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Culturo-Linguistic Congruity in the Residential Care of the Elderly and Cognitively Impaired in North Wales

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Bangor University

Declaration

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.

Rwy'n cadarnhau fy mod yn cyflwyno'r gwaith gyda chytundeb fy Ngoruchwyliwr (Goruchwylwyr)

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.

I confirm that I am submitting the work with the agreement of my Supervisor(s)

Contents

Index of Figures

Index of Tables

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Dedication

This thesis is dedicated to the memory of my mamgu (grandmother), Mabel Jones. She was the kindest person I have ever known, and was always to be found smiling, despite considerable hardships that she endured in her lifetime. She was passionately Welsh, which was not at all fashionable in her youth, and this was passed on to her children and grand-children, to their great benefit. I saw her cognition deteriorate towards the end of her life, and realised the importance of her first language and culture to her at this time. I always think of her when working with the elderly, especially the Welsh, and she was at the forefront of my mind during this research. Cysga'n dda, Mamgu.

This work is also dedicated to the residents and staff of Homes A and B, without whom it would not have been possible. They bore me with good grace, humour and kindness, which I will never forget. Diolch i chi gyd.

My children, Gwilym, Kyffin and Mabli are the next generation of citizens of Wales, and the world. They are a never-ending source of joy to me, and I dedicate this work to their future - chi yw y byd!

Summary

Background: Despite the multitude of cultures and languages that co-exist across the world, and the increasing impact of the ageing population and dementia on societies, public services, and economies, there is a dearth of evidence on the subject of linguistic and cultural congruity in the care of people who live in care homes. This is particularly true in Wales, where 19% of the population speaks Welsh, varying significantly according to region.

Aim: To review the available relevant literature, and to subsequently investigate the well-being of Welsh-speaking residents with dementia in care homes, in relation to the culturo-linguistic congruity of the environment they were living in.

Design: Scoping review (paper 1), documentation search and multiple embedded case study (paper 2).

Data Sources: Published literature in English and Welsh between 1990 and 2016 from Medline, CINAHL and ASSIA, key journals and citation tracking.

Documentation search for national and local policies surrounding the issue of cultural and linguistic congruity in the care of older people in care homes at case study, regional and national levels.

Direct observational work at two care homes in North Wales, followed by semi-structured interviews with 6 each of residents, relatives, and carers in each home, as well as the manager in each home.

Results: The scoping review suggests that culturo-linguistic congruity is beneficial (and that its absence is detrimental) towards the well-being of people with dementia who live in care homes across the world. This appears to be due to the dementia process leading to a loss of familiarity with the person's second languages and cultures, with resulting communication and cultural barriers within the care environments. Where congruity is provided, the person experiences an improvement in the care experience and their well-being due to enhanced communication and cultural understanding, allowing appropriate care, social stimulation and happiness. The review also found a comparative lack of research in relation to culturo-linguistic congruity for people with dementia living in care homes, particularly for those who are first language Welsh.

The documentation search and case study found that a presence of linguistic congruity (and to a lesser extent, cultural congruity) are of great importance in the care and well-being of first language Welsh residents with dementia living in care homes, by facilitating *Homeliness and Familiarity*, *Appropriate Care and Understanding*, *Happiness and Calm*, and *Social Stimulation*.

By providing congruity, a care home may be allowing an older, cognitively impaired resident continued access to a homely, safe place in their own biopsychosocial structure. This, in turn, may provide a frail individual with the baseline well-being needed to navigate their lives. It was also found that a lack of linguistic congruity for these residents poses significant detriment to their well-being. Providing culturo-linguistic congruity is challenging for care homes, mainly due to logistical problems such as training and workforce issues.

Conclusion: These findings should form the foundation of future discussion regarding the care of frail, elderly people in relation to language and culture, especially in Wales. At international, national, regional and local levels, the following should occur: the mapping of capacity and gaps in the provision of congruity; recruitment of culturo-linguistically competent carers; and relevant culturo-linguistic competency training. Research also needs to occur at these levels, particularly to understand the attitudes towards these requirements, as well as social care workforce studies of the prevalence and training of culturo-linguistic competencies. In Wales, a priority should be to urgently ensure the provision of at least one member of staff on each shift, who is culturo-linguistically competent for residents in care homes whose first language is Welsh.

Keywords: Care Homes; Congruity; Culture; Dementia; Language; Well-being; Welsh; Wales; United Kingdom.

Chapter One

Introduction and Policy Background

In the short film, 'Cân i Emrys' [A Song for Emrys] (Williams, Roberts, and Williams, 2013), the elderly residents of a care home in North Wales receive a visit from a harpist as part of their activities programme. The viewers are introduced to a resident named Emrys, who has Parkinson's disease and is cognitively impaired. When the harpist first visited the home, she was told that he didn't 'hear anything, and does nothing but sleep'. She plays a familiar Welsh song from his childhood on the harp, evoking in him strong emotions - at one point crying, and at another laughing and clapping his hands.

Quantitative research, with its p-values and confidence intervals, sample sizes and odds ratios, is often used to guide health and social care practice and policy. However, the complex and subjective concept of well-being, which is the main focus of this thesis, is not easily measured (Cooke, Melchet, Timothy, and Connor, 2016), and may be explored more effectively by using the methods seen in qualitative research. This exploration, in turn, may discover ways to improve the well-being of those who have dementia, many of whom are the 'oldest old', as described by Poon and Cohen-Mansfield (2011, p.3).

'Cân i Emrys' is important for two reasons: it shows that qualitative methods can reveal nuances previously unexplored in the understanding of well-being in the elderly and cognitively impaired; it also illuminates the importance of culture and language to such people. In relation to the Welsh-speaking people living in North Wales, this is an issue that has hitherto been virtually unexplored (see Chapter 2).

1.1 Dementia, Language and Culture

The number of people living with dementia worldwide is currently estimated at 47.5 million, and is projected to increase to 75.6 million by 2030, and to more than triple by 2050 (Wortmann, 2012). There are 850,000 people with dementia in the UK, and there are expected to be over a million by 2025. The financial cost of dementia to the UK is estimated to be £26 billion per year, whilst two-thirds of people living in

care homes have a form of dementia (Prince et al. 2014). For these individuals, the loss of language skills is one of the most common and challenging aspects of their condition (Cummings, Benson, Hill, and Read, 1985). Word-finding difficulty is often among the first presenting abnormalities in dementia, followed by decreased verbal fluency, naming, and comprehension (Cummings et al. 1985). For those individuals with dementia who are bilingual, the difficulties may be more complex - there may be difficulty in maintaining fluency in more than one language, with additional problems due to the effects of cross-language interference (Hyltenstam and Obler, 1989).

Mendez, Perryman, Pontón, and Cummings (1999) surveyed people with moderate cognitive impairment in the USA, whose first language was Spanish. Participants had a consistent preference for Spanish rather than their second language, English, with cross-language interference evident such that Spanish words and phrases emerged when speaking English. Anecdotally, people with dementia are often described as having a tendency to return to their first language, but a literature review by Stilwell, Dow, Lamers, and Woods (2016) identified a number of studies reporting that on testing, both dominant and non-dominant languages are affected to the same degree by dementia. They concluded that the research, to date, is inconclusive regarding the question of whether Alzheimer's disease affects one language of a bilingual to a greater extent than the other.

The principle of linguistic relativity holds that the structure of a language affects its speakers' world view or cognition, with linguistic categories and usage influencing thought and decisions (Lucy, 1997). In the German language, the word *sprachgefühl*, meaning 'language-feeling' ("Sprachgefühl" 2020), refers to not only the character of a language, but also the notion that 'each language has its own personality […] which limits its speakers to a certain mode of thought'.

Language therefore overlaps heavily with culture, but aspects of culture that are independent of language (such as religion, traditional customs and food) also affect experiences of dementia, since they represent the familiar values, norms and beliefs shared by a particular group, and can persist into the dementia process (Cox, 2007). If a person lives in their 'second' culture (for example, as an immigrant) and develops dementia, are they affected differently to a person indigenous to that culture? How do those who care for them perceive this issue? What if the carers

themselves are living in their second culture - does this have implications for the caregiving experience?

1.2 Well-being in dementia, in the context of language and culture

Cognitive Vitality can be defined as the successful application of cognitive skills in one's everyday environment (Poon and Cohen-Mansfield, 2011). Although one may have low cognitive functioning (such as in dementia), high cognitive vitality may still allow successful navigation of one's environment, and thus lead to a 'successful' dementia and higher well-being. It is thought that cognitive vitality may also help buffer future decline (Poon and Cohen-Mansfield, 2011).

Lack of engagement with a social network is an independent risk factor for cognitive decline. Environmental stimulation increases synaptogenesis, neurogenesis and capillary formation in animal studies (Eriksson et al. 1998). If a person with dementia is less able to have social interactions in their immediate surroundings, then it may follow that their cognitive vitality and well-being is at risk. If a person with dementia has lost some of their ability to interact in their second language, and immediate social and task interactions are carried out in that language, what implications does this carry for overall well-being?

1.3 Formal care-giving in dementia, in the context of well-being, language and culture

Relatively little research has been done in these specific areas, especially in the UK. Daker-White, Beattie, Gilliard, and Means' review (2002) examined cultural, ethnic, racial and linguistic diversity in the context of dementia and its relevant care settings. They found that in ethnically diverse groups, varying ability in the English language affected cognitive assessment and the subsequent diagnosis of dementia. Botsford, Clarke, and Gibb (2011) highlighted that further research needs to be done in this area after concluding that different cultural identities do indeed appear to account for differences in experiences of dementia and care-giving. Of note is the fact that they did not include different indigenous cultural identities within the UK (e.g. English, Welsh, Scottish, and Northern Irish) in their review.

Heikkilä, Sarvimäki, and Ekman (2007) examined culturally congruent care in a Finnish care home in Sweden. Both residents and staff had Finnish backgrounds, and therefore the Finnish language, customs, celebrations, and popular culture were used to create a common ground for communication and shared understanding of the individual person. The home claimed that this enabled caring relationships, which, in turn, increased the residents' well-being.

A qualitative study by Söderman and Rosendahl (2016) investigated the experiences of a mix of Finnish and non-Finnish-speaking carers in a nursing home in Sweden, with Finnish-speaking immigrants as residents. The Swedish (non-Finnish) speakers could provide satisfactory and equitable care, but observations showed that the challenge was greater for them than for the bilingual nursing staff who spoke the same language as the residents.

1.4 The Welsh language, culture and dementia

Of specific interest is this issue applied to the linguistic and cultural minority of Welsh speakers in Wales. The author regularly encounters the problem of providing equitable care for first language speakers of Welsh in our clinical work, in an area of mostly Welsh-speaking people. According to the National Census of 2011, 19% of Wales' population speaks Welsh, fluctuating significantly according to region (for example, in Gwynedd, over 60% of the population speaks Welsh, whereas in Monmouthshire, less than 10%). Of the 44,000 people with dementia estimated to be living in Wales (Alzheimer's Society, 2015), around 8,000 would therefore be Welsh-speaking, with 5,000 living in care homes (Prince et al. 2014).

In the passing of the Welsh Language Act of 1993, concrete duties were placed upon public bodies to provide for Welsh speakers. Every public body providing services to the public in Wales are since legally obliged to prepare a scheme setting out how it will provide those services in Welsh. Since the Act came into force, the range of Welsh public bodies that have sought to provide services in Welsh has increased, but the lack of opportunities to use the Welsh language continues to be reported in a range of health and social care contexts. The Welsh Language Measure of 2011 modernised the legal framework regarding the use of the Welsh language in the delivery of public services, and established the office of the Welsh

Language Commissioner, to work towards ensuring that the Welsh language is treated no less favourably than the English language.

Despite this, a report by the Welsh Language Commissioner in 2014 found that Welsh speakers and their families experience problems in accessing healthcare services appropriate to their needs, due to their status as minority language speakers. One individual said: 'When I have to go to see the English doctor at the surgery, I feel I'm speaking awkwardly with him or her, and it's very difficult to explain clearly how I feel' (p.39). This and numerous other examples are clear indicators of the potentially adverse effect of linguistic incongruity on healthcare, and in Wales this issue remains a largely unexplored issue in the literature, especially in regards to dementia.

1.5 Implications for this research

This introduction demonstrates where further work could be done in these fields. The next step illustrates a comprehensive literature review of the work already done on this specific subject. This literature review subsequently revealed the areas and manner in which to carry out original empirical work on the well-being of Welsh-speakers with dementia in care homes, in relation to the congruity of language and culture in those environments.

Chapter Two

Literature Review

This review has been published as: Martin, C., Woods, B., & Williams, S. (2018). Language and culture in the caregiving of people with dementia in care homes - what are the implications for well-being? A scoping review with a Welsh perspective. Journal of Cross-cultural Gerontology, 34(1), 67-114. https://doi.org/10.1007/s10823-018-9361-9

2.1 Introduction

As explained in chapter 1, the starting point for identifying what kind of empirical research could be done in the area of well-being, dementia, language and culture was to establish what work had already been done on this subject. Before embarking on such a review, it was essential to choose between carrying out a *systematic* or a *scoping review.*

2.2 Systematic vs Scoping Review

Arksey and O'Malley (2005, p.20) state that a whilst a systematic review might typically focus on a *well defined question* where 'appropriate study designs can be identified in advance', a scoping study tends to address *broader topics* where 'many different study designs might be applicable.' Furthermore, the systematic review aims to 'provide answers to questions from a relatively narrow range of quality assessed studies', whilst a scoping study is 'less likely to seek to address very specific research questions nor, consequently, to assess the quality of included studies'. To consider the subject in question, the nature of the topic appeared broad rather than narrow, by including all types of dementia, all languages and all cultures, (whilst also considering Welsh language and culture in relation to dementia in its own right), and many ranges of care settings.

There would clearly be limited feasibility of conducting a focused, systematic review on such a broad topic. A systematic review demands that the research question addresses one narrow topic only, and will allow for studies of certain designs and quality. It is therefore, by nature, exclusive, in that the onus of the literature review is on *excluding* studies from its remit. A scoping review, on the other hand, allows for

studies of various designs and quality to be included, and is by nature, therefore, *inclusive.*

For the purposes of gathering useful information about the subject in question, the scoping method was chosen to allow a more thorough exploration of the topics, without limiting the review to strict parameters. Additionally, it would enable a more in-depth examination of the (predicted to be minimal) literature available on the subject. It would also allow for analysis of diverse circumstances, e.g. the experiences of a foreign caregiver in a native area.

The final advantage of using a scoping method for the literature review was that the manner in which themes eventually emerge (see section 2.5, 'Data Extraction and Analysis', below) is a natural fit for a method to generate the framework and questions for the qualitative empirical work - instructing observation and semi-structured interview schedules, as well as directing the queries required from a documentation search.

2.3 Approach and Strategy

Our protocol was developed using the scoping review methodological framework proposed by Arksey and O' Malley (2005) and further refined by the Joanna Briggs Institute (2015). A preliminary search for existing scoping reviews on the topic was conducted, and found that none had addressed the issue of language and culture in the caregiving of people with dementia. There were no studies that had investigated the possibility of impaired well-being due to decreased linguistic and cultural congruity in the care of Welsh-speaking people with dementia. Accordingly, we aimed to survey the world-wide literature to identify research which could be extrapolated to the specific context of Wales, but which would be relevant to bilingual people with dementia in many countries. Our objective was to complete a scoping review within the healthcare context to answer the following question:

> 'What is known from the existing literature about culture and language in relation to caregiving of residents with dementia in care homes, and the implications therein for the residents' well-being?'

This was further broken down to these three questions:

1. What is known from the existing literature about culture and well-being in the caregiving of care home residents with dementia?
2. What is known from the existing literature about language and well-being in the caregiving of care home residents with dementia?
3. What is known from the existing literature about the Welsh language and culture, in the context of healthcare provision and caregiving for people with dementia and older people, and what implications are there for their well-being?

2.4 Search strategy and criteria

The inclusion criteria were developed using the PEO (Population, Exposure, Outcome) format seen in Table 2.1, as prescribed by Bettany-Saltikov (2016):

Table 2.1: Development of Inclusion Criteria using PEO format

PEO Format	Questions 1 & 2	Question 3
Population & Problems	Older people with dementia living in care homes who are multicultural/linguistic; Relatives of residents; Carers in this setting.	Older people whose first language is Welsh +/- have dementia in the healthcare or general care setting; Relatives of residents; Carers in this setting.
Exposure	Different cultural/linguistic environment	Healthcare/General care provision in a Welsh language environment
Outcome or themes	Experiences, wellbeing, less challenging/perceived better caregiving	Experiences, wellbeing, less challenging/perceived better caregiving

Each question was treated separately and the data collated together after collection:

Questions 1 (culture, dementia, caregiving and well-being), and Question 2 (language, dementia, caregiving and well-being):

We included all types of literature that addressed older people with dementia living in care homes who are multicultural and/or multilingual, and the involvement of

caregiving in this context, specifically including an interest in the cultural and/or linguistic environments and the experiences and well-being of residents, as well as the challenges of caregiving that can arise in these circumstances.

Question 3 (Welsh language and culture, dementia and elderly people, healthcare provision and caregiving and well-being)

We included all types of literature that addressed the well-being of older people whose first language is Welsh, in the setting of healthcare or general care provision, specifically including an interest in the linguistic environment - Welsh or English as comparators.

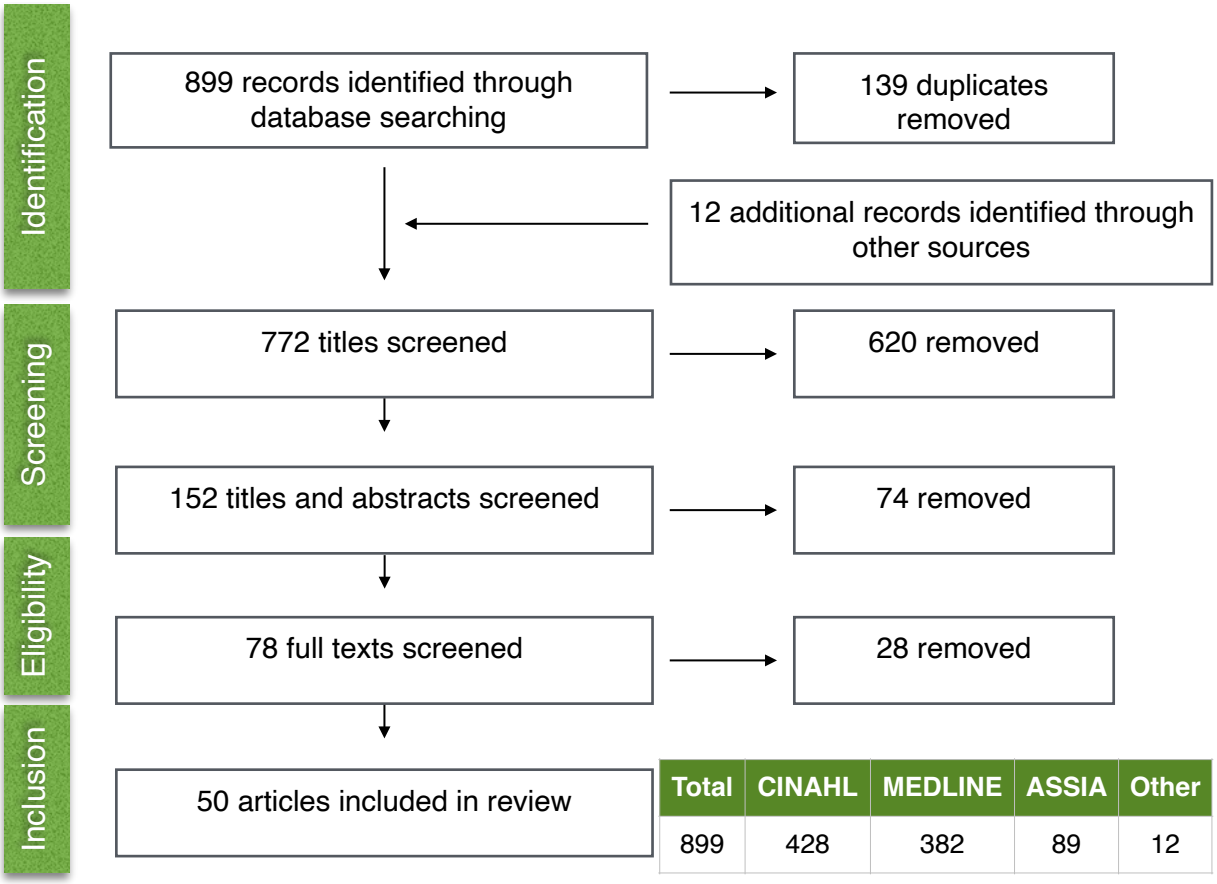
Studies addressing 'Culture of Care' or the 'Organizational Culture' of dementia, language impairment or language function in dementia, the care outside of a care home/healthcare provision setting (e.g. family caregivers at home), cognitive assessment, and access to care rather than the 'care experience' itself were all excluded from questions 1 and 2 as being irrelevant to the matter of interest. The care outside of a care home/healthcare provision setting (e.g. family caregivers at home), and access to care, however, were included in question 3 to attain reviewable literature in this narrow field.

The first step (see figure 2.1, below, for overall search strategy) was an initial limited search of two online databases, Medical Literature Analysis and Retrieval System Online (MEDLINE) and Cumulated Index to Nursing and Allied Health Literature (CINAHL). All types of literature were acceptable for consideration of inclusion in this review. This initial search was then followed by an analysis of the text words contained in the title and abstract of retrieved papers, and of the index terms used to describe the articles. A second search using all identified keywords and index terms was then undertaken across all included databases, which were Medline, CINAHL and Applied Social Sciences Index and Abstracts (ASSIA). Thirdly, the reference list of all identified reports and articles was searched for additional studies.

Studies included had to be reported in English or Welsh, and the timeframe of 1990 to 2016 was chosen to ensure representation of more modern care settings. The year 1990 also coincides with the NHS and Community Care Act (1990), which redefined the provision of care for vulnerable adults in the community in the UK. The

final number of articles included in the review was fifty. For the search terms used for each question, please refer to Table 2.2.

Figure 2.1: Scoping Review Search Strategy



Total	CINAHL	MEDLINE	ASSIA	Other
899	428	382	89	12

Table 2.2: Search terms for Scoping Review

Question	Search terms
Question 1 (Culture)	1. Culture OR Ethnicity AND Dementia OR Alzheimer's AND Care Homes OR Residential Homes OR Nursing Homes 2. Culture OR Ethnicity AND Dementia OR Alzheimer's AND Language 3. Culture OR Ethnicity AND Dementia OR Alzheimer's AND Caregiving
Question 2 (Language)	1. Bilingual AND Dementia OR Alzheimer's AND Care 2. Language AND Dementia OR Alzheimer's AND Care Homes OR Residential Homes OR Nursing Homes 3. Bilingual AND Dementia OR Alzheimer's AND Care Homes OR Residential Homes OR Nursing Homes 4. Person Centred Care AND Dementia OR Alzheimer's AND Language
Question 3 (Welsh language)	1. Welsh Language AND Care

2.5 Data extraction and thematic analysis

The data was extracted to a table (see Table 2.3) according to Ritchie and Spencer's method of qualitative data analysis (2002). The charting approach is akin to a 'narrative review', which takes a broader view that can include, for example, recording information about the 'process' of each programme or intervention included in the review so that its 'outcome' is contextualised and more understandable to readers. The technique for synthesising and interpreting qualitative data includes sifting, charting and sorting material according to key issues and themes, and initially charts the following data: Author; Literature Type; Aims/Purpose; Study size, Population and Location; Methodology and Intervention; Outcomes; Key Findings; and Relevant Comments to the Scoping Review (see Table 2.3).

This was done, then reviewed and refined twice. The chart was imported into the Atlas.ti™ software which had been pre-loaded with data codes (see Figures 2.2-2.4) as per Miles and Huberman's methodology of qualitative data analysis (1994).

The data was then coded for areas of relevance to the scoping review and reviewed twice. Codes were grouped into families (see Figure 2.5) and weighted according to the frequency of their appearing throughout the literature. Themes were therefore identified by the weight of each data group family, and the sub-themes were identified in the same fashion. These were mapped out, and are discussed under their respective headings, in section 2.6.

2.6 Results

This scoping review found that the presence of cultural and linguistic congruity was generally perceived as beneficial for persons with dementia (PWD) who live in care homes, and that their absence was perceived as detrimental. The full results can be viewed in Table 2.3.

Figure 2.2: Coding Guide, Cultural Congruity, Literature Review

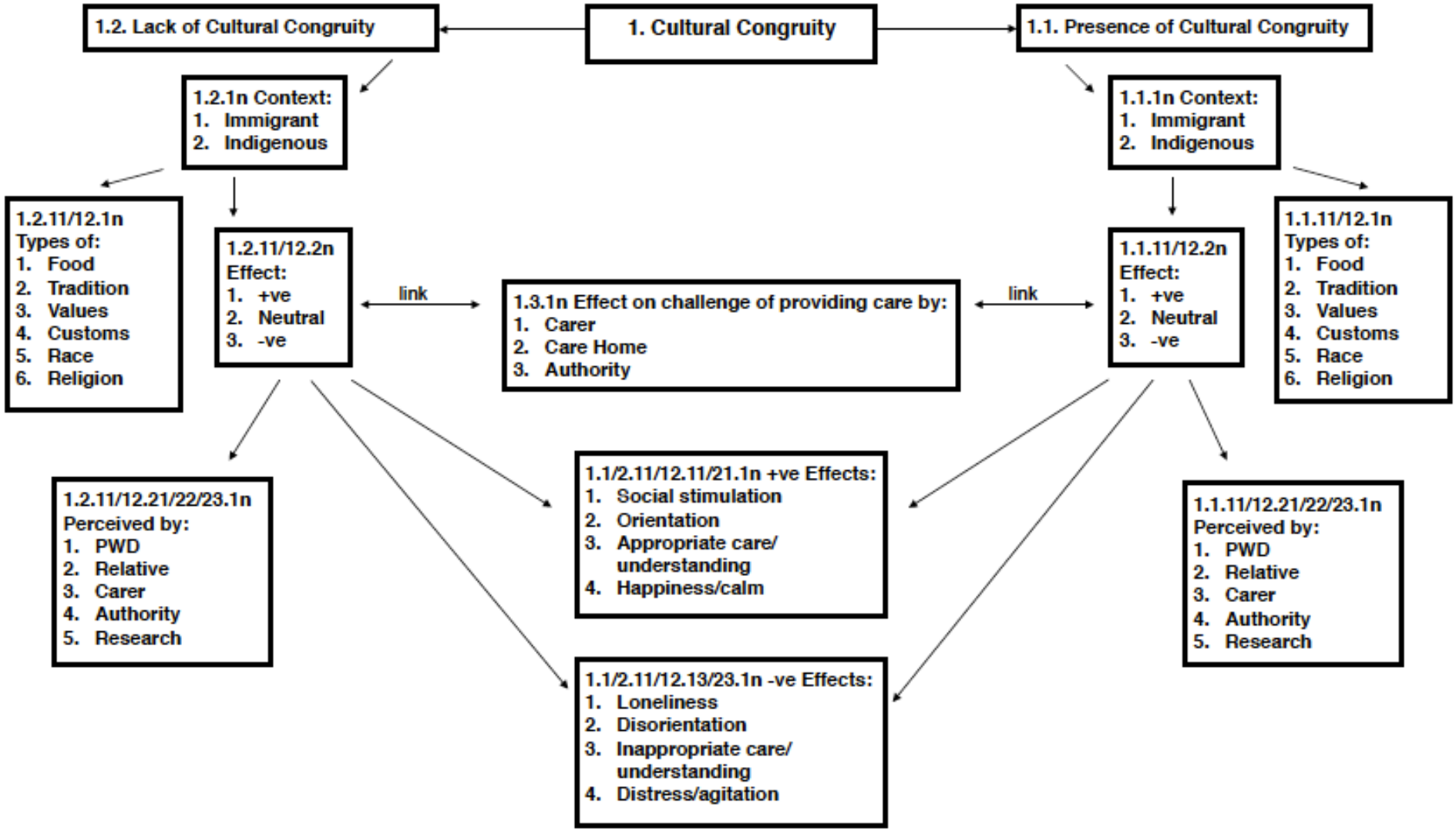


Figure 2.3: Coding Guide, Linguistic Congruity, Literature Review

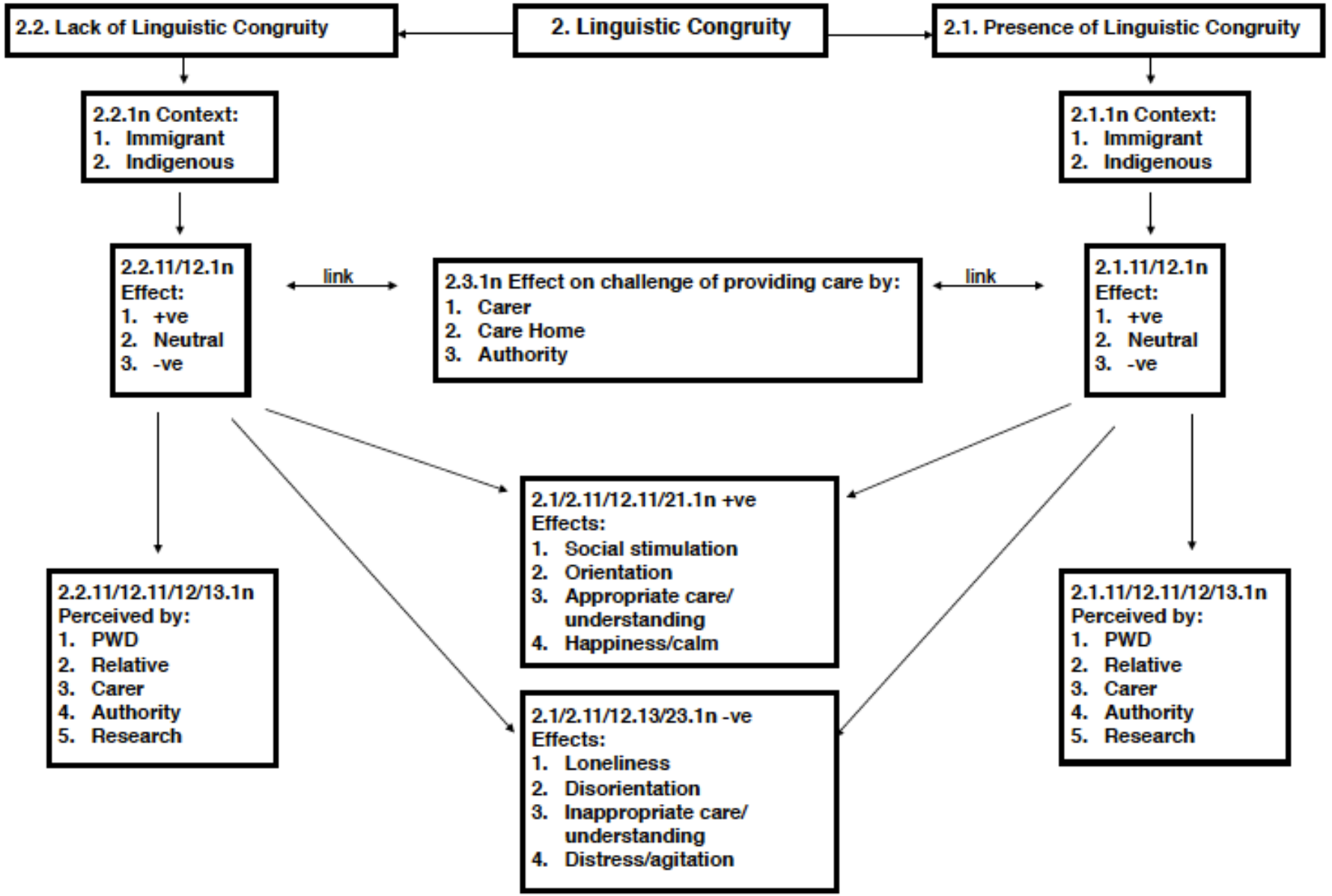


Figure 2.4: Coding Guide, Welsh Language Congruity, Literature Review

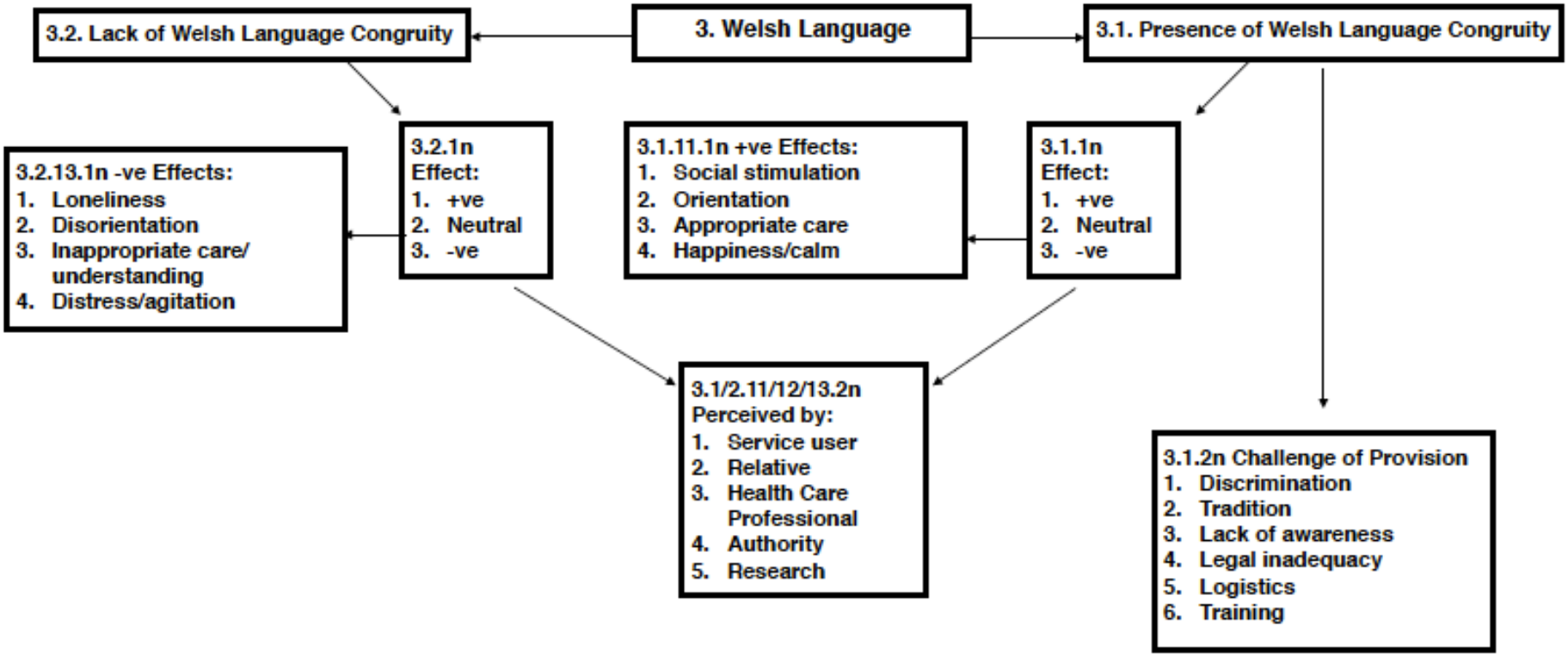


Figure 2.5: Example of Data Code families on Atlas.ti software, and their weighting in thematic analysis according to the frequency of their appearing in literature

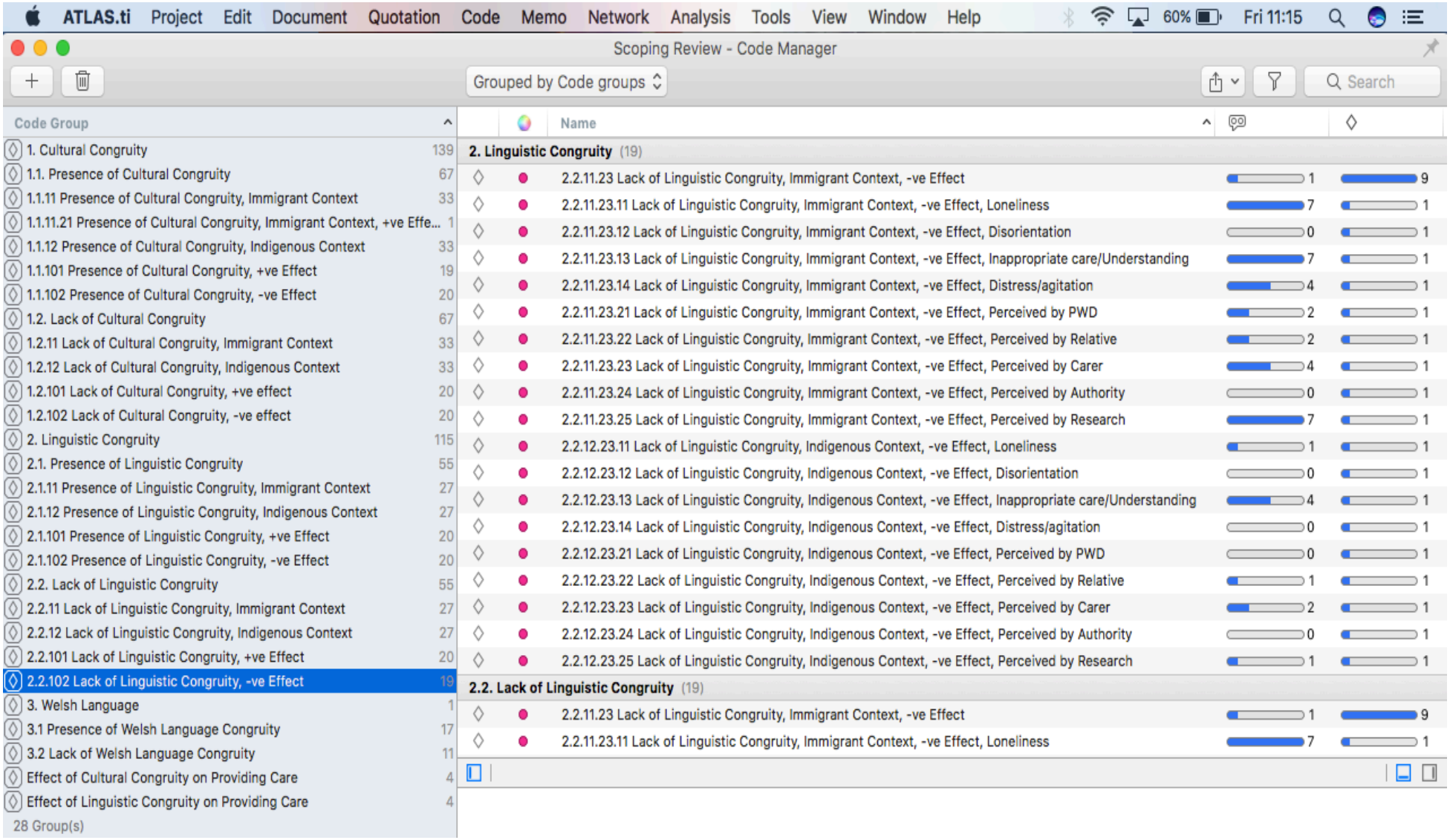


Table 2.3: Data Extraction and Charting from Included Literature

#	Author / Ref / URL	Type of Literature	Aims/purpose; Question addressed	Study population, sample size (if applicable), and location	Methodology; Intervention (if any); comparator (if any)	Outcomes	Key findings	Relevant comments
1	Wu, H. Z. Y., Low, L., Xiao, S., & Brodaty, H. (2009). A pilot study of differences in behavioral and psychological symptoms of dementia in nursing home residents in sydney and shanghai. International Psychogeriatrics / IPA, 21(3), 476-484. doi: 10.1017/ S1041610209008643	Quantitiative Research	To increase understanding of the effects of culture on behavioural and psychological symptoms of dementia (BPSD) by comparing the rates of BPSD in nursing home residents across three residential facility types; Culture	1. Mainstream nursing homes in Sydney; 2. Ethno-specific Chinese nursing homes in Sydney; and 3. A long-term high care facility in Shanghai known as a dementia hospital. N = 149, and their caregivers Australia, China	The rates and levels of BPSD were assessed by interviewing staff with the Neuropsychiatric Inventory-Nursing Home Version (NPI-NH). Clinical interviews using the Mini-mental State Examination (MMSE) and Global Deterioration Scale (GDS) were conducted with residents to assess dementia severity; 1. Geographical location 2. Cultural congruence	The mean NPI-NH total score for the sample was 28.5 with no significant differences across the three facility types. Comparison of subscales showed residents from the ethno-specific Chinese facilities had lower rates of hallucinations than Shanghai residents, but no differences from those in mainstream facilities. Shanghai residents had lower frequencies of disinhibition and irritability than ethno-specific Chinese residents, but no differences with mainstream residents.	The prevalence of BPSD does not differ among nursing home populations of different cultural backgrounds. Longitudinal community studies among different cultural groups would better elucidate the effects of culture on BPSD at different stages of dementia.	Cultural congruence and/or geographical location did not improve an element of well being, in this case behavioural and psychological symptoms of dementia. It was felt that a further research was needed with a different study design (longitudinal community studies)

#	Author / Ref / URL	Type of Literature	Aims/purpose; Question addressed	Study population, sample size (if applicable), and location	Methodology; Intervention (if any); comparator (if any)	Outcomes	Key findings	Relevant comments
2	Skomakerstuen Ødbehr, L., Kvigne, K., Hauge, S., & Danbolt, L. J. (2015). A qualitative study of nurses' attitudes towards' and accommodations of patients' expressions of religiosity and faith in dementia care. Journal of Advanced Nursing, 71(2), 359-369. doi: 10.1111/jan.12500	Qualitative research	To investigate nurses' attitudes towards and accommodations of patients' expressions of religiosity and faith in dementia care Culture	Nurses and carers in 4 nursing homes N = 31 (16 nurses, 15 care workers) Norway	Eight focus group interviews with 16 nurses and 15 care workers in four Norwegian nursing homes	Three themes identified: 1. Embarrassment in openly considering residents' religiosity and faith, and the perception that this was a private matter for the resident; 2. Varying familiarity with different religious practices ('known' and 'unknown'); 3. Difficulty in discussing death and therefore a focus on life and quality of life	Nurses and care workers were uncertain and lacked knowledge of the patients' expressions of religiosity and faith. Nurses struggled with ambivalent feelings about patients' religious expressions and did not clearly understand of the significance of religiosity. These challenges compromised person-centred and holistic care	Cultural congruence (in this case religiosity), and therefore care, was compromised by staff's unfamiliarity with this aspect of culture. Suggests well being could be affected

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3	Davis, B. H., & Smith, M. K. (2013). Developing culturally diverse direct caregivers for care work with older adults: Challenges and potential strategies. Journal of Continuing Education in Nursing, 44(1), 22-30. doi: 10.3928/00220124-20121101-54	Literature review	To examines three cultural factors that underlie challenges for nursing educators and supervisors in dementia care who oversee direct care workers: 1. The effect of immigrant cultures and languages; 2. The effect of different intergenerational cultural constructs; and 3. The effect of culturally derived attitudes about aging and dementia Culture; Language	Unspecified USA	Review of selective literature and comment	1. A significant proportion of caregivers are from a non-English speaking background which may impair ability to understand workplace English; 2. Inter-generational cultural differences may foster workplace dissatisfaction and ageism 3. Culturally derived attitudes about dementia may present barriers to providing good care for residents	1. The care of U.S. patients with dementia requires an increasing number of direct care workers; 2. Training for direct care workers needs to include training in language, print literacy, and health literacy; 3. Retaining direct care workers means understanding cultural attitudes toward dementia and age cohort attitudes toward work.	Caregivers made errors in following directions for giving medications due to inadequate dominant language (English) skills; Culturally derived attitudes (e.g. ‘Chinese families tend to stigmatize dementia and emphasize filial piety’) may be inappropriate in the dominant (American) culture’s care setting

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4	Palese, A., Oliverio, F., Girardo, M. F., Fabbro, E., & Saiani, L. (2004). Difficulties and workload of foreign caregivers: A descriptive analysis. Diversity in Health & Social Care, 1(1), 31-38.	Qualitative research	To identify the cultural issues involved, the type and the amount of caregiving done by women from Eastern Europe working as carers in Italy ('badanti'), and their educational/ information needs; Culture; Language	Women from Eastern Europe working as carers ('badanti') of elderly and disabled people in Italy N = 50 Italy	An anonymous questionnaire was administered as an interview lasting between 40 minutes and one hour. Each interview took place at a time and in a place chosen by the caregiver	A range of difficulties were encountered such as homesickness, communication difficulties and fear of not knowing how to do things correctly. None had problems with cultural or religious differences between their home country and Italy	Foreign careworkers have a central role in maintaining elderly people in their homes. They have the same functions as family and formal caregivers, the same workload and the added burden of emotional isolation and loneliness in daily care	Foreign caregivers from a different culture did not identify any problematic cultural differences from their point of view. Would their clients agree? 40% found difficulty in communication at the beginning of their job. Could impair caregiving and clients' well being? Not discussed in detail

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5	Bentwich, M. E., Dickman, N., & Oberman, A. (2017). Dignity and autonomy in the care for patients with dementia: Differences among formal caretakers of varied cultural backgrounds and their meaning. Archives of Gerontology and Geriatrics, 70, 19-27. doi:// dx.doi.org/10.1016/ j.archger. 2016.12.003	Quantitiative Research	To trace any substantial gaps between formal caregivers from different cultural groups regarding their stances on the human dignity and autonomy of patients with dementia, as well as understand the meaning of these gaps; Culture	Caregivers from different cultural backgrounds (Israeli born Jews, Israeli Arabs and migrants from Russia) N = 197 Israel	Quantitative analysis utilizing structured self-report questionnaires Cultural background of caregiver	In nursing homes, substantial differences were found in the attitudes to human dignity and autonomy of patients with dementia between Russian and Israeli Arab as well as Israeli Jewish caretakers. In the hospital, there was no influence for the ethno-culture variable on dignity or autonomy	Significant differences were found between certain ethno-cultural groups (Arabs and Russians) regarding their stance towards the dignity of patients with dementia. Arab caretakers hold a conception of dignity and autonomy that resonates strongly with person-centered care and outweighs institutional settings as well as may be related to the fostering of virtues.	Cultural values significantly affected attitudes towards dementia in nursing homes only. Cultural congruence was not measured but Israeli Arabs are presumed to be Muslim in this context, caring for Jews, and yet still displaying the attitudes that will strongly contribute to well being of the residents

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6	Abrahamson, K., Pillemer, K., Sechrist, J., & Suitor, J. (2011). Does race influence conflict between nursing home staff and family members of residents?. Journals of Gerontology Series B: Psychological Sciences and Social Sciences, *66*(6), 750-755. doi:10.1093/geronb/gbr093	Quantitiative Research	To examine the influence of race on perceived similarity and conflict between nursing home staff and family members of residents; Culture	A representative sample of Certified Nursing Assistants working in predominantly White (94.7% of residents) nursing homes N = 404 USA	Quantitative analysis utilizing structured interviews Race (and culture) of caregiver	Race was not a predictor of staff perception of conflict with family members or of poor treatment from residents' families. However, Black nursing assistants were more likely to perceive that their own expectations of nursing care are dissimilar from those of residents' family members. Dissimilarity predicted reports of poor treatment from family members, and poor treatment was a positive predictor of perception of conflict.	The personal long-term nature of nursing home care necessitates a high level of connectedness between family caregivers and nursing home staff. Results highlight the importance of establishing organizational pathways for communication of expectations between nursing staff and residents' families.	Difference in race led to dissimilarity in expectations of care between caregivers and family members, which then led to caregivers perceiving poor treatment from family members, increasing likelihood of conflict. 'Dissimilarity' is not qualified but background says previous research shows that Black families may more highly value maintaining older relatives at home. The implication is not followed through.

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7	Hodder, R. (2003). Forgetting: A memoir about culture, language, and religion. American Journal of Alzheimer's Disease & Other Dementias, 18(5), 317-319.	Case study as an Opinion Piece	To illustrate the challenges that multi-cultural, multi-lingual families face with the difficult task of caring for a loved one with Alzheimer's disease. Culture; Language	Case study of a Armenian-Canadian Protestant with dementia whose English was her third language after Armenian and French N=1 Canada	Description of events by case's daughter	The case's well being suffered greatly due to isolation within her nursing home as she lost the ability to speak English and not all carers could speak French. Moving to a French-speaking home in Canada was not an option as these were explicitly Catholic which would be culturally inappopriate for the case. She alsp started losing her French and reverting to Armenian, which isolated her further	The daughter found that Canada's policy of bilingual service provision as per the Official Languages Act of 2001 applied to federal institutions only and not to private ones. She also discovered that being in a cultural minority (French Protestantism in an English-speaking area of Canada) meant that finding culturally congruent care was difficult	Can be compared to Welsh Language Act which often exists in principle only. Providing cultural/ lingual minorities with congruent care can be practically difficult even when they are official cultures/languages of that country. This can lead to decreased well being for those with dementia from in these minorities, living institutional care

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8	Antelius, E., & Kiwi, M. (2015). Frankly, none of us know what dementia is: Dementia caregiving among iranian immigrants living in sweden. Care Management Journals, 16(2), 79-94. doi: 10.1891/1521-0987.16.2.79	Qualitative research	To explore concepts of language and culture mixing, with culturally and linguistically diverese (CALD) person with dementia Culture, Language	Culturally congruent caregivers of immigrated Iranian persons with dementia in two settings (ethno-specific care home and lingual-specific carers visiting clients' homes) N = 66 Sweden	Observations, in combination with semistructured in-depth interviews, followed by content and ethnographic analysis	See Key Findings (analysis of results)	4 main findings: 1. A wider recognition of people from different CALD backgrounds possibly having different perceptions of what dementia is; 2. A possibility that such ascribed meaning of dementia has a bearing on health maintenance and health-seeking behavior as well as the inclination to use formal services or not; 3. Choosing to use formal service in the forms of ethnoculturally profiled dementia care facility seems to relate to being able to "live up to ideals of Iranian culture;" and 4. "Culture" appears to be a relevant aspect of people's lives, an aspect that is both acquired as well as ascribed to oneself and to others	The main attraction of the ethno-specific care home was that "being home in Iran" (in Sweden) allowed traditions, customs, food, religion and other aspects of life to be culturally congruent for the residents. It also seemed to partially help in easing the shame of family members of not fulfilling cultural standards about filial piety.

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9	Bhattacharyya, S., Benbow, S. M., Bhattacharyya, S., & Benbow, S. M. (2013). Mental health services for black and minority ethnic elders in the united kingdom: A systematic review of innovative practice with service provision and policy implications. International Psychogeriatrics, 25(3), 359-373. doi: 10.1017/S1041610212001858	Systematic Review	To review published examples of innovative services which serve to fill highlighted gaps in Mental health services for Black and Minority Ethnic (BME) elders; Culture; Language	Service developments aimed at BME elders in the UK; N = 16 (papers) UK	A search was carried out on Pubmed, Medline, and Google Scholar	Commissioning issues included were forward planning for continuing funding and mainstreaming versus specialist services. Provider management issues included were employing staff from the communities of interest, partnership, and removing language barriers. Provider service issues included were education for service provider staff on the needs of BME elders, making available information in relevant languages, building on carers' and users' experiences, and addressing the needs of both groups.	A model for structuring understanding of the underutilisation of services by BME elders is suggested. The main emphasis in future should be to ensure that learning is shared, disseminated, and applied to the benefit of all communities across the whole of the UK and elsewhere. Person-centred care is beneficial to all service users.	Suggests that models for developing services for BME elders fit the idea of person-centred care, but are currently lacking and need more investment and high-quality research.

