────┘
        ↙                         ↘
   Minor concern              Major concern
        ↓                          ↓
┌──────────────────────┐  ┌──────────────────────┐
│ Inform the manager   │  │ Inform the manager   │
│ Discuss with         │  │ Discuss with         │
│ supervisory team     │  │ supervisory team     │
│ - they will advise   │  │ - they will advise   │
│ as per University    │  │ as per University    │
│ procedures.          │  │ procedures.          │
└──────────────────────┘  └──────────────────────┘
   ↙ Resolved   ↘ Unresolved          │
   ↓              ↓                    ↓
┌──────────┐ ┌──────────────────┐ ┌──────────────────────┐
│ Re-open  │ │ If unresolved or │ │ Refer as appropriate │
│ study    │ │ student feels it │ │ to –                 │
│          │ │ cannot be        │ │ CSSIW                │
│          │ │ resolved or it   │→│ NMC                  │
│          │ │ cannot be        │ │ Local Authority      │
│          │ │ discussed with   │ │ Safeguarding team    │
│          │ │ manager          │ │ GP                   │
└──────────┘ └──────────────────┘ └──────────────────────┘
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APPENDIX TWENTY-ONE: WORKFORCE CHARACTERISTICS

Current workforce characteristics (per case)

Case (capacity)	Total staff	Management staff	Registered Nurses	Unregulated staff	Number of total care workforce	Other staff employed
A (52 beds)	61	2 managers 1 matron 2 administrators	8	35	44	6 kitchen staff 6 cleaners 1 maintenance man
B (27 beds)	45	1 nurse manager 1 deputy nurse manager	7	27	36	2 cooks 3 cleaners 1 laundry assistant 2 kitchen assistants 1 maintenance man
C (18 beds)	31	1 nurse manager 1 administrator support	5	15	21	2 cooks 1 kitchen assistant 1 activities person 2 cleaners 1 accounts person 2 maintenance men
D (23 beds)	42	1 nurse manager 1 deputy matron 1 administrator	7	22	31	2 cooks 1 kitchen staff 4 housekeepers 1 maintenance man 2 activity organisers

Workforce changes (2014-2017)

Case	Staff Group	Left	Employed	Comments
A	Manager	0	0	Manager >20 years
	RNs	2	2	1x taken on own residential home 1x disagreement
	Unregulated staff	12	10	3x nurse training 3 x change of role 2x moved to NHS -bank 2x domiciliary care 2x ill-health
B	Manager	0	0	Manager >30yrs
	RNs	3	2	2x retired 1x relocation (out of area)
	Unregulated staff	8	5 recruiting	4x retired 2x change of role 2x another care home – too far to travel Actively recruiting for carers
C	Manager	0	0	Manager > 9 years
	RNs	3	2	1x retired 1x moved to NHS 1x ill-health
	Unregulated staff	5	5	1 dismissed 1 change of role 3x ill-health
D	Manager	0	0	Manager > 5 years
	RNs	3	2 recruiting	1x relocation (out of area) 1x moved to NHS 1x disagreement
	Unregulated staff	3	4	1x relocation (out of area) 2x Change of role - redeployed in home

Staff turnover data per case (2014-2017)

Case	Left	Employed	Reason for leaving
A (52 beds)	14	12	1x taken on own residential home 1x disagreement 3x nurse training 3x change of role 2x moved to NHS - bank 2x domiciliary care 2x ill-health
B (27 beds)	11	7	6x retired 1x relocation (out of area) 2x change of role 2x another care home – too far to travel
C (18 beds)	8	7	1x retired 1x moved to NHS 4x ill-health 1 dismissed 1x change of career
D (23 beds)	6	6	2x relocation (out of area) 1x moved to NHS 1x disagreement 2x Change of role - redeployed in home

Turnover Rates per staff groups, all cases (2014-2017)

Staff group	Left	Employed
Managers	0	0
RNs	11	8
Unregulated staff	28	24

Length of Staff Employment (per case)

Cases	Less than 1 year	1-5 years	5-10 years	10-20 years	More than 20 years	More than 30 years
A	2	5		2	1	
B	3	3		2	1	1
C	1	2	3	3	1	
D	1	4		2	3	

Completed NVQ qualifications for unregulated staff (n=27)

Cases	No NVQ	NVQ Level 2	NVQ Level 3
A	2	0	4
B	1	2	4
C	0	5	2
D	0	1	6

APPENDIX TWENTY-TWO: SUMMARY OF DOCUMENT CONTENT

The staff-related documentation detailed mainly employment terms and conditions, policies and procedures, occupational screening and contractual obligations to meet quality and care standards for the residents. Most documents referred to employment procedures within the home and identified daily care practices and routines for staff. One document reported promotion of job satisfaction. Several documents reported the need for robust recruitment practices to ensure the selection of suitable staff.