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10	Espino, D. V., Mouton, C. P., Del Aguila, D., Parker, R. W., Lewis, R. M., & Miles, T. P. (2001). Mexican american elders with dementia in long term care. Clinical Gerontologist, 23(3), 83-96.	Combined Case Series and Literature Review	To review cultural issues associated with the delivery of long-term care services to Mexican American elders suffering from dementing illnesses; Culture	Mexican American elders suffering from dementing illnesses; N = 3 USA	Basic descriptive case studies with relevant selective literature and comment discussion	See Key Findings (analysis of review and case series)	Mexican Americans with dementia suffer from delayed diagnosis, significant impairment and prolonged caregiver burden, interfacing with long-term care services late in the disease process. Family care providers are anxious to reproduce the home environment in the facility. If families' expectations are not met, partly due facility's personnel's failure to understand the basic cultural concepts of familiarity and respect, this results in conflict. End-of-life decisions must be made within the family context in order to preserve cultural integrity.	Once case illustrated family tensions and dynamics when filial piety was percieved by other family members not to be fulfilled by the daughter. This was tenuously linked to the daugher's subsequent lawsuit against the facility, traced to her supposed guilt over afore-mentioned unfulfilled filial piety. In this context cultural congruence may have helped the situation as in # 8

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11	Mold, F. (2005). Minority ethnic elders in care homes: A review of the literature. Age and Aging, 34(2), 107-114.	Literature review	To review the literature concerned with minority ethnic elders in care homes; Culture	Papers concerned with minority ethnic elders in the care home sector N = 28 UK	Searches were conducted using the following online databases: Web of Science, Pub Med, Sociological Abstracts, Social Sciences Index, AMED, British Nursing Index, Medline, PsycInfo and CINAHL.	The literature was classified into two key areas: 1. Issues arising from international literature, including factors relating to access, equality and workforce issues, care satisfaction and placement decision-making. 2. Issues emerging from the UK literature, including barriers to care provision for minority ethnic older people, loss of independence and the recognition of cultural needs.	The review indicated how problems remain in ensuring the delivery of best-quality long-term care to ethnic elders in care homes. The review also highlights the absence of studies focusing on the perception of care from residents' perspectives and their involvement in making placement and care decisions.	One UK paper identified several barriers to accessing respite care, e.g. a lack of knowledge regarding service availability, access details and referral processes, language and communication barriers, and a scepticism by ethnic minority clients regarding the appropriateness and cultural sensitivity of services

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12	Daker-White, G., Beattie, A. M., Gilliard, J., & Means, R. (2002). Minority ethnic groups in dementia care: a review of service needs, service provision and models of good practice. Aging & mental health, 6(2), 101–108. https://doi.org/10.1080/13607860220126835	Literature review	To uncover the state of professional knowledge, practice, and guidelines in relation to the care and provision of services to people with dementia from minority ethnic groups; Culture	Articles about dementia and ethnic minority groups; N = 67 UK	Eighteen electronic databases in health, medicine, and social science were searched using a hierarchical search strategy	See Key Findings (analysis of results)	Language ability affects cognitive assessment Studies into the caregiving experience amongst different ethnic or racial groups suffer from theoretical and methodological weaknesses. Studies of help-seeking among various ethnic groups in the US found that many do not prioritize dementia as a health problem in the face of more pressing concerns. There is little consensus about whether services should be provided specifically for different ethnic groups, reflecting a lack of evidence concerning the efficacy of different models of service provision	Adamson (1999) found that Afro-Carribeans Dementia sufferers and their carers did not expect specialist provision but rather wanted high-quality care; Haringey Social Services found that some minority groups (AC and Irish) did not want separate services as they felt that they would be marginalized as a result; but Gujaratis did - is this based in language?

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13	Hanssen, I., & Kuven, B. M. (2016). Moments of joy and delight: The meaning of traditional food in dementia care. Journal of Clinical Nursing, 25(5-6), 866-874. doi: 10.1111/jocn.13163	Qualitative research - 3 similar studies analyzed as a whole	To learn about the meaning of traditional food to institutionalised patients with dementia; Culture	1. Ethnic Sami patients with dementia in an ethno-specific care Home in Norway; 2. Ethnic Norwegians in a care home in Norway; 3. Residents with dementia at four nursing homes in South Africa N = 15, 3, 37 respectively; Norway and South Africa	Nurses and patients' family members were interviewed in depth about their experiences regarding their patients' food preferences and reactions to the dishes they were served; Compared across three different cultures	Traditional foods created a feeling of belonging and joy. Familiar tastes and smells awoke pleasant memories in patients and boosted their sense of wellbeing, identity and belonging, even producing words in those who usually did not speak	In persons with dementia, dishes remembered from their childhood may help maintain and strengthen cultural identity, create joy and increase patients' feeling of belonging, being respected and cared for. Traditional food furthermore improves patients' appetite, nutritional intake and quality of life. To serve traditional meals in nursing homes demands extra planning and resources, traditional knowledge, creativity and knowledge of patients' personal tastes.	Cultural congruence extends to food served at the care homes and contributes towards increased well being

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14	Stuart, P. (2012). Overseas nurses' experience as support workers in the UK. Nursing & Residential Care, 14(12), 660-663.	Qualitative research	To explore the experiences of international nurses, working as support workers in the independent sector, of culture, racism, coping with reactions and understanding dementia; Culture; Language	International students working as support workers, and accessing the BSc international Nursing and Healthcare course at University of Northampton; N = 52 UK	A phenomenological approach using a variety of ways to collect data such as interviews, focus groups and observations to describe the participants' experiences. Data was collected using a journaling method where participants recorded and reflected on situations in their workplace	The main issues identified were Communication; Questioning custom and practice; Understanding the behaviour, symptoms and needs of the client group; and Practical skills and understanding correct practice and process	Participants new to the UK and working in the independent sector in the UK report difficulty adjusting to the culture. This is not only dialect, colloquialisms and accents but also basic information such as the transport arrangement, accommodation and finances. This makes them a vulnerable group and simple measures can help their confidence and experience such as orientation packages, mentoring, buddy or befriending systems.	Subtle language differences such as accent and dialect created a communication barrier for foreign caregivers. This may cause a challenge for the caregiver to provide high-quality care. They also needed time to adjust to cultural perceptions of dementia and care in the UK

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15	Valins, O. (2004). Religion, culture and institutional care: Caring for older jews in the united kingdom. The Leveson Centre for the study of Ageing, Spirituality, and Social Policy. GB: Jessica Kingsley Publishers	Report	To describe the provision of long-term care services for older Jewish people in the UK; Culture	Older Jewish people UK	Review of selective literature, comment discussion and survey results	See Key Findings (analysis of review, comment and surveys)	Most Jews in the UK want to be cared for in an environment they feel is closer to who they are and that is in sympathy with their religious, spiritual and cultural values. It is ideologically inconsistent for the government to support faith schools, but not faith homes. The Jewish community is an example of where the local community provides added value for the care of older people in financial and volunteer support. Jewish homes are facing major challenges and many will struggle to survive if funding patterns do not change radically.	Strongly supports the idea of cultural congruence. 'What matters is that care homes allow them to spend the end of their days with fellow residents who are seen to be . same. These homes allow them to return to their cultural and religious roots, even though for many this contrasts with their low levels of religiosity when they were younger. They may not want to involve themselves directly in Jewish activities, but they certainly don't want to live in a home that serves bacon for breakfast.'

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16	Botsford, J., Clarke, C. L., & Gibb, C. E. (2011). Research and dementia, caring and ethnicity: A review of the literature. Journal of Research in Nursing, 16(5), 437-449. doi:10.1177/1744987111414531	Literature review	A review of the impact of ethnic background on dementia and caregiving; Culture	N = Unspecified UK	Review of selective literature and comment	Ethnic background appears to account for differences in experiences of dementia and caregiving, but other compounding variables, including socio-economic factors and education, also need to be taken into account when considering the experiences of specific ethnic communities.	Ethnicity is significant in regard to how people experience dementia and caregiving, but also highlights a continuing need for research which explores the impact of ethnic background in a sensitive and sophisticated manner.	Seemed not to address (or possibly realize) the possibility of significant cultural/ ethnic differences within the native UK white population, which is an interesting issue within this field and the wider general research field.

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17	Iliffe, S., & Manthorpe, J. (2004). The debate on ethnicity and dementia: From category fallacy to person-centred care? Aging & Mental Health, 8(4), 283-292.	Literature review and Comment (Position Piece)	To argue that language and cultural issues are applicable to all individuals with dementia, independent of apparent ethnicity, and that promotion of cultural competence in service provision should not be relegated to an ethnic minority agenda Culture	N = Unspecified UK	Review of selective literature and comment	See Key Findings (analysis of review)	Ethnicity is unlikely to have much impact on the pathology underlying dementia syndromes, but it may have some effects on the understanding and expression of dementia. Ethnicity is a problematic concept, or a category fallacy, whose effects are overshadowed by those of socio-economic status and education. Migration leads to acculturation, so that responses attributed to a presumed stable ethnic identity may be cohort effects, confined to one or two generations only.	Accepts that cultural differences matter in dementia care and should be accomodated (e.g. food and personal care practices); Argues that 'ethnicity' potentially stands in the way of tailored, wrap-around services for diverse individuals; No mention of the stable ethnic identities (not subject to migration effects) already present in the UK (English, Welsh, Scottish, etc), which adds to my point made in relevant comments of # 16

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18	Hanssen, I. (2013). The influence of cultural background in intercultural dementia care: Exemplified by sami patients. Scandinavian Journal of Caring Sciences, 27(2), 231-237. doi: 10.1111/j. 1471-6712.2012.01 021.x	Qualitative research	To gain knowledge about how the original culture may influence communication and interaction with institutionalised patients with dementia and of what particular cultural aspects may come to the fore, exemplified by Sami patients; Culture, Language	Sami patients with dementia living in care homes, their family members and nurses N = 15 Norway	Qualitative narrative interviews with family members of Sami patients with dementia, and nursing staff experienced with dementia care were conducted	Although the way dementia influence mental functions, language, etc. is universal, behaviours, reactions and responses may be coloured by the patient's background culture. Knowledge of language, cultural codes and the patient's former life are primary keys to understanding.	Rhythm of life, spirituality, singing and tangible aspects of traditional culture like clothes and food constitute important aspects of culture-appropriate care.	First issue mentioned by respondents was language, difficulty in communication when Sami not spoken by staff; Residents preferred cultural congruence (e.g. traditional singing, sleeping patterns as per working lives herding reindeer, wooden pillars as would be in a Sami house/tent placed incorrectly in the home) and traditional Sami food. Cultural congruence strongly emphasized

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19	Day, K., & Cohen, U. (2000). The role of culture in designing environments for people with dementia: A study of russian jewish immigrants. Environment and Behavior, 32(3), 361-399.	Literature review and Qualitiative Research	To outline key aspects of culture to be considered in designing for people with dementia including cultural group history and life experiences, assets, beliefs and values, caregiving practices, and activities and preferences. Culture, Language	Literature Review - unspecified Qualitative Research: Convenience sample of respondents in two different Russian Jewish immigrant communities. N = 30 USA	Data collection methods including a literature review on Russian immigrants to the United States and in-depth semistructured interviews conducted with community members and social service providers to these local Russian communities.	Key aspects of culture to consider in designing for people with dementia include significant aspects of cultural group history and life experiences, assets, beliefs and values, caregiving practices, and activities and preferences.	Culture may serve as a therapeutic barrier or as a therapeutic resource in caring for this population. Cultural heritage is currently underused as a therapeutic resource in environments for people with dementia and for other older adults. Accommodation of cultural heritage in these settings requires sensitive spatial organization and appointment of the physical environment to support culturally based activities and rituals.	As evidenced in interviews, difficulties with English disconnect older Russians from everyday interactions and reduce their comfort in conducting daily routines.

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20	MacKinlay, E. (2009). Using spiritual reminiscence with a small group of latvian residents with dementia in a nursing home: A multifaith and multicultural perspective. Journal of Religion, Spirituality & Aging, 21(4), 318-329. doi://dx.doi.org/10.1080/15528030903030003	Qualitative research	To examine spirituality and meaning in the experience of dementia of older Latvian residents living in Australia; Culture, Language	Latvian residents in a nursing home with Mini Mental State Examination (MMSE) scores of 18–20; N = 3 Australia	Individual in-depth interviews followed by weekly small group work, applying a previously designed and tested set of broad questions based on the model of Spiritual Tasks and Process of Ageing, with one theme each week conducted over six weeks.	Main themes identified were need for connectedness; spiritual and religious practices; vulnerability and transcendence, physical health issues; wisdom and memory, war experiences; hope/ fear and communication style of facilitator	Further staff education will be important for increasing awareness of the issues and to form a means for improving support for older people of different ethnic backgrounds. These issues will become more prominent as groups of displaced persons from World War II grow still older and need residential care. Issues of language, faith, and culture, interlaced with memories of trauma will become important aspects for care for these elderly people.	‘ “I sit down and my lady who comes with me, and she said “why didn’t you speak?” but my mind keeps going up around and around and I really don’t nothing what to do with her, because she is different, she does not speak in our language.” Matilda was able to express her concern that the volunteer who came to visit her didn’t speak her language. Matilda was doubly disadvantaged, with English as her second language and dementia that made it difficult for her to express herself in English.’

#	Author / Ref / URL	Type of Literature	Aims/purpose; Question addressed	Study population, sample size (if applicable), and location	Methodology; Intervention (if any); comparator (if any)	Outcomes	Key findings	Relevant comments
21	Runci, S. J., Eppingstall, B. J., O'Connor, D. W., Runci, S. J., Eppingstall, B. J., & O'Connor, D.,W. (2012). A comparison of verbal communication and psychiatric medication use by greek and italian residents with dementia in australian ethno-specific and mainstream aged care facilities. International Psychogeriatrics, 24(5), 733-741. doi:10.1017/S1041610211002134	Qualitiative Research	To investigate older migrants with dementia and limited English language proficiency in residential care, who may have unmet needs for social interaction Language, Culture	Older Australians of Greek or Italian background who had been diagnosed with dementia and were residing in mainstream or ethno-specific care N = 82 Australia	Residents were observed and their language use was recorded. An assessment of cognitive impairment was conducted. A structured interview was held with a family member and a staff member. Linguistic and cultural congruence Ethno-specific care	The observed rate of resident-to-resident communication was higher in the ethno-specific facilities. Staff-to-resident interaction rate did not differ between the facility types. Residents in ethno-specific care were prescribed antipsychotics at a significantly lower rate.	Residents with dementia and limited English language proficiency in mainstream care would benefit from greater opportunities to interact with peers in their own language. Prescribed medication should be monitored to ensure that these residents are not misinterpreted as "disruptive," or are not actually more agitated due to difficulty in communicating their needs.	61% of next of kin (NOK) noticed deterioration in English language proficency Ethno-specificity leads to greater resident-to-resident social interaction - ? increased wellbeing Less antipsychotics - ? less frustrated in ES care; ? misinterpreted as 'disruptive' due to communication difficulties No difference in staff to resident interaction

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22	Runci, S. J., Eppingstall, B. J., van der Ploeg, E.,S., & O'Connor, D.,W. (2014). Comparison of family satisfaction in australian ethno-specific and mainstream aged care facilities. Journal of Gerontological Nursing, 40(4), 54-63. doi: 10.3928/00989134-20131219-01	Qualitative research	To identify specific aspects of care that increased satisfaction of family members of Greek and Italian residents with dementia in mainstream or ethno-specific aged care facilities Language, Culture	Relatives of aged care residents with Greek or Italian backgrounds who were also cognitively impaired, in mainstream or ethno-specific aged care facilities in Australia N = 83 Australia	Structured interview with residents' relatives, rating their satisfaction with the facility and suggesting improvements regarding the care provided. Linguistic and cultural congruence Ethno-specific care	Family members with relatives in ethno-specific care were more satisfied, in terms of the facility's ability to meet the resident's language and cultural needs, social/leisure activities, and the food provided. The presence of a bilingual staff member and greater perceived reduction in family caregiver stress upon admission were associated with higher satisfaction.	Results implicate the role of activities programs, catering, resident interaction, supporting caregivers upon admission, and bilingual staff members to increase family satisfaction, with the potential to improve the care provided to residents in mainstream care.	Key findings suggest residents' well being would be better in an ES care facility, due to linguo/cultural congruence Families express preference for ES care - ? due to perceived better well being Families suggest less improvements in ES facilities Most commonly suggested improvements in mainstream were increased bilingualism and cultural-specific activities e.g. Italian-speaking entertainment, festive days.

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23	Shanley, C., Boughtwood, D., Adams, J., Santalucia, Y., Kyriazopoulos, H., Pond, D., & Rowland, J. (2012). A qualitative study into the use of formal services for dementia by carers from culturally and linguistically diverse (CALD) communities. BMC Health Services Research, 12, 354. doi: 10.1186/1472-6963-12-354	Qualitative research	To address the lack of literature on the use of formal services for dementia by people from culturally and linguistically diverese (CALD) backgrounds Language, Culture	Family carers and from four CALD communities – Italian, Chinese, Spanish and Arabic-speaking, and relevant health professionals working with these cohorts N = 121 family carers (in 15 focus groups), 60 health professionals Australia	Focus groups with family carers and one-to-one interviews with bilingual/bicultural community workers, bilingual general practitioners and geriatricians. Linguistic and cultural congruence Ethno-specific care	CALD communities are often unfamiliar with the concept of formal services and there may be strong cultural norms about maintaining care within the family, rather than relying on external services. While there is a preference for ethno-specific or multicultural services, mainstream services also need to ensure they are more flexible in providing culturally appropriate care. Positive outcomes occur when ethno-specific services work in partnership with mainstream programs.	While members of CALD communities may have difficulties accessing formal services, they will use them if they are culturally and linguistically appropriate and can meet their needs. There are a number of ways to improve service provision to CALD communities and the responsibility for this needs to be shared by a range of stakeholders.	One participant stated that other residents would reassure family carers about the care provided : ‘ “No, she’s OK. We are from the same village. We speak about the language; I’m two years older than your mum. She’s OK”, so it’s why the culturally appropriate care is a positive thing’ (Kelly, Chinese BBW) The problems identified with ethno-specific services were the long waiting lists due to high demand, the observation that staff were not always well trained in dementia: “If you put someone that just speaks the language without having the training, then it’s a very, very narrow type of service provision”

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24	Söderman, M., & Rosendahl, S. (2016). Caring for ethnic older people living with dementia - experiences of nursing staff. Journal of Cross-Cultural Gerontology, 31(3), 311-326. doi:10.1007/s10823-016-9293-1	Qualitative research	To explore and describe the nursing staff's experiences of caring for non-Swedish speaking persons living with dementia in a Finnish speaking group home in relation to a Swedish speaking group home in Sweden. Language, Culture	Nursing staff in two separate care homes: one Finnish-speaking group home for persons living with dementia, the other a Swedish speaking group home caring for non-Swedish older persons with dementia N = 27 Sweden	Qualitative semi-structured interviews Linguistic and cultural congruence Ethno-specific care	The first main category, 'Communication', concentrated on language abilities and deficiencies, non-verbal language, highlighting the consequences of not understanding and the benefits of a common language. The second main category, 'culturally oriented activities', focused on being served traditional food, celebrating holidays at the group home, the importance of traditions and the importance of familiar music as cultural elements.	The Swedish speaking nursing staff could provide qualitative and equitable care, but the challenge was greater for them than for the bilingual nursing staff who spoke the same language as the residents.	"She was aggressive there (Swedish speaking group home)…She did not, in fact, understand what they said… she was very angry… and threw stuff like that, but when she moved here, she was happy and spirited and talked and laughed a lot" (Marja, Finnish speaking group home) Residents became passive and silent in the linguistically alien environment and some withdrew socially. The Swedish speaking nursing staff felt that conversation between them and the residents was limited because of language difficulties. Therefore decreased well being in linguistic incongruence

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25	Heikkila, K. (2007). Culturally congruent care for older people: Finnish care in sweden. Scandinavian Journal of Caring Sciences, 21(3), 354-362	Qualitative research	To describe how cultural congruency is used in care for older Finnish immigrants in order to promote their well-being. Language, Culture	Residents, staff, and visitors in a Finnish Home in Sweden N = Unspecified Sweden	Ethnographic design, based on participant observations and interviews	In the core of the cultural congruency is the use of the Finnish language, and the fact that both residents and staff have Finnish backgrounds. In addition to this, Finnish customs and celebrations, popular culture, and topics of discussion, are actively used in order to create a common ground for communication and shared understanding of the individual person.	Cultural congruency, based on the residents' mother language, shared ethnic background with staff, and shared customs creates a common ground for communication and an understanding (sic). This enables caring relationships, which, in turn, increases the residents' well-being.	Residents felt that the question of wellbeing was peculiar as care in Finnish was the only type of care they knew. The residents' relatives, however, were convinced that the residents would have experienced more health problems in an ordinary Swedish care setting, because the majority of the residents could not manage in Swedish.

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26	Müller, N., & Guendouzi, J. A. (2009). Discourses of dementia: A call for an ethnographic, action research approach to care in linguistically and culturally diverse environments. Seminars in Speech & Language, 30(3), 198-206. doi:10.1055/s-0029-1225956	Literature Review, Comment and selected Case Study Series	To suggest that practicing speech-language pathologists and students, as well as researchers, will benefit from strategies using participatory action research and ethnographic methods To illustrate this with data involving persons with dementia from linguistically and culturally diverse backgrounds Language, Culture	Selective articles about ethnographic research; Selected case studies of persons with dementia whose first languages were Louisiana French or Creole N = Unspecified USA	Review of selective literature and comment Ethnographic interviews	See Key Findings (analysis of review and case series)	Action research, which shares a methodological basis with ethnography, is undertaken with the aim of improving the functioning of the social institution, practice, or structure investigated for the benefit of those most closely involved with that institution or practice	For one resident, (Ms Anne), language held a deeper meaning: the connection with close family and friends. Even though many residents also spoke French, she said “they don’t speak French here’, taken to mean that those she had spoken French to in the past were not there, leaving her socially isolated despite a degree of lingual congruence One woman (Ms Betty) in her 70s was initially lonely in the home, but sought out the friendship of an older lady (Ms Frances) in her 90s of a similar cultural background (Louisiana French), whom she called ‘maman’ (a term of endearment for a grandmother in the region)

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27	Rosendahl, S. P., Söderman, M., & Mazaheri, M. (2016). Immigrants with dementia in swedish residential care: An exploratory study of the experiences of their family members and nursing staff. BMC Geriatrics, 16, 1-12. doi:10.1186/s12877-016-0200-y	Qualitative research	To explore and describe the experiences of family members and professional caregivers regarding the care provided to immigrants with dementia Language, Culture	Professional caregivers and family members of people with dementia with Finnish, Estonian, Hungarian and Ingrian backgrounds in a group home. All people with dementia had lost their Swedish language skills as their second language N = 14 (9 caregivers and 5 family members) Sweden	An exploratory, descriptive study with a qualitative approach, using in-depth semi-structured interviews	Three categories: 1) A new living situation: *adjusting to new living arrangements* and *expectations regarding activities and traditional food at the group home;* 2) Challenges in communication: *limited communication resident and the staff* and *the consequences of linguistic misunderstandings and nuanced communication in a common language*; 3) The role of the family member at the group home: *a link to the healthy life story of the resident* and *an expert and interpreter for the nursing staff*.	The family member played a crucial role in the lives of immigrants with dementia living in a group home by facilitating communication between the nursing staff and the person with dementia (PWD) and also by making it possible for PWD to access the cultural activities they wanted and which professional caregivers were either not able to recognise as needed or could not deliver.	Language and Culture were confirmed as crucial aspects of a resident's well being, shown by the residents' need for access to desired activites via the specifically linguistically and culturally congruent family members (and not incongruent caregivers) One monolingual caregiver percieved a Finnish-speaking resident as being introverted, whereas a bilingual caregiver who spoke Finnish perceived the same resident as being very sociable and chatty

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28	Kokorelias, K. M., Ryan, E. B., & Elliot, G. (2016). Innovative practice: Conversational use of english in bilingual adults with dementia. Dementia (London, England),	Qualitative research	To explore the use of bilinguals' two languages for five older adults with mild-moderate dementia living differently cultured care homes Language	Greek–Canadian residents with mild-moderate dementia experiencing language regression to Greek in two separate care homes: one mono- and another multi-cultural N = 5 Canada	Ethnographic observation and 'The Montessori Way-based English language activities' used in fostering conversational use of English. Linguistic and cultural congruence Ethno-specific care	Over 10 sessions, participants' vocabulary or grammatical structure in English did not improve. However, four of the five participants were able to maintain a conversation in English for longer periods of time.	This study contributes to strategies for optimizing meaningful conversation for bilingual long-term care residents with dementia. Moreover, the data suggest a change in the policy and practice for dementia care so that there are more opportunities for residents to speak English in non-English mother-tongue facilities. Greater attention to the specific language needs of bilinguals in English-dominant settings would also be advisable.	Study suggests that the way to cope with second language (although dominant language in that location) regression and its implications for 'threatening personhood of individuals' is to stimulate second language use rather than to provide linguistic congruence in their care setting

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29	Strandroos, L., & Antelius, E. (2016). Interaction and common ground in dementia: Communication across linguistic and cultural diversity in a residential dementia care setting. Health:, 21(5), 538-554.	Comment based on ethnographic fieldwork	To address the multidimensional character of communication and interaction, in reference to the difficulty experienced in spoken language, as a consequence of the dementia disease Language	Residents at a municipal dementia residential care facility with varying native languages, and their caregivers N = 19 residents, 7 permanent caregivers Sweden	Ethnographic participant observation, interviews and video recordings were conducted for a year, and field notes continuously kept. Linguistic congruence	A shared spoken language is advantageous, but is not the only source of, nor a guarantee for, creating common ground and understanding. Communicative resources other than spoken language are for example body language, embodiment, artefacts and time. Furthermore, forms of communication are not static but develop, change and are created over time.	Ability to communicate is thus not something that one has or has not, but is situationally and collaboratively created. To facilitate this, time and familiarity are central resources, and the results indicate the importance of continuity in interpersonal relations.	Not sharing a spoken language has practical and social consequences - A woman who almost exclusively spoke Polish, was a social person who often approached others. This was difficult for her as she could not make herself understood in Polish. Other residents were often annoyed with her for not speaking Swedish. She could not participate in activities based on spoken language, often turning to the member of staff who spoke Polish, explaining that she appreciated being able to do. She experienced negatively that others did not speak Polish, commenting about the author: 'She's nice, but she doesn't speak Polish'.

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30	Burant, C. J., & Camp, C. J. (1996). Language boards: Enabling direct care staff to speak foreign languages. Clinical Gerontologist, 16(4), 83-85.	Case Study	Explores the concept of overcoming language barriers in immigrant elders with dementia in care homes. Language	An elderly Russian immingrant woman N = 1 USA	Case Study Observation An intervention was developed using a prototype of The InterpreCare System™ (ICS) on which English words were phonetically translated into Russian, and displayed on language boards behind the resident. Staff were trained for approximately five minutes before each meal in the pronunciation of the Russian phrases.	The intervention produced a substantial reduction in both verbal and physical aggression from the resident, and humanized the interactions between staff and the resident. Time spent feeding the resident increased. Staff would name a food item, ask if she would want to eat it (or eat more of it), offer alternatives if she refused a food item, thank her for eating, ask if a food item was good, etc. This in turn increased her willingness to sit through a meal and increased the number of positive interactions between staff and the resident during meals. Members of the staff became enthusiastic about the intervention, (cont.)	(cont.) and asked for new phrases for purposes other than feeding (e.g., dressing, bathing, etc.) Repetitive use of the ICS enabled staff to speak and understand frequently used phrases without having to refer to the ICS. Staff sought the advice of Russian-speaking staff on pronunciation, etc, how to speak new phrases etc, increasing socialization between staff. Russian staffers were no longer constantly being asked to translate for Russian residents.	Linguistic congruence increased emotional well being and offered scope for improved physical well being Caregivers developed autonomous interest after commencing programme Improved interaction between staff of different backgrounds due to interactions on linguistic-specific topic

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31	Runci, S. J., Redman, J. R., & O'Connor, D.,W. (2005). Language use of older italian-background persons with dementia in mainstream and ethno-specific residential care. International Psychogeriatrics, 17(4), 699-708.	Qualitative research	To compare language use of older Italian-background persons with dementia who were residing in mainstream care with those in Italian-specific care Language	Older Italian-background persons with dementia who were residing in two separate care homes: one a mainstream home and another an Italian-specific care home N = 39 Australia	Participants were observed and language use was recorded. Medication regime and language proficiency information was obtained. Linguistic congruence	Participants in mainstream facilities engaged in less communication with co-residents and were prescribed daytime benzodiazepines at a higher rate than those in Italian-specific facilities.	Older persons in mainstream facilities with dementia and lower levels of English proficiency may benefit from additional language-relevant resources. The finding of higher prescription rate of daytime benzodiazepines requires further investigation.	Linguistic congruence seemed to lead directly to increased well being due increased social interactions and decreased sedative medication use No difference in staff to resident interaction

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32	Smith, K., Milburn, M., & Mackenzie, L. (2008). Poor command of english language: A problem in care homes? if so, what can be done? Journal of Dementia Care, 16(6), 37-39.	Survey report	To examine the nature and extent of communcation problems that occur as a result of an influx of foreign care workers whose first language was not English Language	Health care professionals working in the care home setting N = 85 UK	Self-administered questionnaire about extent and nature of communication problems in this sector due to poor command of English language Linguistic congruence	Most subjects came across staff with poor command of the English language; viewing the issue as moderately problematic. Themes identified in interactions between staff and residents: *Misunderstandings*, *Interpersonal problems*, *Challenging behaviours*, *Resident need not met;* Themes identified in interactions between staff and participants: *Communication problems, Inaccurate information, Social Unease, Time issues* and *Others.*	The issue needs further investigation as it is both common and perceived as problematic. Participants highlighted the need for Training, Better Communication within the homes, Policies and Supervision.	Linguistic incongruence of carers for residents living in their native countries is percieved to lead to conditions which may impair well being for residents, specifically: 'Residents being unable to obtain the help they require to self-care and maintain their well being'

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33	Ekman, S. L., Wahlin, T. B., Norberg, A., & Winblad, B. (1993). Relationship between bilingual demented immigrants and bilingual/ monolingual caregivers. International Journal of Aging & Human Development, 37(1), 37-54.	Qualitative research	To illuminate the relationship between bilingual demented patients and bilingual/ monolingual caregivers during morning care sessions regarding the promotion of integrity in demented persons. Language	Demented Finnish immigrants and their bilingual and monolingual Swedish-speaking caregivers. N = 7 residents Sweden	The residents were videotaped during morning care together with bilingual and monolingual Swedish-speaking caregivers. An analysis of the videotapes was performed, and comparisons were made regarding demented immigrants' relationships with Swedish-Finnish speaking and Swedish speaking caregivers respectively.	Three different patterns of relationship were seen: positive, negative, and mixed relationship. The study showed that bilingual caregivers' relationships with bilingual patients was positive or mainly positive (mixed), while the monolingual Swedish speaking caregivers had severe problems communicating with the same patients and therefore had more difficulties creating a positive relationship with them.	It seems important that bilingual caregivers engage in the care of demented bilingual patients in order to help them use their latent competence and show themselves more clearly in the communication with their caregivers.	Verbal communication in the patients' native language makes it easier for caregivers to promote patients' integrity, which in turn enables patients to disclose more of their latent capacity. Well being seems to be increased by linguistic congruence by allowing them to practice or express greater competence

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34	Plejert, C., Jansson, G., & Yazdanpanah, M. (2014). Response practices in multilingual interaction with an older persian woman in a swedish residential home. Journal of Cross-Cultural Gerontology, 29(1), 1-23. doi:10.1007/s10823-013-9217-2	Case Study	To examine a care encounter between an older multilingual woman and staff in an ordinary, Swedish residential home Language	An older multilingual (Farsi/Swedish/ English) Persian woman and staff in a Swedish residential home N = 1 Sweden	Case Study Observation - conversation analysis of how the woman's contributions in her mother tongue, Farsi, are responded to by a carer, who is also multilingual and speaks Swedish as a second language (L2), but has a very limited knowledge of Farsi.	Most of the woman's contributions in Farsi are responded to in L2-Swedish by the carer, primarily by means of seven different response practices: soothing talk, instrumental talk, minimal responses, explicit expressions of understanding, mitigating talk, questions, and appraisal.	The carer's response practices have been problematized as potentially imposing to the resident. Despite this, considering the carer's limited linguistic skills in the lady's language, she was able to resort to emphatic moves, e.g., using prosodic cues in soothing talk, expressed her sympathy in terms of claiming that she "understands," acknowledging that the lady is saying "something" (but mostly not understanding what) by means of minimal responses, and offered praise when she is acting cooperatively. She puts a lot of effort into acting in a respectful and sympathetic manner towards her.	Well being was clearly compromised in this simple daily routine of getting washed and dressed as the resident was not able to be understood due to the linguistic divide. This curbed the resident's autonomy and illustrated how even simple interactions such as this can become difficult and distressing for a person with dementia who is being cared for in a linguistically incongruent setting.

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35	Saldov, M., & Chow, P. (1994). The ethnic elderly in metro toronto hospitals, nursing homes, and homes for the aged: Communication and health care. International Journal of Aging & Human Development, 38(2), 117-135.	Survey report	To develop a database on ethnic elderly persons, to examine the extent of communication problems they face in hospitals, nursing homes, and homes for the aged in Metropolitan Toronto, and to report on the institutional responses to the situation. Language	Nursing unit supervisors in hospitals, nursing homes and care homes for the aged in Metropolitan Toronto N = 77 Canada	Self-administered questionnaire about the needs of non-English speaking ethnic elderly patients or residents, and the poicies and budgets of the instituiion in regard to these persons	Communication was essential to the health care needs of the ethnic elderly individuals. A majority of health care institutions had developed some form of interpreter services albeit frequently informal, unprofessional, and ad hoc. Without interpreter services problems developed that in some cases were seen as critical to the health care of ethnic elderly individuals. Even with interpreter services available, problems developed, suggesting that the services provided were not effective in some cases.	It is suggested that further study be conducted to examine the relative effectiveness of formal, professional, and informal interpreter services. Few institutions had workshops or training to help staff understand ethnic variations on the perceptions of illness and health.	It is diificult to provide equitable care to multicultural residents or patients with dementia who do not speak English. Interpreter services are not always available. Well being is therefore being affected by these individuals' inability to obtain the care needed to meet their daily living requirements

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36	Kong, E., Deatrick, J. A., & Evans, L. K. (2010). The experiences of korean immigrant caregivers of non-english-speaking older relatives with dementia in american nursing homes. Qualitative Health Research, 20(3), 319-329. doi://dx.doi.org/10.1177/1049732309354279	Qualitative research	To describe Korean immigrant caregivers' experiences regarding American nursing home placement of their non-English-speaking older relatives with dementia. Language, Culture	Korean immigrant family caregivers who had non-English-speaking older relatives with dementia living in nursing homes N = 10 USA	Semi-structured interviews	The 'Korean way of thinking' results in shame when putting parents with dementia into nursing homes, leaving them unable to fulfil filial piety (part of Confucian philosophy). Some mention language barrier as an issue between their dependant and the nursing home staff, resulting in aggression and behavioral issues in the resident.	For NES family caregivers, health care professionals need to assess acculturation, English proficiency, difficulties, and needs, which are very important for developing interventions.	Specific cases of difficulty providing care due to language barriers: unable to say when wanting to use the toilet, difficulty explaining when hungry and when not hungry, social isolation within a home Assessing basic needs can be difficult, proving that well being could be adversely affected. Family members also left feeling less satisfied and happy

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37	Jacobs, E., Chen, A. H., Karliner, L. S., Agger-Gupta, N., & Mutha, S. (2006). The need for more research on language barriers in health care: A proposed research agenda. The Milbank Quarterly, 84(1), 111-133. doi:MILQ440 [pii]	Literature review	To describe what is currently known about language barriers in health care and to outline a research agenda based on knowledge gaps Language	Papers concerned with language barriers in health care N = 151 USA	Systematic review	See Key Findings (analysis of review)	Three broad areas needing more research are discussed: the ways in which language barriers affect health and health care, the efficacy of linguistic access service interventions, and the costs of language barriers and efforts to overcome them.	Studies of language-concordant provider-patient pairs found higher rates of patient and also reported better well-being and functioning Unfortunately, the literature provides little guidance on which interventions, and under which circumstances, best reduce language barriers. When purchasers, insurers, or clinicians decide to request, cover, or implement linguistic access services, they have little empirical evidence to help them decide which interventions should be at the top of their list.

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38	Boughtwood, D., Shanley, C., Adams, J., Santalucia, Y., Kyriazopoulos, H., Rowland, J., & Pond, D. (2013). The role of the bilingual/bicultural worker in dementia education, support and care. Dementia (London, England), 12(1), 7–21. https://doi.org/10.1177/1471301211416173	Qualitative research	To gain a better understanding of the role of bilingual/bicultural workers within the dementia field. Language, Culture	Bilingual/bicultural dementia workers working in culturally and linguistically diverse (CALD) communities N = 24 Australia	Semi-structured interviews	Seven themes emerged: importance of working with family; process of building trust when moving between two cultures; importance of understanding the culture; self-care and culture; flexibility of their role; linking community members; and linking communities to mainstream services	Bilingual/ bicultural workers play a significant and complex role in supporting individuals and families within their community who are affected by dementia. The significance of their role needs to be more clearly acknowledged in the development of policy, further research and service provision within the dementia field.	It was suggested that having an understanding of the culture was as important as language abilities. '…having someone who speaks Italian but doesn't understand the culture, is also very, very difficult for the person and I think also for the family members because you don't get a sense of where this person is coming from, um and that is all part of it, you know, when you walk into someone's home and they ask you to sit down for two minutes just; just to have a chat, or they offer you a cup of coffee or a biscuit you know, or; and you don't accept it, very often that's a; it's almost like you are offending them, all those little things are really important.'

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39	Nichols, P., Horner, B., & Fyfe, K. (2015). Understanding and improving communication processes in an increasingly multicultural aged care workforce. Journal of Aging Studies, 32, 23-31. doi:10.1016/ j.jaging.2014.12.003	Qualitative research	To explore how culture shapes relationships in aged care and the extent to which the residential aged care sector supports a cohesive multicultural workforce Language, Culture	Staff who provide direct care to residents; managers; and family members from six residential care facilities N = 58 Australia	An exploratory methodology utilising semi-structured questionnaires	Communication issues emerged as an over-arching theme, including interpersonal communication, the effect of cultural norms on communication and the impact of informal and formal workplace policies relating to spoken and written language. Sixty percent of participants from a culturally and linguistically diverse (CaLD) background had experienced negative reactions from residents with dementia, linked to visible cultural difference. They used a range of coping strategies including ignoring, resilience and avoidance in such situations. CaLD participants also reported prejudicial treatment from non-CaLD staff	The findings highlight the need for organisations to incorporate explicit processes which address the multiple layers of influence on cross cultural communication: internalised beliefs and values; moderating effects of education, experience and social circumstance; and factors external to the individuals, including workplace culture and the broader political economy, to develop a cohesive multicultural workplace.	Language and literacy skills enable care staff to participate in day-to-day activities on an equal basis with those whose first language is English. In recognition of the language and literacy deficits amongst staff working in various sectors of the workforce, programs have been developed for CaLD staff and others with poor literacy. Some of the participating facilities were assisting carers to access English language classes, which is available to organisations through competitive grants. Several CaLD participants had identified a need for this type of support.

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40	Nia Davies Williams. (2012). `Y golau a ddychwel': Cerddoriaeth a dementia yng nghymru. Gwerddon, 01(10/11), 113-131. http://www.gwerddon.cymru/en/editions/issue10/article5/	Case Series	To look at methods of using music as ways of communicating with patients who suffer from dementia, in a Welsh context Welsh, Culture	Residents in Welsh care homes with dementia N = 6 UK	Case study observations - analysis of how each resident responded in different ways to different songs from their past played on the harp with accompanying singing	The familiarity and recognition of the “fixed” songs bring safety and structure, bring bonds to the past, and bonds to the other person who is present, singing the song. The music sessions gave the residents a respite from their exhaustive wandering, and caused calm in those who were agitated, and stimulated those who were withdrawn.	Instead of trying to slow cognitive deterioration, care approaches are needed that stimulate present abilities, focus on improving the quality of life of the residents and reduce problematic behaviours associated with dementia.	Many residents were made visibly happy (smiling and engaging in conversation), especially when presented with song that was familiar to the culture of their past. Cultural congurence improved wellbeing

#	Author / Ref / URL	Type of Literature	Aims/purpose; Question addressed	Study population, sample size (if applicable), and location	Methodology; Intervention (if any); comparator (if any)	Outcomes	Key findings	Relevant comments
41	Irvine, F. E., Roberts, G. W., Jones, P., Spencer, L. H., Baker, C. R., & Williams, C. (2006). Communicative sensitivity in the bilingual healthcare setting: A qualitative study of language awareness. Journal of Advanced Nursing, 53(4), 422-434. doi://dx.doi.org/10.1111/j.1365-2648.2006.03733.x	Qualitative research	To assess the level of Welsh language awareness amongst healthcare professionals across Wales, and to identify the factors that enhance language choice within service delivery. Welsh, Language	Nurses, midwives or health visitors; clinicians, and allied health professionals, all working in Wales N = 83 UK	Semi-structured interviews	Three main themes were identified: care enhancement, which focussed on the process and outcome of offering language choice to bilingual patients; organizational issues, which reflected issues relating to the infrastructure of service provision; and training implications, which focused on Welsh language learning in health care.	Complex dynamics of language use are in operation within bilingual healthcare settings and organizational as well as individual factors are important in facilitating appropriate language use. Many of the issues highlighted are not peculiar to the Welsh context, but apply to healthcare settings across the world, where other minority languages are in use	As well as enhancing communication, language choice was also perceived to promote feelings of comfort amongst patients, particularly among older people: 'With the elderly, I believe that it is quite important that they… would much prefer to speak to someone in Welsh – just to make them feel more comfortable to start with – especially if it's about something like health.' Most Welsh speakers described a shared language as a bond between themselves and clients: 'I'm able to bond with them in a way that the other nurses can't bond with them…(the patient) is then more than happy to relax with me and to tell me what the problems are and how I can help.'

#	Author / Ref / URL	Type of Literature	Aims/purpose; Question addressed	Study population, sample size (if applicable), and location	Methodology; Intervention (if any); comparator (if any)	Outcomes	Key findings	Relevant comments
42	Owen, H. & Morris, S., Effaith iaith ar adsefydlu corfforol: Astudiaeth o ddylanwad iaith ar effeithiolrwydd therapi mewn cymuned gymraeg. (2012). Gwerddon, 01(10/11), 83-112. http://www.gwerddon.cymru/cy/rhifynnau/rhifyn10/erthygl4/.	Quantitiative Research	To investigate the influence of language on the effectiveness of physiotherapy in a Welsh community Welsh, Language	Individuals undergoing physiotherapy in a Welsh community N = 1309 UK	Observational study - collecting data on demographics and therapy outcomes in individuals undergoing physiotherapy from two different therapy teams - one totally bilingual and the other mostly monolingual English Linguistic congruence	Although therapy input was measured to be equitable between the two teams, therapy outcomes were worse for Welsh speaking individuals when treated by non-Welsh speaking therapists. Proportionally less Welsh speaking individuals were referred to the service	Welsh speaking patients did not gain the same benefit as their non-Welsh speaking counterparts from physiotherapy if not seen by a Welsh speaking therapist/ team. Therapists/staff need to be able to speak Welsh for Welsh speaking patients to reach their full potential in rehabilitation.	Positive discrimination in recruitment of Welsh-speaking staff can be a politically sensitive subject which may leave the patients' well being unaddressed.

#	Author / Ref / URL	Type of Literature	Aims/purpose; Question addressed	Study population, sample size (if applicable), and location	Methodology; Intervention (if any); comparator (if any)	Outcomes	Key findings	Relevant comments
43	Roberts, G. W., Irvine, F. E., Tranter, S., & Spencer, L. H. (2010). Identifying priorities for establishing bilingual provision in nurse education: A scoping study. Nurse Education Today, 30(7), 623-630. doi://dx.doi.org/10.1016/j.nedt.2009.12.011	Scoping Study - (i) literature analysis (ii) policy review and (iii) stakeholder consultation	To report on bilingual provision in nurse education in the bilingual context of Wales, UK, as a means of informing the evidence base for national strategic planning Welsh	Literature review: empirical and theoretical papers centred on minority language/ bilingual provision in healthcare or higher education, and related to Welsh medium provision in healthcare delivery Policy review: Key policy documents and position papers published between relevant to bilingual provision in nurse education in Wales Stakeholder consultation: Tutors, course directors and nursing students N = 70 UK	1. Literature analysis; 2. Policy review and 3. Stakeholder consultation via telephone interviews and questionnaires	Six themes emerged from the stakeholder consultation, reflecting the main drivers and barriers associated with bilingual provision in course delivery. These themes aligned with findings identified from the policy and literature review that related to strategic, organisational and individual influences on bilingual educational provision	Strategic planning for bilingual provision in nurse education in Wales should take account of the factors that affect provision at different levels. These factors feature across bilingual settings outside the UK, thus giving the study international relevance and scope to inform the delivery of nurse education that meets the needs of wider diverse language communities	Priorities were reflected amongst the stakeholders who claimed that bilingual education offers positive advantages for student learning and care delivery in the bilingual setting. “Bilingual education prepares nursing students to work with and care for people through their first language at a time when the patient and the family are often feeling vulnerable. This is essential and makes a difference to the patient experience.” (lecturer)

#	Author / Ref / URL	Type of Literature	Aims/purpose; Question addressed	Study population, sample size (if applicable), and location	Methodology; Intervention (if any); comparator (if any)	Outcomes	Key findings	Relevant comments
44	Roberts, G. W., & Burton, C. R. (2013). Implementing the evidence for language-appropriate health care systems: The welsh context. Canadian Journal of Public Health, 104, 88.	Comment piece	To outline the context and significance of bilingual health care provision in Wales and the implications for building and embedding the evidence base Welsh, Language	Not applicable UK	Comment and selective literature review	While global evidence shows that acting in a sensitive way to language and cultural diversity improves health and reduces inequalities, there is limited understanding about the impact of Welsh language use in health care; and the evidence is largely reliant on small-scale qualitative studies of user and provider experiences. Although there is political legitimacy and urgency, the fragmented evidence base for strategies and interventions makes it difficult to answer the question “what works?” in the promotion of language-sensitive health services. In practice, the delivery of Welsh language services relies on the knowledge, attitudes and skills of individual staff (cont.)	(cont.) members as well as the organizational capacity that enables staff to use these for patient benefit. The Welsh Government recently launched a new framework for language services in care, placing responsibility on services to respond to the needs of individuals through adopting the “active offer” principle inherent in Canadian language legislation; moving responsibility from the user to ask for services through the medium of Welsh, to the service to provide them. This means that organizations will need to adopt a whole-system approach in mainstreaming language services as an integral aspect of service delivery and workforce planning.	Although most Welsh speakers also speak English, there are important exceptions; and these have a significant bearing on the delivery of language-sensitive health care services. For example, preschool children from Welsh-speaking homes tend to have a limited grasp of English, and older Welsh speakers are more likely to revert to using Welsh in later life. Moreover, even those who are generally fluent in both languages may temporarily lose their command of English in stressful situations and this can impact dramatically on the accuracy of assessment and quality of ongoing treatment and care.

#	Author / Ref / URL	Type of Literature	Aims/purpose; Question addressed	Study population, sample size (if applicable), and location	Methodology; Intervention (if any); comparator (if any)	Outcomes	Key findings	Relevant comments
45	Madoc-Jones, I., & Dubberley, S. (2005). Language and the provision of health and social care in wales. Diversity in Health and Social Care, 2(2), 127-134.	Literature review and Comment (Position Piece)	To explore the discrimination that may be experienced by Welsh-speaking individuals accessing health and social care services in Wales Welsh, Language	Unspecified UK	Selective literature review and Comment	The paper explores the contemporary significance of the Welsh language, & the insights bilingual theory offers into the importance of providing linguistically appropriate services in Wales. The provision of services in the Welsh language in Wales is limited or inappropriately framed. Four reasons are examined: legal inadequacies, ignorance about the complexities of bilingualism, continuing prejudice, & the basis of language claims. If further provision needs to be made, it looks at on what basis such provision could be substantiated, & what forms further provisions might take.	Recommendations are proposed: 1 Language prejudice and discrimination should be treated in the same way as other forms of discrimination. 2 People in Wales have the right to engage with all services, including the health and social care system, through the medium of Welsh or English. 3 This will require all services to be available in Welsh and English at the point of contact. 4 This will necessitate that all front-line staff speak Welsh and English. 5 As part of the process, all health and social care staff in Wales should be provided with opportunities to develop their Welsh language skills. 6 Education/ training for health and social care justice staff should be available fully bilingually. 7 Public media (such as video, newspapers, leaflets, magazines and posters) in health and social care agencies in Wales must reflect the bilingual nature and the equal status given to English and Welsh.	Take-up of services in the Welsh language might be low: many Welsh language users may feel they lack the proficiency in formal settings to conduct their affairs in Welsh. In a range of care settings, there is a lack of staff who are trained or proficient in the Welsh language. A study of the use of minority languages within midwifery education in North Wales (Welsh), Barcelona (Catalan) and Western Ireland (Irish) indicates that use of minority languages within education varies considerably and is dependent upon supportive organisational policies, teaching and learning resources and IT software

#	Author / Ref / URL	Type of Literature	Aims/purpose; Question addressed	Study population, sample size (if applicable), and location	Methodology; Intervention (if any); comparator (if any)	Outcomes	Key findings	Relevant comments
46	Roberts, G. W., Irvine, F. E., Jones, P. R., Spencer, L. H., Baker, C. R., & Williams, C. (2007). Language awareness in the bilingual healthcare setting: A national survey. International Journal of Nursing Studies, 44(7), 1177-1186. doi:// dx.doi.org/10.1016/ j.ijnurstu. 2006.03.019	Survey report	To report on the nurses, midwives and health visitors (NMHV) data set of the first phase of a large-scale national study, commissioned by the Welsh Assembly Government, to examine the nature and extent of Welsh language awareness amongst healthcare professionals in Wales Welsh	Healthcare professionals working in the public, private and voluntary sectors of healthcare in Wales N = 1042 UK	Self-administered questionnaire survey	A strong positive correlation is identified between the NMHV use of the Welsh language in practice and their Welsh language proficiency, language attitudes, and language region. Mean language attitude scores are more positive than expected, particularly amongst those with limited Welsh language proficiency and those working in regions with the lowest proportions of Welsh speakers.	In view of the universal drive for culturally and linguistically appropriate healthcare practice, the findings have important implications for bilingual and multilingual healthcare settings worldwide. The evidence emerging from this survey confirms that cross-cultural communication is enhanced by NMHV language attitudes as well as their proficiency levels. Language awareness training is therefore recommended as a way of enhancing care delivery for minority language speakers.	Nurses are ideal 'natural mediators' in healthcare, in view of their position and role within the multi-disciplinary team. Their role as 'communication brokers' is further supported by Bourhis et al., (1989) who described nurses as key mediators in healthcare, using 'everyday language' with patients and 'medical language' with doctors. It is reasonable, therefore, to suggest that NMHV should be supported to maintain their leading role in establishing language awareness within the delivery of healthcare.

#	Author / Ref / URL	Type of Literature	Aims/purpose; Question addressed	Study population, sample size (if applicable), and location	Methodology; Intervention (if any); comparator (if any)	Outcomes	Key findings	Relevant comments
47	Madoc-Jones, I. (2004). Linguistic sensitivity, indigenous peoples and the mental health system in wales. International Journal of Mental Health Nursing, 13(4), 216-225.	Qualitative research (pilot study)	To explore the significance and availability of mental health services in the medium of Welsh in Wales Welsh	Past users of mental health services in Wales who were first language Welsh N = 5	Semi-structured interviews	Being bilingual can be a significant factor in the complex biopsychosocial matrix that underpins mental health problems amongst Welsh speakers. The destructive effects of linguistic oppression, and the difficulties of second language communication for mental health service users, are such that an appropriate health and social care response in Wales involves providing services in a user's preferred language.	In Wales, current mental health services are provided in the context of language being seen as unimportant or an optional added value as opposed to essential element to service provision. Nonetheless, from an effective practice point of view it is clear that the mental health system in Wales needs to engage more proactively with the bilingual context of Wales. The largely passive approach in responding to the linguistic needs of Welsh speakers in Wales is not experienced as helpful by service users.	All five service user respondents commented that they found speaking Welsh easier, and that they had greater difficulty expressing exactly what they wanted to, or understanding what they were being told, through the medium of English: 'I said I was ok speaking English to him, but then he wanted to talk about my life and feelings I didn't have the words.' 'At the time I was hearing voices you see. So there I was hearing voices in Welsh in my head being told by an English speaking nurse to describe exactly what I was hearing. Well, silly uh?'

#	Author / Ref / URL	Type of Literature	Aims/purpose; Question addressed	Study population, sample size (if applicable), and location	Methodology; Intervention (if any); comparator (if any)	Outcomes	Key findings	Relevant comments
48	Wyn Roberts, G. (1994). Nurse/ patient communication within a bilingual health care setting. British Journal of Nursing (Mark Allen Publishing), 3(2), 60-67.	Qualitative research	An examination of language switching within nurse/patient interaction in a bilingual setting provides a further dimension for the study of cross-cultural communication Welsh, Language	Nurse, doctors and patients on a general surgical ward in West Wales N = 9 UK	Participant and non-participant observation followed by in-depth formal interviews	Language switching is demonstrated to a large extent in the study, with five main categories emerging from the data. The analysis of language switching in terms of sociolinguistic and social-psychological theory proves particularly beneficial to the analysis of nurse/patient interactions within a bilingual setting.	The results suggest that bilingual nurses are provided with additional insight into the problems of cross-cultural patient communication — problems that may prove difficult at times for monolinguals to comprehend. Furthermore, through the use of language switching strategies, bilingual nurses and semi-speakers demonstrate this awareness and attempt to improve communication channels with patients, thus strengthening the nurse/patient relationship.	Bilingual nurses demonstrated that, through specific language switching strategies, communication channels are improved, so that patients are encouraged to share their fears and problems, while nurses are able to provide more meaningful information to patients. Bilingual patients' responses to limited phrase switching were supportive of the practice. Patients were particularly appreciative of the respect shown towards their first language by nurses. Moreover, nurses who initiate language-switching in this manner were deemed by patients as 'more homely' and 'more intimate'

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49	Roberts, G. W. (1996). The power of language in a bilingual community. Nursing Times, 92(39), 41-43.	Comment piece	Addresses the significance of promoting cultural and linguistic sensitivity in health care Welsh, Language	Not applicable UK	Comment and selective literature review	See Key Findings (analysis of review and comment)	Describes the developments of Welsh language services and sensitivity within the health care system in Wales and state that these have far-reaching implications for nursing education and should lead to positive outcomes for health care in the bilingual community in Wales	There are a number of obstacles to the uptake of services in Welsh. It is suggested that in Wales there is a tradition of deferential language switching when dealing with those in authority

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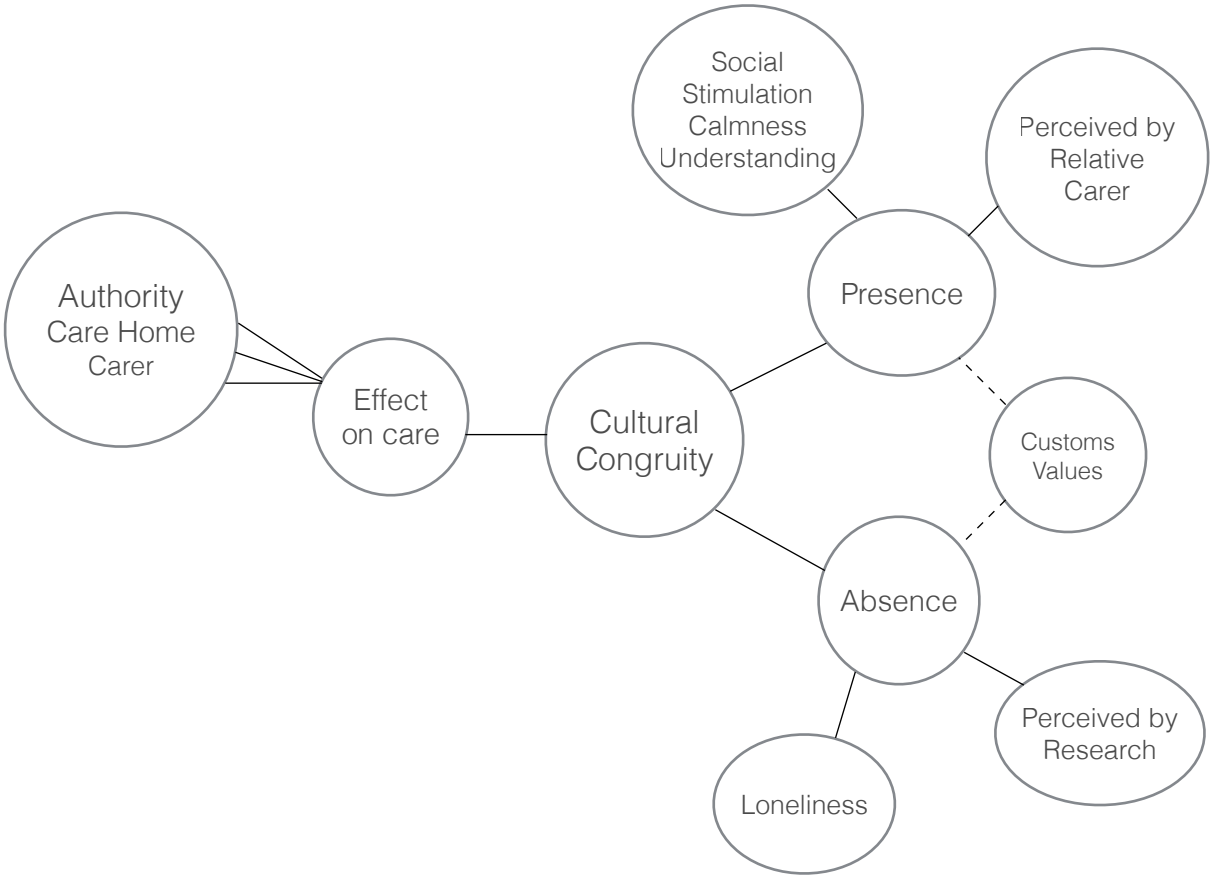
50	Misell, A. (2000). In Welsh Consumer Council (Ed.), Welsh in the health service : The scope, nature and adequacy of welsh language provision in the national health service in wales. Cardiff: Cardiff : Welsh Consumer Council.	Report	To investigate the scope, nature and adequacy of Welsh Language provision in the National Health Service in Wales Welsh	Not applicable UK	Desk research; Contacts with Key Individuals and Institutions; In-depth, face-to-face interviews were conducted with 20 key individuals; telephone interviews were conducted with 4 key individuals; observation work in hospitals; questionnaire survey	The report concludes that in the case of Welsh-speaking patients, there are instances when they cannot be treated effectively except in their first language, or in both their languages. This is especially true in the case of those receiving speech and language therapy, and for the following key groups: people with mental health problems; people with learning disabilities and other special needs; older people; and young children.	The report contains recommendations and calls for a fundamental change of approach on the part of the NHS in Wales. The report also calls for greater leadership from the National Assembly itself. Most importantly, the report calls for a change of thinking. It must become clear that the responsibility for ensuring that the language used within the health service is one with which everyone is comfortable rests with service providers and not with consumers.	“She’s 91 and she’s a first language Welsh speaker, and she finds Welsh easier as she becomes more frail. She’s quite frustrated, she gets confused, she’s had several strokes. She finds it very frustrating. I hear her speaking Welsh to the staff and they don’t understand a word of Welsh. She had a very bad stroke recently and she had to go into hospital. And she was really very unhappy at times. It didn’t help her at all to get better. And she was suffering from depression, and a lot of that came from the fact that when she was living in her own flat she used to live 90% or more of her life in Welsh. Being disabled, having trouble with her speech, and not being about to speak Welsh with people - well, it was a cruel blow to her.”

The separate questions are analysed separately as follows:

2.6.1 Cultural congruity

Figure 2.6: Theme Mapping, Cultural Congruity, Literature Review



For the purposes of this study, Cultural Congruity is defined as the match of the person with dementia's (PWD's) cultural values with those of the environment of the care home. This review has identified that the presence of Cultural Congruity in the care setting for the PWD is reported to lead to a positive effect on well-being. The main manifestations of this positive effect are *Social Stimulation*, *Calmness* and *Understanding*. The full results are mapped in Figure 2.6.

Examples of such cultural effects found in the literature are now discussed. Hanssen and Kuven (2016), for example, sought to understand the importance of traditional foods in ethno-specific care homes in Norway, finding that 'familiar tastes and smells awoke pleasant memories in patients and boosted their sense of well-being, identity and belonging, even producing words in those who usually did not speak', and that 'dishes remembered from their childhood may help maintain and

strengthen cultural identity, create joy and increase patients' feeling of belonging, being respected and cared for' (p.866).

Davies-Williams (2012) visited care homes in Wales and played traditional songs to residents with dementia. Many were made visibly happy (smiling and engaging in conversation), especially when presented with a song that was familiar to the culture of their past. The music sessions gave some residents a 'respite from their exhaustive wandering', and caused 'calm in those who were agitated', and 'stimulated those who were withdrawn' (p.129). Antelius and Kiwi (2015) found that in an Iranian ethno-specific care home in Sweden, residents were able to 'be home in Iran' [in Sweden] (p. 81), allowing traditions, customs, food, religion and other aspects of life to be culturally congruent for the residents. It also seemed to 'partially help in easing the shame of family members of not fulfilling cultural standards about filial piety' (p.90).

This is a good example of the finding that in research, the positive effect of Cultural Congruity is mainly perceived by the PWD's relative. Family members are often relieved that care in such environments are culturally congruent (p.89):

> '[They] feel a sense of shame about their parents' dementia [and] want to tell friends and acquaintances in Sweden and Iran that their relatives live in a special residential home, with Persian-speaking staff, Persian food, and Persian nurses and doctors who all give the parents the best possible service..'

Carers were also seen to report the positive effect, mostly those who were providing the congruity and were therefore from the PWD's culture (for example, in the above Iranian-specific care home).

The absence of Cultural Congruity in this setting has a negative effect on a PWD's well-being. It was seen to have provoked *Distress*, such as in a care home accomodating indigenous nomadic Sami residents in Norway (Hanssen, 2013, p.233), where one nurse reported that:

> '..two ladies, both with nomadic backgrounds, had one day rushed around removing the duvets from all the beds on the ward, and put them in duvet covers. They had been so quick about it that the staff had not been able to stop them. When a daughter came to the rescue, it turned out that they were

making ready for the seasonal reindeer trek and were in a hurry to 'strike camp' as they believed the animals were approaching.'

Loneliness was another issue, for example in the case of a lady in a care home in the New Orleans area of the US (Müller and Guendozi, 2009) who was socially isolated until she made friends with an older lady who shared her cultural background (Louisiana French), and whom she affectionately called 'maman' (p.202).

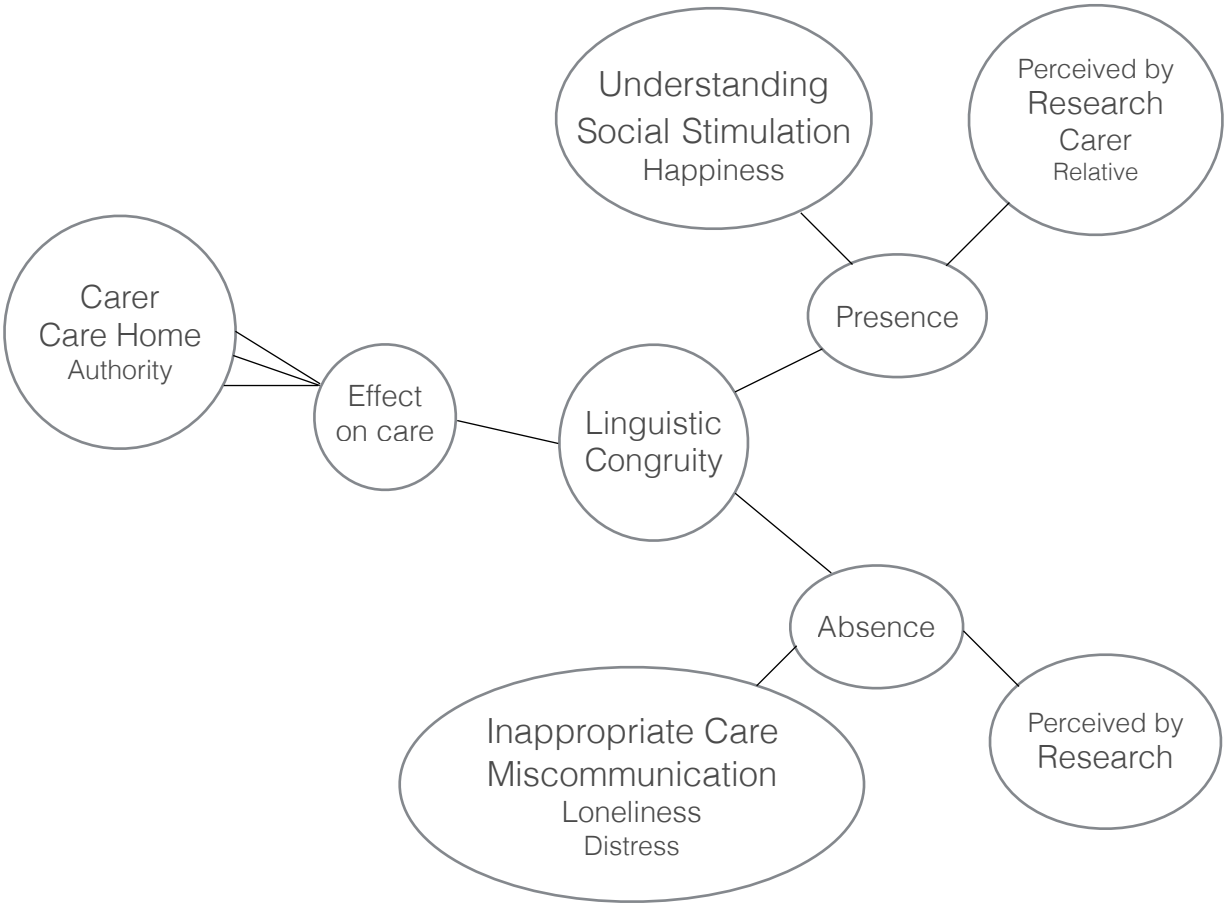
This adverse effect is mainly perceived by the Researcher in the literature, rather than the PWD, relatives or carers, which may reflect the reluctance of individuals to portray the mainstream care environments (that they themselves have chosen for their family members) in a negative light - the emotional difficulty of placing parents in residential homes was a prominent theme throughout.

The most prominent aspects of Cultural Congruity emphasised in the research were *Customs* and *Values*; that is, particular and established behaviours according to one's culture, and the principles and standards in life which are judged to be important in that culture. In an exploration by Runci, Eppingstall, and O'Connor (2012) of these themes, the suggested areas of improvement for homes (by relatives) would be to provide culturo-specific festive days. Heikkilä et al. (2007) found that Finns living in Swedish care homes greatly enjoyed Finnish traditional dance music, and conversations about rowing on Finnish lakes, amongst other examples. A report by Valins (2004) about Jewish elders in the UK stated that although many British Jews have low levels of religiosity, 'they certainly don't want to live in a home that serves bacon for breakfast.' (p.8)

The effect that the presence or absence of Cultural Congruity has on the challenge of providing good care for PWD is mainly felt by the Authority or Organization responsible for providing care, followed by the Care Home itself and then the Carer. One paper (Bhattacharyya and Benbow, 2013) found that 'commissioning issues' (p.359) were frequent, including forward planning for continuing funding, and tending to choose funding mainstream, rather than specialist services. Another challenge is retaining direct care workers (often from an immigrant background), who are competent in local cultural attitudes toward dementia (Davis and Smith, 2013).

2.6.2 Linguistic congruity

Figure 2.7: Theme Mapping, Linguistic Congruity, Literature Review



For the purposes of this review, Linguistic Congruity is defined as the match of one's dominant language with that of the environment of the care home. The *presence* of Linguistic Congruity appears to have an overwhelmingly positive effect on the well-being of PWD in the care setting. The positive effect is mainly due to the ability of language to facilitate *Understanding* between PWD and carers, and increased *Social Stimulation* in linguistically congruent settings. It also has the effect of causing feelings of *Happiness* in PWD (as opposed to when in a linguistically incongruent environment). The full results are mapped in Figure 2.7.

In a case study of an elderly Russian woman living in a care home in the US, Burant and Camp (1996) reported that language boards were used by carers to communicate in Russian. This produced a substantial reduction in both verbal and physical aggression from the resident, and this increased her willingness to sit

through a meal, as well as the number of positive interactions between staff and the resident.

Greek and Italian residents in ethno-specific care in Australia (Runci et al. 2012) were prescribed antipsychotics at a significantly lower rate than their counterparts in mainstream services. In this instance, linguistic incongruity was thought to cause agitation due to communication difficulties in mainstream homes, which was interpreted as 'disruptive behaviour', and subsequently managed with sedative medications. In the ethno-specific homes, there was also significantly increased resident-to-resident social interaction compared to mainstream services, which could potentially increase well-being. Also in Australia, Shanley et al. (2012) reported that in a Chinese ethno-specific care home, other residents would reassure family members about the care provided: "No, she's OK. We are from the same village. We speak about the language; I'm two years older than your mum. She's OK." (p.5)

These effects are mainly perceived (in decreasing order) by the Researcher, the Carer and the Relatives of the people with dementia in the literature. Relatives (mostly younger, and without dementia) may be more likely to be able to cross any language divide, meaning that the concept of linguistic congruity may not occur to them, unless absent for the PWD.

The *absence* of Linguistic Congruity has a strongly negative effect on well-being in this setting, and this was the most prominent theme found in this review. This appears to be due to language barriers causing *Misunderstanding* and subsequent *Inappropriate Care*. *Loneliness* is also a factor, and to a lesser extent the PWD experience more *Distress* and *Agitation* in these circumstances. In the literature this is mainly perceived by the Researcher. In a care home of mainly Chinese, cognitively-impaired residents in Canada (where most staff did not speak a Chinese language), Small et al. (2015) reported that a resident who was asking for assistance in getting repositioned in her wheelchair was ignored until another resident's family member attended to translate her request. As well as the afore-mentioned increased use of antipsychotics in a linguistically incongruent environment (Runci et al. 2012), there are frequent examples of PWD displaying frustration and bewilderment in these situations. A Latvian resident in an Australian care home is quoted by MacKinlay (2009) as saying:

> ‘I sit down and my lady [her carer] who comes with me […] she said “why didn’t you speak?” but my mind keeps going up around and around and I really don’t know what to do with her, because she is different, she does not speak in our language.’ (p.324)

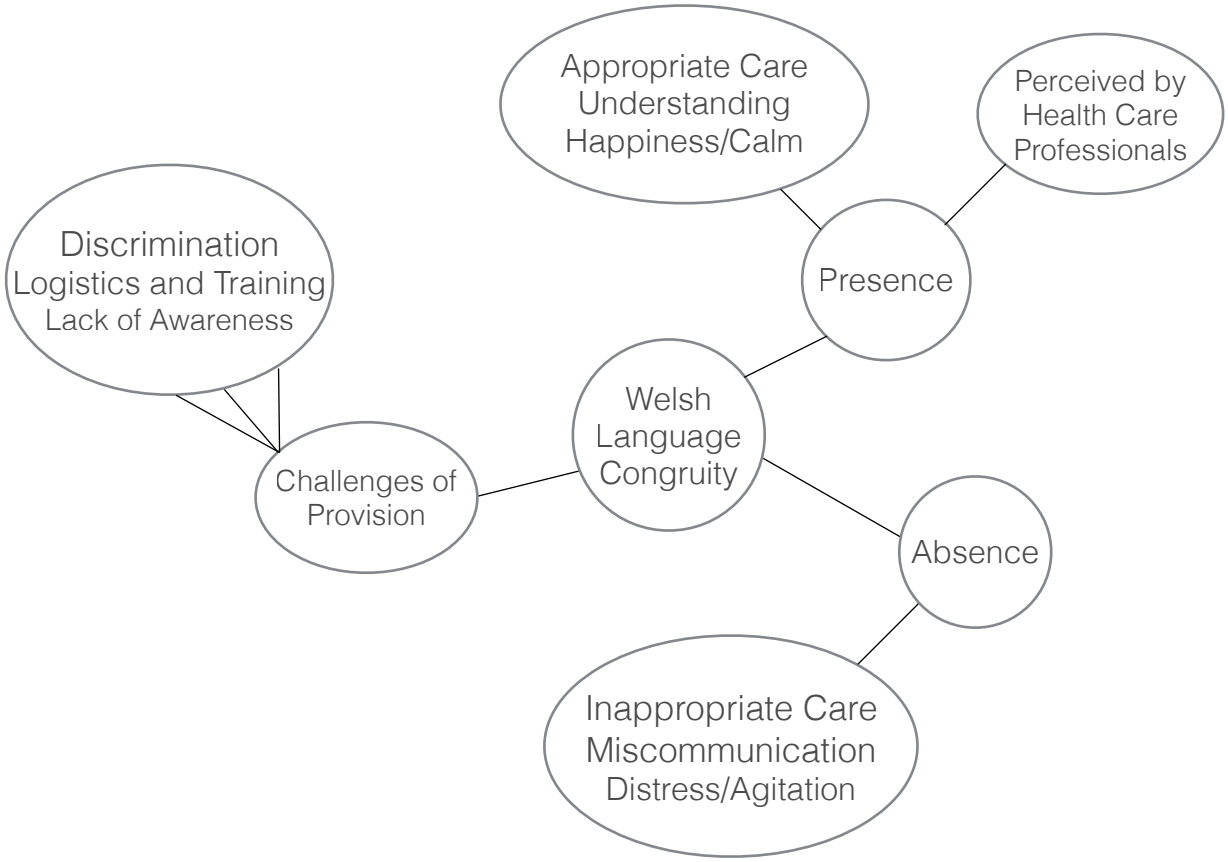
Ekman, Wahlin, Norberg, and Winblad (1993) found that monolingual Swedish-speaking caregivers had severe problems communicating with Finnish PWD and therefore had more difficulties creating positive relationships with them compared to bilingual caregivers. One Finnish resident in a mainstream home in Sweden was perceived by a Swedish carer as being introverted, whereas a bilingual caregiver who spoke Finnish perceived the same resident as being very sociable and chatty (Rosendahl, Söderman and Mazaheri, 2016). A case study by Plejert, Jansson, and Yazdanpanah (2014) in another Swedish residential home showed how a simple activity such as assisting a Farsi-speaking woman to get dressed became a difficult and distressing experience for her, due to communication barriers.

Immigrant caregivers who struggled to speak English in the UK were reported by Smith, Milburn, and Mackenzie *(*2008) to find difficulty in maintaining a good standard of care, including ‘residents being unable to obtain the help they require to self-care and maintain their well-being’ (p.38). There were also frequent misunderstandings between staff as a result of linguistic limitations. In the US (Davis and Smith, 2013), some immigrant caregivers were found to have made errors in following directions for giving medications due to inadequate English language skills, which could clearly have an adverse impact on the PWD’s care and well-being.

Interestingly, the effect that Linguistic Congruity has on the challenge of providing good care is opposite to that of Cultural Congruity’s, in that it is mainly perceived by the Carer, followed by the Care Home and least of all by the responsible Authority or Organization. This suggests a lack of emphasis on the responsibility of authorities and organizations to provide linguistically congruent care, and that the challenge of providing it is either not met, or left to the individual carer and care homes (for example, to use relatives as interpreters (MacKinlay, 2009)).

2.6.3 Welsh language congruity

Figure 2.8: Theme Mapping, Welsh Language Congruity, LIterature Review



For the purposes of this study, Welsh Language Congruity is defined as the match of the individual's Welsh language preference with that of the health care provision and caregiving environment. The *presence* of Welsh Language Congruity in the healthcare setting for older people whose first language is Welsh appears to be a positive influence on their well-being. As in Linguistic Congruity, this is due to a common language facilitating *Understanding* and *Appropriate Care,* as well as invoking feelings of *Happiness* and *Calm.* The full results are displayed in Figure 2.8.

In the limited research, this is mainly perceived by Welsh-speaking health care professionals, who have described being 'able to bond with them in a way that the other nurses can't...(the patient) is then more than happy to relax with me and to tell me what the problems are and how I can help' (Irvine et al. 2006, p.427). Despite this, to our knowledge there is no literature that has looked directly at PWD and Linguistic Congruity in the Welsh context.

The *absence* of Welsh Language Congruity in this setting is more prominent, and has a powerful negative effect on well-being. Again, this is due to decreased communication leading to *Misunderstanding* and *Inappropriate Care,* as well as *Distress* and *Agitation* which may be directly linked. In a case series about mental health patients (Madoc-Jones, 2004), respondents commented that they found speaking Welsh easier, and that they had greater difficulty expressing exactly what they wanted to, or understanding what they were being told, through the medium of English: 'I said I was ok speaking English to him, but then he wanted to talk about my life and feelings I didn't have the words' (p.219). A daughter of an older woman described her mother's plight in a commissioned report (Welsh Consumer Council, 2000, p.33):

> 'I could hear her speaking Welsh to the staff and they don't understand a word of Welsh. She had a very bad stroke recently and she had to go into hospital. And she was really very unhappy at times. It didn't help her at all to get better. And she was suffering from depression, and a lot of that came from the fact that when she was living in her own flat she used to live 90% or more of her life in Welsh. Being disabled, having trouble with her speech, and not being about to speak Welsh with people - well, it was a cruel blow to her.'

The provision of Welsh Language Congruity in these circumstances is mainly inhibited by *Logistics and Training,* according to the literature. Roberts and Burton (2013) reported that the Welsh Government launched a new framework for language services in care, placing responsibility on services to respond to the needs of individuals through adopting the 'active offer' principle inherent, for example, in Canadian language legislation; moving responsibility from the *user* to ask for services through the medium of Welsh ('passive offer'), to the *service* to provide them. This means that organizations will need to adopt a whole-system approach in mainstreaming language services as an integral aspect of service delivery and workforce planning, which will clearly be a logistical challenge. This also reflects the more general challenge for authorities or organizations to provide cultural congruity in care homes, as found in the Cultural Congruity section above. Another strong factor impeding Welsh Language Congruity is the issue of *Discrimination* towards the language. Madoc-Jones and Dubberly (2005) cited regular and continuing prejudice in British society towards the Welsh language, which was not addressed

in the Race Relations Act (Amendment) 2000 by leaving 'unclear the extent to which peoples of the different national entities - England, Wales and Scotland - constitute protected ethnic groups, and therefore what protections language communities might enjoy under the Act' (p.131). According to this paper, discrimination against the Welsh language leads to under-recognition of the needs of the Welsh-speaking people accessing health and social care services. To a lesser extent, a *Lack of Awareness* on the part of stakeholders and organizations also affects provision. Illife and Manthorpe (2004) argued that ethnicity is a 'category fallacy' standing in the way of person-centred dementia care: 'migration leads to acculturation, so that responses attributed to a presumed stable ethnic identity may be cohort effects, confined to one or two generations only' (p.289). This statement starkly illustrates the general lack of awareness, even amongst researchers, of the stable ethnic identities (not subject to migration and acculturation effects) already existent in the UK (national: English, Welsh, Scottish, and Northern Irish; or religious: Protestant, Catholic, Jewish, Muslim), whose separate needs are not prioritised.

2.7 Discussion

This scoping review identified that cultural, and especially linguistic congruity, are important factors in the well-being of people with dementia who are cared for in residential homes. The absence of linguistic congruity is a particularly strong predictor for decreased well-being in people in such settings, due to the communication barriers between residents and carers which seem to result mainly from the loss of a PWD's second (or even third, etc) language skills. On other occasions, it is the carers themselves who may not be fully competent in the local dominant language. Such communication barriers may lead to inappropriate care, e.g. residents being unable to obtain the help they require to self-care. It may also lead to social isolation, which is an independent risk factor for depression and feelings of loneliness, decreasing quality of life, and self-confidence in PWD (Oken, Zajdel, and Kishiyama, 2006). However, where culturo-lingustic congruity is provided (albeit as a challenge to organisations, care homes and carers), there is evidence of increased well-being, social stimulation and happiness.

The majority of those affected by such circumstances are immigrants who have developed dementia in their non-native countries and are therefore living in their

second cultures and languages. The challenge to provide ethno-specific care for these people is great, especially when they are from a less populous ethnicity within a specific country (e.g. Russians in the UK). Even catering for larger ethnic minorities may be challenging due to the recruitment, training and retention of suitable carers (Davis and Smith, 2013).

On the basis of this review, to what extent should culturo-linguistic congruity be provided, and at what cost? On the subject of language, should homes go to the extent of recruiting linguistically congruent carers, or simply look at the most feasible ways of communication (e.g. communication boards)? It may be true that concentrating on ethnicity and language may stand in the way of person-centred care, as Illife and Manthorpe (2004) argue, especially as acculturation of individuals within immigrant families is expected to occur within two generations. However, this does not address the current problem of people with dementia in residential homes, who may be receiving significantly inequitable care due to the culturo-lingustic incongruities they face in day-to-day life. Additionally, immigration is a constant and fluid phenomenon, so that by the time one cohort is acculturated, another may have taken its place.

Cultural and linguistic congruity are overlapping phenomena in dementia, with similar issues identified in the literature regarding their respective presences and absences. Many studies (for example, Runci et al's work (2012) with Greek and Italian immigrants in Australia) consider the subjects in tandem, and the findings that emerge from one are often indistinguishable from the other. This review found that the relationship between cultural and lingusitic congruity is very close, but will vary depending on the cultural or linguistic cohorts studied. The exact nuances are yet to be fully explored in detail and would be an interesting topic for further research - for example, to which extent customs and values depend on language, and how this affects provision of care.

One area not explored much in the available literature is the extent to which language and culture allow residents to interact with each other (rather than with carers), from a 'social'-orientated aspect. Is this important to PWD, and if so, how would it affect the care arrangements in a home? Should there be homes that set specific criteria for PWD to be accepted as residents on the basis of similarity of cultures and language? It seems that from a 'task'-orientated aspect (i.e. interacting

with care staff), culturo-linguistic congruity is preferable (Plejert et al. 2014), but this again needs more clarification and could be incorporated into future research.

The topic of 'mixing' cultures in people with dementia is another which seems as yet unexplored. It can be assumed that there are countless examples of this occurring across the UK, especially in multi-cultural cities and towns. Are there advantages or beneficial effects of doing this? For example, would a PWD from one culture enjoy aspects of another PWD's culture (e.g. customs, food)? This, too, could be investigated by seeking the views of residents of their preferences in this area.

This review suggests that strategies need to be developed and implemented by governments across the world to accommodate those who have emigrated to their countries (and in the cases of the vast majority, will have made a positive economic impact (Smith and Edmonston, 1997)) and then require residential home care for their dementia and care needs. The bulk of responsibility for this challenge should be taken out of the individual carers' and care homes' hands, and placed into those of governments and local authorities, who should co-ordinate national streamlined approaches to designing and providing services for these minorities.

The first step in this process is to commission more research into the area. Mold's review (2005) revealed a paucity of UK research regarding the needs of minority ethnic elders in UK care homes, and the most effective modes of care delivery within these facilities, compounded by an absence of UK statistics on the number of specialist care homes in the UK catering for ethnic elders. It also illustrated a clear demand from ethnic minority communities for ethno-specific care. Daker-White et al's review found that there was little consensus in the literature examined about whether services should be provided specifically for different ethnic groups, reflecting a lack of evidence concerning the efficacy of different models of service provision. Additionally, it could be argued that ethno-specific care could be best provided in the community and at home by the family and culturally congruent carers - and could be potentially more cost-effective. This model needs further investigation, as does the provision of culturo-lingusitic congruent care in care homes.

Alongside the identification of a suitable model of provision, greater partnership between government, the independent care home sector and voluntary agencies

needs to be established (Oken et al. 2006). Training and education initiatives informed by robust research and aimed at care home staff are needed in order to raise awareness of ethnic diversity and the needs of older residents from different ethnic backgrounds, as well as involving organisations such as Ethnic Minority Forums and Refugee Networks.

On the other hand, there are native ethnic groups (e.g. the Sami in Norway, the Welsh in Wales, Jews in the UK), who have stable identities, cultures and languages, yet whom are not provided the culturo-linguistic congruity which has been shown to be important to their well-being when living with dementia in care. This review showed that the presence of culturo-linguistic congruity for these groups has a powerfully positive effect on their well-being, and that the absence of it has the opposite effect. It also showed that congruity for Welsh speakers in Wales is not provided to an acceptable level.

There is evidence from this review that there are significant barriers to providing culturo-linguistically appropriate care in Wales, the largest being the logistics of service provision redesign, and training of staff. To a certain extent, a suitable model is already available in Canada, where the needs of the minority French language speakers are met by the policy of bilingual service provision as per the Official Languages Act of 2001 (Hodder, 2003). Roberts and Burton (2013) have shown that although health care organisations in Wales have a statutory duty to deliver equitable Welsh language services, there are reports of failures to implement national programmes. On the basis of our review, a responsibility on services to provide Welsh language services *actively* rather than *passively* would benefit residents; thus, organisations should integrate them into a mainstream whole-system approach as part of service delivery and workforce planning. For this to take place, a discussion should occur at the highest level (in the Welsh Assembly) to facilitate provision redesign and to allocate the appropriate resources; furthermore, the Welsh Language Commissioner can only implement change if given the appropriate capacity to regulate bilingual service provision.

The delivery of this radical system change is by no means an issue exclusive to Wales: Betancourt, Green, Carrillo, and Ananeh-Firempong's review (2003) found that internationally, sociocultural barriers to care were identified at the organizational (leadership/workforce), structural (processes of care), and clinical (provider-patient encounter) levels. They developed a framework of cultural competence

interventions to countenance these barriers, including minority recruitment into the health professions, development of interpreter services, language-appropriate health educational materials, and provider education on cross-cultural issues. This framework could be examined by relevant authorities, to help devise strategies for tackling this issue on a case-by-case basis.

Roberts et al. (2007) found in a national survey, that 45% of nurses, midwives and health visitors demonstrated positive attitudes towards the Welsh language in healthcare, whilst only 12% demonstrated negative language attitudes, showing that there is potential to drive through this change with stakeholders. According to Roberts, Irvine, Tranter, and Spencer (2010), there is already a degree of bilingual nursing education occurring at local levels in Wales, offering 'positive advantages for student learning and care delivery in the bilingual setting' (p.627). These models should therefore be given formal status, developed, and expanded upon to provide an example to training staff working in healthcare in Wales.

A task equally difficult to navigate as logistics and training may be the effort of changing attitudes, on a national level across the UK, towards the Welsh language. Discrimination and a lack of awareness of the problems faced by Welsh speakers are cited by Madoc-Jones and Dubberly (2005) as being persistent in British society. A significant step towards progress would be legislation: by reviewing the Equality Act (2010), there should be clarification of the extent to which peoples of the different national entities - England, Wales and Scotland - constitute protected ethnic groups, and which protections should be given to language communities. Specifically, language prejudice and discrimination should be treated in the same way as other forms of discrimination.

In an example of the potential disadvantage that may be experienced in culturo-linguistically incongruent care in Wales, Owen and Morris (2012) showed that Welsh-speaking patients did not gain the same benefit as their non-Welsh speaking counterparts from physiotherapy if not seen by a Welsh speaking therapist/team. Our personal experiences can attest that this is a daily occurring scenario in many places in Wales. The review has demonstrated that this area of research, especially for people with dementia, is in its infancy.

2.8 Review limitations

By its very nature, a scoping review does not seek to undertake quality assessments of the included literature, and there are considerable challenges in assessing quality among the vast range of published and grey literature that may be included. It remains unclear whether the lack of quality assessment impacts the uptake and relevance of scoping study findings (Levac et al. 2010). However, due to the simultaneuoulsy broad (care of dementia in relation to language and culture) and narrow (the Welsh perspective) nature of the subject investigated, and the comparative dearth of surrounding literature, we felt that a scoping study was the best tool with which to review all the available evidence.

2.9 Conclusion and implications for empirical work

This scoping review suggests that culturo-linguistic congruity is beneficial (and that its absence is detrimental) towards the well-being of people with dementia who live in care homes across the world. This appears to be a result of the dementia process leading to a loss of familiarity with the person's second languages and cultures, leading to communication and cultural barriers within the care environments. Where congruity is provided, the person will experience an improvement in the care experience and their well-being due to enhanced communication and cultural understanding allowing for appropriate care, social stimulation and happiness.

Further research was stated as a requirement by nearly every article analysed. This would inform the development of care delivery models which needs to occur in order for ethno-specific cohorts to receive equitable care. This review has highlighted the lack of attention given to this issue, and which has hitherto escaped policymakers globally, especially in the case of linguistic congruity, and even more so in native minority groups (Roberts and Burton, 2013) such as the Catalan-speakers in Spain, Gaelic-speakers in Ireland, and Welsh-speakers in Wales.

In the case of the latter, very little research had been done into those who speak Welsh, have dementia and live in residential care. This review identified the issues which urgently required further investigation relation in this area. It also demonstrated the ability of qualitative studies to extract important information and ideas surrounding languages and cultures in relation to dementia, and to cross

ethno-geographical borders in the process - garnering results from all over the world. Another revelation was the value of seeking a range of views to inform the findings - residents, family members and formal care-givers.

The basic tenets of an empirical piece of research were therefore established - to undertake a qualitative study to investigate the well-being of Welsh-speaking residents of care homes with dementia, in relation to the culturo-linguistic congruity of the environment they were living in. How important to them was a Welsh language and culture environment? Did they want congruity in the care home or would they prefer to mix with other cultures (e.g. English or Anglo-Welsh; European and beyond)? Who are the people they would potentially have liked to share congruity with - residents, staff or both? In which types of interactions is it more important to maintain congruity - social, or task-orientated? This work would also pay attention to the question of the relationship between cultural and linguistic congruity - what are the common and distinguishing traits? The aim would be to generally help strengthen the evidence base, and to help expedite the mainstream whole-system integration of the Welsh language into services for people with dementia, in the face of logistical, training and discriminatory barriers.

Chapter Three

Methodology and Methods

3.1 Introduction and Rationale

The empirical part of this study examines how the well-being of first language Welsh people who live in care homes is affected by the linguistic and cultural surroundings of their living environment. In particular, the concept of *congruity*, which is the degree of harmony and consistency between two (or more) things, is studied. A *culturo-linguistically congruent* environment for people in a care home would mean that the residents would be cared for by, and be spending time with, people who can speak their language and understand their values. In theory, the well-being of residents in these circumstances is affected by the degree of congruity provided, and this study set out to discover if and how this is evident in practice. The rationale for this work is illustrated in the scoping review (see chapter 2), which found that internationally, cultural and linguistic congruity is advantageous for people living in care homes (especially for those who are cognitively impaired), and that incongruity is disadvantageous. The absence of *linguistic* congruity is a strong predictor for decreased well-being in people in such settings, due to communication barriers between residents and care staff, which seem to result mainly from the loss of the resident's second language skills as cognitive skills decline. The purpose of this study is to examine whether these findings also apply to bilingual people in Wales, and whether culturo-linguistic congruity should be a priority for those individuals (especially those who are cognitively impaired) who reside in care homes in this part of the UK.

Despite the multitude of cultures and languages that exist in the UK, and the acknowledged importance of the increasing impact of the ageing population and dementia on society, public services and the economy (Prince et al. 2014), there is a dearth of evidence on the subject of the significance of linguistic and cultural congruity in the care of people who live in care homes (see Chapter 2). This is particularly true in Wales, where hardly any research at all has been conducted on the role of the Welsh language and culture in the care of people in care homes (see

Chapter 2). Within Wales, 19% of the population speaks Welsh (Office of National Statistics, 2016), varying significantly according to region (see chapter 1).

Of the 44,000 people with dementia estimated to be living in Wales (Prince et al. 2014), at least 8,000 would therefore be expected to be Welsh-speaking. The Alzheimer's Society found in 2014 that the total prevalence of dementia in (non-Elderly and Mentally Infirm (EMI)) care homes was estimated to be 69% of residents. They also found that 38.7% of people with dementia reside in care homes, meaning that over 3,000 Welsh-speakers with dementia could currently be living in care homes. There are no available statistics as to the proportion of care homes in Wales that offer linguistic and cultural congruity in their living environments.

As mentioned above, the available literature generally shows that culturo-linguistic congruity is beneficial (and that its absence is detrimental) to the well-being of people who live in care homes (especially those with dementia) across the world. This appears to be a result of the decline in cognitive processes causing a loss of familiarity with residents' second languages and cultures, leading to communication and cultural barriers within the care environments. Where congruity is provided, the person will experience an improvement in the care experience and their well-being due to enhanced communication and cultural understanding allowing for appropriate care, social stimulation and happiness. In one example described in the scoping review, Greek and Italian residents in ethno-specific care in Australia (Runci et al. 2012) were prescribed antipsychotics at a significantly lower rate than their counterparts in mainstream services. In this instance, culturo-linguistic incongruity was thought to cause agitation due to communication difficulties in mainstream homes, which was interpreted as 'disruptive behaviour', and subsequently managed with sedating antipsychotic medications. In another example (Rosendahl et al. 2016), a Finnish resident in a mainstream home in Sweden was perceived by Swedish care staff as being introverted, whereas a bilingual caregiver who spoke Finnish perceived the same resident as being very sociable and chatty.

Drawing parallels between these immigrant cohorts and the Welsh-speaking population in Wales can be useful, but does not offer a fully satisfactory model on which to base the provision of care. Illife and Manthorpe (2004) argue that ethnicity is a 'category fallacy', standing in the way of person-centred care: 'migration leads to acculturation, so that responses attributed to a presumed stable ethnic identity may

be cohort effects, confined to one or two generations only' (p.289). This cannot be applied to the native Welsh-speaking population, as the linguistic and cultural identity can be considered as native to the geography of the area, and stable to the point that it is active, living and inherent to many districts in Wales.

Also of interest is the challenge to caregivers who are unable to speak Welsh to the appropriate residents. In some cases, immigrant caregivers in the UK, whose first language was not English, were reported (Smith et al. 2008, p.38) to find difficulty in maintaining a good standard of care, including 'residents being unable to obtain the help they require to self-care and maintain their well being', therefore it was considered that investigating the same theme from a Welsh language perspective would be of some worth.

Investigation of *cultural* congruity in the care of people in care homes is of its own individual and separate interest. Although there is often an overlap with linguistic congruity, other aspects of culture that are independent of language (such as religion, traditional customs and food) also affect experiences of dementia, since they represent the familiar values, norms and beliefs shared by a particular group, and can persist into a cognitive impairment process (Cox, 2007). Heikkila et al. (2007) examined culturally congruent care in a Finnish care home in Sweden, finding that both residents and staff had Finnish backgrounds. The Finnish language, customs, celebrations, and popular culture were therefore used to create a common ground for communication and shared understanding of the individual person. The home claimed that this enabled caring relationships, which, in turn, increased the residents' well-being. Such findings could clearly inform practice in the UK, especially in Wales.

Further research on care, dementia, and the Welsh language and culture was identified by our scoping review to be acutely required. Against a background of an ageing population, increasing immigration, mixing of cultures, and rising dementia incidence across the world, engagement with this area of research in this study was considered particularly prudent, to advise on how best to design models of long term care for people in care homes in Wales, especially for those who are cognitively impaired.

3.2 Methods

3.2.1 General approach

This study addressed the research question: 'How is the well-being of first language Welsh people who live in care homes affected by the linguistic and cultural surroundings of their living environment?'. In particular, the concept of congruity, which is the degree of harmony and consistency between two (or more) things, was examined in detail. The following definition of a culturo-linguistically congruent surrounding for people in a care home informed the understanding of its effect on well-being:

> An environment where residents reside with, and are also cared for by people who can speak their language, understand their values, and which includes culturally appropriate facilities, activities and media access.

This study used a multiple embedded case study approach (see figure 3.1) as exemplified by Yin (2014), covering multiple cases, and drawing a single set of cross-case conclusions. It utilised theoretical statements developed with Baxter and Jack's methods (2008) to guide data collection and analysis, framed by Spradley's dimensions of observation (1980). Themes from the data were elicited by applying thematic analysis using the approach detailed by Miles and Huberman (1994), and subsequent analysis followed Yin's logic model (2014) to illustrate the existence of a repeated cause and effect sequence of events.

3.2.2 Study Design

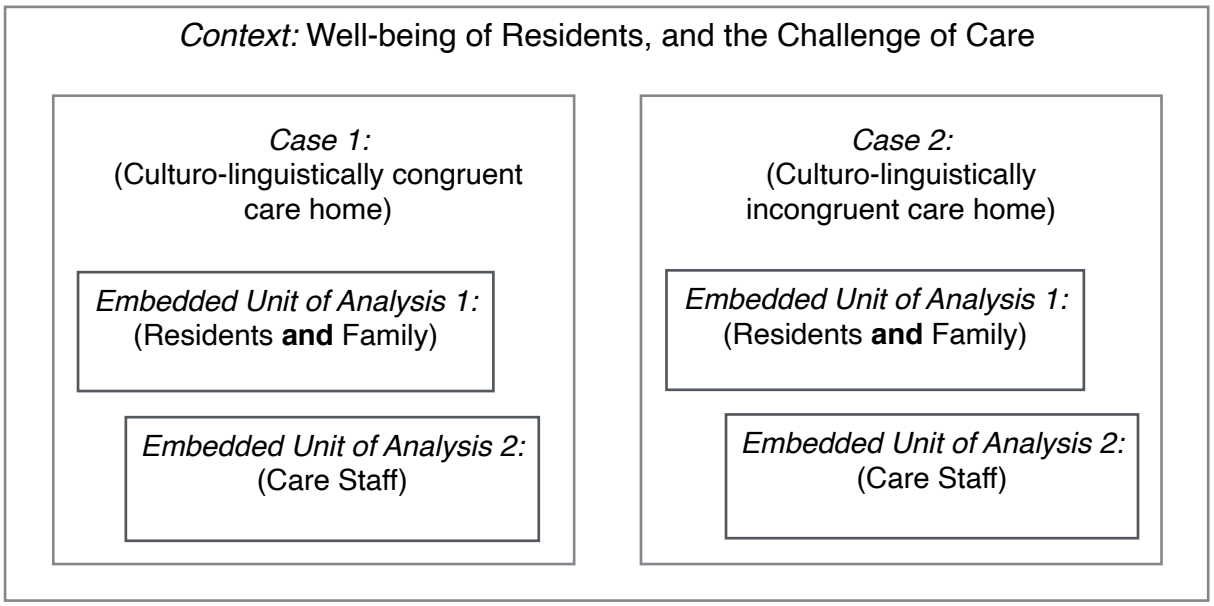
The theoretical proposition for the study imitated the logic model (Yin, 2014) to strengthen the analysis of the results. It also enabled collection and presentation of data pertaining to the transitions between the events. The theoretical proposition for this study, therefore, was:

> A culturo-linguistically congruent living environment for people who are first language Welsh speakers and living in care homes in North Wales (many of whom are cognitively impaired), increases the potential for communication, which in turn increases understanding and social interaction, which

subsequently leads to greater well-being for residents, which also reduces the challenge of care provision for care staff.

The study utilised (see Figure 3.1) two contrasting main cases (care homes) in the North Wales area, in order to map the effect of culturo-linguistic congruity on a resident's well-being.

Figure 3.1: Diagram of Multiple Embedded Case Study Approach



One case fulfilled criteria to allow investigation of experiences within a largely 1LW culturally and linguistically **congruent** environment, and another fulfilled different criteria to allow investigation of experiences within a largely 1LW culturally and linguistically **incongruent** environment. In both cases, the home selected was council-run, for two reasons. One was that in this area, council-run residential homes are more likely to employ local people (and therefore be able to fulfil the first case's congruity criteria). They have similar care ethos, similar facilities and limitations. A vital difference in the chosen cases was that one care home possessed a greater linguistic congruity for Welsh language speakers (due to its having a mostly Welsh language environment), whilst the second home had greater congruity for English speakers (due to its having a mostly English language environment), and therefore, greater incongruity for Welsh speakers. The second reason for choosing council-run homes was to eliminate a possible confounding variable between the cases (e.g. council versus private homes).

Within each case were separate embedded units of analysis, which corresponded to the other case's units respectively. These units could be compared within and across

the cases, and consisted of the residents and their relatives on one hand, and the care staff on the other. The overall context in which the cases were examined was the well-being of the residents, and the challenge of providing care.

To strengthen the internal validity of the study, the cases were pre-defined by these criteria:

> **Case 1:** A council-run care home in North Wales which accommodates (but not exclusively) cognitively impaired residents, and whose residents and staff are mostly first-language Welsh speakers;
>
> **Case 2:** A council-run care home in North Wales which accommodates (but not exclusively) cognitively impaired residents and some (but not most) of whom are first-language Welsh speakers.

A first language Welsh-speaking resident's culture was initially defined by their language preference; the meaning of that culture was thereafter explored in the study, looking at areas such as customs, media (television, radio, newspapers), food, sport, religion and festivities.

3.2.3 Sources of Evidence

To maximise the construct validity of this study, multiple sources of evidence were pursued, to allow for triangulation and convergence of the evidence. These sources took the form of a literature review, documentation search, observational work at the homes, and semi-structured interviews with participants. The sources were gathered across two phases and then analysed in the third and final phase:

> Phase 1: Literature (Scoping) Review and Documentation Search;
>
> Phase 2: Observational Work and Semi-structured Interviews;
>
> Phase 3: Cross-case Analysis.

Phase 1 - Literature (Scoping) Review and Documentation Search

The literature review forms the first chapter of this MRes thesis, laying the foundation for the empirical work that followed. The documentation search involved a search for relevant literature pertaining to national and local policy surrounding the

issue of cultural and linguistic congruity in the care of older people in care homes. This was done at three levels: case study, regional (county) and national levels. The types of documents unearthed and analysed ranged from the 'statement of purpose' documents for each care home, job specifications and inspection reports, to county councils' strategic frameworks and standards policies, to national strategic frameworks.

Phase 2 - Observational Work and Semi-structured Interviews

Over the whole research period, the researcher spent an estimated 20 hours, over 7 days, over a number of months, within each home. This was mostly spent in 'public' areas, such as communal lounges and dining rooms. The initial observational work consisted of at least four embedded hours in each case, with field notes of observations made, particularly appertaining to interactions and well-being. An observation guide, based on Spradley's dimensions of observation (1980), was used to record data and to record the participants' activities. Spradley's criteria guide the observer to describe what they are seeing by focusing on nine elements - common but essential features within a given social situation - and a matrix is provided to guide the researcher to consider how the elements are linked, thus identifying relationships between elements if they exist. The elements and matrix that were applied are illustrated in Figure 3.2.

The purpose of these observations was to gather instances of congruity and incongruity in language and culture, and to record, at a micro-level, the impact, if any, on moment-to-moment well-being and affect. The recording of well-being was based on residents' verbal and non-verbal responses to interactions and what was happening in their environment. Field notes were informed by the indicators of well-being and ill-being proposed in Kitwood's person-centred approach (1997) to dementia care. The observational phase also included spontaneous conversations with residents, relatives and friends of residents; and staff. These were on informal bases, reacting to events, behaviours and conversations observed, and recorded in the field notes.