Orientation and induction programmes identified expected learning and highlighted the need for ongoing training and development ensuring high standards of care were achieved. Training and ongoing development was reported in several documents, mainly in relation to ensuring care practices and standards maintained. Supervision and appraisals were identified with the need for staff to undertake competency assessment and linking to regular training. A summary of each individual document findings is reported in Appendix 20.

APPENDIX TWENTY-THREE: DOCUMENTATION FINDINGS

Code	Case A
Dsa1	The report found the home to be compliant with all care standards and no recommendations were made. Staff liked working in the home and the residents experienced warmth, attachment and feelings of belonging. Evidence of induction and ongoing training was seen with competent relaxed staff working towards national standards. When staff felt supported by management, they appeared able to cope with the workload demands.
Dsa2	This guide was written for resident purposes only and provided information relating to their care schedules, plan of care, activities and expectations when living in the home. It did include the philosophy of care and reflected the core values within the home. It recognised training and development for staff, including induction programme. Work practices report thorough screening and selection of new staff. It did report staff job satisfaction could be achieved through willing listening and resident friendship.
Dsa3	This was a formal employment handbook which reported on responsibilities, rules and policies within the home.
Dsa4	This formal document identified employment terms and conditions, provided guidance and direction to rules, regulations, and contractual information. It reported on staff induction and appraisal scheme.
Dsa5	It included an employment record, health and safety record and was a questionnaire format requiring staff personal information and occupational health data for completion.
Dsa6	This pack was to be used in conjunction with the training schedule to ensure progress was achieved. It identified a range of duties and instructions for care practices lining the carer to policies and regulations within the home.
Dsa7	A booklet which forms part of the carer induction programme, with competency assessments expected to be completed within 3 months of employment.
Dsa8	It was written to guide nursing staff through a programme of orientation and induction, which included information on the home structures and care practices. It included the philosophy of care and a philosophy of learning, which encouraged learning and development and for staff to reach their full potential. It reported supervision, appraisal, along with directing staff to duties, routines, regulations and policies within the home.
Dsa9	This booklet was a policy documents. It encouraged staff development according to national training standards.
Dsa10	This booklet identified policy statements within the home
Code	**Case B**
Dsb1	The report found the home achieved all areas of compliance with national standards. It was seen to be a warm and friendly home with recent environmental improvements. It reported staff attachments with residents but on occasions made more difficult due to low staffing numbers.

Code	Case C
Dsc1	This report found the home to be compliant with all care standards and no recommendations were made. It reported the home as a warm, friendly environment which supported good interaction between staff and residents, reflecting person centred care.
Dsc2	This document was provided to staff and was a supportive document to assist them attain standards of care practices, understanding, and achievement of a range of skills and knowledge. It was also a guidance document for trainer to ensure progress of learning objectives were achieved. It directed the staff to specific policies, daily structure and care practices and activities.
Dsc3	This guide was written for resident purposes only and provided information in relation to their care schedules, plan of care, activities, expectations when living within the home
Dsc4	This document provided clear instruction for staff as to daily workload and tasks throughout the day.
Code	**Case D**
Dsd1	The report recognised recruitment practices were robust ensuring safe recruitment of staff. It noted positive relationships between staff and residents and family involvement and values were upheld. It encouraged more regular staff supervisions but appreciated they occurred alongside staff meetings and access to training courses.
Dsd2	The framework sets out a common understanding to induction outlining the need for knowledge and competent workers and the requirement to demonstrate this within the first 12 weeks of employment. The 6 common modules with learning objectives underpin the principles and values of care. It encompasses the requirements of the role, identifies policies and procedures, reflects safety, communication and safeguarding. It acknowledges staff require support and supervision within their role, learning and development
Dsd3	This pack is provided to the workers and reflects all the learning aims and objectives and requirements of the national framework, with guidance for evidence to ensure completion and progress achieved.
Dsd4	This local home document reflects the elements within the national induction framework.
Dsd5	The booklet recognised the high standards required within the home and the need to develop skills and dedication through training and career development. It had a philosophy which recognised core values and the need to support staff through supervision and appraisal. It reported safe recruitment practices and selection of staff was performed, relation to safeguarding of residents. It clearly presented a variety of information for residents and relatives including a mission statement.