Figure 3.2: Spradley's Dimensions of Observation

	SPACE	ACTORS	ACTIVITIES	OBJECTS	ACTS	EVENTS	TIME	GOALS	FEELINGS
SPACE	Layout of setting e.g. lounge								
ACTORS		Persons involved e.g. residents							
ACTIVITIES			What the actors are doing e.g. watching TV						
OBJECTS				Physical elements involved e.g. furniture					
ACTS					Individual actions of note				
EVENTS						Particular occasion, e.g. mealtime, meeting			
TIME							Sequence of events		
GOALS								What the actors are trying to accomplish	
FEELINGS									Emotions evident in this context

Figure 3.3: Coding Guide, Cultural Congruity, Field Work

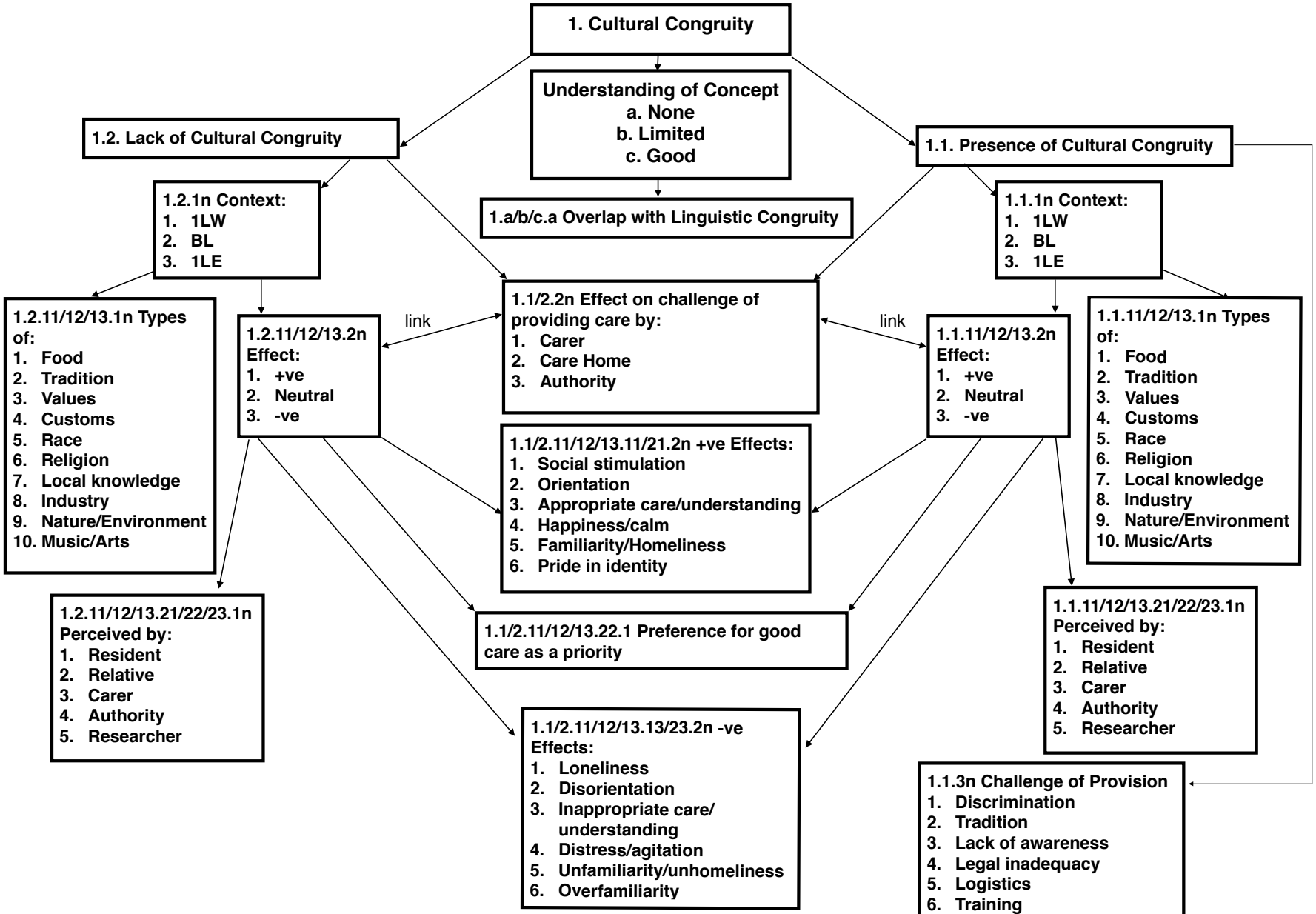
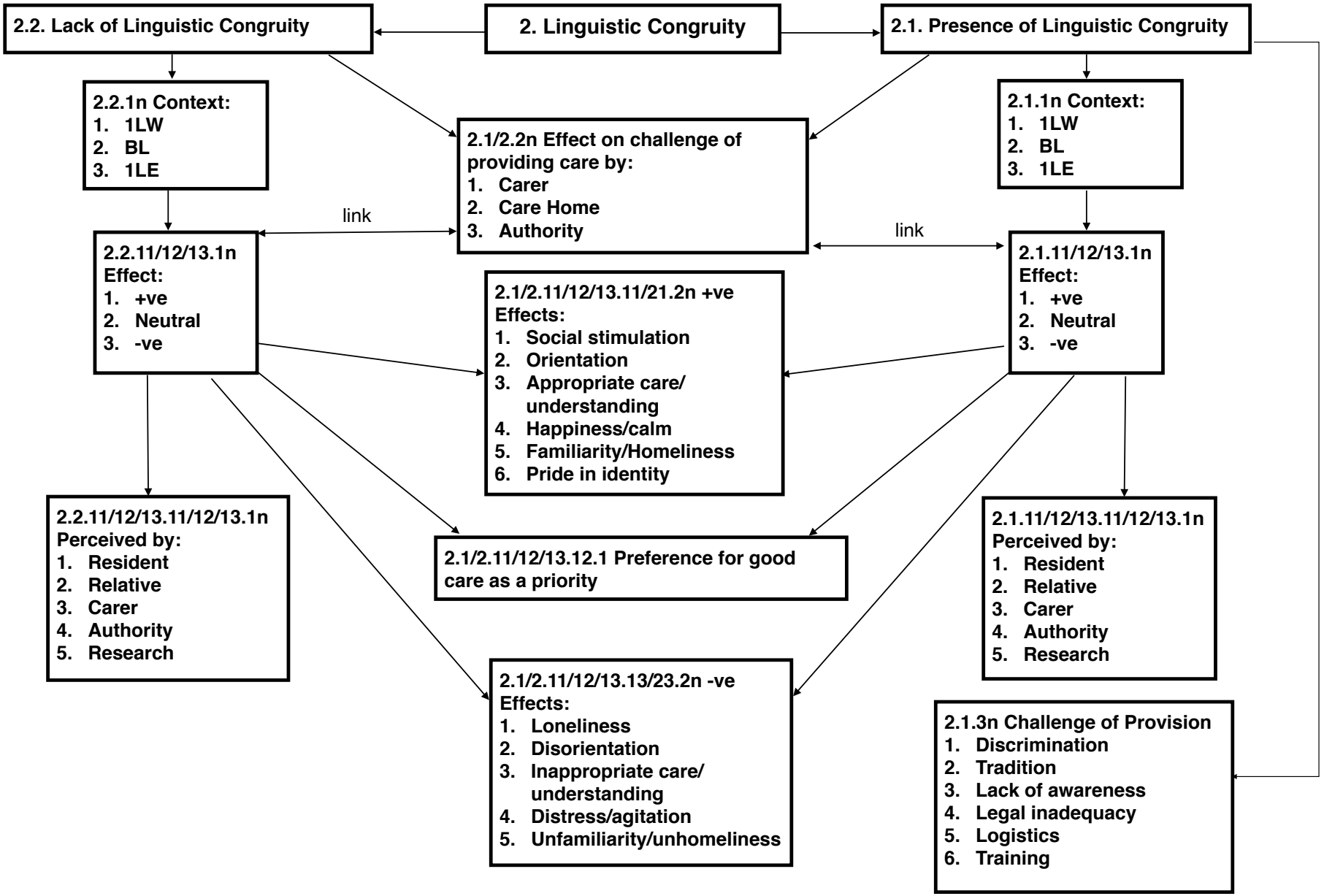


Figure 3.4: Coding Guide, Linguistic Congruity, Field Work



In order to understand the level of cognitive impairment in the sample, the Clinical Dementia Rating (CDR) scale (Hughes et al. 1982, see Appendix 1) was used, allowing for the categorisation of residents into different stages of dementia-related cognitive impairment (if any). The scale was completed from information provided by care staff, the resident and any relatives. It uses an algorithm to combine ratings from six different domains (Memory, Orientation, Judgment and Problem-solving, Community Affairs, Home and Hobbies, Personal Care) into a single overall rating, ranging from 'Healthy' to 'Questionable dementia', 'Mild dementia', 'Moderate dementia', and 'Severe dementia'. The CDR was chosen for this purpose due to it being relative quick and easy to use; this allowed the researcher to collate each resident's relevant information without having to subject him or her to a cognitive assessment, such as the Mini-Mental State Examination. Apart from adding to the burden of time and data required from each resident, such cognitive assessments are problematic due to the lack of standardization of their Welsh-language versions. Since Hughes et al. developed the CDR, it has been widely used internationally for the purpose of staging dementia, and its reliability and validity have been amply demonstrated (Rikkert et al. 2011)

To complete data collection, open-ended informal interviews (see Appendix 8) were conducted with selected participants - a roughly equal number in both case studies, being around six each of residents, relatives, and staff members, as well as the manager of each home. This number was chosen for practical reasons, in terms of the relatively large amount of time involved in participant selection, consent, interviewing and transcribing; but also to allow for a fairly broad range of views, as well as affording the opportunity to also interview non-1LW residents. Relatives and staff were interviewed in groups, wherever possible, for convenience. These 'conversations with a purpose' (Burgess, 1990) were essentially semi-structured interviews, loosely guided by an agenda - a broad guide to topic issues that might be covered in the interview, rather than the actual questions asked. The conversations aimed to cover the person's background (which could inform their culture), their linguistic preferences, and their ideas around culture, values and belonging. Interview data were collected using digital audio-recording of the encounters. Relevant demographic information of those interviewed is displayed in Tables 3.1a-c, including identifier (Resident A1, etc), gender, age (in 5-year bands to ensure anonymity), and Clinical Dementia Rating (CDR) for residents; identifier,

gender and designated role of staff members; identifier, gender and relation to (unspecified) participants of relatives.

Tables 3.1a-c: Identifiers and Demographics of Participants

Table 3.1a: Residents

Resident ID	Gender	Age	CDR
A1	Female	66-70	Mild (6)
A2	Male	86-90	Mild (5.5)
A3	Female	76-80	None (1)
A4	Female	91-95	Moderate (11)
A5	Female	91-95	Mild (3.5)
A6	Female	91-95	Questionable (1.5)

Resident ID	Gender	Age	CDR
B1	Female	91-95	Questionable (2)
B2	Female	96-100	Moderate (8)
B3	Male	86-90	Moderate (9)
B4	Male	71-75	Mild (4)
B5	Female	81-85	Questionable (2)
B6	Female	71-75	None (0)

Table 3.1b: Staff

Staff ID	Gender	Role
A1	Female	Carer/Deputy Manager
A2	Female	Carer
A3	Female	Carer
A4	Female	Carer
A5	Female	Carer
A6	Female	Carer
Manager A	Female	Manager

Staff ID	Gender	Role
B1	Female	Carer
B2	Female	Carer
B3	Female	Carer
B4	Female	Carer
B5	Female	Carer
B6	Male	Chef/Carer
B7	Female	Carer
Manager B	Female	Manager

Table 3.1c: Relatives

Relative ID	Gender	Relation to resident
A1	Female	Daughter-in-law
A2	Female	Daughter
A3	Male	Son
A4	Male	Son
A5	Female	Daughter
A6	Female	Daughter

Relative ID	Gender	Relation to resident
B1	Female	Daughter
B2	Female	Wife
B3	Male	Son
B4	Female	Daughter

Phase 3 - Cross-case Analysis

The data collection process was informed by the data analysis plan, by constantly comparing findings from interviews within the 'Residents and Relatives' units of analysis, the 'Staff' units of analysis, and across units and cases. Analysis was therefore an ongoing process, from the beginning of the data collection phase. In its final form, analysis was informed by using the modified Spradley's dimensions of observation (1980). For example, the narrative generated by the observational work was framed by the nine elements, which assisted as a heuristic. This was applied to each source of evidence, which were then thematically analysed using Miles and Huberman's approach (1994), applied to Yin's logic model (2014). After transcribing the audio material, all data were read and re-read to formulate codes, which were generated by using Atlas.ti™ (see Figures 3.3 and 3.4). Codes were grouped into relevant families to establish patterns from the data, which in turn were weighted according to their prominence and frequency in the overall data set (see Figure 2.5 for prior example), thus identifying the main themes and findings in the study.

3.2.4 Ethical Conduct

This study was reviewed and given favourable opinions by Bangor University's School of Health Sciences, and the Wales Research Ethics Committee (REC) 5 (REC reference 17/WA/0372). We sought and gained written informed consent from potential participants, using bilingual English and Welsh language information sheets (see Appendices 4 - 7 for English language examples), and there were no instances of declined consent during the observational phase. Research only took place in public areas of the care homes, other than during the semi-structured interview phase, where interviews were carried out in some residents' bedrooms for reasons of privacy (with consent of the resident and to the full knowledge of staff members), and intimate care-giving was not observed. Where one individual possibly lacked the capacity to consent, advice about their participation was sought from someone in a position who knew them, and who was able to give this advice as a consultee (following the Mental Capacity Act 2005).

Chapter 4

Findings

4.1 Introduction

The context of the results are as follows:

Home A

The first ‘case’ is a residential home in a rural location in North Wales, accommodating 21 residents, as well as 7 residents in a separate Elderly and Mentally Infirm (EMI) unit on site. All but 2 residents were female. It is situated in an area which is considered part of the Welsh-speaking heartlands - ‘Y Fro’ (Aitchison and Carter, 1994) with around 60% of the immediate area being Welsh-speaking (Office for National Statistics, 2016). The local constituency was represented by a Plaid Cymru Member of Parliament (UK Parliament, 2019) at the time of conducting field research. The area’s local population was mostly employed in heavy industry until the mid-20th century, although there is also a strong agricultural tradition in the area (Jenkins, 1992; Morgan, 2002). Of the 21 residents in the main unit, 19 were first language Welsh-speaking (1LWs), and one other was able to speak Welsh. After the observation period and a discussion with the manager at the home, the residents were individually reviewed and assigned a Clinical Dementia Rating (CDR). Only one resident was assigned as ‘No Dementia’, leaving twenty with ‘Questionable Dementia’ or above, with more than 50% having ‘Mild Dementia’ or above. In the EMI unit, 6 residents were 1LW, and one was first language English, second language Welsh (1LE/2LW). According to the CDR, three had ‘Mild Dementia’, one had ‘Moderate Dementia’, and three had ‘Severe Dementia’. All staff in both units were fluent in Welsh, including the manager.

Home B

The second case is a residential home in a market town in a rural area of North Wales, accommodating 23 elderly residents. 6 residents were male, and 17 female. The percentage of Welsh speakers in the immediate area was around 40% as recorded in the 2011 census, but in the county itself this is lower, at a proportion of

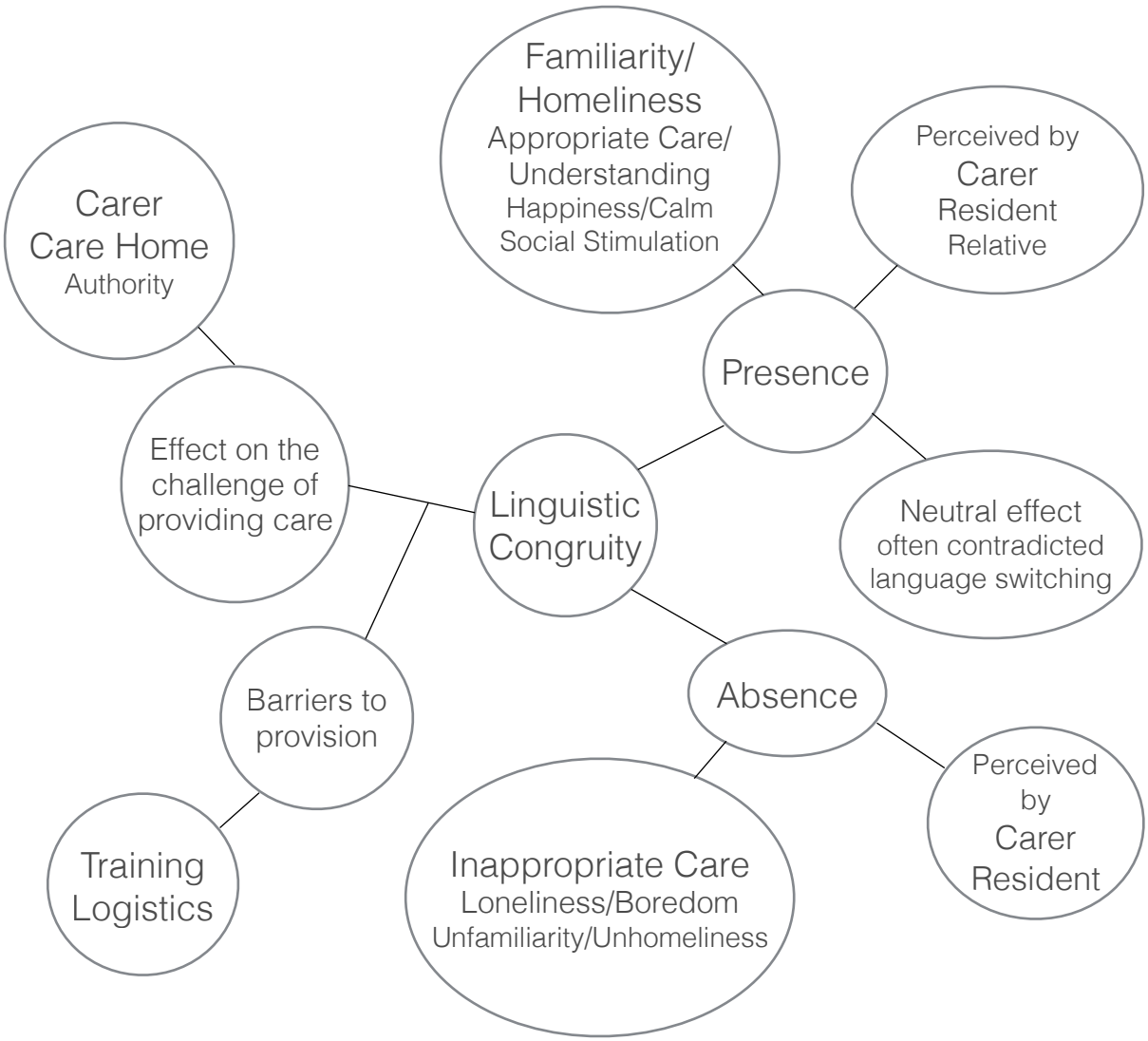
around 25%. The local constituency representation has, in recent history, frequently switched between the Labour and Conservative Parties (UK Parliament, 2019). The area's local population was traditionally mostly employed in agriculture and in the regional hospital until the mid-20th century; it now reflects a variety across the sectors similar to the United Kingdom averages (Jenkins, 1992; Morgan, 2002). 8 of the 23 residents were 1LW, and 14 were 1LE. One was first language German. Of the 1LEs, around half could also speak Welsh as a second language (1LE/2LW). All of the 1LWs were fluent in English. 14 staff members were fluent in Welsh, out of 34, but not including the manager or her deputy. According to the CDR, only 3 residents scored as 'No Dementia' leaving 20 with 'Questionable Dementia' or above, and over 30% of residents scoring as Mild Dementia or above.

Participants, when quoted, are referred to according to their type, home, and identifier, e.g. 'Resident A1', 'Staff B3', 'Relative A4', 'Manager B', etc. Thematic analysis of the field work produced a number of emergent themes. The most prominent themes are discussed below in their broad forms, and following further analysis, in their sub-theme forms. Where reference is made to the prominence of a result, this refers to the weight given to this sub-theme during thematic analysis (see 'Cross-case Analysis', in 'Methods' section (3.2.3)). The types of congruities and the challenges in providing them are discussed separately, as follows:

4.2 Linguistic Congruity

For the purposes of this study, linguistic congruity is defined as the match of the resident's first language with that of the immediate and wider environment of their care home. In the majority of residents interviewed, the first language was self-identified as Welsh, but the study also includes residents whose first language is English, and others who said they had no language preference, i.e. identified as purely bilingual between Welsh and English. The results are summarized in Figure 4.1, with themes prominent (in proportion to font size) in accordance with the weighting of their coding emerging during analysis.

Figure 4.1: Theme Mapping, Linguistic Congruity, Field Work



Presence of Linguistic Congruity

There was considerable evidence that a presence of linguistic congruity in a care home led to a strong positive effect on well-being for Welsh speakers. The main manifestations of this (in order of frequency of appearance) are *Familiarity and Homeliness*, *Appropriate Care and Understanding*, *Happiness and Calm*, and *Social Stimulation.* These positive effects were perceived mainly by the carers at the care homes, followed by the residents themselves, and then by residents' relatives. Quotes from the field work are presented firstly in colloquial Welsh, and then in their translated form in English.

Familiarity and Homeliness

The most prominent positive effect produced by linguistic congruity was a feeling of familiarity and homeliness for the residents. The initial embedded observational field work established the tone of how 1LW residents felt about linguistic congruity. In Home A, residents were observed greeting each other in Welsh in a friendly, familiar and jocular manner. Conversations in different lounges were in Welsh, and the only permanent 1LE resident was in fact conversing in Welsh with other residents. Residents approached informally told me that they found the Welsh language environment 'haws' [easier]. One lady with dementia even boasted that 'Does na'm llawar o Susnag yma. Neis, de! 'Does na'm tebyg iddo.' [There isn't much English here. Nice, isn't it? There's nothing like it], and that 'well genna i siarad Cymraeg. Fyddai'n atab y Saeson yn ol yn y Gymraeg weithia!' [I prefer speaking Welsh. I answer the English back in Welsh sometimes!]

In Home B, there was much less Welsh spoken in the general day-to-day environment of the home and it was therefore harder to perceive, in the observation phase, whether the presence of it could produce a beneficial effect.

Particularly striking was the recurrence of key words and phrases used by 1LW residents to describe their preference for using Welsh on a daily basis. These included 'cyfforddus' [comfortable], 'felna da ni di cael ein magu' [that's how we were raised], but most frequent of all: 'cartrefol' [homely]. For example, Resident A2, a gentleman in Home A: 'Ma'n gymuned fwy clôs, efo ni yn y Gymraeg. Dio'm yn 'mhoeni i, de, siaradai i Susnag, de, dwi di bod yn yr armi, neud fy national service, Susnag odd ran fwya ohono nhw, de. Ond da chi'n fwy gartrefol yn yr iaith [gyntaf].' [It's a closer community, with us in Welsh. It doesn't bother me, you know, I'll speak English, I've been in the Army, done my national service, they were mostly English. But you're more homely in the [first] language]. Another lady, Resident B1 in Home B, said that speaking Welsh made her feel: 'Cartrefol. Sa ond isio fi mynd i fewn i stafall, a rhywun newydd ar duty, de [yn siarad Cymraeg], 'Ŵŵ! Cymraes!' - dyna be sy'n dod i mi'n syth.' [Homely. I only need to go into a room, and a new Welsh speaker on duty, 'Ooh, a Welsh-speaker!' - that's what comes to me immediately]. She also said that being able to speak Welsh was 'O, help garw. Ma'n rhywsut fel adre, ynde.' [Oh, a great help. It's somehow like home, isn't it]. One lady in Home A, Resident A6, said that she was 'Lot fwy cyfforddus yn y Gymraeg. Ma'n Susnag i'n waeth, de. Odd 'y Susnag i'n lot gwell cyn y strôc.' [Much more

comfortable in Welsh. My English is worse, you know. My English was better before the stroke]. The 1LE resident in Home A, Resident A3, said that she appreciated the staff speaking English to her (although she was fluent in Welsh), and that the residents also 'do try' to speak English to her, although she understood that 'there are a few from the countryside who don't' [i.e. can't].

Care staff frequently used words such as 'cyfforddus' [comfortable], 'naturiol' [natural], 'at ease', 'saffach' [safer], and once again in recurrence, 'catrefol' [homely], to describe 1LWs' preference for a Welsh language environment. For example, in Home A, Staff A3 describing the provision of linguistic congruity for 1LWs during caregiving: 'Dwi meddwl bod nhw'n teimlo yn fwy cartrefol, dydi. Mae o 'iaith nhw'u hunain, dwi'm yn gwbo, ma nhw'n agosach ata ti rywsut.' [I think they feel more homely, don't they. It's their own language, I don't know, they're closer to you somehow]. Staff A6 said, 'Ma nhw'n teimlo'n gartrefol, wedyn, a bo' nhw'n gallu dallt ni.' [They feel homely, and then, they can understand us]. She also worked in the dementia unit, and felt that 1LW residents with dementia felt 'saffach' [safer] communicating in Welsh. A 1LW staff member (Staff B7) in Home B said that 'ma nhw'n dueddol, ma nhw'n fwy cyfforddus, mae o'n mwy naturiol i nhw siarad yn eu iaith.' [they have a tendency, they're more comfortable, it's more natural to speak their language]. On the whole, 1LE care staff in Home B were able to recognize that linguistic congruity benefitted 1LW residents. The manager there said, that in her experience, 'Most people whose memory is not as good, they go back to their mother tongue', and a carer felt that providing linguistic congruity 'makes a big difference. It just makes them feel more comfortable, and at ease as well.'

Family members who were interviewed for Home A felt strongly that a linguistically congruent environment was important to their relatives. For example, Relative A4: 'On i ddim isio iddi fynd i gartref henoed ond os oedd hi'n mynd, wel yn bendant bod yr awyrgylch yn Gymraeg a fod rhan fwya o'r staff yn siarad Cymraeg.' [I didn't want her to go to an old people's home but if she was, well certainly the environment had to be Welsh and that most of the staff had to speak Welsh]. Others affirmed that their relatives were better able to communicate through Welsh: 'dwi'm yn credu bod Mam di cal Susnag o'i chwmpas hi, so dwi'm yn siwr sut sa hi'n ymateb a deud y gwir!' [I don't believe Mum has had English around her, so I'm not sure how she'd react to be honest!] (Relative A2); 'yn bendant, mae hi dipyn yn mwy hyderus yn siarad yn Gymraeg' [for sure, she's much more confident speaking in

Welsh] (Relative A4); and ‘os oes na rhywun Cymraeg yno ma hi’n ffeindio hi dipyn yn haws i siarad.’ [if a Welsh speaker is there she finds it quite a bit easier to speak] (Relative A4). On the flip side, a son (Relative A3) whose mother was 1LE said of the staff that ‘os ma nhw’n gwbo fod rhywun yn fwy *comfortable* yn siarad Susnag, neith nhw siarad Susnag.’ [if they know someone is more comfortable speaking English, they’ll speak English].

In Home B, where residents had lived a more bilingual experience in the local area, family members still felt that their relatives benefitted from being able to communicate in Welsh, when able. Relative B2's husband had Dementia of Parkinson’s disease: ‘I know when he had carers in the house, they used to take him to get washed and dressed, he always used to ask them, ‘Do you speak Welsh?’ And if they said yes, then he would speak Welsh to them, if not he’d speak English to them. But he always used to ask them. And he asks them here, ‘Can you speak Welsh?’ And the carers here that do speak Welsh, they all speak Welsh to him. It seems to me, I suppose, that he’s always been brought up, and he feels more comfortable, in Welsh. I think it helps him to feel more settled.’ A resident’s son, Relative B3, said simply that ‘dwi meddwl bod pawb yn teimlo, efo iaith, pan ma nhw mynd i ystafell neu i gwmni, ma pawb yn anadlu yn fwy rhwydd pan ma nhw’n gwbo bod rhywun arall yn siarad yr un iaith a nhw.’ [I think that everyone feels, with language, when you go into a room or into company, everybody breathes easier when they know that [there is] somebody else who speaks the same language as them].

Appropriate Care and Understanding

The next most prominent positive effect produced by linguistic congruity was that it facilitated appropriate care for the residents and enabled proper understanding between residents and carers.

In Home A, the observational work was consistent with the semi-structured interview results for this sub-theme. Carers were explaining to the residents in Welsh on the medication rounds, promoting compliance with their medical care. A carer was observed assisting a resident to walk down the corridor, explaining to the resident in Welsh what they were doing. Residents affirmed that Welsh was always

the language used when interacting with carers. In Home B, interactions in Welsh between carers and residents were generally not seen during the embedded observational phase.

Many residents stated in the interviews that they were simply more fluent in Welsh, especially in Home A. This gentleman, Resident A2, said that 'Ma'n bwysig fod y staff yn dallt Cymraeg. Dwi'n dallt y ddwy iaith de; ond […] ma'n well gen i drafod efo chi rwan yn Gymraeg na Susnag, de, faswn i'n lluchio amball i air Cymraeg i fewn. Os ydi nhw'n Saeson, mi a i'n Susnag, de, dim problam! Ond dwi'n fwy hyddysg yn y Gymraeg, cofiwch.' [It's important that the staff understand Welsh. I understand both languages, you know, but […] I prefer discussing with you in Welsh rather than English, I'd be throwing the odd Welsh word in [to an English conversation]. If they're English, I'll go to English, no problem! But I'm more well versed in Welsh, you know]. Other residents said that they had their care through the medium of Welsh, and said that this was important because 'dyna dwi di arfer efo' [that's what I'm used to].

This seemed less of a priority in Home B, where Resident B1 said that she would receive care in whichever language, 'dibynnu be 'di 'hiaith nhw' [depending on their [the carers'] language]. However, her stated preference was to receive care in Welsh, 'yn siwr' [for sure].

Staff at both homes felt strongly that linguistic congruity was key to understanding during provision of care. In Home A, we were told by Staff A1 'ma'r dealltwriaeth gynna nhw o be da ni'n ofyn iddyn nhw neud' [they have the understanding of what we are asking them to do], and 'ma'n hawsach i nhw gyfathrebu efo ni.' [it's easier for them to communicate with us]. Manager A said that 'efo bobol efo dementia, am bod nhw mynd yn ol i'r iaith odda nhw'n siarad pan odda nhw'n blant, ma hynny'n anoddach iddyn nhw ddeall [Saesneg].' [with people with dementia, because they go back to the language they spoke as children, that makes it harder for them to understand [English]].

There was good awareness amongst 1LE staff in Home B, with comments such as 'You can tell if they struggle with the English, it would be a lot easier for them to speak Welsh' (Staff B1), and 'I think it's nice for them to be able to have a normal conversation, [with] the ones with higher needs, if you can speak Welsh it's easier to be able to explain, can you wash your face, for example' (Staff B3). A 1LW carer at

Home B (Staff B7) confirmed this, saying ‘efo dementia, ‘’di nhw methu cael nhw i neud yr un fath, ’di nhw’m yn gallu dod drosodd iddyn nhw yr un fath, ag hwyrach swn i yn medru cael nhw i wneud rhywbeth yn eu hiaith nhw’u hunen, ynde. Ma nhw fatha ’sa nhw yn fwy agos at rhywun, rhywsut, ’i ’hiaith nhw’u hunen, ynde.’ [with dementia, they [non-Welsh-speaking staff] can’t get them [1LW residents] to do the same, and perhaps I could be able to get them to do things in their own language. It’s as if they are closer to you, somehow, [in] their own language].

Staff B3 described a resident with dementia living in a different home that she worked in, in the same county: ‘He can really become quite confused and not really sure of what’s going on at all, especially when it comes to the personal care side of things. He becomes quite upset, agitated - and I have seen if somebody can go in there, and say in Welsh, what we’re there for, then there is a difference.’ This can also apply to 1LEs living in England, as Staff B5 related of her time working in London, when a 2LE carer had been providing care for a client: ‘I used to go in in the morning, and she wasn’t able to get him out of bed, she wasn’t able to get him to have a shave, little things like that, and obviously I’d go in, and I could coax him up. I think it might have been the language.’

Happiness/Calm

The field work showed that linguistic congruity also contributed to happiness and calm amongst residents. This was mostly reported by care staff, although 1LW residents also said they were ‘hapusach’ [happier] speaking Welsh, and Resident B1 said that speaking Welsh to visiting relatives simply made her feel ‘hapus’ [happy].

Staff B3 noted that ‘a pair … who like to sit and chat and like to listen to the Welsh radio station together and watch Welsh TV, I think it probably does make them happier.’ She also recalled the gentleman whom she cared for in a different home, who could become ‘quite aggressive and unsettled, until somebody will come in a speak Welsh to him and he changes’, showing the calming effect of being spoken to in his first language. Staff B4 said that ‘if they’re very upset about something … they might prefer a Welsh speaker’.

Family members also felt that being able to use Welsh made 1LW residents happier. This was especially important in Home A, where residents had spent most of their

lives speaking Welsh. A daughter, Relative A1, said, ‘Ma hi’n licio siarad efo’r bobl sy’n gweithio yma a’r bobl sydd yn byw yma hefyd, a ma hi’n hapusach yn y iaith Gymraeg.’ [She likes speaking with the people who work here and the people who live here as well, and she is happier in Welsh]. Another relative (A4) relayed that ‘petai efo gofalwr Susnag, mi fasa hi’n manijio, ond does na’m dwywaith mae’n hapusach yn siarad yn Gymraeg.’ [If she had an English carer, she'd manage, but there’s no doubt she’s happier speaking Welsh]. Another example (from Relative A5) was ‘Ma‘ Mam yn naw deg chwech, dim ’di cal llawar o Susnag … Mai’n hapusach bo‘ ’na staff Cymraeg yma.’ [Mum is ninety six, she hasn’t had much English … She’s happier that there are Welsh staff here].

The wife (Relative B2) of a 1LW resident in Home B felt that ‘it makes a big difference … I think it helps him to feel more settled. He’s very comfortable in Welsh’, illustrating the calming effect once again. Relatiev B4, a daughter, said of her mother that her friends ‘come and visit her a lot, and they all speak Welsh together, but there are one or two members of staff who speak Welsh here, as well, so that helps’, as well as simply saying that ‘she obviously enjoys speaking Welsh’.

Social Stimulation

Lastly, this study has shown that linguistic congruity is beneficial to residents because it increases the amount of social stimulation that they experience. Initially, this was seen in the observational phase - residents in Home A were observed joking around with each other in Welsh in the morning. Resident A1 said that she spent some of her time helping with laying the tables, clearing up, and taking walks, and that many of the residents suffered from ‘Clefyd Dydd Sul’ [Sunday Disease], meaning that she thought they rested excessively. Resident A2 replied to this comment by quoting the Bible: ‘Na lafuria ar ddydd Sul!’ [Do not labour on Sunday!]. This gentleman said that he enjoyed ‘tynnu coes [pulling the leg]’ of other residents and staff. Here the use of Welsh language religious idiom was inherent to the humour used during interactions, and it would be difficult to envisage the same gentle teasing happening as fluently with these individuals in their second language. Again, such interactions were not observed in Home B due to the generally much less linguistically congruent environment for 1LWs, but residents were observed

conversing in English, and did take part in social interactions in English with the carers.

Conversely, English residents at Home A were observed enjoying the benefits of their own linguistic congruity - residents had specific seats that they would sit at for each meal, and the three 1LEs (two attending for day care) all sat together, and the language of conversation at that table was English. Had they been sitting at different tables it would have been difficult for them to join in conversation, as all the other residents were strongly 1LW.

The best examples of social stimulation in residents due to linguistic congruity was seen in Home B, where two ladies (Resident B1 and B5) kept each other's company due to their preference of speaking Welsh to each other. Resident B5 was asked why the other was her best friend in the home, and she answered, 'Am fod ni'n siarad Cymraeg efo'n gilydd, dwi meddwl, ynde.' [Because we speak Welsh with each other, I think, you know]. When asked what she would do without her friend, she said, 'Wel, gyda'r nos fasa raid i mi fynd i'r *room* fawr ne rwbath efo'r lleill, da chi'n gwbo, de… Susneg ma nhw gyd yn siarad yn fanne.' [Well, in the evening I would have to go to the big room or something with the others, you know… They all speak English there]. Staff B3 said of them: 'It's probably nice for the Welsh speakers, because everybody, at least here, speaks English, but I think… you do see some of the first language Welsh speakers will sit together so they can have conversation… I think they quite like it, I think it's nice to have somebody to talk to, in their own language, and they share that in common.' Staff B6, originally of the Philippines, tried to put himself in their shoes: 'If I find a fellow Filipino on the street, when I'm on my own, then I feel like, 'oh yeah, there's somebody there who speaks my language.'

This vignette is especially illuminating in showing the effect being able to talk in Welsh had on one resident, as relayed by Staff B7, a 1LW carer in Home B:

> 'Wsnos dwythe, o' 'ne ddynes 'di dod yma o gartre arall, a wedyn odd hi 'di setlo fyny grisie, wrth y bwrdd bwyd, ac yn lwcus, mi o' 'ne siaradwyr Cymraeg yne, odd G yne, G arall, odd Gr yne, a oedd M yne, a odd y ddynes yma wedi dod o R, ac odd hi'n Gymraeg, a odd hi'n reit gyfforddus ar y bwrdd a petha felly. Wedyn odd 'i merch hi'n meddwl, odd hi isio… Drwg oedd, yn y lounge, odde nhw ddim yn aros, odde nhw'n mynd i'w llofftydd

mwy, wedyn odd hi isie bod efo rei erill, ac 'aru hi benderfynu dod lawr grisie am y pnawn, 'chos odd na lot lawr grisie, a odd 'ne fwy yn yr ystafell. Wedyn odd hi'n mynd i iste ar y bwrdd, lawr grisie, ond yn anffodus, Susneg odd y ddwy arall - un efo dementia, so odd hi ddim yn siarad llawer. Ond odd hi reit hapus i gochwyn, ynde, ond wedyn, 'aru hi fynd i iste lawr yn y lounge, a doedd na'm llawer o neb yn siarad Cymraeg yn fanno, a wedyn erbyn diwedd y noson, oedd hi fatha, yn teimlo fod hi isio mynd yn ol fyny grisie at y Cymry, i siarad Cymraeg, ti'n gwbo?'

[Last week, a lady came here from another home, and she had settled upstairs, by the dinner table, and luckily, there were Welsh speakers there, there was G, the other G, Gr was there, and M was there, and this lady had come from R [nearby town], and she was Welsh[-speaking], and was quite comfortable by the table and so on. Then her daughter thought, she wanted.. The problem was, in that lounge, they don't stay there, they go to their bedrooms more, and she wanted to be with others, and she decided to go downstairs for the afternoon, because there were many downstairs, and more in the room. Then she went to sit by the table, downstairs, but unfortunately, the other two were English - one with dementia, so she didn't speak much. But she was quite happy to begin with, but then, she went to sit in the lounge, and there weren't many speaking Welsh there, and then by the end of the night, she was as if, she felt that she wanted to go back up to the Welsh[-speakers], to speak Welsh, you know?].

Despite being fluent in English, this lady preferred socializing with Welsh-speaking residents, and therefore, linguistic congruity increased her social stimulation.

Family members agreed that 1LW residents were generally happier socializing in Welsh. One daughter in Home A observed her mother becoming more animated when a Welsh-speaking minister came to talk with the residents, in a way that she perhaps wouldn't have with an English speaker. Relative B3 in Home B recounted that when his father first arrived at the home, he was helped by the presence of another Welsh-speaking resident (Resident B3, or 'D'), whose wife (Relative B2) was also taking part in the discussion):

Relative B3: 'Pan odd D yma, odd hynny'n help mawr … Oedda nhw wedi bod am amser byr yn [ysbyty] R, oedd y ddau yn siarad Cymraeg. A wedyn

pan odd o'n dod yma, odd D yma, odd hynny'n gret. [When D was here, that was a great help … They had been at R [hospital] together for a short while, they both spoke Welsh. And then when he came here, D was here, that was great.] Wasn't it?'

Relative B2: 'Mm, and they got on from day one, didn't they.'

Relative B3: 'When he knew D was here, he had someone..'

Relative B2: 'To converse with.'

These are the conversations and observations that showed that linguistic congruity has a powerfully beneficial effect on the well-being of 1LWs (and others) in residential homes. The next most prominent theme was the negative effect that an absence of linguistic congruity can have on those who live in residential homes.

Absence of Linguistic Congruity

The main manifestations of the negative effect that an absence of linguistic congruity has on residents in care homes were found to be *Inappropriate Care and Misunderstanding*, *Loneliness and Boredom*, and *Unfamiliarity and Unhomeliness*. These negative effects were perceived mainly by carers at the care homes, and the residents themselves.

Inappropriate Care and Misunderstanding

Residents in Home A were generally wary of the prospect of having their care through the medium of English, for example, ''Swn i ddim yn licio cael gofalwr Saesneg - 'swn i ddim yn 'i ddallt o!' [I wouldn't like to have an English[-speaking] carer - I wouldn't understand him!]'. Another added that 'mae Saesneg yn rhy anodd' [English is too difficult]. One gentleman said that his English had become 'bratiog' [ragged], whilst his neighbour said she did speak English, but that it was 'anodd' [difficult]. Resident B4, from a rural background, stated that his English was 'iawn, ond 'mod i'm yn dallt ambell i air weithia, ynde.' [okay, but I don't understand the occasional word, you see]. The other Welsh speakers at Home B tended to be from the local town, and did not have any issues with understanding spoken English.

Carers at Home A were consistent in their opinion that their 1LW residents would struggle in an English language environment. As an example, Staff A1 said that if an English carer spoke to the 1LW residents,‘’neith na rhei ohonyn nhw, de, ddeud ‘Be ma’n ddeud, dwad?’, ’di nhw’m yn dallt, de.’ [some will say, you know, ‘What’s he saying, eh?’, they don’t understand, you know]. They relayed that they had often had to act as translators for the residents consulting with a 1LE doctor, saying that the residents would become ‘anghyfforddus’ [uncomfortable] speaking English, and that they couldn’t explain their symptoms effectively. The same problem recurred in Home B, where the 1LW Staff B7, said that ‘enwedig gyda’r doctoriaid, ma nhw’n fatha yn naturiol yn siarad efo chi, os di’r doctor yn ail iaith. Dwi’n teimlo ’dy nhw ddim mor gyfforddus i siarad, i gael y problem yn iawn drosodd idda nhw, de’ [especially with the doctors, it’s as if they naturally speak to you, if the doctor is in the [resident’s] second language. I feel that they aren’t as comfortable to talk, to get the problem over to them properly, you know].

One resident in Home A was invited to partake in staff selection interviews, but when a 1LE candidate spoke to them in English, she simply exclaimed ‘Dwi’m yn dallt iaith o!’ [I don’t understand his language!]. Staff A5 concluded that ‘efo’r salwch, de, fel mae o’n dirywio, de, ’sa chi’n cal un Susnag mewn, de, ella sa nhw’m yn dallt o o gwbl, de’ [with the illness [dementia], you know, as it deteriorates, if you had an English [carer] maybe they wouldn’t understand at all, you know].

At Home B the carers were also aware of the potential for misunderstanding when linguistic congruity was unavailable to residents, e.g. Staff B1: ‘You can tell if they struggle with the English, it would be a lot easier for them to speak Welsh, and they seem to understand. Especially if their first language is Welsh. They’ll struggle with certain words.’ Staff B5 said that ‘there’s been a couple who have refused to take their medication, but then another carer’s gone and spoke to them in their own language and you know, a little bit more understanding, I think’, and Manager B felt that with more advanced dementia, linguistic incongruity ‘could confuse them more. It also could make them want to go home more, thinking they’re somewhere foreign.’ She also felt that linguistic congruity was important ‘to help them with their care, really - there’s nothing worse than someone slightly confused and they can

only think of the Welsh word for something that they want, and nobody understands.'

Family members confirmed some residents' difficulties with the English language, for example, Relative A1 - 'O, ma hi yn gallu [siarad Susnag], hwyrach bo hi'm yn dallt certain geiria a therma - bosib ryw eiria mawr.' [Oh, she can [speak English], perhaps she doesn't understand certain words and terms, possibly some longer words]. Relative B1 said of her father, who had suffered and died from dementia in a different home, 'He was so predominantly Welsh … he had to translate into English in order to converse in the EMI residential home … He found that he struggled more to communicate … it got lost in translation at times, he would mean one thing in Welsh, but when it was translated to English it would mean something else'. On the other hand, Relative A3 reported that his 1LE mother sometimes struggled in the 1LW environment of Home A: ''Sa hi'm yn gallu siarad [Susnag efo pobol] a 'sa bob dim yn cael ei neud yn y Gymraeg, 'sa hi'm yn hapus' [if she couldn't speak [English with people] and everything was done in Welsh, she wouldn't be happy], and 'Ma mam yn ffeindio hi'n frustrating, 'di hi'm yn clywad yn dda iawn eniwe, ond pan dwi'n dod fan hyn … dwi'n siarad Cymraeg efo pobl, so dwi yn gallu gweld weithia bydd mam yn mynd yn frustrated'. [Mum finds it frustrating, she doesn't hear very well anyway, but when I come here … I speak Welsh to people, so I can see sometimes Mum will become frustrated].

Loneliness and Boredom

The next most prominent sub-theme within the negative effect of linguistic incongruity for residents in care homes was its isolating influence, causing a lack of social and cognitive stimulation. The only linguistic incongruity on a day-to-day basis in Home A tended to be the overwhelmingly Welsh environment for the 1LE residents, and this was shown in some instances in the embedded observational period spent in the home. The 1LE Resident A3 (also fluent in Welsh) complained that 'it's very boring here', and that 'you are sitting around waiting to die', but that it was 'better than being on your own at home.' She added that 'it would be the same in England', but it should be noted that none of the 1LW residents spontaneously complained of boredom. She also said 'there's only three English people here', suggesting she may have been less isolated in a more linguistically congruent

environment. The linguistic incongruity in Home B was inverse, of course, with a mostly English language environment. This prompted Resident B4 to say, ‘Sa’n help os fasa na fwy o Gymraeg … fasa ni’n gallu siarad mwy efo’n gilydd wedyn’ [It would help if there was more Welsh … we could all speak to each other more then].

The same resident, who had mild dementia, declined to attend a communal activity at the care home, which was an English singer who had come in to give a concert to the residents. He acknowledged that he probably would have attended such an event had the singing been in Welsh, and also admitted that ‘mae’n well gen i’r Gymraeg’ [I prefer Welsh], and that he would prefer if there was ‘mwy o Gymraeg’ [more Welsh language] at the home. This illustrates the difficulty a strongly 1LW resident with cognitive impairment faces with socializing in a predominantly 1LE care home. Many residents in Home A agreed that they would be more lonely in an English language environment, with Resident A1 simply saying, ‘Ma ’ngwaed i’n goch’ [My blood is red] - an idiom referencing the Welsh ‘Red Dragon’, used to emphasize one’s ‘Welshness’.

Loneliness and boredom was a theme that the carers also recognized. Resident B4 described above was said by staff to have ‘very little English, so he would struggle’ in an exclusively English environment. In his lounge there were a couple of Welsh speakers, which did enable him to socialize to a reasonable degree. For 1LE residents, the manager at Home B felt that loneliness had been a problem for them in the past when there used to be more 1LW residents: ‘we had somebody that didn’t speak any Welsh at all, and it was in the whole lounge [where there] were quite a lot of Welsh speakers, and they felt very isolated, in that they couldn’t understand, it did impact on them’. Staff B4 said, ‘we’ve got a mix of Welsh and English ones, and some of the English ones don’t like it when the Welsh ones do speak’, suggesting that they become isolated in such circumstances, which may be reinforced further if a 1LE resident feels that an active choice is being made to exclude them.

Some family members saw that loneliness was a potential problem for their relatives and that linguistic congruity was important in these circumstances. Relative A4 whose mother (in Home A) was already fairly socially withdrawn in her dementia, said that ‘’sa hi’n cymysgu llai fyth’ [she’d mix even less] in a less Welsh environment. Resident B1 was noted by her daughter to stay away from the day

room due to the lack of Welsh language television: ‘she loves S4C [Welsh language TV channel], and she never goes into the day room, because the television’s always on, and it’s always Eastenders, or something like that, which she doesn’t like.. but she’s got her own television now, and she does bring her own friends in here with her, to watch it sometimes.’ When Relative B4 was asked about how her 1LE father, who was in Home B, would cope in a Welsh environment (such as in Home A), she stated that ‘he wouldn’t be able to understand … he wouldn’t make the effort. I think his philosophy has probably always been that, well yes, these are Welsh-speaking people, but the majority of them also speak English.’

Unfamiliarity and Unhomeliness

The other sub-theme emerging from the negative effect of linguistic congruity was that residents in care homes felt less familiar and comfortable in their second language. In some respects this took on an anti-English tone in Home A, such as when, during the observation phase, the researcher was speaking English to a 1LE resident, and a 1LW resident walked past exclaiming ‘Saesneg mawr heddiw!’ [A lot of English today!]. At the dinner table, one resident insisted that ‘Da ni ’misio Saesneg’ [We don’t want English], and ‘Ma gynno‘ ni hawl i siarad ein hiaith ein hunain! [we have a right to speak our own language!].

Resident A1 felt that ‘Os da chi’n siarad Cymraeg o flaen rhywun Saesneg, ma nhw’n deud ‘Be da chi isio siarad Cymraeg am?’ Ond na fo’n iaith ni! Dwi’n teimlo’n prowd mod i’n Gymraeg. Swn i’n siarad Saesneg [os faswn i mewn cartre mwy Saesneg]. Dwn i’m, dwi di arfer siarad Cymraeg, ’chi’ [If you speak Welsh in front of an English person, they say ‘why do you want to speak Welsh?’ But that’s our language! I feel proud to be Welsh. I’d speak English [if I was in an English-speaking home]. I don’t know, I’m used to speaking Welsh, you know]. Resident A6 said, when considering an English-speaking home, ‘Swn i’m yn licio hynna, dwi’m yn meddwl! Am y rheswm bod well gennai siarad Cymraeg, de.’ [I don’t think I’d like that! Because I’m used to speaking Welsh, you know].

In one mini-lounge in Home A were two residents, one 1LW from a nearby valley and another 1LE from Manchester. The 1LE could manage a few words in Welsh but could not understand spoken Welsh conversation in the home. She said that she didn’t mind Welsh being spoken in the room, but that she doesn’t find a Welsh

environment ‘as easy’ as an English one, showing that unfamiliarity can also be a problem for 1LEs in a predominantly Welsh environment.

Staff working in the dementia unit in Home A said that they had seen 1LW residents ‘pull back’ when an English speaker had worked with them, as if there was a ‘barrier’. Staff A3 reported that ‘ma na lot o nhw yma, sy ddim cweit yn hapus i siarad yn Susnag.’ [there are lots of them here, that aren’t quite happy to speak English]. Staff B7 said that 1LW residents could speak English, ‘ond dio ddim mor naturiol ag yn eu iaith nhw, de … rhaid i bobol efo dementia, ma nhw yn fwy dueddol o fod yn cyfforddus yn siarad Cymraeg, yn eu hiaith cynta nhw.’ [it isn’t as natural as their language, you know … people with dementia, they tend to be more comfortable speaking Welsh, in their first language].

Resident B3, who has Dementia of Parkinson’s Disease, was said by his wife that ‘if he’s on a bad day, when he doesn’t know what he’s saying, they’ve walked past, he’ll shout - ‘’da chi’n siarad Cymraeg?” [do you speak Welsh?].

These experiences show that for many residents in care homes, especially those who are 1LW, and for those who are cognitively impaired, an absence of linguistic congruity has a significantly negative effect on their well-being.

Neutral Effect of Linguistic Congruity often Contradicted, and Code-Switching for Courtesy

Some residents rejected that linguistic congruity affected their well-being, and stated that they were just as happy speaking either English or Welsh in their care homes. These same residents were often found to be taking a different viewpoint, in a matter of moments later. Furthermore, it seems that many 1LW residents are often anxious to show that they are willing to code-switch languages to suit any non-Welsh speakers in a room, which may be a cultural norm in Wales. These issues are explored below.

Neutral effect of Linguistic Congruity

Although this theme did not emerge in anywhere near the same prominence as the benefit of linguistic congruity and the detriment of its absence, it is important to

note that it appeared frequently enough to merit discussion. It is equally important to note that residents also contradicted themselves on this point, often within the same sentence or paragraph. This may be an indication of a tendency amongst Welsh people to appear eager to code-switch for the benefit of non-Welsh speakers, which is discussed in more detail later.

The neutral effect of linguistic congruity was more prominent in Home B, where residents have tended to have more bilingual lives prior to moving into the residential home, but also where cognitive impairment was less advanced than in Home A (see Clinical Dementia Ratings, 'Context of Results' section, above). Comments from 1LW residents in Home B included ones such as: 'Duw, 'sna'm gwahaniaeth, de. Susnag i'r Saeson de a Cymraeg i'r Cymry' [Lord, there's no difference, you know. English for the English and Welsh for the Welsh] (Resident B4). She also said that she would speak more Welsh if there was 'more Welsh around', but that she didn't mind what language was spoken in the living room. Resident B1 said, 'Wel, dwi'n reit hapus yn Susnag. Dio'm yn neud llawer o wahaniaeth i mi.' [Well, I'm quite happy in English. It doesn't make much difference to me]; she had immediately preceded this by saying that speaking Welsh was a 'great help' to her, and that it was 'somehow like home'. Purely bilingual individuals at Home B, e.g. Resident B2, said that the carers would 'atab yn Gymraeg' [answer in Welsh] if required, but that 'os dwi'n siarad i nhw'n Sasneg na nhw'n ateb i'n Sasneg' [if I speak to them in English, they'll answer me in English], and 'ga' nhw siarad y ddau efo fi' [they can speak both to me]. Resident B5 said, ''dio'm gwahaniaeth gynna i' [it makes no difference to me].

This was less prevalent in the more monolingually Welsh Home A, but there were some residents (e.g. A5) who felt that ''sa'm yn neud gwahaniaeth i mi, de. Rhaid i chi gymyd pawb fel 'da chi'n cal nhw.' [it wouldn't make a difference to me, you know. You have to take everyone as you get them'. Resident B2 said, 'Os dio'n Sais, ma'n Sais … Dio'm yn 'mhoeni i, de, nad ydyn nhw'n gallu siarad Cymraeg.' [If he's English, he's English … It doesn't bother me, you know, if they can't speak Welsh]. However, this same individual also said, in the same conversation, 'Mi ai'n Susnag, de, dim problam! Ond dwi'n fwy hyddysg yn y Gymraeg, cofiwch.' [I'll go English, no problem! But I'm more well versed in Welsh, you know].

Carers at the homes were generally less inclined to devalue the importance of linguistic congruity, but there was one notable exception, which was Staff B4 (1LE). She was originally from England and did not speak Welsh. Her feeling was that linguistic congruity didn't affect well-being 'at all. I mean, we have got quite a few whose first language is Welsh, but they're happy speaking in English. But obviously, if the family come and then they're speaking Welsh, then that's their choice.' She also didn't think that caring for a 1LW resident would be any easier for a 1LW carer, saying 'it's about the same, really', and that she didn't feel that linguistic congruity affected sociability, saying 'They tend to mix, really'. The reason that this was notable was her background, in that she had limited experience with the Welsh language, which could have led to a general lack of awareness of linguistic needs for 1LW residents. All local carers in Home B, even if not 1LW or even bilingual, affirmed that linguistic congruity was important for residents to some degree, which was different to this non-local staff member.

Families of 1LWs were also generally of the view that linguistic congruity was beneficial to their relatives, with one more notable exception - a 1LE daughter of a 1LW resident (Relative B1). She said that for her mother, 'she's quite happy, she's fluent in English as well, and there's no problem … it doesn't matter whether it's Welsh or English.' Regarding the language in which care occurred, she said that 'I mean, I'm speaking from my point of view, I would have thought she wouldn't mind either way … my mother is completely bilingual, she speaks Welsh and English perfectly well.' Ultimately, she felt that, regarding language, 'I don't think it matters that much to her … I don't think her happiness here is affected by language.' Interestingly, this was in direct opposition to much of what her mother (Resident B1) said independently, and she was the resident in Home B who voiced most strongly that speaking and hearing Welsh made her feel at home, comfortable and happy. Again, it could be argued that this daughter's lack of familiarity with the Welsh language (she was not raised by her parents to speak Welsh) has led to a lack of awareness around its importance to residents and people who are cognitively impaired, even if that does include her own mother.

Code-switching 1LWs for the benefit of 1LEs

Many 1LW residents stated that they will code-switch (the practice of alternating between two or more languages or varieties of language in conversation (Goldstein and Kohnert, 2005)) for the benefit of their 1LE fellow residents, or even for their 1LE carers. This was usually not required in the mostly Welsh language Home A, but even for the fluent Welsh-speaking 1LE Resident A3, her fellow residents would switch to English, saying that their abilities were: 'very good. There are a few, from the countryside, who don't speak [English], but they do try.' Almost certainly the reason for this is the discomfort that 1LWs feel when excluding 1LEs from a Welsh language conversation, as shown by Resident B1: 'Na i ddim siarad Cymraeg taswn i'n gwbo fod na rhywun Susnag yn y grwp, dechi gwbo. Cwrteisi di hynny.' [I won't speak Welsh if I know that there is someone English in the group, you know. That's courtesy].

This was reaffirmed by staff members in both homes - in Home A, residents will actively 'mynd atyn nhw i siarad' [go to the [English speakers] to talk], and a typical example of this was noted in the embedded observational phase. In the Dementia Unit one morning, a 1LW resident was conversing with others in Welsh, but when a 1LE/2LW entered the room, she immediately addressed her in English. When turning to another 1LW shortly afterwards, she returned to Welsh. A conversation between the residents and carers thereafter ensued, switching from Welsh to English appropriately, depending on who was speaking, or whom was being addressed. This was despite the 1LE being fluent in Welsh, showing the willingness of 1LWs to accommodate 1LEs' comfort in conversation.

Perhaps another reason for code-switching is previous negative reinforcement of discouraging Welsh conversations in the presence of 1LEs. At lunchtime, a resident at Home A pointed to the 1LE who came to the home once a week for respite and said ''di hi ddim yn licio ni'n siarad Cymraeg' [she doesn't like us speaking Welsh]. Staff B4 also openly admitted that 'some of the English ones don't like it when the Welsh ones do speak, but we do explain it's their first language.'

In Home B, Staff B1 said of 1LWs that 'they mix quite well, they generally have conversations, and if there's an English person they will turn perhaps to English'. Staff B2 admitted that 'some of the ladies who do speak Welsh who know I'm not fluent in Welsh, will take the time to speak to me in English.'

One of the few 1LEs in Home A was helped by her fellow residents, her son (Relative A3) felt, in that ‘ma ’na lot o’r bobl sy’n ista fanna efo hi, mi wnawn ni nhw siarad Susnag efo hi, am bo‘ nhw’n gwbod fo‘ hi’m yn [siarad Cymraeg].’ [a lot of the people that sit there with her, they’ll speak English to her, because they know she doesn’t [speak Welsh]. Relative B1 gave an example of local bilinguality and code-switching: ‘People here, are quite often happy speaking English or Welsh, and will swap from one to the other, in the middle of a conversation. My mother’s chapel friends are just as happy in English as they are in Welsh.’

Effect of Linguistic Congruity on the Challenge of Providing Care, and the Barriers to Provision of Linguistic Congruity

During the ethnographic field work, information was gathered to establish the effect that the presence or absence of linguistic congruity has on the challenge of providing care for residents in care homes. This was done in conjunction with a scouting documentation search regarding linguistic congruity in these specific care homes. In examining this theme, a major overlapping theme emerges, which is the presence of barriers to the provision of the linguistic congruity in care. The challenges and barriers are discussed from the point of view of carers, upwards through the care homes and to the authorities. These are manifestly different between Homes A and B, due to the very different linguistic identities inherent in each area, reflected in the make-up of residents, relatives and staff at each home. It appeared that the care home itself is the system component that is most affected by linguistic congruity, followed by the carers, and finally the local or national authorities.

Challenges and Barriers for Carers

On the whole, language was not perceived to be an issue in providing care in Home A, as all carers could speak Welsh to 1LW residents, and fluent English to the 1LE residents. Many carers felt that although they didn’t ‘gwahaniaethu rhwng neb’ [differentiate between anyone], language ‘yn bendant’ [definitely] still affected the challenge of providing care. All care staff participating in the study in Home A were 1LW, and Staff A1 said, ‘Dwi’n teimlo yn bersonol, yn fwy gyfforddus yn siarad

efo nhw yn yr iaith Gymraeg, de, am mai dyna di'n iaith cynta fi hefyd, 'de.' [I feel personally, more comfortable speaking with them in the Welsh language, because that is my first language, you know]. They were also required to act as unofficial translators for residents, e.g. Staff A3: 'pan ma nhw'n mynd ar appointments o 'ma, ynde, i 'sbytai a bob dim, ma 'na ddoctoriaid o dramor, ma nhw'n cal dipyn go lew o draffarth … Wedyn 'da ni'n goro cyfathrebu.' [when they they go for appointments away from here, you know, to hospitals and everything, there are foreign doctors, they have quite a bit of difficulty … We then have to communicate [on their behalf]]. Interestingly, Staff A5 extended the challenge to include colloquial Welsh:

> 'Ydi, mae o'n bwysig, 'tydi, 'da ni'n siarad yr un un iaith rwan, 'dydan, ond 'swn i'n symud lawr dudwch i rwla, South Wales ne be bynnag, 'swn i'n cal job dod i dallt yr acen, de, 'swn i isio amsar wedyn i feddwl, 'O, be odd hynna, wan?', ond da ni gyd yr un un fath o Gymraeg yma!'
>
> [Yes, it's important, isn't it, we're speaking the same language now, aren't we, but if I moved down, say to South Wales or wherever, I'd have a job getting to understand the accent, you know, I'd want time to think, 'What was that, now?', but we are all the same type of Welsh here!]

On the other hand, in Home B, where most carers were 1LEs, many expressed that language difference could be an obstruction to providing care. Staff B7, who was fluent in Welsh, felt that this made it easier for her to care for 1LW residents, whilst one 1LE carer (Staff B3) said that, when a resident in a different home she worked at was 'having a particularly bad day, then that's when I prefer to find someone who is more Welsh' than herself. She also said that 'before working in the care sector I never had much interest in learning Welsh, to be honest, but since being here, I've thought actually, if I want to stay in the care sector in Wales, I would like to learn more Welsh.' The 1LE from England (Staff B4) did not feel that language affected the challenge of caring: '..it might to some, but not in general. I think as long as you're a kind, caring person … it's how you speak, not what you speak'. The 1LW carer, Staff B7, had a different view:

> 'Ma rhei yn dallt lot mwy, a mwy am neud efo chi, achos bo chi yn eu hiaith nhw, de … Weithia efo dementia a petha felly, 'dy nhw methu cael nhw i neud yr un fath, 'dy nhw'm yn gallu dod drosodd iddyn nhw yr un fath, ag hwyrach 'swn i yn medru cael nhw i wneud rhywbeth yn eu hiaith nhw'u hunen, ynde.

> Ma nhw fatha 'sa nhw yn fwy agos at rhywun, rhywsut, 'i hiaith nhw'u hunen, ynde.'
>
> [Some understand a lot more, and do more with you, because you are in their language, you know … Sometimes with dementia and such things, they [non-Welsh speaking carers] can't get them [1LW residents] to do the same, they can't come over to them the same, and perhaps I would be able to get them to do something in their own language, you know. It's as if they were closer to someone, somehow, in their own language, you know.]

For carers, the main barrier to providing that linguistic congruity for 1LWs was their lack of Welsh language skills. Many acknowledged that they would like to learn Welsh, e.g. Staff B2: 'it would be something I'd be willing to do … It would be nice, you know, because it would be nice to speak to people in their own language, confidently.' This carer also said that she would prefer 'conversation classes' rather than formal Welsh language lessons, suggesting that she would not be able to commit to the more time-consuming courses - a familiar logisitical barrier to the recruitment and retention of adults to Welsh language courses (Powell and Smith, 2003). There was good awareness of the need for linguistic congruity in Home B, except for the carer (Staff B4) from an English background, which suggests that mandatory language awareness training is not something that is generally required in this area.

Challenge and Barriers to the Care Homes

The challenges faced by those managing the care homes in relation to linguistic congruity were entirely different to those faced by the carers themselves. These mainly involved the employment, training and rota arrangements of staff, as well as seeking to provide the appropriate environment and activities for residents.

In Home A, the manager said that an understanding of spoken Welsh was an essential requirement of staff members employed there, and that a good level of spoken Welsh was desired. She said that a good 1LE candidate would be given a chance to work at the home, but that they would be expected to learn Welsh within a certain timeframe. She also said that it would be essential for someone in her position (manager) and the assistant manager to have spoken Welsh skills. The

residents‘ notes were written in the residents‘ preferred language, as would be any relevant reports about a resident. She said that this did not pose any difficulty to her, as the manager.

This was different in Home B, where neither carers or manager were necessarily expected to be able to speak Welsh. Manager B felt that, regarding the Welsh language, ‘the majority of the staff do have a good knowledge. If they don’t feel comfy in speaking it, they do understand it.’ Perhaps this is illustrated by an observation note, where in a room (in which the predominant language was English), residents were sat in their armchairs, being served a round of hot drinks. Both carers working in the room could switch to (second language) Welsh on serving one of the 1LWs, but their vocabulary was limited, putting the cup of tea down on the table next to the 1LW and saying ‘Panad [Cuppa] here’.

One challenge in the less linguistically congruent Home B lay in ensuring that on any given shift, there was a carer who could speak Welsh. There would ‘more or less’ always be someone working who could speak Welsh, according to Manager B, ‘or even if someone’s not fluent Welsh, they know bits and bobs.’ This reflects the bilingualism inherent in the town and its local area, in that the majority of residents are able to communicate effectively in English, and that the local workforce are generally unable to speak Welsh fluently. It does not, however, reflect an ability to cater to resident language preference. This is a good representation of the challenge that linguistic congruity poses to providing care for a 1LW resident in Home B, and one of its barriers - staff language skills.

Due to the bilingual fluency of their staff, language skills were generally not an issue at Home A. In Home B, the manager stated that *Training* and *Logistics* were the main barriers to improving linguistic incongruity when it was identified. In terms of *Training*, she said that lessons were available from the council, and that staff would be paid for attending lessons (as if they were at work). However, this was not mandatory, and at the time of research, ‘nobody’s interested’ (which may also be a barrier), although at other times they would go through ‘spells’ where a lot of staff showed interest. She and her assistant manager had attended lessons, and found them to be beneficial. It can be inferred that the ‘shift’ pattern of working would greatly inhibit staff from attending regular scheduled lessons, and the manager explained, for example, that a lesson ‘could land on their rest day.’ The manager in Home A said that there had been a 1LE worker employed at the home who had

gone on to learn Welsh, but that this had been entirely independent of the council, having attended classes at a local college (for which he was not reimbursed).

In terms of *Logistics*, one barrier was the language skills of the local workforce, and the co-ordination of this in the shift patterns. As discussed in the initial description of the homes, Home B lies in an area where less Welsh is spoken than around Home A, and even less so in lower socio-economic status (Jones, 2012; North Wales Economic Ambition Board, 2018). As the care workforce is generally recruited from this demographic (National Audit Office, 2018; Older People's Commissioner for Wales, 2014), the problem of providing linguistic congruity for elderly people in residential homes is encountered immediately. As homes become even more specialized, this problem can become more acute, with a home not able to serve the whole spectrum of needs in its immediate locality, as Manager B attests: 'we've got Welsh speakers here, who, perhaps, their needs have changed to nursing, or EMI [Elderly or Mentally Infirm] - it is really, really hard to … get a home that's Welsh-speaking. It's very hard to get [a] nursing or EMI [home] in this area, or the surrounding areas, it's quite far away, and you're moving people away from their culture, then, aren't you? … In R [nearby town], which is just twelve miles away, there isn't any [Welsh].' The only 1LW carer in Home B recruited for the study (Staff B7) said that ''Swn i'm yn deud fod nhw'n cael cam, ond ma'r lefel.. Dwi meddwl 'swn i'n hŷn 'swn i isio pethe Cymraeg, mwy.' [I wouldn't say that the residents are done a disfavour, but the level.. I think if I was older I would want more Welsh]. Home A, which has its own EMI unit, shows that this does not appear to be a problem in its overwhelmingly Welsh-speaking area.

Another issue flagged up by the manager of Home B were practical *Logistics* such as ensuring that signage and other visual language was bilingual - 'I've not got enough bilingual signs around. I've got some, but I'd like to improve on that. If I have got them, they're ones that we've done here and laminated. You can't get any that look [professional].' She also said that 'I spoke to a company, they said they had a Welsh section, and in the Welsh section there wasn't really anything much there. It is quite difficult to buy anything ... So I tend to go for pictures, rather than actual writing, and that seems to.. I've got a barber pole at the moment, outside the hairdresser's 'cause I think it's more visual.' As the residents themselves did not comment upon this it is difficult to know whether this would have any bearing on their well-being; the Welsh Language Act (1993) states that signs displayed by any

public body should be bilingual. This represents another logistical challenge to a care home that does not have a 1LW manager or any freely available sign-translating service, and may be typical of similar bureaucratic challenges facing care homes across Wales.

1LW residents who may wish to socialize or take part in activities, but are not attracted to English language events, may have their well-being compromised by this further logistical challenge. Such observations were not made at Home A, but one 1LE resident in Home B (Resident B6) commented that 'a few Welsh speakers … don't go to the day centre' because 'it is all in English.' This is evident in a Resident B4's preference not to attend an English singer's concert in the day centre (see *Loneliness and Boredom*, Absence of Linguistic Congruity), and his admission that he would in fact attend a Welsh language event, if held. The *Logistics* of this provide a challenge to the manager of Home B, who has to cater to a bilingual audience, as well as booking entertainers from the local area who may not be able to speak Welsh or have any knowledge of Welsh language songs.

Challenge and Barriers to the Local/National Authority

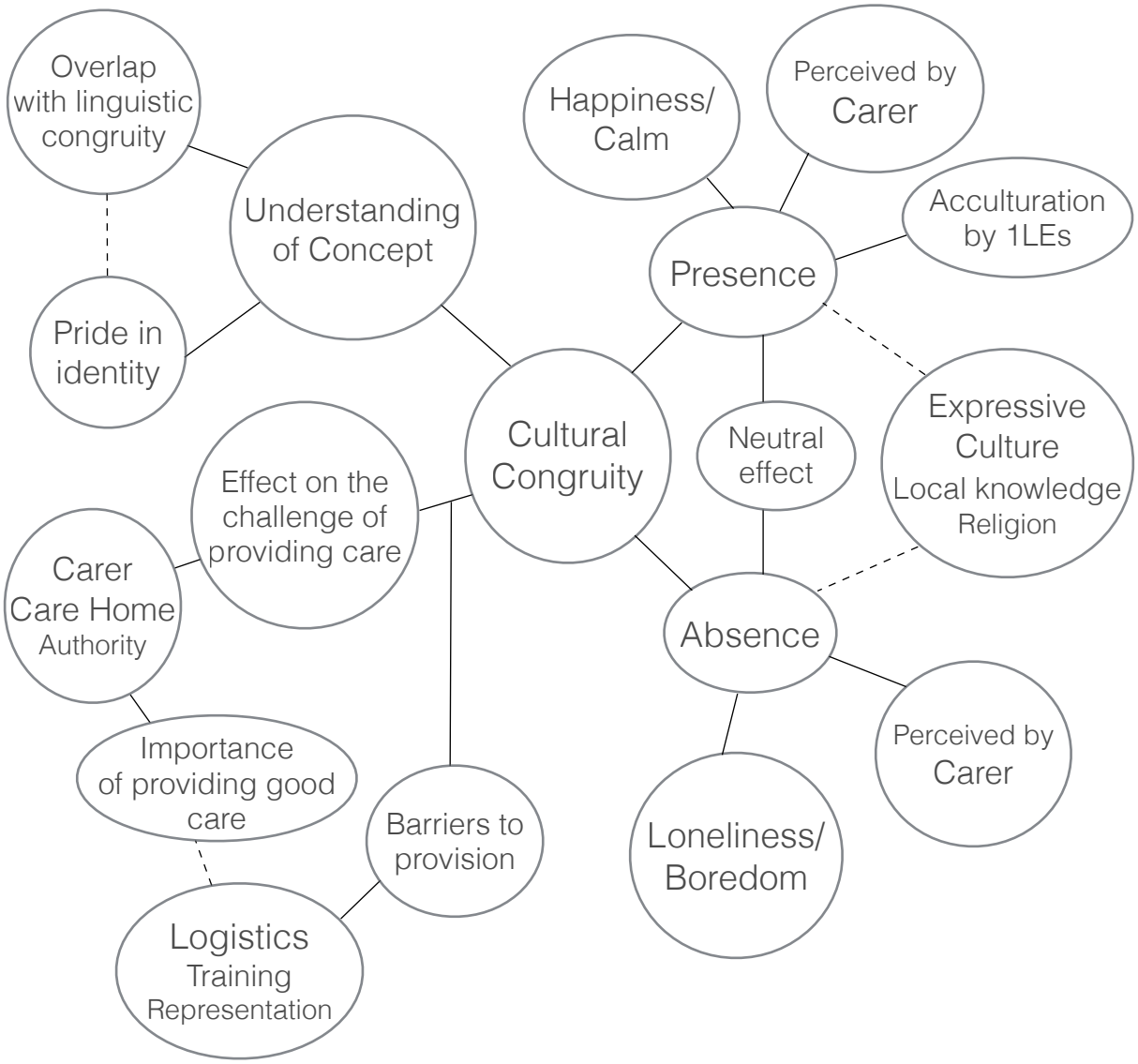
This project, which was done at the level at which care occurs, did not identify many direct challenges to providing linguistic care for the local or national authorities overseeing these care homes, other than the issues already presented, for which these authorities do bear overall responsibility. The issue of *Training* was raised by a 1LE carer in Home B, who was under the impression that Welsh language lessons were not easily available from the county council. This is belied by the council's website, which advertises Welsh language courses available to council workers (with managerial support), but her comments may indicate that improving awareness about these courses is necessary. It would be anticipated that this would be a more significant issue in homes which are not managed and supervised by a local authority.

It was clear from the observational phase of this research that *Logistical* questions are raised regarding the overall care of linguistically different residents, which should be posed to the authorities rather than the care homes themselves - should 1LW residents have the option to reside in homes where all carers can speak Welsh, or at least have one or more Welsh-speaking members of staff on shift? How much

resources should be allocated to training staff to speak Welsh? Should homes be required by mandate to provide Welsh language activities for 1LWs? These questions, and more, are considered in further detail in Chapter 5, 'Discussions and Recommendations'.

4.3 Cultural Congruity

Figure 4.2: Theme Mapping, Cultural Congruity, Field Work



For the purposes of this study, cultural congruity is defined as the match of the resident's cultural norms, values and interests with that of the immediate and wider environment of their care home. This is a less easily demonstrated concept than linguistic congruity, due to the many different facets of culture which can vary across a region, as well as the potentially heterogenous nature of an area's

population. Even in a care home located in a specific town, one can find different ‘cultures’, e.g. urban vs rural, industrial vs agricultural, middle vs lower class, and ‘Welsh’ vs ‘English’, to name but a few. Another confounding issue is the significance of language in culture. In this work, it is evident that many people consider there to be a large overlap between the two, but academically, this is also a hugely debated issue - see, for example, the Sapir-Whorf hypothesis (or Linguistic Relativity) which holds that the structure of a language affects its speakers’ world view or cognition (Lucy 1997). If so, people's perceptions are therefore relative to their spoken language - which may be further complicated by bilingualism. Certainly, this field work has found that some individuals found it difficult to differentiate between what constitutes language and culture, which may further strengthen the case for linguistic congruity in the care of these residents. The results are summarized in Figure 4.2, with themes prominent in accordance with the weighting of their coding emerging during analysis.

Presence of Cultural Congruity

Evidence was identified in the field-work suggesting that the presence of cultural congruity has a positive effect on the well-being of care home residents. The effect appears to be markedly less than that of linguistic congruity (according to its prominence in the weighting of each theme during analysis), and in this work it is manifested mainly in the form of *Happiness*. The effect was perceived mainly by carers at the homes. The most important facet of culture to residents was its expressive form - music and eisteddfods (traditional Welsh festivals of literature, music and performance (“Eisteddfod” 2020)), television and radio programmes, and such like. An overlap existed here with religion (with its hymns and sermons), which appeared to be very important to some but not at all to others. Another important cultural commodity was local knowledge, which has less of a link with language, and which may explain the phenomenon of acculturation by English residents to their local surroundings, which was also often noted. Again, quotes are presented firstly in colloquial Welsh, and then in their translated form in English.

Happiness/Calm

Residents in these care homes found benefit from cultural congruity, because it contributed to their happiness. This was evident, even in the observational phase, when a group of residents in Home A were witnessed singing an array of traditional Welsh songs and hymns (such as 'Calon Lân', 'Myfanwy', 'Ar Lan y Môr', 'Gwahoddiad', and 'Ar Hyd y Nos'), and who said that they enjoyed singing songs 'pan mae'r awen yn taro' [when inspiration strikes]. This would only be possible in a culturally (and arguably linguistically) congruent cohort of residents, steeped in traditional Welsh language singing - which could be difficult to achieve in Home B. Indeed, Resident B1 said that she would 'hum' along with the radio, but that there wasn't any Welsh singing in the home. Staff A5 said that the residents very much enjoyed Welsh singing, more so than in English as 'ma nhw'n gwbo nhw'n well' [they know [the songs] better]. Relative B1 said that her mother had 'always been involved with Eisteddfod, and singing, Welsh singing, my father and her used to sing duets in Welsh', so she will 'always watch the Eisteddfod on television'. Relative A2 agreed that regarding events on television such as the Llangollen International Musical Eisteddfod and the Royal Welsh Agricultural Show, 'ma nhw'n enjoio fo, bo nhw'n cal y canu, ti'n gwbo ma nhw wrth eu bodd efo hynny.' [they enjoy it, that they get to sing, you know they love that].

Many 1LW residents preferred Welsh language television programmes - e.g. Resident A2, 'dwi'n gwylio S4C mwy na'm byd arall' [I watch S4C [Sianel 4 Cymru (Welsh Channel 4)] more than anything else], illustrating a common theme. They reported watching programmes such as 'Pobol y Cwm', 'Rownd a Rownd', and 'Noson Lawen', and indeed eschewed English language channels, for instance, Relative A1, 'Dwi'm yn licio'r hen Eastenders a betha felly' [I don't like that old Eastenders and such things]. Resident B5 said the only thing she was allowed to watch when she lived with her husband at home (who watched 'golf, golf, golf, morning, noon and night!') was 'y canu ar ddydd Sul' [the singing on a Sunday]. Families also noted the importance of television, especially Welsh language television, to their relatives, for example, a daughter (Family A4) in Home A: 'Mai'n hoffi gwylio'r teledu, a mai'n dal i hoffi'r rhaglenni Cymraeg' [She enjoys watching television, and still likes the Welsh programmes], as well as 'pan mae sioe Royal Welsh ymlaen 'lly, a ma genna hi diddordeb mawr ynddo fo, oherwydd cefndir amaethyddol, wrth ei bodd yn gwylio'r sioe. A hefyd, Steddfod, ynde. Mai'n hoff o

ganu ac adrodd, 'lly.' [when the Royal Welsh [agricultural show] is on, she has a great interest in that, because of her agricultural background, very happy to watch that. And also, Eisteddfod, you know. She likes singing and recitals, you know]. As discussed in the Language section, Staff B3 felt it could be 'enriching … if they've got things from a familiar culture [such as] the two ladies upstairs, that like to be together, listening to Welsh radio, and watch the Welsh TV' - showing that enjoying culture can be a shared experience for these residents, promoting happiness in company. On the other hand, Relative B3 said of his father that ''Dio 'rioed di bod i 'Steddfod. Ond, yn ei ffordd ei hun, mae o'n gystal Cymro ac unrhywun arall. Mae o'n gweld ei hun fel Cymro - 'dwi'n Gymraeg - ella nad oes gynno i y wisg gwyn ond dwi'n Gymro'.' [He's never been to an Eisteddfod. But, in his own way, he's as good a Welshman as any other. He sees himself as Welsh - 'I'm Welsh - maybe I don't wear the white [druidic Eisteddfod] robes, but I'm Welsh'].

In a similar vein to the television, 1LW residents who listened to the radio seemed to prefer the Welsh language station (Radio Cymru), for example Resident A2 in Home A: 'Weithia fyddai'n gwrando i'r radio yn y bora, Cymraeg, di hi'm ar 'im byd arall de!' [Sometimes I listen to the radio in the morning, Welsh, it's not on anything else, you know!]. In the observational phase, the staff were noted to have ensured that Radio Cymru was on the communal radio in the dementia unit of Home A. Resident B1 said that she listens to Radio Cymru for 'y corau - rwbath i wneud efo canu. 'Steddfod Genedlaethol, yr Urdd - byth yn colli rheina, de' [the choirs - anything to do with singing. The National and Urdd [youth] Eisteddfods, I never miss those, you know]. Her daughter described her mother's culture as 'very Welsh' due to her affinity to Welsh music, chapel and culture, and agreed that 'S4C is her main channel. She loves listening to anything, like a choir.' A bilingual lady, Resident B5, said that 'Dwi'n licio gwrando ar Radio Cymru, hanner awr 'di pedwar ar ddydd Sul, ma na Caniadaeth y Cysegr yndoes' [I like listening to Radio Cymru, half four on a Sunday, there is Caniadaeth y Cysegr [Welsh hymn-singing programme], isn't there]. She also belonged to a choral society, linked to the local church, and said that singing was important for Welsh people.

This love of choir-singing and hymns illustrates the overlap between music and religion in Welsh culture, and the importance of the Christian faith to many

residents, as opposed to its diminishing relevance to the more secular younger generations. The homes received visits from chaplains from the traditional Welsh language Non-conformist chapels, as well as the (usually English language) Church of Wales, for residents of both denominations. Resident B1 would go out to attend her local chapel service as often as she could, but also received communion on a weekly basis in the home, which had arranged for the chapel and church to come on alternate weeks for this purpose. She said that religion was important to her because 'dwi di cal fy nwyn i fyny hefo fo … Mae'n bopeth i mi' [I've been raised with it … It's everything to me], and that praying made her feel as if 'bod na rhywun yn gwrando' [that someone is listening]. She felt that the chapel was extremely important to the Welsh people, and that she ''misio gweld y drws 'na yn cau' [don't want to see that [chapel] door closing]. Resident B5 said that, as long as she received communion, she did not mind which denomination the service was done in - which also implies that she had no linguistic preference as regards to the service. This may suggest, that, for her, the detail of religion is less important than the simple presence of it. Resident A4 said that her faith was important to her as 'o'n i wrth fy modd efo gwasanaeth yr Eglwys, y morning prayer, y canu salmau.' [I loved the Church service, the morning prayer, singing psalms].

To others, religion was less important. Resident A2 said that it 'ddim yn fy ngweddu i, de' [doesn't suit me, you know]. His fellow resident (A6) said that she did not want any more religion in the home as ''Dwi di suro.. Ma 'ngwr i 'di marw, flwyddyn, a dwi … ddim yn gwbo lle mae o di mynd.' [I've soured.. My husband has died, a year, and I … don't know where he's gone]. Resident B3 said that it was 'sut da chi'n byw sy'n bwysig' [how you live that's important], so she didn't need any visits from a minister. Relative B3 in Home B said of his father that, ''Sgenna fo'm dim byd i ddeud wrth y Capal. Na, erioed. Ath o pan odd o'n fach, cael ei arddodi, ond dwi'n credu fod y rhyfel wedi gwneud gwahaniaeth mawr. A pethe yn ei fywyd wedi neud iddo teimlo - 'os oes na Dduw, dio'm yn llawer o dduw'.' [He hasn't much to say to the Chapel. No, never. He went when he was little, was confirmed, but I believe the [Second World] War made a big difference. Things in his life made him feel - 'if there is a God, he isn't much of a god'].

Home B appeared to have a more formal arrangement, as Resident A4 said that she had not seen anyone for a few months, and that she would like to receive more

visits, ‘i mi gal sgwrs a hanas yr Eglwys a petha felna.’ [so I can hear the latest news from the Church and suchlike]. This illustrates the part that religion plays in an older person’s community, but also the happiness that being part of that community brings.

Many residents across the two homes reported that they enjoyed speaking to people from their own area, showing how community cultural congruity can contribute towards well-being. This ‘local’ effect seemed more pronounced in Home B, where Staff B7 said that ‘Ma na nifer o cysylltiade … Ma na nifer o staff yn dod o ’dre ma, ’di bod yn byw yn ’dre, ’nabod nhw, ma’n neud gwahanieth, dwi meddwl, ’de.’ [There are a number of links … Many of the staff come from the town, been living in the town, know them [residents], it makes a difference, I think]. Relative B3 , the son of a resident in Home B, reported this vignette which perfectly illustrates this point:

> ‘Ma na rhei, a ma ne un yr arbennig, mai’n wyres i rhywun odd o’n cofio pan odd o’n fach. Cymeriad yn y dre. A mae o'n meddwl y byd ohoni hi. Mae’n hawdd deud pwy di’r rhei sydd o’r dre. Ma na rhei sydd yn fwy o’r dre na’r lleill, a ma hwn yn mynd i swnio'n wirion efallai, ond deud y gwir - efo rhei o’r bobol ma na rwbeth caredig … ma na jyst rhwbeth, a ma’n hoffi hynny, de. Dio’m ots gynno fo os di nhw’n Gymraeg neu beidio, ond os di nhw o dre, a bod o’n medru adnabod nhw trwy teulu … wedyn ma hynny’n gwneud gwahanieth mawr.’
>
> [There are some [staff], one especially, she’s a grand-daughter to someone he remembers from his youth. A character in the town. He thinks the world of her. It’s easy to tell which ones are from town. Some are more from the town than others, and this sounds absurd perhaps, but to be honest - with some of them there is a kindness … there’s just something, and he likes that, you know. He doesn’t care if they’re Welsh[-speaking] or not, but if they come from town, and he knows them through family … then that makes a big difference.]

It appears that the local connection makes a resident feel at home and as part of a wider family in the community, and gives them the opportunity to reflect on local memories and people in a positive way. Manager A said that the residents like ‘siarad am yr hen amsar’ [talking about the past] and that they had recently enjoyed

a slide reel of local pictures from the 1960s. She said that the local industries were farming and slate quarries, and that this was important to residents. One resident in the dementia unit who frequently worries about her husband (who is deceased) is reassured by staff that he is 'ar y ffarm' [on the farm], as she 'knows' that she is a 'gwraig fferm' [farmer's wife]. The manager also said that one would 'cal lot allan ohonyn nhw' [get a lot out of residents] if they were asked about the local slate works. The residents would 'mynd trwy hen posters a hen lunia di cal eu tynnu, a ma na rhei yn mynd yn ol blynyddoedd, a ma nhw wrth eu bodd' [go through old posters and pictures [of the quarry], going back many years, and they are delighted], according to one carer. Resident A2 said of his culture that 'ma'r gwreiddiau yn y creigia ma, yntydi? Creigiwr yn y chwaral oedd 'nhad' [the roots are in these rocks, aren't they? My father was a rock worker in the quarry].

Even if a resident's immediate culture is not congruent with a carer's, the effort to make a connection is appreciated, according to Staff B4: 'Sometimes you might have a bit more in common, you know, like I say I come from Chester and some of them come from round that area, or they've got family around there, and they might mention a certain place, you know, and is that place still there, and you know, is there still a lot of shops in Chester, things like that - and you start to get talking, and it sort of brings back memories for them then.'

An interesting finding in this research was the discovery that many non-native residents (from England) had previously acculturated to the area and were therefore comfortable in the local culture. Resident B6, a 1LE from Lancashire, said that 'I've lived here longer than I've lived in England, and if there's any [sport] matches on I'm for Wales, cos all my children were born here.' She also said that 'I think music's a great part of Welsh culture. I love listening to Welsh music, I really do, but, I always have, before I ever came here!' This lady was also observed humming along with the Welsh national anthem when played on an Alexa device by the staff. The acculturation phenomenon was most prominent in the case of Resident A3, a 1LE in Home A who had learnt Welsh - 'When I came there in 1963, nobody spoke English. So I thought, shut myself off? If I'm staying here I'm going to have to learn it' - and was therefore linguistically congruent in Home A. She also said that she felt more comfortable around Welsh people, as 'we talk about local things'. She intimated that when she was younger and English people came to holiday in the nearest town, they had a superior attitude, and did this by gesturing a thumbed-up nose,

suggesting an unconscious anti-English bias as part of her acculturation. Despite all this, she said that she would prefer to be in England as 'I was born there' - which further supports that cultural congruence is important for residents' well-being.

Absence of Cultural Congruity

This work has found that cultural incongruity has a detrimental effect on a care home resident's well-being, but to a markedly lesser extent than does linguistic incongruity. This appeared to manifest itself mainly in missed opportunities to entertain or engage a resident in their interests, due to a lack of understanding of their core culture, which could result in *Loneliness and Boredom*. On other occasions it appeared that some residents did not get on well with carers or health professionals who were from different cultures to them, seemingly due to a *Culture Clash,* or in some cases, *Racial Discrimination*.

Loneliness and Boredom

In Home B, it appeared that many of the Welsh-speaking residents preferred to engage in culture independently or together, rather than communally with the rest of the Home's residents. As Staff B7 said, 'Ma na rei, gyda'r nos, ma nhw'n mynd i'w llofftydd at eu gilydd … i wrando ar y Cymraeg, ynde.' [Some, by night, go to their bedrooms together, to listen to the Welsh [radio], you know]. This was corroborated by a Resident B6 who said that 'a few Welsh speakers … don't go to the day centre' because the activities are 'all in English'. Ultimately, it may be that their minority status in the home makes them vulnerable to isolation, according to Staff B7: 'Mi o 'ne nifer mwy o Gymry yma, a wedyn odd o'm yn gymaint o broblem, ond rwan ma na llai o Gymry, ti'n gweld o'n fwy fod nhw mynd i bod ar ben ei hunen a bod nhw ddim yn cymysgu, ti'n gwbo be dwi'n feddwl?' [There was a greater number of Welsh here, then it wasn't such a problem, but now there are less Welsh, you see it more that they are alone and don't mix, do you know what I mean?]. Resident B4 said that regarding television preferences, there wasn't much Welsh language television on in the common room as ''di nhw'm yn ei roi o ar' [they don't put it on].

Staff B7 felt that the previous (1LW) manager had ensured that Welsh activities were available, but that this didn't happen anymore. She said that 'Os sa 'ne gofalwyr, sy

ddim yn Gymraeg, fysa nhw'm callach efo 'Steddfod, a pethe' [If there are carers, who are not Welsh[-speaking] they wouldn't know the first thing about the Eisteddfod and suchlike], suggesting that these staff members are less well-equipped to enable residents to engage with their core culture - for example, when such culture is on the television or radio.

This was not necessarily restricted to carers who did not share a first language with residents. In Home A, where all carers spoke Welsh, Relative A2 bemoaned the fact that 'weithia dwi'n dod yma a ma'r TV yn switched off a dwi meddwl fod hynna'n ofnadwy de, yn enwedig pan fo Llangollen ymlaen, neu Steddfod ymlaen' [sometimes I come here and the TV is switched off and I think that's awful, especially when Llangollen [International Eisteddfod] or the Eisteddfod are on]. This may be explained by the difference in culture between the older residents and younger carers - this same relative felt 'fod pawb sy' i mi yn ddiwylliannol yn y ardal yma yn ifanc yn gadal, 'dydy?' [that every young person in this area who is cultural, to me, has moved away, haven't they?]. In saying this she suggests that educated individuals who could engage with her mother's culture (e.g. poetry discussion) are not working in low-paid jobs in the area. Further to this, staff may also not have an understanding of the area's agricultural past, as her vignette shows:

> 'Yr amsar oedda hi'n siarad efo fi, oedd hi yn yr ha', ac mi ddoth un o'r carers, mi 'steddodd hi lawr efo ni am funud, a dudodd hi, 'Dow, dwi'm 'di clywed Mrs W yn siarad fel hyn!'. Siarad am hen betha oedda ni, 'lly, a gath hi sioc, yn amlwg … Dudwch os di hi'n gwylio rhaglen, Sioe Llanelwedd, fel enghraifft, o'n i yma rywbryd, 'Ew, sbia ar y tarw yna!', a wedyn, ceffylau - ma hi'n cofio pan oedden nhw'n trin y tir efo ceffyla, 'Aw, yli smart ydi'r ceffyl yna!', wedyn, 'Yw, ma hwnna'n debyg iawn i Prince!', ceffyl oedd gennyn nhw ar y ffarm. Oni bai mod i yna, sa hi'm di deud, ac oni bai bod rhywun yn gwybod am amaethyddiaeth.. 'Swn i'n gofyn i rhan fwya o'r staff yma, dwi'm yn meddwl fod nhw'n gwbod am ceffylau yn trin y tir … Eu hoedran nhw yn fwy na dim.'
>
> [The time she was speaking with me, it was in the summer, and one of the carers came and sat with us for a minute, and said, 'Gosh, I haven't heard Mrs W speaking like this before!'. We were talking of olden matters, you

know, and she obviously had a shock … Say if she's watching a programme, the Royal Welsh, for example, I was here one time, 'Ooh, look at that bull!', then, horses, she remembers when they farmed the land with horses, 'Awh, look how smart that horse is!', then, 'Eh, that looks like Prince!', a horse they had on the farm. Unless I had been there, she wouldn't have said, and unless one knows about agriculture.. If I asked most of the staff here, I don't think they'd know about horses farming the land … Their age more than anything.]

Culture Clash and Racial Discrimination

On occasion, in both homes, there was evidence that residents' well-being was potentially adversely affected by a clash between their own, and a different culture. This may be sometimes a simple difference in cultural norms of care provision, but also due to racial prejudice on a resident's behalf (which could in itself be a historic cultural norm). A simple example is seen in Home B, where Relative B1, a daughter of a 1LW, said that 'there's a German lady [resident] here … I get the impression that she and her are from totally different backgrounds'. Other than this, there didn't seem to be any enmity between residents from different backgrounds, which may serve to emphasize the many shared and overlapping aspects of Welsh, English and British culture. It should also be noted (see *Acculturation,* above) that many 1LE residents from England had integrated into the local cultures.

Any potential issues between cultures were more likely to be between resident and carer. The manager at Home B felt that it was 'easier' to have carers from the same culture as the resident, as 'We've had, in the past, different nationalities working here, and it's just, the way someone presents themselves. It's a whole vibe, it's a different thing - someone from a different nationality is a totally different culture to someone from this area. It can be just as far as somebody who's English, and people from Liverpool have come in, it's totally, totally different. It's the same as somebody from a city to here, I think the whole vibe, I suppose, is different'. She felt that communication could be an issue, due to 'the strong accent' and 'the lack of words used … people that are living here have slight problems with understanding them … I've heard some of the residents say that, 'this person doesn't understand me". More explicitly, she had experienced that 'what we've found is that different

nationalities are different, so you've got [carers from] Poland, Russia - they're quite aggressive in their manner'.

On the other hand, carers had witnessed residents discriminating against carers or health professionals from different ethnic backgrounds. In Home A, Staff A3 reported that a resident had said "Ww, ma'r doctor ma'n ddu', ac odd hi'm yn keen wedyn, a odd raid i mi jyst ddeud, 'O, ma 'run fath a ni" ['Ooh, this doctor's black', and then she wasn't keen, and I just had to say 'Oh, he's the same as us']. They also stated that one resident had taken issue with a BAME (Black, Asian and Minority Ethnic) community psychiatric nurse. The manager of Home B said that in such circumstances, it was 'not an issue with the care - it's an issue with what [the residents] say. It's not politically correct, and you cringe a little bit, how they say things'. A BAME carer in Home B (Staff B6) described this encounter: '[the resident's] daughter said - 'Mum, you go with him' [to the bathroom], and I heard her say, this is in front of me, 'I'm not having foreigners taking charge of me". However unpalatable this may be, it may be the ultimate example of the desire of residents to be cared for by someone they perceive as a local person who can empathize with their own culture.

Neutral Effect of Cultural Congruity

It has been noted in this work, that for some residents, cultural congruity is not something that is important to them. Some simply said, 'Dwi'm yn meddwl' [I don't think so], on being asked whether a similarity in culture made any difference to them. It appears that a person's character was more important, for example Resident A4: 'Wel, ma'r ledi bach na sy hefo fi, de, Susnas di hi, a ma hi di dod o Manchester. Ond ddaru hi briodi a bachgan Gymraeg o LLB, a wedi byw yna. … mae'r un fath a fi yn union. Ychi, mae'n andros o ddynas neis.' [Well, the little lady who is with me, she's English, has come from Manchester. But she married a Welsh boy from LLB, and has lived there … she's the same as me, exactly. You know, she's an awfully nice woman]. That same 1LE resident said that she 'didn't mind' having 1LW culture on the television and radio in their shared living room as she 'enjoyed the music'.

One resident's son (Relative B3) in Home B said that 'Mae'n dibynnu ar y person. 'Chos ma na rhywun arall yma, sydd yn Gymro pur, a sgenna fy nhad dim byd i

ddeutha fo. So personoliaeth ydi hynny, yn benna.' [It depends on the person. Because there is someone else here, a pure Welshman, and my father has nothing to say to him. So that's personality, mainly]. Relative B2 said, 'It's not about language, culture or race with [him], it's about people. As long as they can talk to him, he's happy.' Relative B1 also said that of culture and other residents, 'I think he's probably open-minded enough to think that it doesn't really matter.' This issue of culture also raises the question of the difference (if any) between the 'Welsh' and 'English' cultures. Although most participants agreed implicitly that these are separate entities, Relative B1 stated that, 'I don't even consider between Welsh and English, there being this sort of difference, but maybe that's because I grew up in both those situations. It's not like we're talking about a Muslim culture [as a comparator].' Of note, this person was not familiar with any Welsh language culture, but it is interesting that this may be the perception of many people.

Carers in Home A agreed that residents tended to 'cymysgu'n dda' [mix well], and in Home B that 'they mix quite well', where they were described as a 'social bunch'. Home B, it should be noted, sits in a historically more culturally heterogenous area, so residents may have the advantage of having had friends and associates across different cultures throughout their lives. However, as in Linguistic Congruity, some of the individuals professing that cultural congruity was not important were found to have voiced statements to the contrary elsewhere in the conversations. Again, this may be a result of wanting to appear courteous, tolerant of different cultures, and even stoic. Nevertheless, cultural congruity seems to be less important than linguistic congruity to residents, and to some it is not important at all. One theme that emerged which may contribute to explaining these contradictions, is that the concept of 'Culture' as a personal characteristic is often poorly understood in this cohort.

Understanding of Concept of Personal Culture

During the design phase of this research, the decision was taken to examine the idea of cultural congruity alongside linguistic congruity. The reasons for this were twofold: firstly, to determine the significance of culture to the well-being of residents in care homes; secondly, to explore the close relationship between language and culture in this cohort. To accomplish the former, the participants would need to have

some understanding of the concept of ‘Culture’. What transpired was that understanding was often limited, and in fact, cross-referenced heavily into the latter aim of mapping the dynamic between language and culture: many see these as inseparable.

None of the 1LW residents who were asked, ‘How would you describe your culture?’ were able to answer this without requiring further guidance as to the concept of the question. The reasons for this may be multifactorial, not least that most were cognitively impaired. Most responses varied along the line of ‘Dwi’m yn siwr be da chi’n feddwl?’ [I’m not sure what you mean?]. The researcher would attempt to explain this by giving examples (e.g. Welsh, English), or asking which ‘people’ they were from. 1LW residents usually replied that they were ‘Cymraeg’ [Welsh], but on being asked to elaborate, often found it difficult to explain what this meant. As the researcher would have to provide this framework for discussion, this meant that results were affected by bias. This interaction was typical (Resident B3 on left, researcher on right):

‘Be da chi’n feddwl, diwylliant?’

‘Wel, yda chi’n un o’r bobol Cymraeg?’

‘Wel, ydw, debyg iawn.’

‘A be sy’n bwysig i bobol Cymraeg?’

‘Wel, dwi’m yn gwybod..’

‘Fasa chi’n deud fod pobol Cymraeg yn wahanol i bobol Susnag?’

‘Yndan, yndan.’

‘Ym mha ffordd?’

‘Mwy cartrefol, ynde.’

[What do you mean, culture?

Well, are you one of the Welsh?

Well, yes, most likely.

And what is important to Welsh people?

Well, I don't know..

Would you say that Welsh people are different to English people?

Yes, yes.

In which way?

More homely, you know.]

Although this illustrates the difficulty in conducting these discussions, it also serves to remind us of the key word for this research: *homeliness*. This lady cannot fully express what her culture is, and what it means to her, but she can definitively tell us that being around 'Welsh' people makes her feel 'homely'. Others simply said that they were Welsh because 'dyna sut da ni di cael ein magu' [that's how we were raised], which is in a very similar vein to homeliness, harking back to childhood and what feels familiar and comfortable to them. In describing local culture, some residents would reference the importance of dialect, such as Resident A2: 'Duw, wel, 'Su' mai was?' de, a 'Duw, sud wt ti?' a dyna fo! … Ma na idioma chwarelyddol, da chi'n deud nhw weithia.' [Well, 'How are you, lad?', and 'Lord, how are you?', and that's that! … There are quarry idioms, that you might use sometimes]. This may emphasize the importance of linguistic locality to residents, which local carers can theoretically provide (although dialect may vary across generations). The manager in Home B summarized: 'I think culture, upbringing and language, really - they're all the same.'

If it was in the describing of culture that the *Overlap with Language* featured, it was also where *Pride in the Language* surfaced. A bilingual lady, Resident B2, had been raised by her grandparents in a monolingually Welsh household in a country village. She had married an English speaker, and her children were 1LE. Despite this, when asked about her culture, she responded: 'Wel, Cymraeg, ia. Peidiwch a troi y Cymraeg i ffwrdd.. Na. Ma'r Cymraeg yn bwysig i mi, fel Sasneg, wel mwy. Dwi di cal fy nwyn i fyny'n Gymraeg. Cymraeg oedd y cartre, ynde.' [Well, Welsh, yes. Don't turn Welsh off.. No. Welsh is important to me, like English, well, more. I was raised [in] Welsh. It was Welsh in the home, you know]. Resident A4, when describing what is important to Welsh people, said 'Ma'n bwysig fod ni'n cal yr iaith Gymraeg, yndydi' [It's important that we have the Welsh language, isn't it]. Her

fellow resident (A5) said, ‘Ddim isio anghofio Cymraeg, nac oes?’ [Don’t want to forget Welsh, do we?] Resident B1 felt that, regarding language and culture, ‘O ma’r ddau yn cyd-fynd, rywsut, yndyn?’ [Oh, they go together somehow, don’t they?]. Resident B5 said that it was important ‘i drio cadw fo fynd’ [to keep [Welsh] going], and ‘Dwi’n licio meddwl bod yr iaith yn cael byw’ [I like to think that the language is kept alive]. Resident B3 simply said that ‘Wel, s’im isio gwadu’r iaith ynde. Arna i!’ [The language should not be denied. Not by me!]

Non-Welsh speaking residents, and staff, were also respectful of the overlap between language and culture. This lady, a 1LE resident in Home B, said that ‘I think it’s very important. It’s a different language and they should be able to use the language.’ Staff B1 felt that ‘Language, definitely’ was an important aspect of potential shared culture between carer and resident. This doesn’t apply solely to Welsh speakers - Resident A3, a 1LE resident in Home A, felt that her language (English) meant that her culture is ‘kept alive.’

These data show the complexity involved in understanding, demonstrating and expressing a culture which appears to have a strong tie to language. Whether this understanding can subsequently affect the provision of care is also a complicated issue, which is now examined in detail.

Effect of Cultural Congruity on the Challenge of Providing Care, and the Barriers to Provision of Cultural Congruity

The findings from this field work have found that cultural congruity can facilitate the provision of care for residents in care homes, by allowing for *Understanding* and *Familiarity*. There appears to be a good awareness of this amongst staff, but there is also a strong emphasis on *Good Care* rather than exclusive focus on congruity. Cultural congruity appears to be of less significance to the provision of care than does linguistic congruity. Providing this cultural congruity is a challenge for care homes, but again, perhaps less so than linguistic congruity. The focus of the challenge lies once more in *Logistics* rather than anything else, and mostly affects the care homes themselves (rather the local or national authorities). A scouting documentation search did not reveal much on this subject, which perhaps reflects the dependence for each individual care home to regard the issue, rather than the existence of a considered national strategy.

Challenges and Barriers for Carers

Most carers agreed that cultural congruity reduced the challenge of providing care for residents, but many were also at pains to point out that good care was the most important aspect of their role. The manager at Home A (see *Happiness,* Presence of Cultural Congruity) was able to demonstrate that local knowledge of industry and farming contributed towards the caring of her residents. During the observation phase it was seen that carers in Home A were attuned to their residents' cultural tastes, by arranging for the communal spaces to have S4C or Radio Cymru on in the background - something that was perhaps innate due to their shared culture. This was less easy to achieve at Home B due to the heterogenous spread of residents' cultures, and maybe also due to cultural incongruity on behalf of the carers. For example, this vignette from Staff B7 looking after 1LW residents:

> 'O'n i di dechre'i fáth, amser pnawn, ac odd o'n deud, 'O, ma'n 'Pnawn Da' wan', a ma fi'n deud 'O, nawn ni neud o wedyn.' Ti'n gwbo - hwyrach fasa na rei ddim callach be ydi hwnnw, mewn ffordd, ti'n gwbo be dwi'n meddwl? Ond dyne pam ma'n bwysig bod na rhei Cymry yne, ti'n gwbo? … Ma na un yn gwrando ar y radio, gwasanaeth dydd Sul, a dio'm yn gorffen dan bump, wedyn ma na rhei yn deud, 'Lle mae o?', a ti'n deud, 'Wel, ma'n gwrando ar hwnne', ma'n gorffen am bump a mae o'n dod i lawr, ti'n gwbo be dwi meddwl? 'Dy nhw'm yn dallt hyn, 'dy nhw'm yn dallt be mae o'n gael.'
>
> [I had started his bath, in the afternoon, and he said, 'Oh, it's 'Pnawn Da' [Radio Cymru programme] now', so I said, 'Oh, we'll do it later'. You know - some possibly wouldn't know the first thing about that [show], do you know what I mean? But that is why it's important that there are some Welsh [carers] here, you know? … One [resident] listens to the radio, Sunday service, and it doesn't finish until five, then other [carers] are saying 'Where is he?', and you say, 'Well, he's listening to that', that finishes at five and he comes down, do you know what I mean? They don't understand this, they don't understand what he gets from it.]

As well as illustrating the importance of cultural congruity, and its effect on care provision, this once again shows the overlap between culture and language. This carer (Staff B7) knows these residents' culture because she shares a language with them, which in turn means that she is aware of the importance of these

programmes to them, as she is familiar with the same radio station. To her, an innate understanding of 1LW culture helps her cater for 1LW residents in a way that others can't. This also demonstrates the inherent difficulty involved in 'learning' a culture - she added that ''Dy nhw ddim yn dod o'r diwylliant.. Ma nhw'n dysgu Cymraeg, ond 'dy nhw ddim yn gwbod dim byd am y diwylliant, i radde.. Dio'm yn y nhw, rywsut, 'dy nhw'm callach, mewn ffordd.' [They [non-Welsh speaking carers] don't come from the culture.. They've learnt Welsh, but they don't know anything about the culture, to a degree.. It's not in them, somehow, they don't know any better, in a way.] If this is true, it has significant implications for the provision of cultural congruity in care homes. Despite this, shared local culture was seen by her as a positive in delivering care for residents: 'Hyd yn oed os dydi nhw ddim yn siarad Cymraeg, mae'r preswylwyr yn gwerthfawrogi os na rhywun yn dod o B, ma nhw'n gwbod petha am B.' [Even if they don't speak Welsh, the residents appreciate if [a carer] comes from [Home B area], and knows things about [Home B area].

One carer in Home B (Staff B3) lamented that she did not share the residents' culture: 'I think it can be, I guess nice, and more enriching, for the ones, especially for the people who have got the ability to get involved in, you know activities, things like that, if they've got things from a familiar culture … It doesn't [make a difference] in terms of how you'd care, or the kind of care that you'd give, I think it could make a difference if you do share the same culture as someone you could perhaps do more to just gain that idea of enrichment rather than the basic care.' Although she feels that cannot offer that 'enrichment' that sharing a culture would offer, she does feel that she is still able to provide good care. This was a common theme expressed in both homes.

Importance of Providing Good Care

Many staff members stressed that this was their priority. As Staff A5 said, 'dio'm bwys pwy sy'n dod yma, 'sa ti yn cal rywun odd yn byw yn Turkey, duda, ac yn dod i fyw i'r ardal, sa rhaid chdi rhoi yr un un parch i'r person yna a dod i ddallt y person yna, cynnig fwy o amser, sa chdi'n goro gweithio efo'r person yna, a dod i ddallt y person, i weithio.. Rhaid ti rhoi yr un un parch i bawb, dio'm bwys.' [it doesn't matter who comes here, if you had someone from Turkey, for example, who'd come to live here, you'd have to give the same respect to that person and get to know

them, offer more time, you'd have to work with that person, come to understand them, to work.. You have to give the same respect to everyone, it doesn't matter]. Staff A1 felt that ‘'swn i mynd i ofalu yn Llundain swn i neud yr un gofal - dio'm yn neud unrhyw gwahaniaeth.' [if I went to London I would give the same care - it doesn't make a difference]

In Home B, Staff B5 said ‘To me it doesn't make a difference. I don't think it's makes any difference where you're from, or anything', and Staff B3 said that ‘as long as the culture is respected, which I guess is probably the same across language, religion, everything … It's more about that respect and that caring nature, than necessarily sharing the same culture.' Perhaps the best summary is offered in this succinct quote by Staff B2 - she considered that good care can be provided, ‘as long as you're a kind, caring person'.

Challenges and Barriers to the Care Homes

The challenges that a care home faces in providing cultural congruent care, and the barriers to provision identified, are in a sense a bureaucratic embodiment of those described in relation to carers. This is in the sense that the challenges are in fact the managing of the residents' day-to-day lives, and the staffing administration of their carers, in regards to cultural congruity. The challenges and barriers are therefore greater to the care homes themselves, being the sum of the parts; however, this is not duly passed up to a local or national authority, due to a lack of coherent national strategy (see *Challenges and Barriers to Local/National Authority,* below). The onus is therefore upon the care homes themselves (i.e. the management) to consider and manage the issue. These challenges are mainly *Logistical* in nature, as well as to do with *Training.* They are also reminders of the overlap between language and culture.

Whilst Home A's statement of purpose mentions that a person's cultural needs should be addressed with a person-centred plan, there was no reference to culture in Home B's statement of purpose. During the observational phase at both homes, it was noted that there had been a concerted effort to provide culturally congruent living environments. Externally, both homes had daffodil flower displays planted near their entrances, and Home A had the county crest mounted on the wall. Both homes‘ interiors were decorated with such furnishings as Welsh dressers, mock

traditional fireplaces and mantlepieces, old-fashioned clocks, and comfortable arm chairs. Home A had a small library corner, which in addition housed a traditional carved wooden local Eisteddfod chair. The overall effect of this decorating was of traditional British living rooms with a slight Welsh flavour.

As stated, Home A frequently had Welsh culture on broadcast in the background (S4C, Radio Cymru), which was congruent due to the homogenous nature of 1LW residents. This was not the case in Home B, where 1LW speakers were in the minority. Should S4C or Radio Cymru be on in the communal areas, most of the 1LE residents would not understand the content, and it would have been linguistically and culturally incongruent (e.g. songs played, topics of discussion) for 1LEs. This demonstrates the challenge for the administration of the care home of providing cultural congruity for their mix of residents. This mix in itself is a challenge to the homes - should 1LW residents be given the option of sharing communal spaces with other 1LWs, to enable linguistic and cultural congruity? If so, does this represent segregation? Residents (especially bilingual and bicultural ones) may prefer to be mixed in, or to be with other residents from their own home town or with similar interests, even if they do not share a first language.

Following from this is the question of resident 'activities' at the homes. In Home A, any activities would be culturally congruent if arranged with a local supplier (e.g. singer), again due to the almost entirely 1LW client base (although this does not discount potential incongruity for the very few 1LEs at the home). In Home B, a 1LW resident declined to attend an English singer concert due to the language barrier (see Absence of Linguistic Congruity, *Loneliness and Boredom*). In this situation, it would be impossible to cater for all of the residents, all of the time. There may also be less availability of Welsh language activity suppliers (e.g. singers) in the local area of Home B due to the linguistic spread of the town and its surroundings.

This would also appear to account for what may be the most significant influence on cultural incongruity for residents in care homes, which is the staff mix. There have been numerous examples throughout this research of how first language almost defines one's personal culture, most prominently in Home B. The staff in both homes appeared to be mainly locally recruited, which means that the staff in Home A were mainly 1LW, and the staff in Home B were mainly 1LE. The implication of this is that the 1LE staff in Home B, on the whole, do not share basic 1LW cultural references with the 1LW residents, e.g. Eisteddfod culture, Welsh language hymn

singing, idioms and linguistic devices to describe landscapes, nature and industry. Add to this the theory of Linguistic Relativity, which holds that the structure of a language affects its speakers' world view or cognition, then there is a tangible barrier to providing that cultural congruity. This would be even more difficult to achieve with staff recruited from outside the area, or even the country (which could affect 1LEs to the same extent). On the other hand, the 'local' aspect of a carer (regardless of language) is seen as a positive. In both homes, there is also a generational divide in culture (also separate to language) between cares and residents.

Approaching these barriers with recruitment is challenging, due to local population mix. Job applications are open to all, and are mostly filled by local candidates. Even if the care home was able to ensure that at least one 1LW culture staff member was theoretically available for each shift, they would still have to ensure that the person with the most appropriate personal attributes - of a patient, caring nature - was employed. Whilst this is a *Logistical* problem, could it be surmounted by *Training*? There are currently no 'culture training' programmes in operation in the counties that these care homes operate. This is considered in further detail, in *Discussion*.

Also of a *Logistical* nature is the fulfilment of cultural needs such as religion. Home B appeared to have a fixed rota of visiting chaplains giving communion, from both Non-conformist (traditionally the mainstay of 1LW religious culture) and Church of Wales (usually 1LE). In Home A, however, this did not appear to be the case, and chaplains visited on an ad hoc basis of their own availability. Many residents voiced that they would like to receive more visits, but some said that it was not relevant to their needs.

Challenges and Barriers to the Local/National Authority

As discussed immediately above, the issues are left entirely to the consideration of those who manage care homes. During the scouting documentation search, there weren't any specific references to the provision of culturally congruent care, at a local or national level. The absence of standards regarding the provision of cultural congruity, set at these levels, means in effect that there aren't any challenges or barriers to these authorities in relation to the issue, at least not from a 'Welsh' culture point of view. This raises the question as to the existence of a 'Welsh' culture

lived by 1LW people, but this has seemingly been answered, at least in part, by this research. It therefore raises a further question of the *Awareness* of those in senior positions in authority of such a culture, and its significance to 1LW residents. Is this also a matter of *Training*, or should there be more *Representation* of this culture in these positions?

These are the themes that have emerged in relation to the presence, absence, and provision of cultural congruity in these residential homes in North Wales.

Chapter Five

Discussion and Recommendations

5.1 Discussion and recommendations in relation to care in Wales

This ethnographic research has found that a presence of linguistic congruity (and to a lesser extent, cultural congruity) are of great importance in the care and well-being of 1LW residents with dementia living in care homes. It has also found that a lack of linguistic congruity for these residents poses significant detriment to their well-being. Providing such congruity is challenging for care homes, mainly due to logistical problems such as training and workforce issues. The results support the theoretical proposition for this study:

> A culturo-linguistically congruent living environment for people who are first language Welsh speakers and living in care homes in North Wales (many of whom are cognitively impaired), increases the potential for communication, which in turn increases understanding and social interaction, which subsequently leads to greater well-being for residents, which also reduces the challenge of care provision for care staff.

This proposition was repeatedly evidenced in our work, as some of the most striking themes to emerge were *Appropriate Care and Understanding*, *Happiness and Calm*, and *Social Stimulation*. However, the most prominent finding in this work, not predicted beforehand, was that culturo-linguistic congruity in this environment brings feelings of *Familiarity*, and most of all, of *Homeliness*, to residents. Why does congruity foster this emotion, and why is it so important? For many 1LWs in this area, the Welsh language and culture was the media by which nearly all daily interactions occurred in their childhoods and younger lives, including the household, village, and work environments. Most of the relationships in their formative years would have been indelibly tied to their first language and culture. By providing congruity, a care home may be allowing an older, cognitively impaired resident continued access to this homely, safe place in their own biopsychosocial structure - which could be imagined as a permanent, ongoing complement to reminiscence therapy. This, in turn, may provide a frail individual with the baseline well-being

needed to navigate their lives, enabling *Vitality* - the successful application of cognitive skills in one's everyday environment (Poon and Cohen-Mansfield, 2011).

To our knowledge, this is the first time that this phenomenon has been demonstrated in Wales with empirical research, making it a novel contribution to the understanding of care-giving, language and culture in old age and cognitive impairment in care homes. Previous case studies and reports have alluded to this, for example Davies-Williams (2012, p.129) found that by using music to communicate with patients on a dementia unit in North Wales, individuals could 'express themselves and be stimulated to hold a conversation'. Consistent with our own research, Roberts' review (1994, p.64) of communication between nurses and patients in a bilingual hospital setting revealed that many patients said that they felt 'mwy cartrefol' [more homely] if their health care was provided in Welsh, and it was noted how frequently those exact same words - 'mwy cartrefol' - were used to describe their feeling towards Welsh speaking staff. Such sentiments were also found in Misell's report on the Welsh language in the health service (2000, p.18) - this quote from a hospital patient, in particular, resonates with those from our own research:

> 'Byddwn i'n fwy cyffyrddus 'sen ni'n gallu siarad Cymraeg 'da'n gilydd. Mae 'na ryw agosatrwydd sy'n gwbl wahanol pan wyt ti yn dy iaith gyntaf.' [I would be more comfortable if we could speak Welsh to each other. There's a certain intimacy which is totally different in your first language.]

Of nearly equal significance is the perceived detriment to well-being found in our study, attributable to any absence of culturo-linguistic congruity. Although factors such as *Loneliness, Boredom, Unfamiliarity and Unhomeliness* were important, of most concern was the potential for *Inappropriate Care* and *Misunderstanding* resulting from linguistic barriers. These appear to be due to a language barrier between 1LW residents who are no longer able to communicate effectively in English, and staff who are unable to speak Welsh to a degree that will enable optimal care and understanding. There were many examples in our findings of 1LW residents' cognitive impairment impacting on their abilities to communicate in their second language, showing that congruity is of particular importance to individuals with dementia. Our findings echo similar ones found in healthcare settings by Misell (2000, p.34):

‘Mae o’n 80 oed, ac mae ei Saesneg o yn eitha bratiog, achos dyna ydy o. Pan oedd o’n wael iawn efo niwmonia ‘oedd o’n tueddu i fod yn colli gafael ar ei synhwyrau a dim ond y Gymraeg ‘oedd o’n siarad. Os na fyddai rhywun Cymraeg ar y ward ar yr adeg yna, fydden nhw ddim yn gallu deall beth ‘oedd o’n ddweud. Heb y Gymraeg fydden nhw ddim yn gallu dehongli’r sefyllfa. Hynny yw byddai’r holl geriach ‘oedden nhw’n rhoi yn sownd ynddo fo wrth gwrs yn rhoi darlun meddygol, ond beth fydden nhw ddim yn neud oedd rhoi darlun o sut ‘oedd o’n teimlo a beth ‘oedd o’n ceisio ddweud wrthyn nhw.’

[He’s 80 years old and his English is pretty ropey, because that’s just how he is. When he was very ill with pneumonia he tended to lose his grip on his senses and he would only speak Welsh. If there wasn’t someone on the ward at that time who could speak Welsh, they wouldn’t able to understand what he was saying. That is, all the equipment they were hooking him up to would of course give them a medical picture, but what it wouldn’t do is give a picture of how he was feeling and what he was trying to tell them]

Here, as with our cohorts, the ability of the elderly, cognitively impaired individual to communicate their core needs is lessened when done so in their second language (English). As repeatedly shown in our work, communication is easier and more intimate in one's first language.

5.2 Implications for Practice and Policy in Wales

These findings should form the foundation of future discussion regarding the care of frail, elderly 1LWs (and indeed, non-1LWs) in relation to language and culture. If the above propositions are accepted, then how should care homes and their supervising authorities use this information to safeguard the well-being of residents? Our recommendations for policy, practice and research are summarised in Table 5.1.

Table 5.1: Recommendations for Policy, Practice and Research*

*These recommendations are based on the findings that congruity of language and culture in care improves wellbeing in 1LW residents, and that incongruity decreases wellbeing, especially in regards to receiving appropriate personal and medical care, as well as the management of residents with BPSD

	Mapping capacity and gaps in provision of congruity	**Recruitment of culturo-linguistic competent carers**	**Culturo-linguistic Training**
National level (Government, Regulatory Bodies)	• Recording of level of language skill in workforce to be made compulsory • Annual publication of relevant data • CSSIW to ensure compliance at Regional and Local levels	• Increase awareness of issue • National recruitment drives • Setting national targets and actions plans e.g. one 1LW staff on shift with 1LW residents • Offer financial incentive to bilingualism • Enforce existing regulation	• Increase awareness • National training drives and targets • Offer financial incentive to bilingualism • Facilitation of training e.g. during working hours • Design of Cultural Competency training (blended with Person-Centred Care) • Regulation of training
Regional (County Councils, Local Authorities)	• Language skill assessments for care sector posts • Collection and submission of language skill data to National level • Statement of language skill levels on relevant public information websites	• Regional recruitment drives • Setting regional targets and action plans • Ensuring adherence to regulation	• Regional training drives and targets • Responsibility for provision of free courses (blended with Person-Centred Care) • Collection and submission of course uptake and completion data
Local (Care Homes, Social Services)	• Inclusion of language skill levels in Statements of Purpose • Submission of this data to Regional level	• Local recruitment drives • Setting local targets and action plans • Ensuring one 1LW staff on shift with 1LW residents	• Local training drives and targets • Care home managers to facilitate training attendance within working hours
Research	• Survey of attitudes towards these requirements • Workforce studies at National level to determine representation of 1LWs	• Social care workforce studies examining recruitment of 1LW carers	• Social care workforce studies examining training of non-1LW carers • Academic involvement in design of Cultural Competency training

This issue should be considered from two overlapping perspectives, both of which are accentuated when cognitive impairment is present:

1. There are clear potential benefits to residents' well-being to be realised, which may result in wider positive effects in other domains, e.g. social care economics;
2. There are urgent issues posed by a lack of congruity for some residents, which should be considered acutely by the relevant authorities. Most pressing are:
    - Residents declining medications and thereby not receiving the appropriate medical care they require to optimise their physical health;
    - Difficulties occurring during obtaining personal care; and
    - The inability of some staff (due to linguistic incongruity) to soothe and reassure 1LW residents with the behavioural and psychological symptoms of dementia (BPSD).

The obvious response is to ensure that each resident (especially when cognitively impaired) has access to carers who speak their first language, and understand their culture. Furthermore, they should be able to socialise with residents from similar culturo-linguistic backgrounds, and take part in leisure activities which reflect these backgrounds, whether this means traditional group singing and musical entertainment, the ability to watch and listen to television and radio programmes that give them cultural fulfilment, or simply by discussing local affairs.

How practical is the fulfilment of these requirements, in reality? And what priority should they take in the context of a care industry which is experiencing financial pressure (Public Policy Institute for Wales, 2015)? For most institutions, priorities lie in providing good basic care, but the Older People Commissioner for Wales stated in a 2014 report (p.14) that 'too many older people living in care homes have an unacceptable quality of life', and that many homes 'simply focus on the functional aspects of care, with a reliance on a task-based approach, rather than delivering care that is person-centred'. There is therefore already a precedent in Wales in calling for a change in the delivery of care in residential homes, which included the concern that there is a lack of awareness amongst care staff about 'the needs of

Welsh language speakers, which can significantly reduce opportunities for social participation'.

Care homes should therefore ensure that a 1LW resident has access to Welsh-speaking carers. In some areas (e.g. Home A), this is not an issue, with most staff speaking Welsh as their first language (and also being able to speak English fluently to non-Welsh speakers). However, in areas such as Home B, Welsh-speaking staff will be in the minority, and in some cases, numbering close to zero. According to the Older People Commissioner for Wales (2014, p.70), 'low staffing levels are often the result of difficulties in the recruitment and retention of care staff', which compounds the issue of availing residents of Welsh-speaking staff. Reasons for these workforce problems were given to that report by the Care and Social Services Inspectorate Wales (CSSIW), Local Authority Commissioners, and the Royal College of Nursing (RCN); they included (p.70):

> '..poor levels of pay, low morale, long working hours that can include 12 hour shifts as part of a 60-70 hour week, and the role of a care worker not being seen as a desirable and viable professional career option'.

Whilst acknowledging these difficulties, care homes and local authorities should not be deterred from providing the culturo-linguistic congruity that definitively improves residents' well-being, and this should be pursued as part of the quest for establishing person-centred care. In 2016, the Welsh Language Commissioner set out, in great detail, the planning involved for a bilingual public sector workforce. Furthermore, there are international precedents, for example in the Basque and Catalonian countries in Spain (Kabia, 2017; Puigdevall i Serralvo, 2005), as well as in Canada (Canadian Library of Parliament, 2018). Of the many recommendations made by the Welsh Language Commissioner (2016, pp. 10-11), those of most relevance to care homes follow. We have added further relevant proposals, emerging from our own work, to strengthen these recommendations:

1. The need to map capacity and identify gaps in provision:
    - This should be done at a national, regional and local level, including setting out the degree of congruity that a care home provides in its 'Statement of Purpose';
2. Setting targets and producing action plans:

- For example, in the initial stage, it is essential that a care home should always have at least one member of staff on shift who speaks Welsh; the aim should be to expand the numbers of care staff with Welsh language skills;
- Care homes should adopt language training programmes for members of staff as part of their professional development;

3. An objective approach should be adopted to determine language skills:
    - Responsible local authorities should ensure that there is a post-related language skills assessment in place for the organisation;
    - In Canada, a monetary 'bilingualism bonus' is given to public service staff who pass a 2-3 yearly linguistic skills test (Canadian Library of Parliament, 2018) - this is part of acknowledging bilingualism as a 'basic skill', regarding language training as an 'essential component of learning and career development plans', and could be used as a model in Wales;
4. Procedures should be adopted to record and update language skills information:
    - This information should be recorded at an individual, care home and local authority level.

Our research has shown that any linguistic barriers in place can significantly increase the challenge of care provision for carers, managers and local authorities. Addressing these barriers would therefore ameliorate aspects of this challenge as well as improve the well-being of residents.

The concept of providing cultural congruity may be more challenging to consider. This was certainly the case for residents, who often struggled to differentiate their culture from their first language. To some extent this represents the problem, as many of the cultural characteristics defining a 1LW's culture (and identified as important to residents) are inherent to the language, e.g. Welsh language singing, television and radio, or discussion of local industry and affairs using local Welsh language idiom. Theoretically, by recruiting 1LW carers, cultural congruity would also be improved, but recruitment is a major hurdle, as already discussed. Is it therefore

possible to ‘train’ non-1LW carers to understand residents‘ culture - i.e. to undergo ‘Welsh culture training’, along the same lines as language skills training?

Some resources do exist for establishing ‘cultural competency’, for example the ‘Cultural Competency Toolkit’, by Diverse Cymru (2016, p.1), which is a ‘practical guide for mental health professionals, other professionals and front-line staff working within the Mental Health, Health and Social Care sector in Wales’. This, however, is solely aimed at training care professionals to understand the cultural values of Black and Ethnic Minorities (BAME) residents, rather than 1LW residents. This focus is also seen in documents such as the recently published resource for carers of people with dementia in Wales, ‘Caring for someone with dementia: A guide for family and friends’, by Carers Trust Wales (2020). There are no references in this document to the linguistic needs of 1LW people with dementia, nor the unique cultural needs of Welsh people with dementia. Despite this, there is a section which (commendably) addresses the specific challenges faced by people from ethnic minorities, both those with dementia and their carers. This may reflect the general lack of awareness that may be prevalent, even in Wales, regarding the existence of the culturo-linguistically distinct 1LW people, who have issues accessing congruent services in dementia care.

Similar resources, and even workshops, should be developed to reflect the need for care staff to have a basic understanding of 1LW residents‘ culture, to enhance their well-being. It should also be considered essential for care home managers and activities co-ordinators to have such cultural competencies, to enable them to design care and activities around the cultural needs of their residents. In the ‘A Place to Call Home?’ report (2014), the Older People’s Commissioner for Wales stated that residents ‘often do not have choice and control over the activities that they are able to participate in’. Examples of this in relation to language and culture were seen in our findings for Home B, where culturo-linguistic congruity was lower.

To this end, a care home’s ‘statement of purpose’ should without question include the degree of linguistic and cultural congruity provided to 1LW and 1LE residents alike. This should thereafter be incorporated into the CSSIW’s inspections and subsequent reports, so that homes are actively demonstrating their commitment to upholding the principles of improving congruity (as laid out in recommendations 1 - 4 above).

It should be noted that the concept of ‘cultural congruity’ is complex, even leaving aside its interaction with language in the Welsh context. Residents may on the surface have a similar up-bringing and background, but quite different cultural needs. This is demonstrated, for example, in the very different attitudes to religion in the 1LW residents in Home A. Culture is not uni-dimensional, and experiences and up-bringing may have been affected also by gender, age-cohort and socio-economic status, for example. Making assumptions regarding residents’ culture and their interests and preferences may potentially also have negative effects. Person-centred care involves staff in seeking to understand and get to know each person as an individual, with their unique constellation of experiences and attributes. Life-story books may help staff to get to know residents better as individuals (Subramaniam, Woods, and Whitaker, 2014), and staff may need training and support to adopt a sensitive curiosity regarding residents’ life-stories.

Ultimately, policies regarding linguistic congruity already exist in Wales following the Welsh Government’s ‘More Than Just Words: A Strategic Framework for Promoting the Welsh Language in Health, Social Services and Social Care’ in 2012. Specifically, the framework asked that organisations ‘recognise and accept responsibility to respond to language need as an integral element of care’ (p.7), referring to this as the “Active Offer” principle. It also pointed out that organisations in the public sector have ‘a responsibility to comply with the new Welsh Language (Wales) Measure’ […] that will ensure Welsh speakers can receive services in Welsh’. Despite this, the Welsh Language Commissioner and Alzheimer’s Society Cymru commented in a 2018 report that the ‘clinical need’ (p.9) of Welsh speakers with dementia is not consistently reflected in the services available, and that Welsh language services are often not offered without people having to ask for them.

Our research echoes the consistent finding that the ‘Strategic Framework for Promoting the Welsh Language in Health, Social Services and Social Care’ (2012) is not being followed, especially in areas where it is difficult to recruit Welsh-speaking carers. The Welsh Government should follow the Welsh Language Commissioner’s simple recommendations from the ‘Welsh Speakers‘ Dementia Care’ report (2018, p.95) - ‘policies and legislation need to be implemented, reviewed and inspected more effectively, and action taken’. What our work comprehensively shows is that when provided, Welsh culturo-linguistic congruity is significantly beneficial to 1LW

elderly and cognitively impaired residents in care homes, and when absent, there is significant detriment to their well-being.

5.3 Limitations in relation to findings in Wales

When interpreting the results of this study, it is important to note the methodological limitations of this research. By its nature, a qualitative, ethnographic multiple embedded case study is time-intensive, meaning that the number of participants are kept relatively low for reasons of practicality. This raises issues regarding the replicability of the analysis - is it possible to apply the findings across the diverse spectrum of language and culture across Wales? This is mitigated to some extent by the purposive choice of different locations, to represent mono- and bi-lingual (and cultural) resident mixes. In theory, these findings could be transferred and applied to similar sets of homes across Wales, as they are reasonably common circumstances in different areas of Wales. There may be some contexts where it would be more difficult to apply these results: private homes, homes in a more urban context, or homes that employ a greater number of staff from other countries and cultures. Further research in these contexts could examine this question.

Another potential limitation is the replicability of analysis of results deriving from interviewing in groups, where individuals may not always give voice to their true opinions, or even speak up, in the company of others. Group interviews were conducted to allow for the time required to consent participants, to collect and transcribe data, and to subsequently analyse it. By using the multiple case study design, replication enhances the validity and generalizability of findings (Galloway and Sheridan, 1994), and it is hoped that this has boosted the replicability of results from the perspective of the group interview limitation.

5.4 Recommendations for further research in relation to Wales

This work, alongside the scoping review, has revealed that there is a real paucity of empirical research into the effects of language and culture on dementia in 1LW people in Wales. There is a pressing need to address this with the ageing population of Welsh speakers in this area of the UK, or there is a risk that their well-being will continue to be adversely affected by the lack of congruity many experience in their

day-to-day lives. Of particular interest would be the correlation and replication of our results in other Welsh-speaking areas of Wales. Table 5.1 summarises the future needs surrounding the following suggested areas of research.

Much work is necessary in order to identify the most effective way to improve provision of culturo-linguistic congruity in social care. How can non-Welsh-speaking carers be engaged in learning the language? Survey research would be a good place to start, followed by qualitative work to tailor the best methods of engagement. Would it be appropriate to incorporate 'culture familiarization' training into language lessons, or even to provide them separately to care staff working with 1LW residents? Or does this unnecessarily duplicate the principles of person-centred care?

A different solution would be the employment of Welsh-speaking carers. How can such individuals be recruited to work with cohorts with whom they share a language and culture? Social care workforce studies would be valuable in answering such research questions.

There appears to be little onus on authorities such as the Welsh Government or local authorities to ensure that the provision of congruent care actually happens for 1LWs. Does this reflect that there is a lack of representation for Welsh speakers in these authorities? Again, survey work would yield interesting results on the backgrounds and views of those who are responsible for care provision in Wales on the Welsh language in social care.

Lastly, a fascinating theme to emerge from this work is the overlap between the Welsh language, and the culture of those who speak it. This would be worthwhile subject of research in the field of linguistics, or even anthropology, in Wales. Does the Welsh language define an individual's culture? What is the place of 'Britishness' in the Welsh-speaking identity? The Welsh-speaking identity remains a lesser understood concept, especially outside of Wales, and perhaps even less so in those who represent the last generation to live in a Wales which was a majority Welsh-speaking nation.

5.5 Discussion and recommendations in relation to care in the wider context

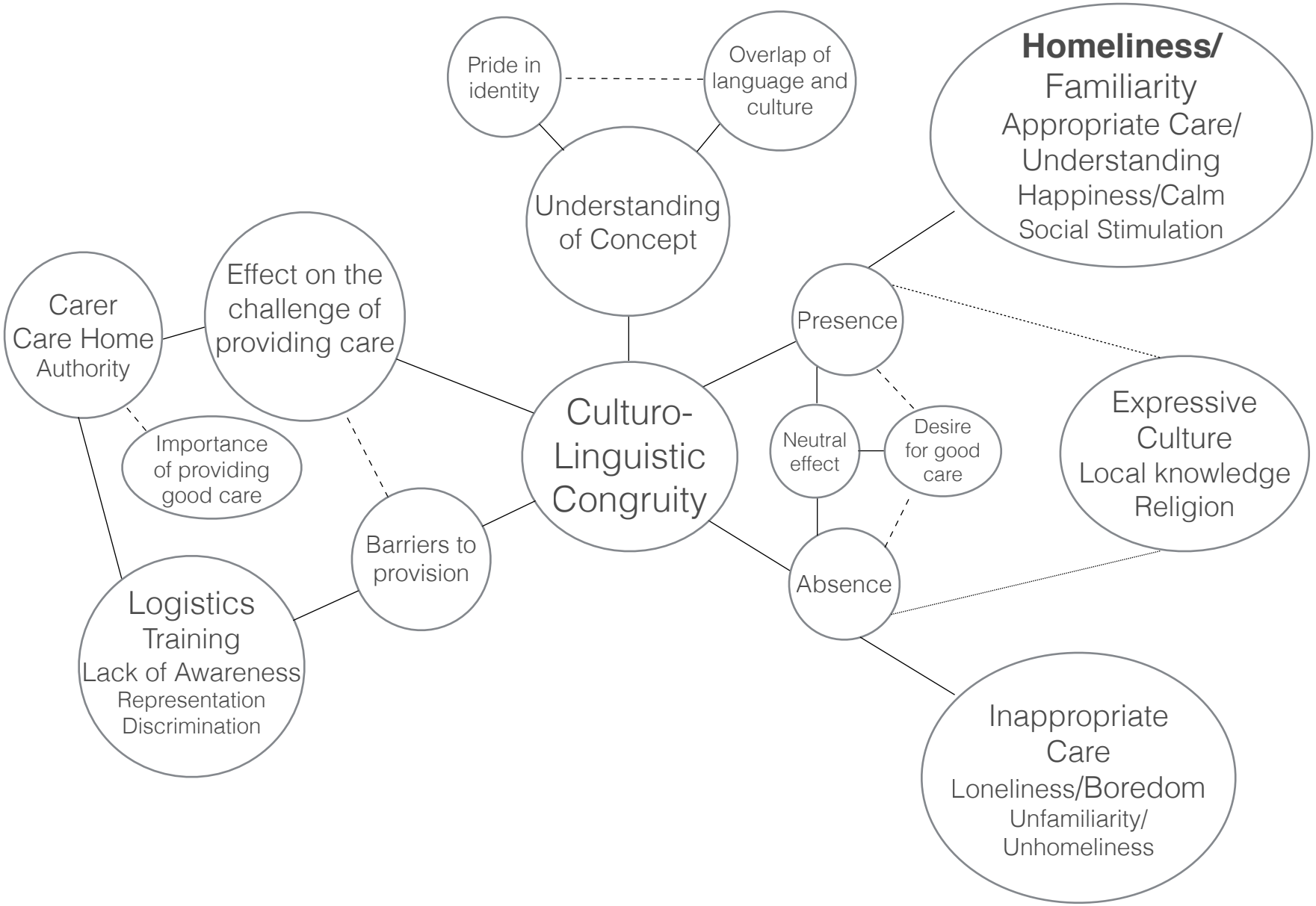
In considering this research as a whole - bringing together the scoping review and the empirical work - there are two consistent themes: culturo-linguistic congruity in care homes improves the well-being of residents, and an incongruity of culture and language decreases well-being. This appears to be especially true in the case of linguistic congruity, which residents, their families, carers and care home managers hold in high value. The overall theme maps for the scoping review and empirical work are strikingly similar (see Figures 2.6-2.8 and 4.1-4.2, respectively), and can be combined to give an overall thematic representation of this important element of care in Figure 5.1.

The most novel finding of the empirical work was the compelling persistence of one emotion to describe culturo-linguistic congruity in the care of residents in care homes: ‘Homeliness’.

To understand this finding, the biopsychosocial model (Spector and Orrell, 2010) is utilised. Kitwood (1997, p.8) stressed the importance of an individual’s ‘personhood’ in understanding their dementia; the factors thought to contribute to this personhood included Health, Personality, Neuropathological Impairment, Social Psychology and Biography. Furthermore, the attributes which make up ‘the uniqueness of a person’ (p.43) were specified as culture, gender, temperament, social class, lifestyle, outlook, beliefs, values, commitments, tastes, and interests. Cohen-Mansfield (2000, p.60) identified ‘lifelong events’ as a ‘key source’ of the heterogeneity observed in people with dementia.

Despite these key developments, there is generally very little discussion of culture and language in the development of non-medical and psychosocial models of dementia. Much of the academia on culture of care is naturally written from the perspective of the ‘English’ language worldview (see Chapter 2), with no need to consider the impact of other languages or cultures due to the high prevalence of English as a first language (SIL International, 2020), and its overwhelming dominance in global culture (Northrup, 2013). Despite this, it would be unthinkable to consider a person’s ‘personhood’ and ‘lifelong events’ without including their first language and culture.

Figure 5.1: Theme Mapping, Culturo-Linguistic Congruity in Care, Overall Findings



We propose that by combining one's first language and culture (themselves inherently inseparable (Levinson and Gumperz, 1996)), a major component of the medium for life experience, personhood and lifelong events is found.

In our work, culturo-linguistic congruity in the care of elderly and cognitively impaired residents, produces a tangible association with a person's core identity. This provides familiarity, an ability to understand one's environment, a link to their past, and the means to socialise effectively, all of which are experienced as 'Homeliness' - the person is able to access their biopsychosocial 'home'. This is a significant contributing factor to a resident's well-being. When this 'Homeliness' is not present, there is an adverse effect on a resident's well-being. In addition to this, congruity is shown to be advantageous to different models of care-giving in dementia. For example, Nolan et al (2006, p.5) proposed going beyond person-centred care to 'relationship-centred care', to fulfil Sheard's call (2004, p.22) for the development of an approach that 'sees the person with dementia within the context of important and significant relationships'. Their 'relationship-centred care' model is based on the 'Senses Framework' (2006, p.5), postulating that 'good care can only be delivered when all 'senses' are experienced by people with dementia, staff & family carers' - the 'senses' being Security, Continuity, Belonging, Purpose, Achievement and Significance. Of particular relevance to our own findings is 'Belonging', described as the older person having 'opportunities to maintain and/or form meaningful and reciprocal relationships, to feel part of a community or group as desired'. These opportunities would be significantly enhanced by the facilitation of culturo-linguistic congruity, blending 'Homeliness' with 'Belonging'. Whether these findings could be extrapolated to care settings outside of residential homes is open to discussion, one that would be best served by a similar investigation of the literature, followed by empirical field work.

Drawing parallels between the culturo-linguistic congruity in the care of native Welsh speakers in Wales, and the wider context of care of older people and cognitively impaired across the world, is a complex task. The majority of academic work carried out hitherto this research (see Chapter 2) has concerned the care of immigrant cohorts living in their second languages and cultures. Whilst the principle (providing an environment which makes the person feel at home and understood) is the same for native and immigrant cohorts, delivering this congruity for minority culture and

language residents in their chosen countries of residence is difficult. This is especially the case where fellow immigrants from their own cultures (i.e. potential congruent carers and co-residents) are not numerous in the country of their residence.

As already discussed, Iliffe and Manthorpe (2004, p.289) consider ethnicity to be a 'category fallacy' standing in the way of person-centred dementia care: 'migration leads to acculturation, so that responses attributed to a presumed stable ethnic identity may be cohort effects, confined to one or two generations only'. Taking this position accepts that the needs of those generations are not fulfilled, if the results of our work are applied. It also assumes that the continuing immigration across the world will generate cohorts of residents in old age and cognitive impairment who must immediately culturally and linguistically assimilate to receive congruent care.

On the other hand, one would presume that a care home resident living in their home country would have access to congruent care as a basic right, even if their culture and language is in the minority. This is demonstrably not always the case in Wales, and has been shown (see Chapter 2) to be unattained for many other cohorts across the world, e.g. the Sami in Norway (Hanssen, 2013), or the Louisiana French in the USA (Müller and Guendouzi, 2013). There may be other culturally distinct groups or ethnicities that have established 'native' status in a country and are not subject to the ethnicity 'fallacy', that have specific cultural or religious needs that are not necessarily always addressed (e.g. Jewish people in the UK (Valins, 2004)). Paradoxically, it may sometimes be the case that native residents from a majority culture and language do not receive congruent care, due to the high proportion of migrant workers in the social care sector. A report in 2014 (Skills for Care) revealed that approximately 17% of the adult social care workforce were non-UK in nationality, therefore this issue must also be considered for culturo-linguistically majority native identities in the UK.

The conclusion of our work is unequivocal - culturo-linguistic congruity is important to the care of people living in residential homes, many of whom are cognitively impaired. But how important is it, in the wider context of care? This is a crucial question, as governments, authorities, care home owners and managers must consider the available evidence to be able to design the most suitable care environment possible to the benefit of residents' well-being. How high a priority is the provision of culturally and linguistically congruent care, as long as the carers

themselves are able to assist people in the residential homes in an empathetic, sensitive and holistic manner? Is the issue simply the extent to which the carer and the care home is prepared to be curious and seek to understand the 'person' that the resident is?

If we take Kitwood's person-centre dementia care (1997) as the gold standard, where does culturo-linguistic congruity fit in? Our scoping review shows that there is a relative dearth of research and academic work on culture and language in the care of people with dementia living in residential homes. This is reflected in that there is little mention of personal culture and language in Kitwood's work (1997) (although 'Biography' is considered, in a broad sense), nor in Brooker's (2006) contemporary update of person-centred care. There are, however, salient points in their seminal works that resonate strongly with the concept of culturo-linguistic congruity. Kitwood, for example, strongly emphasises the need to recognise a person with dementia's 'personhood' in their care, defining this as 'a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being' (Kitwood, 1997, p.8). What our and others' research has shown is that culture and language are critical to a individual's 'personhood' - therefore, designing person-centred care without incorporating culture and language may not be possible.

Arguably, culturo-linguistic congruity is even more important in relation to Brooker's person-centred care 'VIPS' framework (2006, p.119), which encompasses four 'major elements':

1. **V** - A value base that asserts the absolute value of all human lives regardless of age or cognitive ability;
2. **I** - An individualised approach, recognising uniqueness;
3. **P** - Understanding the world from the perspective of the service user;
4. **S** - Providing a social environment that supports psychological needs.

Whilst the first element is assumed as a basic human right and is of less relevance to our work, culturo-linguistic congruity is integral to all other three elements. To pursue an 'individualised' approach, a person-centred care plan would need to recognise a resident's first language and culture, to be able to tailor their individual needs in all aspects of their care and well-being. To understand the 'perspective' of a resident, one would need to seek to understand their identity, which is

undoubtedly heavily influenced by their culture. Some (Lucy, 1997) have argued strongly that language is one of the most important facets of culture and identity. This has certainly been reflected in the findings of our own research, where 1LW residents found it difficult to explain their personal culture without expressing the affinity they have for their first language. It may therefore be imperative to have an understanding of a person's linguistic status to truly recognize their 'perspective'. Lastly, the provision of an optimal 'social' environment to support a resident's psychological needs, has been shown in our and many others' findings to require people and activities around a resident that are culturally, and most importantly, linguistically congruent. We found many examples of enhanced socialising in congruent environments, boosting well-being and happiness; we also found inversely decreased socialising in incongruent environments, with residents displaying loneliness and boredom in these situations. This affected both 1LW and 1LE individuals in our work, alongside many other ethnic minorities across the world in our scoping review, showing that this phenomenon is not confined to Welsh speakers.

Culturo-linguistic congruity is therefore vitally important to the person-centred care of people living in residential homes across the world. Despite this, the scoping review and empirical research reported here has shown that providing this congruity is challenging, even for native minority culture and language residents. The reasons are mostly due to the logistics of recruitment and training, the difficulties of which are amplified in countries which have high net immigration levels from many different countries, cultures and languages. Even for native minority cultures and languages, the challenge lies in attracting staff that share a background with residents, or are competent in those cultures and languages. We have shown that there is such an overlap between language and culture in Wales, that establishing a comprehension of a 1LW resident's culture is not easy without also having a grasp of the activities that revolve around the Welsh language. These include traditional singing, spirituality in the form of religious thought and hymns, cultural events such as bardic competitions and agricultural shows, and local idiom and customs. These aspects of culture may be especially strongly linked to language in older cohorts of Welsh-speaking residents, particularly in 'Y Fro' (the Welsh-speaking heartlands of North-West and West Wales (Aitchison and Carter, 1994)).

The issue of recruitment of staff that share a native background with residents needs to be considered in all countries that aspire to deliver person-centred care for care home residents. Some governments (Canadian Library of Parliament, 2018) have promoted bilingualism as a strongly positive career trait which is financially incentivised. In the context of an uncertain trajectory for many economies, this may be unpalatable, but in the long term could prove to be cost-neutral when factoring in the health benefits that an improvement to well-being could provide. It is not beyond reason to suggest that by increasing congruity (and therefore optimising the social environment), the rate of progression of cognitive impairment and dementia could be slowed to the extent that the requirement for more intensive (and costly) care facilities, such as specialist dementia units, could be delayed or even avoided altogether. When considering the benefits of the Enriched Model (Kitwood, 1997), Dementia Care Mapping (Brooker and Surr, 2005), and Reminiscence therapy (Woods, O'Philbin, Farrell, Spector, and Orrell, 2018), the dividend of incorporating language and culture into these concepts are realised. Preventing ill-being must also be a priority: one could argue that lack of linguistic congruity is likely to lead to aspects of malignant social psychology such as disempowerment (‘not allowing a person to use the abilities they do have’ (Brooker, 2006, p.108)); and ‘Banishment’ (excluding a person psychologically), as described by Kitwood (1997).

Recruitment of carers that share a culturo-linguistic background with residents is not the only solution, however, especially for immigrant care home residents living in culturally heterogenous areas. There needs to be an increased awareness of these residents’ requirements, and a concentrated effort to address them by using the holistic approaches that are already in use - such as life story books (Subramaniam et al. 2014) and cognitive stimulation therapy (Spector et al. 2003). Even the activities that care homes arrange for their residents, such as entertainment and art classes, should involve a conscious effort to include a person’s language and culture. In the case of cognitive stimulation therapy, cross-cultural adaptations have already been developed, for example practitioners in India playing ‘familiar sounds’ from participants’ past, such as rickshaws and horse carts, for the sounds sessions (Aguirre, Spector and Orrell, 2014).

Another perspective is the design of the care home. The most well-known example of designing care around a person’s identity is the ‘Dementia Village’, modelled on the De Hogeweyk Care Concept (van Hal, 2014), a residential complex for

individuals with dementia in the Netherlands. This concept incorporates specialist design of the physical environment to accommodate the needs of people living with dementia - small-scale, home-like ‘group living’, to encourage social interaction and participation in activities of daily life, as well as ready access to outdoor space and gardens. Of greater relevance is that residents are housed with ‘likeminded’ people, in the following ‘lifestyle’ categories:

- ‘Homey’: a simple life, with a focus on housekeeping and family;
- ‘Christian’: where religion is an important part of life, affecting lifestyle choices;
- ‘Craftsman’: traditional and hardworking, early to rise/early to bed;
- ‘Arts and culture’: an interest in travel, colourful interior design, adventurous in food choices;
- ‘Aristocracy’: formal, classic design, accustomed to having servants;
- ‘Indonesian/Colonial’: interested in nature, spirituality, Indonesian food;
- ‘Urban’: outgoing and informal.

These ‘lifestyle’ categories are clearly based upon people’s personal cultures. By using these categorisations, the ‘village’ is, theoretically, able to facilitate cultural congruity, by providing a social and physical environment matching these different personal cultures. How easy is it for a resident and their family to choose a category? How good is the fit for most people? Although not specifically addressing linguistic differences, in principle this concept embraces the intervention of providing cultural congruity. Whilst the De Hogeweyk Care Concept have cited numerous studies supporting their methods to improve quality of life for residents (van Hal, 2018, as cited in Canadian Agency for Drugs and Technologies in Health, 2019), there are no actual peer-reviewed evaluations of their work (Canadian Agency for Drugs and Technologies in Health, 2019). Furthermore, there is a lack of studies examining the clinical care outcomes (such as falls and pressure ulcers) of such villages in general, and there remains some uncertainty as to the cost effectiveness of these facilities (Canadian Agency for Drugs and Technologies in Health, 2019). Certainly, there are now enough similar projects around the world (van Hal, 2014; Ausserhofer et al. 2016) to be able to co-ordinate large scale ethnographic and even quantitative studies that could be peer-reviewed to examine the benefits and risks

inherent in this concept, and thereafter, if appropriate, be used to support the more widespread use of such 'villages', to the benefit of people with dementia.

One question raised by this 'categorisation', is the extent to which this represents segregation. Is culturo-linguistic congruity so important as to necessitate the division of people along linguistic and cultural lines within care homes? Do they themselves want this? In our work, 1LW were often anxious to 'code-switch' for non-Welsh speakers, and there was little evidence of individuals who truly did not wish to spend time with others from different backgrounds. Indeed, some residents appeared genuinely not to have a linguistic preference, and had elements of their personal culture which originated from both the 1LW and non-1LW sides of their identities. 'Segregating' such individuals could result in distress, especially in the more culturo-linguistically heterogenous areas of the UK. Previous examination of this subject in the UK includes Adamson's work (1999, as cited in Daker-White et al. 2002), which revealed that Afro-Carribeans with dementia, and their carers, did not expect specialist provision, but rather wanted high-quality care. A report by Haringey social services and the Alzheimer's Disease Society (1998, as cited in Daker-White et al. 2002) found that Afro-Caribbean and Irish groups in this area did not want separate services, as they felt that they would be marginalised as a result. However, Gujarati groups stated that they would prefer separate services. This may further illustrate the importance of language, both on its own and in relation to culture, as Afro-Caribbean and Irish individuals usually speak English as a first language, whereas Gujarati people have their own (Gujarati) language. Ultimately, caution is advised in implementing any changes too quickly or to *extremis*, and the individual residents' wishes always need to be taken into account.

Due consideration should be given to the availability of technology to support residents who are residing in culturo-linguistically incongruent surroundings. A case report by Burant and Camp (1996) described a care home overcoming some of the language barriers encountered between carers and a Russian resident with dementia and BPSD by using a physical communication board. This enabled carers to use basic Russian words and phrases to facilitate care for this resident. The care home then used this system on a wider basis, training staff to use it in caring for around 28 Russian-speaking residents living in the facility (Camp, Burant, and Graham, 1996). Despite the leaps in technology made since this, there do not appear to be any modern equivalents (e.g. tablet software), nor indeed, the original

boards, in wider use for such residents in incongruent environments. Developing digital applications to increase communication between carers and residents who do not share a common language would not only improve the care experience for the service user, but also raise important awareness about linguistic incongruity in homes, amongst carers. In our case, many 1LE carers were supportive of a 1LW resident's needs but were simply unable to fulfil them. However, some carers did not appear to consider the issue to be a priority, and this demonstrates that it is not only resources that need to change, but also attitudes.

5.6 Review of Methodology as a whole

This is a qualitative piece of work, in both its literature (scoping) review, and its empirical (multiple embedded case study) research. This means that we have been able to apply particular depth in the analysis of the subject under consideration, rather than drawing a set of quantitative conclusions that do not explain *why* things are the way they are. Although the number of cases (two care homes) is small, the data set is rich and offers a narrative which goes well beyond what a quantitative study could offer in this setting. The cases that were selected fulfilled the criteria as planned, offering different levels of congruity to explore, from varied linguistic and cultural perspectives. The separate embedded units of analysis (residents, relatives, carers and managers) corresponded well between the cases, enabling detailed cross-case analysis to draw out the themes within.

In terms of the ethnographic field work conducted, this research could be considered a good example of this approach, considering the immersion of the researcher into the case environments, which established an embedded presence in both the observational and semi-structured interview phases of the data collection process (Prus, 1996, as cited in Miall, Pawluch and Shaffir, 2005). This allowed data collection to happen in an organic way; the researcher was able to observe effectively, using Spradley's dimension of observation (1980), but our presence also facilitated spontaneous and informal conversations which were later of significant value in informing the analysis of data, and theme mapping of results. This was partly due to the researcher's cultural position as a 1LW, enabling closer access to participants, to help achieve reflexivity (O'Reilly, 2012). This cultural position also allowed a deeper insight into 1LW residents' perspectives during the data analysis

and theme mapping, facilitating reflexive analysis (O'Reilly, 2012), as well as enabling accurate translation of the recorded semi-structured interviews. The original integrity of quotes was preserved in the translation process - firstly by allowing accurate transcription of the recordings, and secondly by using the researcher's culturo-linguistic insights to ensure authentic retention of the meanings of idiom, essential to interpretation of a participant's comments (Van Nes, Abma, Jonsson, and Deeg, 2010). However, this culturo-linguistic insight was utilised with caution, to maintain reflexivity in all phases of the research, preventing overlay of this perspective into the analysis and discussion (O'Reilly, 2012).

In the analysis phase, the triangulation and convergence of evidence from the multiple separate sources (literature review, documentation search, observational work, semi-structured interviews) maximised the construct validity of the study. This evidence fed into the situational analysis and theme mapping process (Clarke, 2003) which subsequently produced the distinct themes and results that were discussed from both local (Welsh) and international perspectives. This process could again be considered a good example of the contemporary methods used in qualitative and ethnographic work, representing the current direction of travel and quality of research in this field. The same could be said of the immersive methods used, which best practice is moving towards, rather than the traditional 'in/out' interview method (Jones and Smith, 2017).

5.7 Recommendations for further research

We recommend that similar methods are applied in conducting new research on culturo-linguistic congruity in the elderly and cognitively impaired who receive their care in different types settings, e.g. in their own homes or in sheltered accommodation and day centres. The same topic could also be explored more widely across Wales, the UK and the world, to investigate whether the same findings are produced, to the same or lesser degrees. Cohorts could include native distinct ethnic identities, in minority and majority status, such as Jewish, Black, Asian and minority ethnic peoples in the UK and beyond; minority native language speakers in different countries, e.g. French in Canada, Gaelic in Ireland, Basque and Catalan in Spain, Romansh in Switzerland, Māori in New Zealand, to name but a few. Similar methods could also be used to consolidate the findings already

gathered in our literature review, particularly on the subject of congruity in the care of immigrant cohorts living away from their native languages and cultures in their old age and cognitive impairment.

Due consideration should be given to conducting co-ordinated research into the efficacy of the 'Dementia Village' concept, in view of the potential benefits to be reaped from more widespread implementation of this model, and of the comparative lack of evidence thus far published on this subject, especially when considering the numbers of 'Villages' that now are now operating.

Regarding the provision of culturo-linguistic congruity, we strongly recommend that urgent research is conducted on this topic, specifically in relation to two topics:

1. The recruitment of native language and culture competent carers to the care profession - what are the barriers to this, and how to increase it;
2. Awareness and training regarding the culturo-linguistic needs of those who receive care, amongst existing carers, managers and authorities - how to increase it, and how to incorporate it into contemporary non-medical therapy for those who are cognitively impaired.

These have been identified as the two main issues which currently determine the level of congruity that service users receive, in Wales and abroad. We also suggest that surveys are conducted as to the representation of cultural and ethnic minorities in the consultation of decision-making processes regarding the care of elderly and cognitively impaired individuals.

From a linguistic, or even anthropological point of view, an interesting theme emerging from our work is the overlap between language and culture in the elderly and cognitively impaired. Although linguistic relativity is already an ongoing topic of debate in the world of linguistic academia (Cook and Bassetti, 2011), it would be valuable to investigate how people in old age and cognitive impairment experience this phenomenon. Findings from such research may subsequently inform the issue of culturo-linguistic congruity in care.

5.8 Conclusion

This research has shown that culturo-linguistic congruity is beneficial (and that its absence is detrimental) to the well-being of elderly people living in care homes

across the world, and especially for those who are cognitively impaired. It has also shown that this is particularly the case for first language Welsh speakers living in care homes in North Wales. It has demonstrated that there is much work to be done in this area, as regards to the redesign of the provision of care, as well as research. In the wider context it has contributed to the discussion around the relationship between language and culture in Wales.

Ultimately, it has reaffirmed the role of person- and relationship-centred care, by confirming that a person's individuality is bound to their personhood, and that this is indeed of utmost importance when assisting a person to live their day-to-day life in a meaningful way, when they are no longer able to do so independently.

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Appendices

Appendix 1: Clincial Dementia Rating Scale

Clinical Dementia Rating Scale — CDR

Category	Healthy CDR O	Questionable dementia CDR 0.5	Mild dementia CDR 1	Moderate dementia CDR 2	Severe dementia CDR 3
Memory	No memory loss or slight inconstant forgetfulness	Mild consistent forgetfulness; partial recollection of events; 'benign' forgetfulness	Moderate memory loss, more marked for recent events; defect interferes with everyday activities	Severe memory loss; only highly learned material retained; new material rapidly lost	Severe memory loss; only fragments remain
Orientation	Fully oriented		Some difficulty with time relationships; oriented for place and person at examination but may have geographic disorientation	Usually disoriented in time, often to place	Orientation to person only
Judgment + problem solving	Solves every day problems well; judgment good in relation to past performance	Only doubtful impairment in solving problems, similarities, differences	Moderate difficulty in handling complex problems; social judgment usually maintained	Severely impaired in handling problems, similarities, differences; social judgment usually impaired	Unable to make judgments or solve problems
Community affairs	Independent function at usual level in job, shopping, business and financial affairs, volunteer and social groups	Only doubtful or mild impairment, if any, in these activities	Unable to function independently at these activities though may still be engaged in some; may still appear normal to casual inspection	No pretence of independent function outside home	
Home + hobbies	Life at home, hobbies, intellectual interests well maintained	Life at home, hobbies, intellectual interests well maintained or only slightly impaired	Mild but definite impairment of function at home; more difficult chores abandoned; more complicated hobbies and interests abandoned	Only simple chores preserved; very restricted interests, poorly sustained	No significant function in home outside of own room
Personal care	Fully capable of self care		Needs occasional prompting	Requires assistance in dressing, hygiene, keeping of personal effects	Requires much help with personal care; often incontinent
Score using box overleaf. Score as 0, 0.5, 1, 2, 3 only if impairement is due to cognitive loss.					

ASSIGNING THE CLINICAL DEMENTIA RATING

There are two methods of combining the domain scores to give the overall CDR. The domain scores can either be summed to give the CDR-SB (Sum of Boxes) score, or an algorithm can be used as follows:

The global CDR score is derived from the scores in each of the six categories. Memory (M) is considered the primary category and all others are secondary. CDR = M if at least three secondary categories are given the same score as memory. Whenever three or more secondary categories are given a score greater or less than the memory score, CDR equals the score of the majority of secondary categories that are on whichever side of M has the greatest number of secondary categories. If there are ties in the secondary categories on one side of M, the CDR score closest to M is chosen.

When M = 0.5, CDR = 1 if at least three of the other categories are scored one or greater. If M = 0.5, CDR cannot be 0; it can only be 0.5 or 1. If M = 0, CDR = 0 unless there is questionable impairment in two or more secondary categories, in which case CDR = 0.5.

Score	0	0.5	1	2	3
M					
O					
JPS					
C					
HH					
PC					

Mark in only one box for each category. To assign the CDR, see grids on the right. Shaded areas indicate defined range within which the scores of individual subjects must fall to be assigned a given CDR.

Clinical Dementia Rating ☐

CDR 0 – No Dementia

Score	0	0.5	1	2	3
M	■				
O	■				
JPS	■	■			
C	■	■			
HH	■	■			
PC	■				

CDR 0.5 – Questionable Dementia

Score	0	0.5	1	2	3
M		■			
O	■	■	■		
JPS	■	■	■		
C	■	■			
HH	■	■	■		
PC	■	■			

CDR 1 – Mild Dementia

Score	0	0.5	1	2	3
M			■		
O			■		
JPS			■		
C		■	■		
HH		■	■	■	
PC	■	■	■	■	

CDR 2 – Moderate Dementia

Score	0	0.5	1	2	3
M				■	
O				■	
JPS			■	■	■
C				■	■
HH				■	■
PC				■	

CDR 3 – Severe Dementia

Score	0	0.5	1	2	3
M					■
O					■
JPS					■
C					■
HH					■
PC					■

Appendix 2: Favourable Opinion from Wales Research Ethics Committee 5

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

Gwasanaeth Moeseg Ymchwil
Research Ethics Service

Ariennir gan Lywodraeth Cymru
Funded by Welsh Government

Wales Research Ethics Committee 5
Bangor

Mailing address:
Health and Care Research Wales Support Centre
Castlebridge 4
15-19 Cowbridge Road East
Cardiff, CF11 9AB

Telephone: 02920 785736; 07949 951024
Email: rossela.roberts@wales.nhs.uk
norbert.ciumageanu@wales.nhs.uk
Website : www.hra.nhs.uk

22 November 2017

Dr Conor Martin
Ty Isaf
Bodfari
Dinbych
LL16 4DD

Dear Dr Martin,

Study title:	**Language and Cultural Congruity in Care Homes - implications for Well-Being?**
REC reference:	**17/WA/0372**
IRAS project ID:	**230597**

The Research Ethics Committee reviewed the above application at the meeting held on 16 November 2017. The Committee wished to thank you and Professor Woods for attending to discuss the application.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact hra.studyregistration@nhs.net outlining the reasons for your request.
Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Mental Capacity Act 2005

I confirm that the Committee has approved this research project for the purposes of the Mental Capacity Act 2005. The Committee is satisfied that the requirements of section 31 of the Act will

be met in relation to research carried out as part of this project on, or in relation to, a person who lacks capacity to consent to taking part in the project.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA Approval (England)/ NHS permission for research is available in the Integrated Research Application System, at www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS Sites
The favourable opinion applies to all NHS sites taking part in the study taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion").

Non-NHS sites
The Committee decided that the research did not require Site-Specific Assessment at non-NHS sites as it involves no clinical interventions and all study procedures at sites would be undertaken by your team.

Summary of discussion at the meeting
Ethical issues raised by the Committee in private discussion, together with responses given by you and Professor Woods when invited to join the meeting

The Chair welcomed you and introduced the Committee members.
The following issues were discussed:

Social or scientific value; scientific design and conduct of the study
The Committee requested a clarification on how the protocol has been modified to capture cultural incongruity as a defining factor for well-being - in the context of the multitude of confounding factors.

You clarified that the revised protocol emphasises the qualitative nature of the study and that the purpose of exploring this with participants is to understand their feelings rather than them explaining what their culture is.

Professor Woods added the study does not aim to compare two care homes but to observe situations and document examples of congruity or absence thereof, and to ascertain how important this is for individuals; the study will employ a case study approach – not aim to prove causality but build up a narrative and look at consistency across data points.

The Committee raised a further query on how is the meaning of culture explored.

You clarified that differences in cultural backgrounds are very acute in this age group: for example, Welsh people tend to define their background with an emphasis on religion, their culture built strongly around Methodist/Calvinist doctrine, reflecting a conservative tradition. This has an impact on everyday life and behaviour in this group, which the study aim to capture.

The Committee noted that a more robust justification for including adults lacking capacity was provided in the revised protocol.

Professor Woods added that the cultural congruity is going to be more important to people ith cognitive impairment and it would be unfair not to include them; in addition, the care home work as a system so it would be impossible to tease out from the observation distinct individuals.

Favourable risk benefit ratio; anticipated benefit/risks for research participants
The Committee discussed the anticipated benefits and potential risk for individual research participants, and whether the research team clearly identified them and took steps to minimise or eliminate discomfort and distress and enhance potential benefits.

A clarification was requested in relation to the duty of care: if during the study you would identify a person with previously undiagnosed cognitive impairment is there a duty of care to act on this information.

You clarified that although a dementia scale is used to establish the degree of cognitive impairment for the purpose of the study, this does not have the diagnostic value required to formally diagnose cognitive impairment.

Professor Woods added that many people who live in care homes do not have a formal diagnosis of cognitive impairment or dementia and the project is not necessarily the best way to do this.

The Committee was satisfied that the risks to the research participant were considered proportionate to the benefits and the balance between risk and benefit equitable.

Suitability of supporting information
A question was raised in relation to the Interview schedule

You clarified that observations will be carried out separately; the semi-structured interview has a loose agenda to be covered rather than specified topics. Participants will chose the language in which they wish to communicate and this will inform the discussion about ‘culture’

The Committee agreed that no formal interview schedule was required.

The Committee thanked you and Professor Woods for your availability to speak to this submission and gave you an opportunity to ask questions. You did not raise any issues.

Compliance with the Mental Capacity Act – the Committee agreed the following:

Relevance of the research to the impairing condition
The Committee agreed the research is connected with an impairing condition (dementia) affecting persons lacking capacity and with the treatment of the condition.

Justification for including adults lacking capacity to meet the research objectives
The Committee agreed the research could not be carried out as effectively if it was confined to participants able to give consent.

Balance between benefit and risk, burden and intrusion
The Committee noted that while the research would not benefit participants lacking capacity it is intended to provide knowledge on care of people with dementia. After discussion, the Committee agreed that the risk to participants is likely to be negligible and the research will not significantly interfere with their freedom of action or privacy or be unduly invasive or restrictive.

Arrangements for appointing Consultees
The Committee considered the arrangements set out in the application for appointing Consultees under Section 32 of the Mental Capacity Act to advise on whether participants lacking capacity should take part and on what their wishes and feelings would be likely to be if they had capacity. After discussion the Committee agreed that reasonable arrangements were in place for identifying personal Consultees and for nominated Consultees independent of the project where no person can be identified to act as a personal consultee.

Additional safeguards
The Committee was satisfied that reasonable arrangements would be in place to comply with the additional safeguards set out in Section 33 of the Mental Capacity Act.

Information for Consultees
The Committee reviewed the information to be provided to Consultees about the proposed research and their role and responsibilities as a consultee.
The Committee was satisfied that the information was adequate to enable Consultees to give informed advice about the participation of persons lacking capacity.

Other ethical issues were raised and resolved in preliminary discussion before your attendance at the meeting

No ethical issues were raised in relation to

- Recruitment arrangements and access to health information; fair participant selection
- Care and protection of research participants; respect for participants' welfare and dignity; data protection and confidentiality
- Informed Consent process and the adequacy and completeness of participant information
- Suitability of the applicant and supporting staff
- Independent review
- Other study procedures
- Other general comments missing information/ typographical errors/ application errors/
- Suitability of the study summary

Please contact the REC Manager if you feel that the above summary is not an accurate reflection of the discussion at the meeting.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Covering letter on headed paper [Resubmission cover letter]	-	25 September 2017
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Liability Insurance]	1	01 August 2017
Interview schedules or topic guides for participants [Appendix 5 - Semi-structured Interviews]	2	25 October 2017
Other [Appendix 4 - Modified Spradley]	2	25 October 2017
Other [Letter of Unfavourable Opinion from Wales REC 5]	1	24 October 2017
Other [Appendix 1 - Memorandum of Understanding between Care Homes and Research Institution]	2	25 October 2017
Participant consent form [Appendix 3 - Consent Forms]	2	25 October 2017
Participant information sheet (PIS) [Appendix 2 - Participant Information Sheets]	2	25 October 2017
REC Application Form [REC_Form_30102017]		30 October 2017
Referee's report or other scientific critique report [Supervisor's Letter]	1	22 August 2017
Research protocol or project proposal [Culturo-Linguistic Congruity in Care Homes - V2]	2	25 October 2017
Summary CV for Chief Investigator (CI) [CV CM]	1	10 October 2017
Summary CV for supervisor (student research) [CV Bob Woods]	1	09 October 2017

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

No declarations of interest were made in relation to this application.

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

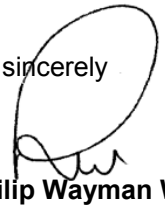
HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

17/WA/0372	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely



Dr Philip Wayman White, MBChB, FRSM
General Practitioner
Chair Wales REC 5

E-mail: rossela.roberts@wales.nhs.uk

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments*

"After ethical review – guidance for researchers"

Appendix 3: Favourable Opinion from Bangor University School of Health Sciences

Lynne Williams

"2017-16101 Language and Cultural Congruity in the...

To: Conor Owain Martin, Cc: Bob Woods, Sion Williams, Susan Metcalfe

Inbox - Exchange 21 December 2017 at 12:25

Details

LW

Dear Conor,

Please accept this re-mail as confirmation of Chair's Actions for approval of the application "2017-16101 Language and Cultural Congruity in the Caregiving of First Language Welsh People with Dementia in Care Homes - what are the implications for Well-Being?" provided you address the following minor points:

- Please clarify who signs the MOU on behalf of the University
- Please check and confirm funders' specification regarding length of data retention and clarify data will be stored only on University drive
- You may wish to consider requesting consent for secondary data use?
- Please ensure the correct University logo used on all participant facing documentation –see https://www.bangor.ac.uk/ccm/brand/logo.php.en

Please confirm that the above is addressed by sending me the revised documentation. You will receive an electronic message as well generated from the system.
Once again, I apologise profusely for the delay in the peer review process, and wish you every luck with the study.
Best wishes
Lynne

From: Conor Owain Martin
Sent: 18 December 2017 13:20
To: Lynne Williams
Cc: Bob Woods; Sion Williams; Susan Metcalfe
Subject: Re: Ethics application

Diolch

Conor

From: Lynne Williams
Sent: 18 December 2017 07:48:33
To: Conor Owain Martin
Cc: Bob Woods; Sion Williams; Susan Metcalfe
Subject: RE: Ethics application

Hi Conor
Apologies for the delay. I have changed one reviewer and contacted the other to see what the issue is. I will be checking the system this week and will make sure the review is completed by the end of this month.
Cofion
Lynne

Appendix 4: Memorandum of Understanding with Care Homes

PRIFYSGOL
BANGOR
UNIVERSITY

MEMORANDUM OF UNDERSTANDING

A programme of work to investigate how the well-being of first language Welsh people with who live in care homes is affected by the linguistic and cultural surroundings of their living environment

SCHOOL OF HEALTHCARE SCIENCES, BANGOR UNIVERSITY & …… CARE HOME

1. Both parties agree to co-operate in a programme of work entitled "**Language and Cultural Congruity in Care Homes - implications for Well-Being**?"
2. Each partner will share information with the other to help promote mutual understanding, and each will respect the confidentiality and intellectual ownership of this information.
3. Each partner will seek to promote co-operation to mutual benefit, and will be responsible for its own actions and its own costs.
4. Each partner 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.
5. If any partner has concerns about any aspect of the programme of work, then they will raise it officially in writing with the research supervisor, Professor Bob Woods. Within the local programme of work events they can be raised with Dr Conor Martin (for Bangor University), or the care home manager (for the care home environment).
6. Within the programme of work, 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 Data Protection policy. Confidentiality and anonymity for all participants is assured in all written reports and publications, and individual written consent will be sought prior to each data collection episode
7. Both parties will endeavour to exploit any commercial or scientific opportunities that emerge from this programme of work. The intellectual property of identified programme of work products is as follows:

a. 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.

b. The interpretation and any new products which emerge from the analysed data will become the property of the Bangor University research team.

This memorandum of understanding will be valid for the lifetime of the programme of work.

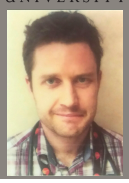
Signed	Signed
Name	Name - Chris Burton
Date	Date
On behalf of …….. Care Home	On behalf of School of Healthcare Sciences, Bangor University

Appendix 5: Information Posters in Care Homes

Information Poster | Version 1 | 25/10/2017

Research Project: Language and Cultural Congruity in Care Homes - implications for Well-Being?

PRIFYSGOL BANGOR UNIVERSITY



Part of a project for Bangor University, led by Conor Martin

Can you help?

We would like to invite you to take part in a research study on the role of the Welsh language and culture in the care of people who live in care homes in North Wales.

Residents, Relatives and Staff!

We are looking for people to tell us about their experiences and feelings on this subject. We would also like to observe day-to-day life in the home. We will only be present in a public place such as the lounge, dining or activities room, and only include those who have agreed to take part. You can:

- Be included in research
- Tell us your views
- Invite your family members
- Discuss your ideas

When:	January - May 2018
Where:	Your Care Home
Time:	9am - 5pm on Tuesdays
Other:	Feel free to ask Conor any questions when he is at the home. You can contact by:

telephone: **07525931775**

email: mhp802@bangor.ac.uk

writing: Conor Martin, DSDC, Ardudwy Normal Site, Bangor University, Bangor, Gwynedd, LL57 2PZ

We will be available at the home on , 2018

Appendix 6.1: Participant Information Sheet (Resident)

School of Healthcare Sciences

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Conor Martin is the researcher on this project. Conor is happy to answer any questions you may have.

Research Project:

Language and Cultural Congruity in Care Homes - implications for Well-Being?

Can you help? We are looking for residents to be a part of our research project!

About the study

You are invited to take part in a research study on the role of the Welsh language and culture in the care of people who live in care homes in North Wales.

Before you decide, it is important for you to understand why the research is being done and what it will involve.

Please take time to read the following information and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this information sheet.

What is the purpose of the research?

It has been suggested that residents in care homes benefit from having staff and fellow-residents who share the same language and cultural background. In North Wales, there are many people who prefer to speak Welsh, whilst others may only speak English. People vary greatly in their background and cultural heritage.

We will explore what difference it makes, if any, for residents and staff to speak the same language and have similar backgrounds. What matters most to residents about language and culture? The results of the study will help inform how care homes should be planned and organized in the future.

Why have I been asked to take part?

You have been asked to take part because you are living in a care home in North Wales that is taking part in the study. The study is going to take 4 months, and we are looking for as many people from your home as possible to take part, as well as relatives and staff. We are inviting Welsh and English speakers to take part, and you will be able to take part in your preferred language.

What does the study involve?

After you have had a chance to ask the researcher any questions, and have signed a consent form, we will ask you to:

1) Let the researcher look at your care plan so we have an understanding of your health and care needs.
2) Allow the researcher to visit the home and take notes while you are going about your day, on several separate occasions. We will only be present in a public place such as the lounge, dining or activities room. During this time the researcher may wish to have an informal discussion with you and take notes about the

things discussed. Things that you say may be used in the final report and in journal articles but it will not be linked to your name and you will not be identifiable.

3) We may also ask you to meet with a researcher to tell them your views on your experiences of living at the home. This will include questions about your feelings and opinions about the use of the Welsh language and culture at the home. We will tape-record the conversation so that we can talk with you without having to write everything down. If you would prefer not to be tape-recorded, you will be given the opportunity to opt out. We estimate it will take less than an hour but you may take as many breaks as you want or feel necessary. You can complete the process over two sessions on the same day or at a later date if you prefer.

Are there any benefits or risks?

We do not expect any disadvantages or risks arising from taking part in this study, neither are there any immediate benefits for those who take part.

What if I don't want to take part?

It is up to you to decide whether or not you would like to take part in this study. Deciding not to take part will not impact on any other aspect of your care at the home.

What will happen to my data?

All data collected will be confidential, and you will not be identifiable in any report, thesis or publication which arises from this study. Confidentiality would only ever be broken if there was a concern that you might be at risk of harm. The data from this study will be stored securely for 5 years. If you choose to withdraw from the study and your data is identifiable to the research team, then you have the right to request that your data is not used.

What will happen to the results of the research project?

The results of the research project will be published in relevant academic journals, and presented at conferences and seminars. No participants will be identified in any publication without their written consent. We will make arrangements for participants to be informed of the findings of the study where desired.

Who is organising and funding the research?

The research is part of an MSc degree being undertaken by Dr Conor Martin, a training doctor in North Wales. It is funded by the Health Board and the Welsh British Geriatrics Society, and is sponsored by Bangor University. **He can be contacted at:** Dementia Services Development Centre, Bangor University, Ardudwy, Normal Site, Holyhead Road, Bangor, LL57 2PZ; Telephone (01745) 710384; email: mhp802@bangor.ac.uk

Who do I contact with any concerns about this study?

Professor Bob Woods, Dementia Services Development Centre, DSDC Wales, Bangor University, Ardudwy, Normal Site, Holyhead Road, Bangor, LL57 2PZ; Telephone (01248) 383719; email: b.woods@bangor.ac.uk

Who has reviewed this study?

This research has been looked at by an independent group of people called a Research Ethics Committee to protect your safety, rights, well-being, and dignity. This study has been reviewed and given favourable opinion by the Wales Research Ethics Committee (REC) 5.

Appendix 6.2: Consultee Information Sheet

School of Healthcare Sciences

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Consultee information sheet

Version 2, 25/10/2017

Introduction

We feel that your relative/friend/resident may be unable to decide for himself/herself whether to participate in this evaluation.

To help decide if he/she should join the study, we'd like to ask your opinion whether or not they would want to be involved. We'd ask you to consider what you know of their wishes and feelings, and to consider their interests. Please let us know of any advance decisions they may have made about participating in research. These should take precedence.

If you decide your relative/friend/resident would have no objection to taking part we will ask you to read and sign the consultee declaration provided with the information leaflet. We'll then give you a copy to keep. We will keep you fully informed during the study so you can let us know if you have any concerns or you think your relative/friend/resident should be withdrawn.

If you decide that your relative/friend/resident would not wish to take part it will not affect their participation in standard of care they receive in any way.

If you are unsure about taking the role of consultee you may seek independent advice. We will understand if you do not want to take on this responsibility.

We would like to clarify that this information sheet does not request that you directly take part in the research - if you have been asked to do so, you will have received the information sheet titled 'Additional Participant (Relative/Friend) Information Sheet'.

The following information is the same as would have been provided to your relative/friend.

Title of Study: Language and Cultural Congruity in Care Homes - implications for Well-Being?

Resident Participant Information Sheet

Version 2, 25/10/2017

About the study

You are invited to take part in a research study on the role of the Welsh language and culture in the care of people who live in care homes in North Wales.

Before you decide, it is important for you to understand why the research is being done and what it will involve.

Please take time to read the following information and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this information sheet.

What is the purpose of the research?

It has been suggested that residents in care homes benefit from having staff and fellow-residents who share the same language and cultural background. In North Wales, there are many people who prefer to speak Welsh, whilst others may only speak English. People vary greatly in their background and cultural heritage.

We will explore what difference it makes, if any, for residents and staff to speak the same language and have similar backgrounds. What matters most to residents about language and culture? The results of the study will help inform how care homes should be planned and organized in the future.

Why have I been asked to take part?

You have been asked to take part because you are living in a care home in North Wales that is taking part in the study. The study is going to take 4 months, and we are looking for as many people from your home as possible to take part, as well as relatives and staff. We are inviting Welsh and English speakers to take part, and you will be able to take part in your preferred language.

Are there any benefits or risks?

We do not expect any disadvantages or risks arising from taking part in this study, neither are there any immediate benefits for those who take part.

What does the study involve?

After you have had a chance to ask the researcher any questions, and have signed a consent form, we will ask you to:

1) Let the researcher look at your care plan so we have an understanding of your health and care needs.

2) Allow the researcher to visit the home and take notes while you are going about your day, on several separate occasions. We will only be present in a public place such as the lounge, dining or activities room. During this time the researcher may wish to have an informal discussion with you and take notes about the things discussed. Things that you say may be used in the final report and in journal articles but it will not be linked to your name and you will not be identifiable.

3) We may also ask you to meet with a researcher to tell them your views on your experiences of living at the home. This will include questions about your feelings and opinions about the use of the Welsh language and culture at the home. We will tape-record the conversation so that we can talk with you without having to write everything down. If you would prefer not to be tape-recorded, you will be given the opportunity to opt out. We estimate it will take less than an hour but you may take as many breaks as you want or feel necessary. You can complete the process over two sessions on the same day or at a later date if you prefer.

What if I don't want to take part?

It is up to you to decide whether or not you would like to take part in this study. Deciding not to take part will not impact on any other aspect of your care at the home.

What will happen to my data?

All data collected will be confidential, and you will not be identifiable in any report, thesis or publication which arises from this study. Confidentiality would only ever be broken if there was a concern that you might be at risk of harm. The data from this study will be stored securely for 5 years. If you choose to withdraw from the study and your data is identifiable to the research team, then you have the right to request that your data is not used.

What will happen to the results of the research project?

The results of the research project will be published in relevant academic journals, and presented at conferences and seminars. No participants will be identified in any publication without their written consent. We will make arrangements for participants to be informed of the findings of the study where desired.

Who is organising and funding the research?

The research is part of an MSc degree being undertaken by Dr Conor Martin, a training doctor in North Wales. It is funded by the Health Board and the Welsh British Geriatrics Society, and is sponsored by Bangor University.

Who has reviewed this study?

This research has been looked at by an independent group of people called a Research Ethics Committee to protect your safety, rights, well-being, and dignity. This study has been reviewed and given favourable opinion by the Wales Research Ethics Committee (REC) 5.

Appendix 6.3: Participant Information Sheet (Friend/Relative)

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Title of Study: Language and Cultural Congruity in Care Homes - implications for Well-Being?

Additional Participant (Relative/Friend) Information Sheet - Part 1: Introduction

Version 2, 25/10/2017

Information about the study

You are invited to take part in a research study examining the role of the Welsh language and culture in the care of people who live in care homes. Before you decide, it is important for you to understand why the research is being done and what it will involve.

Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this information sheet.

Why have I been asked to take part?

You have been asked to take part because you are a relative or friend of a person living in a home that is taking part in this study.

What does the study involve?

After you have had a chance to ask the researcher any questions, and have signed a consent form, we will ask you to:

1) Allow the researcher to visit the home and take notes over 4 hours, observing the day-to-day life in the home, on several separate occasions. We will only be present in a public place such as the lounge, dining or activities room. During this time, if you happen to be visiting, the researcher may wish to have an informal discussion with you, and take notes about the things discussed. Things that you say may be used in the final report and in journal articles but it will not be linked to your name and you will not be identifiable.

2) If selected, meet with a researcher as part of a focus group of relatives to tell them your views and experiences of your relative/friend being cared for at the

home, including questions about your feelings and opinions about the use of the Welsh language and culture at the home. We will tape record the conversation so that we can talk with you without having to write everything down. If you would prefer not to be tape-recorded, you will be given the opportunity to opt out. We estimate it will take less than an hour but you may take as many breaks as you want or feel necessary. You can complete the process over two sessions on the same day or at a later date if you prefer.

Are there any benefits or risks?

We do not anticipate any disadvantages or risks arising from participation in this study. The results of this research are intended to contribute towards the understanding of the role of language and culture in the residential care of people in the future.

What will happen to my data?

All data collected will be confidential, and you will not be identifiable in any report, thesis or publication which arises from this study. Confidentiality would only ever be broken if there was a concern that your relative or friend might be at risk of harm. The data from this study will be stored securely for 5 years. The audio recordings will be anonymised and coded and kept on Bangor University's secure server, and may be transcribed and thereafter will be erased. If you choose to withdraw from the study and your data is identifiable to the research team, then you have the right to request that your data is not used.

What if I don't want to take part?

It is up to you to decide whether or not you would like to participate in this study. Deciding not to take part will not impact any other aspect of your relative or friend's care at the home.

Who do I contact about the study?

Dr Conor Martin, Dementia Services Development Centre (DSDC), DSDC Wales, Bangor University, Ardudwy, Normal Site, Holyhead Road, Bangor, LL57 2PZ; Telephone (01745) 710384; email: mhp802@bangor.ac.uk

Who do I contact with any concerns about this study?

Professor Bob Woods, Dementia Services Development Centre (DSDC), DSDC Wales, Bangor University, Ardudwy, Normal Site, Holyhead Road, Bangor, LL57 2PZ; Telephone (01248) 383719; email: b.woods@bangor.ac.uk

What is the purpose of the study?

The study examines how the well-being of first language Welsh people who live in care homes is affected by the language and culture of their living environment. Specifically, the study explores how well-matched the language and culture of the residents are to the language and culture of the carers, the home, and other residents; and altogether what relevance this has to residents' well-being. If well-being is affected, the study aims to identify which aspects of language and culture matching matter the most to the person, and with whom is it most important to maintain that matching.

This issue has been researched before, but never in Wales. Indeed, the relationship of the Welsh language with in old age and dementia has not been explored in much depth in the past, and this has been highlighted at government level. We seek to understand the benefits and risks of matching the language and culture in people in care homes, and to make this information available if it can contribute to the care and well-being of such people, across the world.

What will happen to the results of the research project?

The results of the research project will be published in relevant academic and practitioner journals, and presented at conferences and seminars. No participants will be identified in any publication arising from the study without their written consent. We will make arrangements for participants to be informed of the findings of the study where desired.

Who is organising and funding the research?

The research is part of an MSc by Research in Ageing and Dementia being undertaken by Dr Conor Martin, a training doctor in Care of the Elderly in the Wales Deanery. It is funded by Betsi Cadwaladr University Board and the Welsh British Geriatric Society, and is sponsored by Bangor University. This funding covers the running costs of the research project which is being led by Dr Conor Martin, Professor Bob Woods, and Dr Siôn Williams.

Who has reviewed this study?

All research in the NHS is looked at by an independent group of people called a Research Ethics Committee to protect your safety, rights, well-being, and dignity. This study has been reviewed and given favourable opinion by the Wales Research Ethics Committee (REC) 5.

Appendix 6.4: Participant Information Sheet (Staff)

School of Healthcare Sciences

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Title of Study: Language and Cultural Congruity in Care Homes - implications for Well-Being?

Additional Participant (Staff) Information Sheet - Part 1: Introduction

Version 2, 25/10/2017

Information about the study

You are invited to take part in a research study examining the role of the Welsh language and culture in the care of people who live in care homes. Before you decide, it is important for you to understand why the research is being done and what it will involve.

Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this information sheet.

Why have I been asked to take part?

You have been asked to take part because you are a member of staff working in a home that is taking part in this study.

What does the study involve?

After you have had a chance to ask the researcher any questions, and have signed a consent form, we will ask you to:

1) Allow the researcher to visit the home and take notes over 4 hours while you are going about your working day, on several separate occasions. We will only be present in a public place such as the lounge, dining or activities room. During this time the researcher may wish to have an informal discussion with you and take notes about the things discussed. Things that you say may be used in the final report and in journal articles but it will not be linked to your name and you will not be identifiable.

2) If selected, meet with a researcher as part of a focus group of staff members to tell them your views on your experiences in caring for residents at the

home, including questions about your feelings and opinions about the use of the Welsh language and culture at the home. We will tape record the conversation so that we can talk with you without having to write everything down. If you would prefer not to be tape-recorded, you will be given the opportunity to opt out. We estimate it will take less than an hour but you may take as many breaks as you want or feel necessary. You can complete the process over two sessions on the same day or at a later date if you prefer.

Are there any benefits or risks?

We do not anticipate any disadvantages or risks arising from participation in this study. The results of this research are intended to contribute towards the understanding of the role of language and culture in the residential care of people in the future.

What will happen to my data?

All data collected will be confidential, and you will not be identifiable in any report, thesis or publication which arises from this study. Confidentiality would only ever be broken if there was a concern that your residents might be at risk of harm. The data from this study will be stored securely for 5 years. The audio recordings will be anonymised and coded and kept on Bangor University's secure server, and may be transcribed and thereafter will be erased. If you choose to withdraw from the study and your data is identifiable to the research team, then you have the right to request that your data is not used.

What if I don't want to take part?

It is up to you to decide whether or not you would like to participate in this study. Deciding not to take part will not impact any other aspect of your work at the home.

Who do I contact about the study?

Dr Conor Martin, Dementia Services Development Centre (DSDC), DSDC Wales, Bangor University, Ardudwy, Normal Site, Holyhead Road, Bangor, LL57 2PZ; Telephone (01745) 710384; email: mhp802@bangor.ac.uk

Who do I contact with any concerns about this study?

Professor Bob Woods, Dementia Services Development Centre (DSDC), DSDC Wales, Bangor University, Ardudwy, Normal Site, Holyhead Road, Bangor, LL57 2PZ; Telephone (01248) 383719; email: b.woods@bangor.ac.uk

What is the purpose of the study?

The study examines how the well-being of first language Welsh people who live in care homes is affected by the language and culture of their living environment. Specifically, the study explores how well-matched the language and culture of the residents are to the language and culture of the carers, the home, and other residents; and altogether what relevance this has to residents' well-being. If well-being is affected, the study aims to identify which aspects of language and culture matching matter the most to the person, and with whom is it most important to maintain that matching. It also explores the question of the relationship between language and culture in dementia.

This issue has been researched before, but never in Wales. Indeed, the relationship of the Welsh language in old age and dementia has not been explored in much depth in the past, and this has been highlighted at government level. We seek to understand the benefits and risks of matching the language and culture in people with dementia in care homes, and to make this information available if it can contribute to the care and well-being of such people, across the world.

What will happen to the results of the research project?

The results of the research project will be published in relevant academic and practitioner journals, and presented at conferences and seminars. No participants will be identified in any publication arising from the study without their written consent. We will make arrangements for participants to be informed of the findings of the study where desired.

Who is organising and funding the research?

The research is part of an MSc by Research in Ageing and Dementia being undertaken by Dr Conor Martin, a training doctor in Care of the Elderly in the Wales Deanery. It is funded by Betsi Cadwaladr University Board and the Welsh British Geriatric Society, and is sponsored by Bangor University. This funding covers the running costs of the research project which is being led by Dr Conor Martin, Professor Bob Woods, and Dr Siôn Williams.

Who has reviewed this study?

All research in the NHS is looked at by an independent group of people called a Research Ethics Committee to protect your safety, rights, well-being, and dignity. This study has been reviewed and given favourable opinion by the Wales Research Ethics Committee (REC) 5.

Appendix 6.5: Participant Information Sheet (Manager)

School of Healthcare Sciences

PRIFYSGOL
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Title of Study: Language and Cultural Congruity in Care Homes - implications for Well-Being?

Additional Participant (Manager) Information Sheet - Part 1: Introduction

Version 2, 25/10/2017

Information about the study

You are invited to take part in a research study examining the role of the Welsh language and culture in the care of people who live in care homes. Before you decide, it is important for you to understand why the research is being done and what it will involve.

Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this information sheet.

Why have I been asked to take part?

You have been asked to take part because you are the manager of a care home that is taking part in this study.

What does the study involve?

After you have had a chance to ask the researcher any questions, and have signed a consent form, we will ask you to:

1) Allow the researcher to visit the home and take notes over 4 hours while you are going about your working day, on several separate occasions. We will only be present in a public place such as the lounge, dining or activities room. During this time the researcher may wish to have an informal discussion with you and take notes about the things discussed. Things that you say may be used in the final report and in journal articles but it will not be linked to your name and you will not be identifiable.

2) Meet with a researcher to tell them your views on your experiences in providing care for residents at the home, including questions about your feelings and opinions about the use of the Welsh language and culture at the home. We will tape record the conversation so that we can talk with you without having to write everything down. If you would prefer not to be tape-recorded, you will be given the opportunity to opt out. We estimate it will take less than an hour but you may take as many breaks as you want or feel necessary. You can complete the process over two sessions on the same day or at a later date if you prefer.

Are there any benefits or risks?

We do not anticipate any disadvantages or risks arising from participation in this study. The results of this research are intended to contribute towards the understanding of the role of language and culture in the residential care of people in the future.

What will happen to my data?

All data collected will be confidential, and you will not be identifiable in any report, thesis or publication which arises from this study. Confidentiality would only ever be broken if there was a concern that your residents might be at risk of harm. The data from this study will be stored securely for 5 years. The audio recordings will be anonymised and coded and kept on Bangor University's secure server, and may be transcribed and thereafter will be erased. If you choose to withdraw from the study and your data is identifiable to the research team, then you have the right to request that your data is not used.

What if I don't want to take part?

It is up to you to decide whether or not you would like to participate in this study. Deciding not to take part will not impact any other aspect of your work at the home.

Who do I contact about the study?

Dr Conor Martin, Dementia Services Development Centre (DSDC), DSDC Wales, Bangor University, Ardudwy, Normal Site, Holyhead Road, Bangor, LL57 2PZ; Telephone (01745) 710384; email: mhp802@bangor.ac.uk

Who do I contact with any concerns about this study?

Professor Bob Woods, Dementia Services Development Centre (DSDC), DSDC Wales, Bangor University, Ardudwy, Normal Site, Holyhead Road, Bangor, LL57 2PZ; Telephone (01248) 383719; email: b.woods@bangor.ac.uk

What is the purpose of the study?

The study examines how the well-being of first language Welsh people who live in care homes is affected by the language and culture of their living environment. Specifically, the study explores how well-matched the language and culture of the residents are to the language and culture of the carers, the home, and other residents; and altogether what relevance this has to residents' well-being. If well-being is affected, the study aims to identify which aspects of language and culture matching matter the most to the person with dementia, and with whom is it most important to maintain that matching. It also explores the question of the relationship between language and culture in dementia.

This issue has been researched before, but never in Wales. Indeed, the relationship of the Welsh language with old age and dementia has not been explored in much depth in the past, and this has been highlighted at government level. We seek to understand the benefits and risks of matching the language and culture in people in care homes, and to make this information available if it can contribute to the care and well-being of such people, across the world.

What will happen to the results of the research project?

The results of the research project will be published in relevant academic and practitioner journals, and presented at conferences and seminars. No participants will be identified in any publication arising from the study without their written consent. We will make arrangements for participants to be informed of the findings of the study where desired.

Who is organising and funding the research?

The research is part of an MSc by Research in Ageing and Dementia being undertaken by Dr Conor Martin, a training doctor in Care of the Elderly in the Wales Deanery. It is funded by Betsi Cadwaladr University Board and the Welsh British Geriatric Society, and is sponsored by Bangor University. This funding covers the running costs of the research project which is being led by Dr Conor Martin, Professor Bob Woods, and Dr Siôn Williams.

Who has reviewed this study?

All research in the NHS is looked at by an independent group of people called a Research Ethics Committee to protect your safety, rights, well-being, and dignity. This study has been reviewed and given favourable opinion by the Wales Research Ethics Committee (REC) 5.

Appendix 7.1: Participant Consent Form (Resident)

Version 2, 25/10/2017
Centre Number:
Study Number:

PRIFYSGOL BANGOR UNIVERSITY

CONSENT FORM - RESIDENT

Title of Project: **Language and Cultural Congruity in Care Homes - implications for Well-Being?**

Name of Researcher: Dr Conor Martin

Please initial box

1. I confirm that I have read and understood the information sheet dated [Dated and version number] for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.	
3. I confirm that I consent to the researcher looking at my care plan.	
4. I confirm that I consent to the researcher visiting and observing the home, and conducting an informal discussion with me.	
5. I confirm that I consent to my informal interview ('converstion with a purpose') being audio recorded by the researcher as part of the study.	
6. I give permission for the researcher to use anonymised quotes from the interview and for anonymised interviews to be shared with any other researchers or stored as data archives.	
7. I agree to take part in the above study.	

Name of Person	Date	Signature

Researcher	Date	Signature

When completed, 1 for participant, 1 for researcher site file; 1 (original)

Appendix 7.2: Declaration Form (Consultee)

Version 2, 25/10/2017
Centre Number:
Study Number:

PRIFYSGOL BANGOR UNIVERSITY

DECLARATION FORM - CONSULTEE

Title of Project: **Language and Cultural Congruity in Care Homes - implications for Well-Being?**

Name of Researcher: Dr Conor Martin

Please initial box

1. I, …… have been consulted about ……. ……..'s participation in this research project. I have had the opportunity to ask questions about the study and understand what is involved.	
2. In my opinion he/she would have no objection to taking part in the above study.	
3. I understand that I can request he/she is withdrawn from the study at any time, without giving any reason and without his/her care or legal rights being affected.	
4. I understand that relevant sections of his/her care record and data collected during the study may be looked at by responsible individuals from Bangor University, where it is relevant to their taking part in this research.	
5. I understand that any interviews with him/her may be audio recorded by the researcher as part of the study.	
6. I understand that the researcher may use anonymised quotes from the interview and that anonymised interviews may be shared with any other researchers or stored as data archives.	

Name of Consultee	Date	Signature

Relationship to Participant

Person consulting (if not researcher)	Date	Signature

Researcher	Date	Signature

When completed, 1 for consultee, 1 for researcher site file; 1 (original)

Appendix 7.3: Participant Consent Form (Friend/Relative)

Version 2, 25/10/2017
Centre Number:
Study Number:

PRIFYSGOL BANGOR UNIVERSITY

CONSENT FORM - RELATIVE/FRIEND

Title of Project: **Language and Cultural Congruity in Care Homes - implications for Well-Being?**

Name of Researcher: Dr Conor Martin

Please initial box

1. I confirm that I have read and understood the information sheet dated [Dated and version number] for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.	
3. I confirm that I consent to the researcher visiting and observing the home whilst I am visiting, and conducting an informal discussion with me.	
4. I confirm that I consent to my informal interview ('converstion with a purpose') as part of a group interview being audio recorded by the researcher as part of the study.	
5. I give permission for the researcher to use anonymised quotes from the interview and for anonymised interviews to be shared with any other researchers or stored as data archives.	
6. I agree to take part in the above study.	

Name of Person	Date	Signature

Researcher	Date	Signature

When completed, 1 for participant, 1 for researcher site file; 1 (original)

Appendix 7.4: Participant Consent Form (Staff)

Version 2, 25/10/2017
Centre Number:
Study Number:

PRIFYSGOL BANGOR UNIVERSITY

CONSENT FORM - STAFF

Title of Project: **Language and Cultural Congruity in Care Homes - implications for Well-Being?**

Name of Researcher: Dr Conor Martin

Please initial box

1. I confirm that I have read and understood the information sheet dated [Dated and version number] for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.	
3. I confirm that I consent to the researcher visiting and observing the home whilst I am working there, and conducting an informal discussion with me.	
4. I confirm that I consent to my informal interview ('converstion with a purpose') as part of a group interview being audio recorded by the researcher as part of the study.	
5. I give permission for the researcher to use anonymised quotes from the interview and for anonymised interviews to be shared with any other researchers or stored as data archives.	
6. I agree to take part in the above study.	

Name of Person	Date	Signature

Researcher	Date	Signature

When completed, 1 for participant, 1 for researcher site file; 1 (original)

Appendix 7.5: Participant Consent Form (Manager)

Version 2, 25/10/2017
Centre Number:
Study Number:

PRIFYSGOL BANGOR UNIVERSITY

CONSENT FORM - MANAGER

Title of Project: **Language and Cultural Congruity in Care Homes - implications for Well-Being?**

Name of Researcher: Dr Conor Martin

Please initial box

1. I confirm that I have read and understood the information sheet dated [Dated and version number] for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.	
3. I confirm that I consent to the researcher visiting and observing the home whilst I am working there, and conducting an informal discussion with me.	
4. I confirm that I consent to my informal interview ('converstion with a purpose') being audio recorded by the researcher as part of the study.	
5. I give permission for the researcher to use anonymised quotes from the interview and for anonymised interviews to be shared with any other researchers or stored as data archives.	
6. I agree to take part in the above study.	

Name of Person	Date	Signature

Researcher	Date	Signature

When completed, 1 for participant, 1 for researcher site file; 1 (original)

Appendix 8.1: Interview Framework (Resident)

Language and Cultural Congruity in Care Homes - implications for Well-Being? - Semi-Structured Interview with Resident

Introduction, confirmation of identity, rehearse consent

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1. Biography

Tell me a bit about your life at the home and before you moved here

Probes

- Where are you from, originally, and where have you spent most of your life?
- What do you most like about living here?
- What do you most dislike about living here?
- What are your main interests or hobbies?
- What newspapers or television channels do you choose to read and watch?
- Do you go to (chapel/church) or do you have a (minister/vicar/priest) attend to you here?

2. Language

Tell me a bit about what language you prefer using in day-to-day life?

Probes

- Which language would you say you are most comfortable in speaking?
- Do you have a second language?
- What difference does being able to speak your first language to the people around you make (residents and care staff)?
- What language do you use if you need help to get washed, dressed or go to the toilet or when you are having your meals?
- Is this important?

3. Social life in the care home

Tell me a bit about day-to-day life in the home here

Probes

- Do you feel that you have enough company here at the home?

  If yes, do you think you would have less company if there were less people that were able to speak your first language?

  If no, do you think you would have more company if there were more people that were able to speak your first language?
- Do you think that you are more content if you are able to talk with people using your first language?

4. **Understanding Culture**

Tell me a bit about how you would describe your 'culture' and how important it is in day-to-day life

Probes

- How would you describe your culture?
- How important is language to your culture?
- Are there any traditional customs, values and festivities that are important to your culture?
- Would you say that the care staff here, on the whole, are from the same culture as you?
- Does it make a difference to you if the care staff are from or not from the same culture as you?
- Does it make a difference to you if your fellow residents are from or not from the same culture as you?

Is there anything else you'd like to add, or say more about?

Thank you for your time.

Appendix 8.2: Interview Framework (Friend/Relative)

Language and Cultural Congruity in Care Homes - implications for Well-Being? Semi-Structured Interview with Family

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Introduction, confirmation of identity, rehearse consent

1. **Biography**

   Tell me a bit about you and your relative's background

   Probes:

   - Where are you and your relative from, originally, and where have you both spent most of your life?
   - Which language would you say you and your relative are most comfortable in speaking, in general?
   - Do they have a second language, and do you consider them fluent in it?
   - How long they lived at the care home?

2. **Language**

   Tell me a bit about what language your relative prefers using in day-to-day life?

   Probes:

   - What difference to your relative, if any, do you feel that being able to interact in their first language makes?
   - What language would they prefer to use when getting help to get washed, dressed or go to the toilet or when having their meals?
   - Do you think that the choice of language used in these interactions matters?
   - In your experience, can you recall any instances where there has been miscommunication between care staff and your relative as a result of a language barrier?

   What are your own experiences of spoken communication with the care home staff?

   Probes:

   - Would you say that you share the same language as the care home?
   - Do you think that the choice of language used in your interactions with the home matters?
   - In your experience, can you recall any instances where there has been miscommunication between the care home staff and yourself as a result of a language barrier?

3. **Social life in the care home**

   Tell me a bit about your relative's day-to-day life in the home here

   Probes:

   - What difference, if any, do you think it makes to your relative to be able to speak to other residents in their first language?
   - Do you feel that your relative has enough company here at the care home?
     A. If yes, do you think they would have less company if there were less people that were able to speak their first language?

B. If no, do you think they would have more company if there were more people that were able to speak their first language?
    - Do you think your relative's happiness is affected by how much they are able to communicate with people their first language?

4. **Understanding Culture**

Tell me a bit about how you would describe your relative's 'culture' and how important it is in day-to-day life

Probes:

- How would you describe your relative's culture?
- How important is language to that culture?
- Are there any traditional customs, values and festivities that are important to your relative's culture?
- Would you say that the care staff here, on the whole, are from the same culture as your relative?
- What difference to your relative, if any, does the care staff being from the same culture as them make?
- In your experience, can you recall any instances where there has been difficulty in your relative obtaining care due to different cultural values or customs?
- Do you think that your relative tends to make friends with residents from a similar cultural background as them, or does culture have no difference in this?
- Do you think that your relative would have less/more company here if there were less/more people that shared the same culture as them?
- Do you think that there is anything the care home could change in terms of language and culture to improve your relative's life here, or is such a change unnecessary?

What are your own experiences of sharing culture with the care home staff?

Probes:

- Would you say that you share the same culture as the care home?
- Do you think that a difference or similarity between your own and the home's cultures matters?
- In your experience, can you recall any instances where there has been misunderstandings between the care home staff and yourself as a result of a cultural barrier?

Is there anything else you'd like to add, or say more about?

Thank you for your time.

Appendix 8.3: Interview Framework (Staff)

Language and Cultural Congruity in Care Homes - implications for Well-Being? Semi-Structured Interview with Staff

Introduction, confirmation of identity, rehearse consent

1. **Biography**

   Tell me a bit about your background, and your work at the home

   Probes:

   - Where are you from, originally, and where have you spent most of your life?
   - Which language would you say you are most comfortable in speaking?
   - Do you have a second language, and do you consider yourself fluent in it?
   - How long have you worked at the care home?

4. **Language**

   Tell me a bit about what language you prefer using in day-to-day life, including at work?

   Probes:

   - What difference to the resident, if any, do you feel that being able to interact with them in their first language makes?
   - What difference to yourselves, as carers, if any, do you feel that being able to interact with them in their first language makes?
   - Do you think that the language of interaction whilst being helped to carry out self-care tasks (washing, dressing, toilets, meals) would make a difference to the residents' experience?
   - Do you think that the language of interaction whilst helping residents to carry out self-care tasks (washing, dressing, toilets, meals) would make a difference to the challenge of providing care?
   - In your experience, can you recall any instances where there has been miscommunication between carers and residents as a result of a language barrier?

3. **Social life in the care home**

   Tell me a bit about day-to-day life in the home here

   Probes:

   - What difference, if any, do you think it makes to the residents to be able to speak to each other in their first language?

- Do you feel that the residents have enough company here at the care home?
  A. If yes, do you think they would have less company if there were less people that were able to speak their first language?
  B. If no, do you think they would have more company if there were more people that were able to speak their first language?
    - Do you think that residents' happiness is affected by how much they are able to communicate with people their first language?

4. **Understanding Culture**

   Tell me a bit about how you would describe your 'culture' and how important it is in day-to-day life

   Probes:

   - What difference to the resident, if any, does the carer being from the same culture as them make?
   - What difference to the challenge of providing care, if any, does being from the same culture as residents make?
   - In your experience, can you recall any instances where there has been difficulty in providing care due to different cultural values or customs?
   - Do you think that the residents tend to make friends with residents from a similar cultural background as them, or does culture have no difference in this?
   - Do you think that some residents would have less/more company here if there were less/more people that shared the same culture as them?
   - Do you think that there is anything the care home could change in terms of language and culture to improve residents' life here, or is such a change unnecessary?
     - If yes, do you think that making a change would be easy to accomplish, or would there be some difficulty or barriers in making the required change?

Is there anything else you'd like to add, or say more about?

Thank you for your time.

Appendix 8.4: Interview Framework (Manager)

Language and Cultural Congruity in Care Homes - implications for Well-Being? Semi-Structured Interview with Manager

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Introduction, confirmation of identity, rehearse consent

1. **Biography**

   Tell me a bit about your background, and your work at the home

   Probes:

   - Where are you from, originally, and where have you spent most of your life?
   - Which language would you say you are most comfortable in speaking?
   - Do you have a second language, and do you consider yourself fluent in it?
   - How long have you been the manager at the care home?
   - How long have you worked in the care service industry?

2. **Language**

   Tell me a bit about what language is mostly used in day-to-day life at the home?

   Probes:

   - How important is language at this care home?
   - What difference to the resident, if any, do you feel that being able to interact with others in their first language makes?
   - What difference to the challenge of providing care (for the home as a whole), if any, do you feel that interacting with residents in their first language makes?
   - What if interacting with residents happens in the staff's second language - does this make a difference?
   - Are there any operational procedures regarding the use of language at the home?
   - If yes, from whom do they originate, and how are they enforced?
   - Do staff have the opportunity to attend any particular training about language?
   - If yes, is this mandatory? Has it been useful?
   - Are there any particular administrative challenges to operating the home in two different languages? For example, in what language are the care notes are written?

3. **Understanding Culture**

   Tell me a bit about how you would describe the local 'culture', and how important it is in day-to-day life at the home

Probes:

- What difference to the resident, if any, does having others around them who are from the same culture make?
- What difference to the challenge of providing care (for the home as a whole), if any, do you feel that having staff from the same culture as residents make?
- In your experience, can you recall any instances where there has been difficulty in the home providing care due to an issue of different cultural values or customs?
- Are there any operational procedures regarding culture at the home?
- If yes, from whom do they originate, and how are they enforced?
- Do staff have the opportunity to attend any particular training about culture?
- If yes, is this mandatory? Has it been useful?

4. Providing Congruent Care

Probes:

- Do you think that there is anything the care home could change in terms of language and culture to improve residents' life and care here, or is such a change unnecessary?
- If yes, do you think that implementing such changes would be easy to accomplish, or are there barriers that would make the task difficult?
- Do you feel that the home is supported by the local authority in providing a suitable linguistic and cultural environment for residents?
- Do you feel that the care home industry in general in supported by the governement in providing this environment?

Is there anything else you'd like to add, or say more about?

Thank you for your time.

Appendix 9.1: Example of Resident Interview Transcript (Resident A1)

Cyfaddasrwydd Ieithyddol a Diwylliannol mewn Cartrefi Gofal - Goblygiadau o ran Lles?

Cyflwyniad, cadarnhau hunaniaeth, ymarfer cydsynio

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1. Bywgraffiad

Dywedwch ychydig wrthyf am eich bywyd yn y cartref ac am cyn i chi ddod i fyw yma

Cwestiynau:

- O ble ydych yn dod yn wreiddiol, a ble ydych wedi treulio'r rhan fwyaf o'ch bywyd?
  - 'XXXXX ydi'n enw i, ond [cyfieithiad cymraeg] ydi'r Gymraeg ynde. Yn wreiddiol o YT, ddim yn bell o H. Yn Sir F odda ni, Gwynedd ydi o rwan de. [Ces i 'magu] yn yr YT, gan Nain a 'Nhaid achos ddaru Mam…, wel di hwn yn confidential yndi? Nain a Taid 'magodd i, odd Taid yn gweithio yn y pylla' glo, a gweithio yn Llechwedd hefyd, ag odd Nain yn dod o HF. Aru hi ddysgu Cymraeg. Briodis i yn XXXX, de, y gwr, cyn hynny on i'n gweithio efo Meddyg, yn Harlech, receptionist nurse, wedyn on i'n llnau ty arall i gal ennill swlltyn.'
  - [Ar ol priodi oeddwn i'n byw] yn TG i ddechra, uwchben Harlech, y gwr a fi de, a wedyn aru ni setlo yn TTTT achos odd y gwr yn gweithio yn yr A, P___ ynde. Hogan lleol ydw i.'
- Beth ydych yn ei hoffi fwyaf am fyw yma?
  - 'Mae'n fendigedig! Fel y bwyd, ne rwbath? Wel bob dim, ma'r staff yn ffeind, ma'r bwyd yn ardderchog yma, ma nhw'n cymyd gofal o olchi'ch dillad yma,

o bob dim, a dwi'n cael mynd allan da chi'n gweld, i siop de, fyddai'n independent.'

- Beth ydych yn ei gasáu fwyaf am fyw yma?
  - 'Ma ne un neu ddau yn gallu bod yn ignorant, ma isio mynadd efo nhw. Ma na ryw ddyn, mae o yn ei wely heddiw, mae'n deutha fi y diwrnod o blaen, 'odda chdi'n meddwl fwy o dy wr pan mae o yn ei fedd rwan na pan oedd o yn fyw. On i'n nabod o o'r surgery o blaen. O, peth brwnt i ddeud. Mai 10fed fydd hi flwyddyn ers i'r gwr farw, mi dorris i.'
  - ['Felly, ma na orfod i chi dreulio amser gyda pobl na fasech chi yn fel arfer?'] Ia, dyna'r unig beth'.
- Beth yw eich prif ddiddordebau neu hobïau?
  - 'O, dwi di bod yn plannu blodau ddoe yn yr ardd, Lily of the Valleys de, darllen, dwi di cael llyfr am rhywun sy'n canu, da chi'n gwbod am Gwyneth Vaughan? Ma di 'chladdu yn Eglwys Llanfihangel y Traethau. Mynd a blodau iddi on i, chi, on i'n ffrind. Coginio de, dwi di neud cacan yn y gegin, nes i sponge cake chydig yn ol, wedyn rhannu fo de. Dwi'n licio cerdded, de, mynd am dro, on i'n sbio ar y briallu, y blodau ger y drws. Trio mynd allan ag edrych ar natur. Siarad yn gall [gyda pobl]. Wrth fy modd yn canu.. Emynau de, Pistyll a Llan, ryw gan de. Myfanwy!'
  - ['Da chi byth yn ganu'n Saesneg?'} 'Nacdw. Dwi'n cofio pan o'n i'n cor on i'n canu rhei Saesneg, de, ddaru ni ennill y genedlaethol 'chi. Gennai lun yn lloft! XXXXX [preswylwr arall yn A] ddaru fynd a ni ar y bws!'
- Pa bapurau newydd neu sianeli teledu ydych chi'n dewis eu darllen a'u gwylio?
  - 'Nacdw [ddim yn darllen papur newydd]. Fyddai'n gwylio sianel 4, S4C. Am mod i'n rhannol ddall ma gen i sgrin arbennig. Dwi'm yn licio'r hen Eastenders a betha felly, rhwbath i neud efo natur a trafeilio wyddoch chi [dwi'n wylio]. Weithia fyddai'n gwylio rhaglenni Saesneg, ond gan fwyaf

Cymraeg.' Mae gen i radio hefyd, John ac Alun, Geraint Lloyd, fyddai ddim yn gwrando ar Chris Needs.'

- A ydych yn mynd i (capel/eglwys) neu a oes (gweinidog/ficer/offeiriad) yn dod i'ch gweld chi yma?
    - 'Eglwyswraig o'n i, o'n i'n mynd yn reit selog, de. Ma nhw fod i ddwad, odda nhw fod i ddod dydd Sul dwytha, ond ddoth nhw ddim. Ma nhw fod i ddod yma unwaith y mis. Does na neb yn dod o'r capel.'
    - 'Mae'n ofnadwy o bwysig i mi. Mae cymyn yn eich cryfhau chi, chi. Ces i 'nghonffyrmio yn unarddeg, a ces i mynd wedyn, blynyddoedd yn ol, mynd yn bore, pnawn a nos ynde! Mae capeli ac eglwysi yn cau, chi'.

2. Iaith

Dywedwch ychydig wrthyf am yr iaith sydd orau gennych ei defnyddio yn eich bywyd pob dydd.

Cwestiynau

- Pa iaith fyddech chi'n ei ddweud ydych fwyaf cyfforddus yn ei siarad?
    - 'O, y iaith Gymraeg.'
- A oes gennych ail iaith?
    - 'Mond Saesneg, de. Dwi'n gwbod dipyn bach o Ffrangeg, jyst i gyfri. Dwi'n iawn [yn Saesneg], de. Basis i'n Saesneg a 'Nghymraeg yn GCEs, ces i wyth i gyd. Gwell gen i siarad Cymraeg.'
- Pa wahaniaeth mae gallu siarad eich iaith gyntaf gyda'r bobl o'ch cwmpas (preswylwyr eraill a staff gofal) yn ei wneud?
    - 'Anodd. Os da chi'n siarad Cymraeg o flaen rhywun Saesneg, ma nhw'n deud 'Be da chi isio siarad Cymraeg am?'. Ond na fo'n iaith ni! Dwi'n teimlo'n prowd mod i'n Gymraeg. Swn i'n siarad Saesneg [os faswn i mewn

cartre mwy Saesneg]. Dwn im [sut faswn i'n dygymod efo hynny]. Dwi di arfer siarad Cymraeg, chi.'

- Pa iaith ydych chi'n ei defnyddio os oes angen help arnoch i ymolchi, gwisgo neu fynd i'r toiled neu pan fyddwch yn cael eich prydau bwyd?
    - 'Ma na un neu ddau [staff sydd ddim yn siarad Cymraeg]. A da chi'n goro, te, siarad Saesneg. Ond ma na lot o staff yn gadal 'ma rwan. [Fasa'n well gen i siarad] Cymraeg. Pan ddos i yma cynta, on i'm yn gallu codi o'r gwely, on i'n canu'r gloch i folchi. Cymraeg [on i'n cael y gofal yna drwy].'
- A yw hyn yn bwysig?
    - 'Ydi. Cymry da ni de. Os di'r iaith yn mynd ar 'i lawr, be sy am ddigwydd? Sa'n anodd i mi [dderbyn gofal drwy'r Saesneg]. Fedrwn i ddim egluro'n hun, de'

3. **Bywyd cymdeithasol yn y cartref preswyl**

Dywedwch ychydig wrthyf am eich bywyd pob dydd yma yn y cartref

Cwestiynau

- A ydych yn teimlo bod gennych ddigon o gwmni yma yn y cartref?
    - 'Wel, ma gen i XXX, a XXX, a XXX yn y gegin. Oes.'
        - Os ydych yn teimlo bod gennych ddigon o gwmni, a ydych yn credu y byddai gennych lai o gwmni petai llai o bobl yma yn gallu siarad eich iaith gyntaf?
            - 'Faswn. Ma 'ngwaed i'n goch'.
        - Os nad ydych yn teimlo bod gennych ddigon o gwmni, a ydych yn meddwl y byddai gennych fwy o gwmni petai mwy o bobl yma yn gallu siarad eich iaith gyntaf?
            - 'O, yndw, yndw.'

- A ydych yn credu eich bod yn fwy bodlon os ydych yn gallu siarad â phobl yn eich iaith gyntaf?

4. **Deall Diwylliant**

Dywedwch wrthyf sut byddech yn disgrifio eich diwylliant chi a pha mor bwysig yw'r diwylliant hwnnw i'ch bywyd pob dydd

Cwestiynau

- Sut byddech yn disgrifio eich diwylliant?
  - 'Diwylliant? ['Culture? Faswn i'n disgrifio fy un fel un o gefndir Cymraeg, teulu a ballu, cerddoriaetjh, a chwaraeon, ond wedyn dwi di bod yn feddyg hefyd. Felly o ran diwylliant fasa rhywun o Pakistan neu Ffrainc gyda diwylliant gwahanol i'n niwylliant i. Felly sut fath o berson yda chi?'] 'O, rargol, ma nhw'n deud fan hyn mod i'n berson caredig sy'n helpu pobl, wedi bod yn ffeind ar hyd 'yn oes i. Os di bobl yn iawn, de, da chi'n gwbo efo XXX os fyddai'n neud panad ne rwbath iddyn nhw, y petha bach mewn bywyd sy'n bwysig'
  - ['Os fasa chi'n disgrifio'ch pobol chi, pwy di'ch pobol chi?'] 'Cymry.' ['Pa betha sy'n bwysig i bobol Cymraeg?'] 'Cadw'r iaith yn fyw.'
- Pa mor bwysig yw iaith i'ch diwylliant?
  - 'Yndi mae o, wir.'
- A oes unrhyw arferion, gwerthoedd neu ddathliadau traddodiadol sy'n bwysig i'ch diwylliant?
  - 'Ma hwnna'n galad. Dydd Gwyl Dewi Sant. Dolig a Pasg.' ['Felly da chi'n meddwl fod petha Cristnogol yn bwysig i bobol Cymraeg?'] 'Argol, yndi!'
- A fyddech yn dweud bod y staff gofal yma, ar y cyfan, yn dod o'r un diwylliant â chi?

- ‘Y rhan fwya ohonyn nhw. [Mae’r rhai sydd ddim yn dod o’r un diwylliant] ma nhw’n siarad gormod o Saesneg. Nac ydyn [yn dod o’r diwylliant a hi].
- [‘Ydy nhw’n dod o rhywle wahanol i chi?’] Nacdyn. [‘Ma nhw’n dod o’r un ardal?’] ‘Ydyn, ond yn wahanol’.

o A yw'n gwneud gwahaniaeth i chi os yw'r staff gofal yn dod o'r un diwylliant â chi neu ddim?

- ‘O, honna’n anodd ‘fyd. Ydi, mae’n bwysig. Byswn’ [yn hoffi i bobl ddod o’r un diwylliant a mi]. [‘Pam hynny felly?’] ‘Am mod i’n Gymraes!’

o A yw'n gwneud gwahaniaeth i chi os yw'r preswylwyr eraill yn dod o'r un diwylliant â chi neu ddim?

- ‘Ydi, mae’n bwysig fod nhw’n gwbod eu Cymraeg’
- [‘Ydi pobl arall yn y cartref, er enghraifft pobl o Benllyn, yn dod o ddiwylliant gwahanol i chi?] ‘Mae’n dibynnu, yntydi.’

Appendix 9.2: Example of Staff Interview Transcript (Staff B1)

Language and Cultural Congruity in Care Homes - implications for Well-Being? Semi-Structured Interview with Staff

PRIFYSGOL BANGOR UNIVERSITY

Introduction, confirmation of identity, rehearse consent

1. **Biography**

   Tell me a bit about your background, and your work at the home

   Probes:

   - Where are you from, originally, and where have you spent most of your life?
     - 'SRSR - just outside DDDD. Most of my life there. I live up there and I work in DDDD.'
   - Which language would you say you are most comfortable in speaking?
     - 'English - but I can speak Welsh fluently but English is better. I spoke Welsh in school and to my family because I was brought up on a farm. When you're little you can take anything in can't you? My mum spoke English and my dad spoke Welsh.'
   - So you'd be very comfortable speaking to residents in Welsh?
     - 'Oh, yes.'
   - How long have you worked at the care home?
     - '1997. Mostly domestic but also a few hours of caring.'

5. **Language**

   Tell me a bit about what language you prefer using in day-to-day life, including at work?

   Probes:

   - What difference to the resident, if any, do you feel that being able to interact with them in their first language makes?
     - 'Yes it does, especially if the resident is Welsh. You can tell if they struggle with the English, it would be a lot easier for them to speak Welsh, and they seem to understand. Especially if their first language is Welsh. They'll struggle with certain words.'
   - Are there certain residents like that in this lounge, or more in the other lounges?
     - 'Two in this one. A few in the others. [Names residents]'
   - I got the impression that GGGG would struggle in English?
     - 'Yeah, he does. And then there's IIII but he's gone to work today.'

- But then there's someone like GWGW who's quite well-spoken in English as well, I think - would you still think that she would much prefer to speak in Welsh?'
    - 'Yeah.'
- What difference to yourselves, as carers, if any, do you feel that being able to interact with them in their first language makes?
    - 'Yes.'
- So you feel that, compared to other carers who don't speak Welsh, you find it easier to..
    - 'Yeah.'
- Do you think that the language of interaction whilst being helped to carry out self-care tasks (washing, dressing, toilets, meals) would make a difference to the residents' experience?
    - 'Yeah, I think that's important. Well it's what they're used to, isn't it. If they're used to doing that themselves, and you go and help a bit, then they know what they're doing don't they, being spoken Welsh to.'
- In your experience, can you recall any instances where there has been miscommunication between carers and residents as a result of a language barrier?
    - 'There probably has been… But not that comes to my knowledge.'

3. Social life in the care home

Tell me a bit about day-to-day life in the home here

Probes:

- What difference, if any, do you think it makes to the residents to be able to speak to each other in their first language?
    - 'They're mostly English in this [lounge], so they do tend to talk English to each other quite a bit here, and then you've got CLCL who's Welsh over there, but he's very good he'll just split from Welsh to English. He's very, very, good.'
- When everyone's together, do the Welsh ones tend to clump together or not - do they tend to mix quite well?
    - 'Upstairs they do. I think they mix quite well, they generally have conversations, and if there's an English person they will turn perhaps to English.'
- Do you feel that the residents have enough company here at the care home?
    - 'Yeah, I think so, yeah.'

A. If yes, do you think they would have less company if there were less people that were able to speak their first language?
    - 'Yeah. Certain residents. The likes of GGGG has very little English so he would struggle.'

4. **Understanding Culture**

   Tell me a bit about how you would describe your 'culture' and how important it is in day-to-day life

   Probes:

   - How would you describe your culture? Which culture are you from, would you say? Would you describe yourself as primarily British, or Welsh.. Or from DDDD or CV? Or from a farming family? What would you say is your main identity?
     - 'I'm British.'
   - That's your main thing?
     - 'Yeah.'
   - Would say that most of the residents here would identify themselves as British?
     - 'Yeah, I think, yeah.'
   - Would there be some who identify different?
     - 'Maybe some would, yeah.'
   - What difference to the resident, if any, does the carer being from the same culture as them make?
     - 'Dunno. Language, definitely.'
   - Culture less so maybe?
     - 'Yeah.'
   - What difference to the challenge of providing care, if any, does being from the same culture as residents make?
     - 'There probably would be a little barrier [with a different culture], wouldn't there. But other than that..'
   - In your experience, can you recall any instances where there has been difficulty in providing care due to different cultural values or customs?
     - 'Not that I can know of.'
   - Do you think that some residents would have less/more company here if there were less/more people that shared the same culture as them?
     - 'Yeah, I think so.'
   - Do you think that there is anything the care home could change in terms of language and culture to improve residents' life here, or is such a change unnecessary?
     - 'I think it's good. Especially the language. Helping with the Welsh or the English, isn't it.'
   - So that's not just you, all of the carers as well?
     - 'Well, they can speak Welsh, quite a few. Most of them [that can speak Welsh] fluent, yes, they come from farming backgrounds as well, so..'

Appendix 9.3: Example of Family Interview Transcript (Families A2 & A3)

Cyfaddasrwydd Ieithyddol a Diwylliannol mewn Cartrefi Gofal - Goblygiadau o ran Lles? Cyfweliad Lled Strwythuredig gyda Theuluoedd

Cyflwyniad, cadarnhau hunaniaeth, ymarfer cydsynio

PRIFYSGOL BANGOR UNIVERSITY

1. Bywgraffiad

Dywedwch ychydig wrthyf am eich cefndir chi a chefndir eich perthynas

Cwestiynau:

- O ble ydych chi a'ch perthynas yn dod yn wreiddiol, a ble ydych wedi treulio'r rhan fwyaf o'ch bywyd?
    - Teulu 2: O N [yn Lloegr], yn wreiddiol, a symud yma yn nineteen-seventy one - wedi bod yma am forty-seven years.
    - 'A ma hi di dod i ddeall Cymraeg?'
    - Teulu 2: 'Yndi.'
    - 'Di hi'n siarad o o gwbwl?'
    - Teulu 2: 'Dim llawar. Neith hi ddeud petha basic fatha, 'diolch yn fawr', 'os gwelwch yn dda', petha felna, ond mae'n deall lot de!'
    - Teulu 3: 'O GLl yn wreiddiol, a wedi bod yn yr ardal yna ar hyd ei hoes. Odd mam yn gweithio yn TTTT.'
- Pa iaith fyddech chi'n ei ddweud ydych chi a'ch perthynas fwyaf cyfforddus yn ei siarad yn gyffredinol?
    - Teulu 2: 'Susnag.'
- A oes ganddynt ail iaith, ac a ydych yn ystyried eu bod yn rhugl ynddi?
- Ers faint o amser maent wedi bod yn byw yn y cartref gofal?
    - Teulu 2: 'Ryw tair mlynadd rwan?'
    - Teulu 3: 'Tair [mlynedd] yn mis Hydref.'

2. Iaith

Dywedwch ychydig wrthyf am yr iaith sydd orau gan eich perthynas ei defnyddio yn eu bywyd pob dydd.

Cwestiynau:

- Yn eich barn chi, pa wahaniaeth mae gallu cyfathrebu yn eu hiaith gyntaf yn ei wneud i'ch perthynas, os o gwbl?
    - Teulu 2: 'Mae'n bwysig. Ma'r staff yn reit dda yma - ma'n mynd yn ddau ffor - os ma nhw'n gwbo fod rhywun yn fwy comfortable yn siarad Susnag, neith nhw siarad Susnag.'
    - 'Wedyn ma'n bwysig i'ch mam chi allu siarad Cymraeg?'
    - Teulu 3: 'O, ydi. Dwi'm di clywad hi'n siarad Susnag ers dipyn go lew; odd hi'n hollol rhugl wrth gwrs, cyn dod yma. Mae'n darllan yn Daily Post [yn Saesneg] yndi, ma'n dallt de.'
- Pa iaith fyddai'n well ganddynt ei defnyddio wrth gael help i ymolchi, gwisgo neu fynd i'r toiled neu pan maent yn cael eu prydau bwyd?
    - Teulu 2: 'Swn i'm yn feddwl.'
    - Teulu 3: 'Sna'm yn lot yn siarad..
    - Teulu 2: 'Dim pan ti'n neud petha felna [gofal]'
    - Teulu 3: 'Nagoes, pan ma nhw'n mynd yn hyn, hefyd..'
    - Teulu 2: 'Sgenna nhw'm cymaint i ddeud, rili, nagoes..'
    - Teulu 3: 'Ond dwi'n gwbo bod Mam di codi yn ganol nos, ma di bod yn siarad efo un o'r genod am rwbath o flynyddoedd yn ol!'
    - A ydych yn credu bod yr iaith a ddefnyddir yn y rhyngweithio hyn yn bwysig?
- Yn eich profiad chi, a allwch gofio unrhyw enghreifftiau lle bu camddealltwriaeth rhwng gofalwyr a'ch perthynas o ganlyniad i rwystr iaith?
    - Teulu 2 & 3: 'Na.'

Beth yw eich profiad chi o siarad â staff yn y cartref gofal?

Cwestiynau:

- A fyddech yn dweud eich bod yn rhannu'r un iaith â'r cartref gofal?
    - Teulu 2 (1LE): 'Ia - ia. Os dwi'n siarad Susnag efo rei o'r staff, neu Cymraeg..'
    - Teulu 3: 'Yndan.
    - 'So da chi'n teimlo'n gyfforddus?'
    - Teulu 2 & 3: 'Ia.'
- A ydych yn credu bod yr iaith a ddefnyddir yn eich ymwneud â'r cartref yn bwysig?
    - Teulu 2 (1LW): 'Dwi'n meddwl fod chi'n teimlo'n agosach os da chi'n siarad yn Gymraeg de.. Yr iaith gynta, dim ots os dio'n Gymraeg neu'n Susnag..'
    - Teulu 3: 'Ia, 'na fo.'
    - Teulu 2: 'Ma rhywun yn well yn eu hiaith cynta o hyd, yndi.'
    - 'A ma'r ffaith bo chi'n gallu siarad Susnag i'r staff yn helpu, os da chi isio mynegi'ch hyn mwy?

- Teulu 2: ‘Ia, wel, ma’n helpu Mam mwy na fi, swn i’n ddeud. Ond hwrach, di Cymraeg fi ddim yn dda iawn, so.. weithia, rhei o’r geiria, dwi fatha ‘o, bedi’r Cymraeg am hwnna?’, so, ma’n haws i fi weithio ond definitely i Mam, chos di Cymraeg hi ddim yn dda iawn, so..’
- ‘Ond mae o’n ddefnyddiol i chi hefyd?’
- Teulu 2: ‘Yndi, yndi. Nath hi byth codi’r iaith i fyny.’
- Teulu 3: ‘Ma na lot o bobol yn teimlo yn self-conscious, braidd, ‘dydyn?’
- Teulu 2: ‘Ia, odd hi’n deud hynna, blynyddoedd yn ol!’
- Teulu 3: ‘Ddoth na lot o Saeson mewn efo’r atomfa, plant i gyd yn siarad Cymraeg, rhieni dal ddim, de. Ma nhw’n dallt o, ond ddim efo digon o hyder i siarad .’

- Yn eich profiad chi, a allwch gofio unrhyw enghreifftiau lle bu camddealltwriaeth rhyngoch chi a staff yn y cartref gofal o ganlyniad i rwystr iaith?

3. **Bywyd cymdeithasol yn y cartref preswyl**

Dywedwch ychydig wrthyf am fywyd pob dydd eich perthynas yma yn y cartref

Cwestiynau:

- Yn eich barn chi, pa wahaniaeth, os o gwbl, mae'n ei wneud bod eich perthynas yn gallu siarad â phreswylwyr yn eu hiaith gyntaf?
    - Teulu 2: ‘Yndi, dwi meddwl, yndi. Y peth ydi dwi’m yn credu bod Mam di cal Susnag o’i chwmpas hi, so dwi’m yn siwr sut sa hi’n ymateb a deud y gwir!’
    - ‘Felly.. yn ei stafell [fyw] hi, mae’r rhan fwyaf o’r preswylwyr yn Gymraeg?’
    - Teulu 2: ‘Yndi, ma nhw gyd yn Gymraeg.’
    - ‘A ma hynna’n bwysig, da chi’n meddwl?’
    - Teulu 2: ‘Yndi, yndi, mae’n bwysig idda nhw gyd, dwi meddwl. Dwi meddwl sa’r un sa ddim yn siarad Cymraeg, sa nhw’n teimlo’n odd one out, bysa? Ma nhw meddwl ‘o, ma nhw’n siarad amdana fi..’
    - ‘Ac ella ma hynna’n wahanol i mam chi - ma hi mewn cylch bach sy’n fwy Gymraeg [na Saesneg] yndi?’
    - Teulu 3: ‘Ma’n wir bod rhei mwy Susnag yna.. fatha MJMJ, ma hi’n Susnag.’
    - Teulu 2: ‘GRGR yn Gymraeg, dydi?’
    - Teulu 3: ‘Yndi.’
    - Teulu 2: ‘So ma na dwy Susnas a dau Gymraeg yn fanna, de.’
    - ‘Ydi o’n bwysig fod na rhywun Susnag yn y cylch yna idda hi - neu dio’m yn neud gwahaniaeth?’
    - Teulu 3: ‘Ti’n gwbo be, dwi’m yn meddwl bod o’n neud gwahaniaeth i Mam.’
    - ‘Am bod hi’n dallt rhan fwya o betha?’

- Teulu 3: ‘Mae’n deall mwy na ma hi’n actually..’
- Teulu 2: ‘A mae’n eitha easy-going yndi?’
- Teulu 3: ‘Yndi, ma Mam reit laid-back, so, sa hi’m yn poeni.’
- Teulu 2: ‘Sa na amball un, ella..’
- Teulu 3: ‘Yn teimlo fatha ‘o dio’m yn iawn bod nhw’n siarad Cymraeg’, ond na, di him ddim felna o gwbwl. Di hi byth di bod felna. Odd lot o ffrindia hi, ti’n gwbo, blynyddoedd yn ol, di bod yn pobol, ti’n gwbo, hollol Cymraeg, de. Ond di’m yn fatha, seekio allan pobl Susnag i bod yn ffrindia hefo, mae’n, ti’n gwbo, relaxed..’

- A ydych yn teimlo bod gan eich perthynas ddigon o gwmni yma yn y cartref?
  - Teulu 3: ‘Dwi yn, definitely, de. Yn fama, cos odd Mam, lle da ni’n byw yn PDPD, wel.. odda ni’m yn gallu edrych ar ol hi eniwe, dyna pam ddoth hi yma, ond sa ni di cal rhywun i edrych ar ol hi adra, neu sa ni di gallu copio efo hi, sa hi di bod yn waeth off, dwi meddwl.’
  - Teulu 2: ‘Mae hynny’n wir, ond ma’n raid i mi ddeud dwi meddwl weithia, fasa na mwy yn gallu cael ei neud gen y carers, rili. Hyd yn oed sa nhw jyst yn siarad efo nhw. Dio’m byd newydd i fynd i fewn a gweld y stafall i gyd jyst yn sbio..’
  - ‘Felly, da chi’n teimlo, fel canlyn, ydy hi’n gallu bod ychydig bach yn unig weithia?’
  - Teulu 2: ‘Ma Mam erioed wedi bod chydig bach yn.. Dydi hi erioed wedi bod yn un am gymysgu yn dda yn enwedig, a heddiw wan, mae’n gallu clywed rhei petha, dwi’m yn gwbod os di hi’n dallt petha yn iawn pan fo pobol yn siarad efo hi, swn i’n ama rwan de..’
  - Teulu 3: ‘Ond, ma Mam ‘run fath. Di hi’m yn clywad dim byd, ti’n gwbo, so dwi meddwl o hynna ma nhw’n methu allan lot, de, a wedyn ti’n tueddu jyst ista nol de, os ti’m yn clywed y conversation.’
  - ‘O’ch safbwynt chi, yda chi’n meddwl fasa gen eich Mam digon o gwmni yma tasa na fwy o bobl yma yn siarad [1LE] Susnag?’
  - Teulu 3: ‘Na, sa hynna’m yn neud gwahaniaeth, dwi’m yn meddwl.
  - ‘Yda chi’n teimlo fasa gen eich Mam chi lai o gwmni os fysa na fwy o bobol yn y stafall yna?’
  - Teulu 2: ‘Ma lot yn dibynnu ar pwy di’r bobol, a dweud y gwir, dydi? Swn i’n licio gweld mwy o betha..[?].. gwrando ar y radio, de, ac ar nos sadwrn sa nhw gyd yn gwrando ar ryw nofel neu rhywbeth felly, ma’n bosib cal talking books a petha felly.. Chos, dwi’m yn gwbo, gewch chi un yn cwyno fod y teledu yn rhy uchal, llall yn deud fod nhw’m yn glywad o, nes fod o’n job plesio pawb, dydi?’
  - Teulu 3: ‘Yndi, yn enwedig ma genna chdi cyn gymaint o pobl mewn un stafall.’
  - Teulu 2: ‘Ia. Ond be sy yn mynd lawr yn dda ydi petha fatha Steddfod Llangollen, a Sioe Frenhinol, ma nhw yn gyd yn enjoio..

- Teulu 3: ‘Ydi, ma nhw’n enjoio fo, bo nhw’n cal y canu, ti’n gwbo ma nhw wrth eu bodd efo hynny.’
- Teulu 2: ‘A ma nhw yn licio petha Cymraeg i rannu, achos dydi rap ma a petha felly yn apelio dim iddyn nhw, hyd yn oed y post-modern, de, well gennyn nhw cor.’
- Teulu 3: ‘Ia, hyd yn oed bod Mam yn Susnag, ma well gen Mam petha felna. Sa hi’n gwrando ar cor ne rwbath felna, de.’
- ‘Ond be am Vera Lynn, ne rwbath felna?’
- Teulu 2: ‘O, sa nhw’n licio hynna.’
- ‘Sa nhw goro dewis rhwng miwisg Susnag o’r forties, neu miwsig Cymraeg?’
- Teulu 2: ‘Job deud. Sa’n grwp Cymraeg o heddiw, [fasa nhw’n dewis] Vera Lynn.’
- Teulu 3: ‘Ia.’
- Teulu 2: ‘Os fasa fo’n Dafydd Iwan, neu rai o rheiny.. dwi’m yn gwbo!’
- Teulu 3: ‘Dibynnu ar yr oedran!’

- A ydych yn credu bod hapusrwydd eich perthynas yn cael ei effeithio gan faint o gyfathrebu maent yn gallu ei wneud â phobl yn eu hiaith gyntaf?
  - Teulu 2: ‘O, yn bendant efo Mam, os fasa hi’m yn gallu siarad Cymraeg fasa na broblam fawr.’
  - Teulu 3: ‘Sa hi’m yn gallu siarad [Susnag efo pobol] a sa bob dim yn cael ei neud yn y Gymraeg, sa hi’m yn hapus. Ond sa hynna ‘run fath i rywun. Os ti’m yn gwbo be sy’n mynd ymlaen.. Ti’n gwbo.’

4. Deall Diwylliant

Dywedwch wrthyf sut byddech yn disgrifio diwylliant eich perthynas a pha mor bwysig yw'r diwylliant hwnnw i'w bywyd pob dydd

Cwestiynau:

- Sut byddech yn disgrifio diwylliant eich perthynas?
  - Teulu 2: ‘O mae’n hoffi barddoniaeth a petha felly, ma raid i fi ddeud, ond dim byd.. dim englynion a ryw betha felly.’
  - ‘Ond sa hi’n goro deud - ‘dwi yn berson..’ be fysa hi’n deud? Person Cymraeg? Person Prydeinig? Person (sir yr ardal)? Be sa’n dod top?
  - Teulu 2: ‘O, person Cymraeg.’
  - Teulu 3: Ia, Susnag. Mae’n Susnag, diwadd y dydd. Ond tydi hi ddim yn - ‘England, Englad!’ ti’n gwbo - na ma hi fatha ‘I’m from England.’
  - Teulu 2: ‘Prydeinig felly, de?’
  - Teulu 3: Ia, ‘British’!

- Pa mor bwysig yw iaith i'r diwylliant hwnnw?
    - Teulu 2: ‘O, hynod o bwysig, yndi. O, yndi.’
    - ‘Pa mor bwysig ydi'r iaith Susnag i’r diwylliant Susnag?
    - Teulu 3: ‘Hmm.. Ie, llai swn i’n ddeud. Hwrach fod pobl Cymraeg ma nhw reit.. ti’n gwbo, ‘Dwi’n Gymraeg’ a dyna fo, de, ond hwrach ma genna chdi rhei Susnag sy felna hefyd, ond.. dwi’m yn gwbo.’
- A oes unrhyw arferion, gwerthoedd neu ddathliadau traddodiadol sy'n bwysig i ddiwylliant eich perthynas?
    - Teulu 2: ‘Ia, ma na hen draddodiadau Cymreig i ryw raddau…’
    - ‘Ydi hynna’n bwysig iddi hi?’
    - Teulu 2: ‘O ydi, da chi’n gwbo, pan oedda chi’n cael eich geni o gwmpas fama, pan odda chi’n blentyn, ar ffarm, ma’i dal i gofio petha de, hanesach rhwng pawb, pawb yn y gymdeithas de, a capal yn bwysig dwi meddwl - dydi o ddim i mi..’
    - Teulu 3: ‘Na, na.’
    - Teulu 2: ‘..mae’n bwysig iawn iddyn nhw. Ym, ma petha.. Achos neith hi holi fi rwan, faint o blant sy’n ysgol GLlGLl, ond ma’r ysgol di cau!
    - ‘[Felly] ma’r gymuned yn bwysig?’
    - Teulu 2: ‘Yndi, er bod hi’n marw’n slo bach, wrth gwrs.’
    - Oes na unrhywbeth Susnag sy’n bwysig i’r diwylliant Susnag, iddi hi [mam Teulu 2]?’
    - Teulu 2: ‘Y teulu brenhinol?’
    - Teulu 3: ‘Na, dim iddi hi. Odd hi byth yn deud hynna, byth, dim petha felna.’
    - Teulu 2: ‘Dwi yn, de! Dwi’n licio’r gossip amdanyn nhw!’
    - ‘Beth amdan eich mam chi?’
    - Teulu 2: ‘Na, sgen hi ddim diddordeb.’
    - ‘I gymharu efo rhywun Susnag? Yda chi’n meddwl fasa hi’n gefnogol?’
    - Teulu 2: ‘Dwi’n licio watchad nhw’n priodi, chos dwi’n licio’r dillad, de, ond dwi’m yn credu ynddyn nhw.’
    - ‘Ond beth amdan eich mam chi?’
    - Teulu 2: ‘Dwi meddwl fasa genddi rywfaint o barch at y Queen a’i gwr, achos ma’r Queen, mwy neu lai, dwy flynadd yn iau na hi, so ma na gysylltiad rwla. Ond jyst achos mae’r oed yna ydi hi. Os bysa fo’n Princess Anne, sa genna hi ddim byd i ddeutha hi ma’n siwr.’
    - ‘Ond sa na rhywun Susnag, yn Lloegr, yr un oed, yda chi’n meddwl fasa fo’n golygu mwy i nhw na fasa fo i Mam chi?
    - Teulu 2: ‘Bysa, bysa. Achos yndi, bob tro o hyd i Lloegr, ma’r teulu brenhinol di bod yno erioed.’

- ‘Ond i chi, ma’ch mam chi [Teulu 2] di bod yn Nghymru am amser hir, da chi’m yn meddwl fod o’n bwysig i’ch mam chi?’
- Teulu 3: ‘Na. Yr un peth.. Ma hi’n licio watchad nhw, a gweld pa ddillad..’
- Teulu 2: ‘Dwi meddwl ma’r pobl nath fyw drwy’r ail ryfel byd, ma genna nhw mwy o feddwl na sy genna ni, da ni jyst yn sbio arnyn nhw..[?]’
- Teulu 3: ‘Wel, ia, ma’r effaith ar y taxpayer.. Ond ma nhw’n dod a lot fewn i’r ardal hefyd.’
- Teulu 2: ‘Sa chi gallu neud pwynt fod nhw lot gwell na gal Trump neu Putin i fewn.’
- ‘Sa’n ddiddorol i mi ofyn.. Pwy da chi meddwl fasa hi’n gefnogi yn y gem [bel-droed Lloegr cwpan y byd] heno?
- Teulu 2: ‘Sa genna hi ddim diddordeb.’
- ‘Ond sa hi’m yn deud - ‘dwi isio Lloegr golli’?’
- Teulu 2: ‘Na. Yr unig ddiddordeb sy gen mam, sa Cymru yn chwara rygbi. Dio’m yn mynd dim pellach na hynna.’
- ‘Ma hi’n licio rygbi mwy na peldroed?’
- Teulu 2: ‘Dwi meddwl fod ni gyd fel hynna rywsut.’
- Teulu 3: ‘Am fod Cymru di bod mwy llwyddiannus yn rygbi.’

- A fyddech yn dweud bod y staff gofal yma, ar y cyfan, yn dod o'r un diwylliant â'ch perthynas?
  - Teulu 2: ‘Nadi, swn i’m yn feddwl.’
  - ‘Ydi hynna oherwydd bod nhw’n dod o rwla gwahanol neu oherwydd fod y cenedhlaethau yn wahanol?’
  - Teulu 2: ‘Dwi meddwl meddwl fod o oherwydd fod y rai sy’n tueddu i roi gofal ddim wedi bod fatha.. da chi’n gwbo ma’n tueddu i fod swyddi ndoes os da chi di mynd yn bellach yn yr ysgol i fod yn siarad Cymraeg, [..?..] sa mam isio siarad barddoniaeth efo [..?..]
  - ‘So o’r safbwynt yna ma nhw'n dod o ddiwylliannau gwahanol?’
  - ‘Teulu 3: A, da chi’n gwbod, yn anffodus mae’n wir i rhei fod pawb sy i mi yn ddiwylliannol yn y ardal yma yn ifanc yn gadal, ‘dydy? Da chi’n gwbo, dyna di’r broblem mwyaf. Achos os oes gynno chi […?…] ac os da chi’n mwy na hynny da chi’n cael lefel A a mynd i brifysgol!’
  - ‘Wedyn da chi’n gadal yr ardal?’
  - Teulu 2: ‘Wel, fues i’n lwcus i cael ddod yn ol i TTTT, ac o na amball un yr fath, neud gradd yn Gaerdydd, a dod nol i fama, bod yn lwcus, de. Ond rwan - does na ddim byd i’r ifanc. Er, eto ma na un carer ifanc fama newydd neud tair mlynedd yn Prifysgol Caerdydd, a dod yma i weithio i hel pres dros yr haf. So ma na rei’n dod i fewn, da chi’n gwbo, a ma na fobol hefyd, rei pobol mam, hefo dipyn o ddiwylliant tu ol i’r teulu i gyd, a pan ma’r teuluoedd yn

dod i fewn, ma na un, ma'i mab 'i chwaer hi'n dod yma, mae o'n gweithio i'r BBC, a wedyn, da chi'n gwbo ma nhw'n dod i nabod pobol yma.'

- 'Yda chi'n meddwl fod y staff gofal yn dod o'r un diwylliant a'ch mam chi [Teulu 3]?'
- Teulu 3: 'Ymm..'
- 'Neu ella fod hi di gweddu mewn i diwylliant nhw?'
- Teulu 3: 'Wel, odd mam yn nyrsio, blynyddoedd yn ol, yn y 1950s, so..'
- 'Yr un teip o bobol?'
- Teulu 3: 'Ia.'

- Yn eich barn chi, pa wahaniaeth, os o gwbl, mae'n ei wneud i'ch perthynas bod y staff gofal yn dod o'r un diwylliant?
  - Teulu 3: 'Ia, ti isio ryw fath o cysylltiad..'
  - Teulu 2: 'Ma'n bwysig i allu cal sgwrs efo nhw, ond allech chi jyst siarad am [..?..] - ffaith bo chi'n siarad sy'n bwysig.
  - 'Felly dio'm yn ofnadwy o bwysig fod nhw'n dod o'r un diwylliant - jyst bod nhw'n gallu uniaethu rywfaint?'
  - Teulu 2: 'Ia, a bod nhw'n gallu, chi'n gwbo, hyd yn oed os da chi'n siarad am y tywydd, na peidio siarad o gwbwl.'
- Yn eich profiad chi, a allwch gofio unrhyw enghreifftiau lle cafodd eich perthynas anhawster yn cael gofal oherwydd gwerthoedd neu arferion diwylliannol gwahanol?
  - Teulu 2 & 3: 'Na.'
- A ydych yn credu bod eich perthynas yn dueddol o wneud ffrindiau â phreswylwyr sydd o gefndir diwylliannol tebyg iddynt hwy, neu a ydych yn credu nad yw diwylliant yn gwneud unrhyw wahaniaeth yn hyn o beth?
  - Teulu 2: 'Dwi'm yn meddwl fof mam y teip..'
  - Teulu 3: 'Ma mam reit ddistaw, hefyd. Di hi'm yn un am gymysgu efo pawb, ond..'
  - Teulu 2: 'A ma hi'n siarad yn eitha [?], dydi? Dydi mam ddim efo'r hyder i wneud hynna. Ond dwi meddwl ella ma diffyg [..?..] ydi o. O naci, falla mai'r salwch ydi o. Chos dwi di deutha hi fod na rhywun odd hi'n nabod hi.. [..?..]
  - Teulu 3: ' Swn i'n gallu deud rwbath i mam, wedyn pum munud wedyn - [ddim yn cofio].'
- A ydych yn credu y byddai gan eich perthynas llai/mwy o gwmni yma petai llai/mwy o bobl yma'n rhannu'r un diwylliant â hwy?
- A ydych yn credu bod unrhyw beth y gallai'r cartref gofal ei newid o ran iaith a diwylliant i wella bywyd eich perthynas, neu nad oes angen newid o'r fath?
  - Teulu 2: 'Da chi'n gwbo be, ma hyn yn swnio'n od, ond weithia dwi'n dod yma a ma'r TV yn switched off a dwi meddwl fod hynna'n ofnadwy de, yn

enwedig pan fo Llangollen ymlaen, neu Steddfod ymlaen, ma nhw wrth eu bodda [efo rheiny].'

- 'Fysa chi'n licio tasa na fwy o ddiwylliant Cymraeg yn y stafall, jyst efo teledu?'
- Teulu 2: 'Ia. Ma raid i mi ddeud, ddois i yma ryw ddydd Sadwrn, a dyna be o gynnyn nhw, odda nhw'n neud kareoke a gallech chi gal DVDs, gallwch, i roi ar y teledu. Ma hynna'n syniad da. [..?..] so masho gofyn i rheiny, dwi'm yn gwbo pwy sy'n gneud nhw.'
- 'Ma'n swnio dipyn bach bod chi isio dipyn mwy o rhyngweithio Cymraeg, yn y stafall yna?'
- Teulu 3: 'Ia, ia.
- 'Da chi'n meddwl, oes na rwbath sa nhw gallu newid?'
- Teulu 3: 'Na, ma nhw'n reit hapus yn siarad, dyna pam ma nhw'n ista allan fama, be arall, ma nhw'n gweld pwy sy'n dod mewn ac allan, so ma nhw'n gallu busnesu ar hynna. Ma'n diwrnod hir!'

Beth yw eich profiad chi o rannu diwylliant â staff yn y cartref gofal?

Cwestiynau:

- A fyddech yn dweud eich bod yn rhannu'r un diwylliant â'r cartref gofal?
  - Teulu 2: 'Na, swn i'm yn feddwl.'
  - Teulu 3: 'Ymm, na yn wahanol.'
- A ydych yn credu bod gwahaniaeth neu debygrwydd rhwng eich diwylliant chi a diwylliant y cartref yn bwysig?
  - Teulu 2: 'Nacdw, nacdw. Achod ar ddiwedd y diwrnod yr unig beth yda chi isio, ma'n job eitha calad swn i'n ddeud, ma raid i chi gal dipyn o fynadd, yn enwedig efo rei.'
  - 'Felly da chi'm yn disgwyl iddyn nhw fod o'r un diwylliant a chi, hefyd? Jyst bod nhw'n rhoi gofal da?'
  - Teulu 2: 'Dwi meddwl be da chi isio mwya ydi amynadd, a deud y gwir. Da chi'n cal rhywun yn canu gloch, isio mynd i toilet bob pum munud, mae'n job de. A gwaeddi, 'dwisio panad!'
- Yn eich profiad chi, a allwch gofio unrhyw enghreifftiau lle bu camddealltwriaeth rhyngoch chi a staff yn y cartref gofal o ganlyniad i rwystr diwylliannol?
  - Teulu 2 & 3: 'Na.'

A oes unrhyw beth arall yr hoffech ei ychwanegu, neu ddweud mwy amdano?

Teulu 2: 'Jyst i neud y pwynt, sa chi'n gallu cal mwy o raglenni, DVDs, be swn i wrth fy modd ydi cal DVDs o fo a fe.. Ryan Davies i mi, odd y gora. Raglenni Gwyn Erfyl, a petha felly.

Teulu 3: ‘C’mon Midffild!’

Teulu 2: ‘Ia! ac y Tair Chwaer, dipyn o ganu a hwyl yn hwnna. Gymaint o betha felly sa nhw gallu neud - yn hytrach na gal y TV i ffwrdd. Ma’r bobol hyn yn licio petha o ‘stalwm. Jane Eyre - ma’n siwr sa nhw’n licio hynna’

Teulu 3: ‘Ma mam yn cofio petha o blynyddoedd yn ol. Di hi’m yn cofio petha o pum munud yn ol, ond blynyddoedd yn ol!’

Appendix 9.4: Example of Manager Interview Transcript (Manager B)

Language and Cultural Congruity in Care Homes - implications for Well-Being? Semi-Structured Interview with Manager

PRIFYSGOL BANGOR UNIVERSITY

Introduction, confirmation of identity, rehearse consent

1. **Biography**

   Tell me a bit about your background, and your work at the home

   Probes:

   - Where are you from, originally, and where have you spent most of your life?
     - ‘I’ve spent most of my life in Wales, my dad is Welsh, my mother is English, and they split up, so I’ve gone with my mother, so I don’t speak Welsh. I grew up in CRCR, which is not far. I sort of speak pidgin Welsh, as I call it, which is a little bit.. little phrases.’
   - How long have you been the manager at the care home?
     - ‘For three years, but I was an assistant manager before that, for ten years.’
   - How long have you worked in the care service industry?
     - ‘I’ve been in the care industry for over thirty-odd years. I started off in CRCR, and I’ve come here when I’ve started taking a lead.’

2. **Language**

   Tell me a bit about what language is mostly used in day-to-day life at the home?

   Probes:

   - How important is language at this care home?
     - ‘I think it’s very important. Most people whose memory’s not as good, they go back to their mother tongue. Now there’s not so much Welsh on the younger generation, but I think with the older ones, there is. I think it’s important. I’ve got certain catchphrases that I can converse in Welsh.

Anything too complex I'm a bit worried about, but I think it's very important that we keep it.'

- If you weren't able to provide Welsh-speaking care, what effect do you think that would have on the resident?
    - 'Well, it could confuse them more. It also could make them want to go home more, thinking they're somewhere foreign.'
- So it would make them feel less homely, really?
    - 'Yeah, it is, yeah. Also, to help them with their care, really - there's nothing worse than someone slightly confused and they can only think of the Welsh word for something that they want, and nobody understands, but here - I'd say the majority of the staff do have a good knowledge. If they don't feel comfy in speaking it, they do understand it.'
- What difference to the challenge of providing care (for the home as a whole), if any, do you feel that interacting with residents in their first language makes?
    - 'You know yourself, when you're memory's going poor, it's only slight words you remember, sometimes it's not connected to what they want but you kind of work it out, and usually, speaking both languages is really good.'
- If the staff is able to understand, but not speak Welsh - I know you do have staff members who do speak Welsh..
    - 'That's quite a large majority.'
- If interacting with the residents happens in the staff's second language, does this make much of a difference to the resident?
    - If we were in a setting, where you were having different nurses or different carers coming in - I think it would be more confusing, but I think they associate the face, and that's homely, and with [the carer] speaking back in English, or trying to speak a little bit of Welsh back, I think that helps, but the majority of the staff do actually speak Welsh.'
- Are there any operational procedures regarding the use of language at the home?
    - 'We follow the DDDDshire policy, a policy which has just been updated, I've got a meeting coming up in regards to the Welsh language, it's more to do with the paperwork side of things.'
- So it's enforced by people coming in, or..?
    - 'Yeah, it's by team managers coming down to my level, from the council, then it pans out to staff. I think there should be more of it, I still think there's a lot of people out there who need to speak Welsh.'
- Do staff have the opportunity to attend any particular training about language?
    - 'Yes, there's training. I've been on training. I found it.. I don't think I'm a person that knows languages, so I can follow what people are saying, but I cannot say it.. I don't know why.'

- But there's training available.. From the council?
    - 'From the council. I think they employ a college - they used to come and give lessons.'
- So would that be during the staff members' work hours?
    - 'Yeah.'
- So they wouldn't have to take time off work to do that?'
    - 'Well, it depends. Because they work shifts here, it could land on their rest day, but they'd get paid for it.'
- If yes, is this mandatory?
    - No.
- Have any staff members found it useful?
    - 'We've had some people that have.. We have 'spells' here. At the moment, nobody's interested. All of a sudden, one person's gonna be interested and then a lot of people are gonna try it, or want to take part in it.'
- So people have found it useful in the past?
    - 'Yeah. Well, I have, my assistant manager and myself have both done it, and I found it beneficial because, I didn't quite understand the mutations, and now, once it's explained to me, I now know what it is.'
- Are there any particular administrative challenges to operating the home in two different languages? For example, in what language are the care notes are written?
    - 'I do, in that I'm having trouble getting translations. I know DDDDshire has.. There's a lot of people who will do it in English, but there don't seem to be many who do it in Welsh, for the translation bit.'
- So if you had someone who could do it here?
    - 'It would be far better.'
- All the care notes here are written in English?
    - 'Yeah. We did have some of the care plans written in Welsh, but for some reason, and I don't understand why, lots of Welsh people like to read it in English. The choice is there - so far, people take up the English option.'
    - 'When I hand out brochure to families in Welsh, they always ask for the English one, and they like [to have] both of them.'

3. **Understanding Culture**

   Tell me a bit about how you would describe the local 'culture', and how important it is in day-to-day life at the home

   Probes:

   - What would you say the local culture is like?

    - ‘I think it’s quite Welsh, and the people we’re having in, it’s still quite ‘chapel’ and things like that.’
- And they’re quite rural slash market town?
    - ‘Yeah, it is very much like that.’
- A few of your residents, as well, are people who have retired to the area, I’ve noticed?
    - ‘Yes. Mostly, I find in DDDD, people tend to be born and bred, and if they’re not related, then they were in school with them, or family. There’s family ties.’
- That’s something that V’s son said - he likes having local people around him. What difference to the resident, if any, does having others around them who are from the same culture make?
    - ‘I think it’s good. And I think culture, upbringing and language, really - they’re all the same.’
- What difference to the challenge of providing care (for the home as a whole), if any, do you feel that having staff from the same culture as residents make?
    - ‘I think it’s easier. We’ve had, in the past - different nationalities working here, and it’s just, the way someone presents themselves. It’s hard to say without sounding racist. It’s a whole vibe, it’s a different thing - someone from a different nationality is totally different culture to someone from this area.It can be just as far as somebody who’s English, and people from Liverpool have come in, it’s totally, totally different. It’s the same as somebody from a city to here, I think the whole vibe, I suppose, is different, cultural.’
- So they would have less understanding of a local person’s priorities?
    - ‘I think so.’
- In your experience, can you recall any instances where there has been difficulty in the home providing care due to an issue of different cultural values or customs?
    - ‘The strong accent, I think. And the lack of words used. And people that are living here have slight problems with understanding them.’
- So that’s more of a communication thing. But, in terms of culture - in terms of what’s expected of the resident or what’s expected of the carer - have you found..?
    - ‘I don’t know how to word it ‘cos of the tape!’
- Well, it’s completely anonymous, remember, I can change the nationalities, or whatever.
    - ‘What we’ve found is that different nationalities are different, so you’ve got.. Poland, Russia - they’re quite aggressive in their manner.’
- Quite forthright, and strict to the residents?

- ‘Yes! And it’s a different culture, in that it’s they’re not as religious, and that.. I don’t know why, but it seems from what I’ve noticed. Then you have people from Thailand, and things like that, where they say ‘Yes’, but they don’t look like they understand what you’re saying.

- So they’re just saying ‘Yes’ to please you?
  - ‘Yes. I think I’ve heard some of the residents say that, ‘this person doesn’t understand me’. Some are brilliant - that’s just picking up the odd one or two who are really quite..’
- Have you ever had any problems with the residents expressing prejudice towards somebody because of their background?
  - ‘Yes. They are not politically correct, we’ve had somebody who was black, and that didn’t go down very well. I suppose it’s rural areas, things like that.’
- Was that agency, or..?
  - ‘Agency.’
- So by the sounds of it, it would be quite difficult to employ someone who was from a different culture on a permanent basis?
  - ‘I don’t know, because we’ve got IR here, who is.. I’d like to give him more hours but he wants to go into cooking, more. He’s done care here.’
- And where is he from?
  - ‘He’s from Thailand, I think.’
- So he doesn’t have a problem - his communication is quite good?
  - ‘He’s got great communication.’
- I suppose if you had somebody who was black and who was from the area, that wouldn’t be an issue.
  - ‘No. It’s not an issue with the care - it’s an issue with what [the resident] say. It’s not politically correct, and you cringe a little bit, and how they say things..’
- Are there any operational procedures regarding culture at the home?
  - ‘No.’
- Do staff have the opportunity to attend any particular training about culture?
  - ‘We’ve had some - but it’s mostly to do with.. DDDDshire did a drive towards people coming in - for asylum seekers, a big job fair. Nothing came of it, here.’
- So at that time, there was some kind of training about it?
  - ‘Yeah.’

4. Providing Congruent Care

Probes:

- Do you think that there is anything the care home could change in terms of language and culture to improve residents' life and care here, or is such a change unnecessary?
    - 'I think, looking around the building, I've not got enough bilingual signs around. I've got some, but I'd like to improve on that. If I have got them, they're ones hat we've done here and laminated. You can't get any that look [professional].
- But do you think that would improve the residents' lives?
    - 'Well, yes.'
- They's like to see [Welsh language signs]?
    - 'I think so, I think so.'
- Otherwise, you think the language and the culture, doesn't really need to be changed, because of the residents are quite happy with the situation?
    - 'This is the thing. I haven't heard anybody saying anything, but whether somebody is sort of thinking, 'well, I'm comfy here and I won't mention it', I don't know, but I think we've kind of got the balance.'
- That has to come from both sides - not just concentrating on the Welsh people, becuase also the English speakers - they've never had a problem with the bilingual aspect of the home?
    - 'Years ago, we had a bit of a problem, in that we had somebody that didn't speak any Welsh at all, and it was in the whole lounge was quite a lot of Welsh speakers, and they felt very isolated, in that they couldn't understand, it did impact on them. But now, we're kind of fifty-fifty, and I think most people are confident in speaking both languages now.'
- Do you think that implementing such changes [signs] would be easy to accomplish, or are there barriers that would make the task difficult?
    - 'It's quite difficult, 'cos I spoke to a company, they said they had a Welsh section, and in the Welsh section there wasn't really anything much there. It is quite difficult to buy anything.'
- So that's - where to go to the bathroom, shower, W.C., things like that?
    - 'Yeah. It's just - where the hairdresser's is, craft room.. So I tend to go for pictures, rather than actual writing, and that seems to.. I've got a barber pole at the moment, outside the hairdresser's 'cos I think it's more visual.'
- Do you feel that the home is supported by the local authority in providing a suitable linguistic and cultural environment for residents?
    - 'I think it's pretty good, I'll be honest with you. We've had local councillors coming in, which are very supportive in both languages, DDDDshire on the whole want to be seen as treating both languages the same.'
- Do you feel that the care home industry in general in supported by the governement in providing this environment?

- ‘I don’t think it’s very high [priority]. Because, we’ve got Welsh speakers here, who, perhaps, their needs have changed to nursing, or EMI - it is really, really hard to get a home that Welsh. It’s along the [less Welsh-speaking] coast, and it’s really difficult to get a home that’s Welsh-speaking.

- So when people’s needs increase - they have to go to areas where there’s less Welsh spoken?
  - ‘Yeah, they move them. It’s very hard to get [a] nursing or EMI [home] in the DDDD area, or the surrounding areas, it’s quite far away, and you’re moving people away from their culture, then, aren’t you?’
- And is that something that families mention, in particular?
  - ‘All the time. I think that someone has gone as far as PFPF, CDCD. It’s far for them, they think of it as going over the hills. In RRRR, which is just twelve miles away, there isn’t any [Welsh].’