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What Makes A Nursing Home Homely? A Scottish Based Study, Using Q Methodology of the perceptions of Staff, Residents and Significant Others.

## **Introduction**

The aim of this paper is to report on a part of a larger doctoral study in Scotland, exploring stakeholder perceptions of what constitutes a homely environment. This issue is of relevance because of past and current National Care Standards (Scottish Government, 2002/2007) recommending that all care home providers should provide a homely environment for their residents. The Task Force for the Future of Residential Care in Scotland (2014) outlines three types of accommodation being at the heart of the development of the residential sector over the next 20 years:

- 1) An evolution and expansion of the extra-care housing sector
- 2) A residential sector focused on rehabilitation and prevention
- 3) A smaller more specialised residential sector delivering high quality 24-hour care to people with substantial care needs.

The Task Force (2014) highlights that older people are not a homogenous group and therefore care provision must reflect cultural, racial and lifestyle diversity. The report goes on to state that residential facilities should not be developed in isolation from the communities they serve. For this reason the Task Force recommendations include the concept of 'Place-making' – which is defined as the provision of personalised care in a physical environment that supports individual preference. However these recommendations come with little guidance on what is meant by 'homely' in relation to the nursing/care home environment. Similarly the Scottish Government's *Health and Social Care Standards: My*

*Support, My Life* (2017: 14) which replaces the National Care Standards (Scottish Government, 2002/2007) and comes into effect in 2018, states that individuals will experience a homely environment. Again there is little definition of what constitutes a homely environment; however some of the descriptive statements used to underpin these standards resonate with the opinions held by the participants in this study.

The main study had three research aims:

- 1) To develop an understanding of what is meant by 'homely' in the care home environment.
- 2) To explore if a 'homely' care home is a priority in the expressed needs and wishes of residents, staff and the relatives who visit care homes.
- 3) To explore what features, if any, contribute to the creation of homeliness in the care home environment.

Due to the volume of work regarding dementia friendly design, it was decided to restrict the study to the views of frail older people, their relatives and care home staff. This is pertinent today as Green et al (2017) report the increasing frailty of new care home residents and their increased support needs.

## **Methodology**

A mixed methodology design was approved by the West of Scotland Research Ethics Committee. This consisted of a narrative literature review, the Sheffield Care Environment Assessment Matrix [SCEAM] (Barnes et al, 2003) and Q methodology (Stephenson, 1953; Brown, 1993; Watts and Stenner, 2012). The results from the literature review can be found in Fleming and Kydd, (2017) and a short explanation of the SCEAM (Barnes et al, 2003) is provided below for information. But the main thrust of this paper is to report on the design,

implementation and the results of the Q Methodology, which sought to find out what stakeholders perceived a homely care home to be.

### *Sheffield Care Environment Assessment Matrix (SCEAM)*

The SCEAM (Barnes et al 2003) was selected as it was designed in the UK specifically for measuring use of rooms and building design in care homes. *The Multiphasic Environmental Assessment Procedure (MEAP)* (Moos and Lemke, 1996) and the *Therapeutic Environment Screening Survey for Nursing Homes (TESS-NH)* (Sloane et al, 2002) were considered, but rejected as the MEAP (Moos and Lemke, 1996) published in 1996, pre-dated the care standards (2002) and the TESS-NH (Sloane et al, 2002) was developed in another country (Canada) which may have presented problems in use of terminology. More recent building assessments are available, but have either been developed for specific environments such as hospices (Kader, 2017) and dementia friendly care environments (Waller, Masterson and Evans, 2017), or are more general such as *The Built Environment: An Assessment Tool and Manual* (National Centre for Chronic Disease Prevention and Health Promotion (2015)).

The SCEAM (Barnes et al, 2003) was developed as part of a study assessing the impact of the built environment on the quality of life experienced by the residents of residential and nursing homes. The review of the literature in this study did not find a single assessment tool that would measure all aspects of the desired elements of building design. In the Barnes et al (2003) study, the desired building elements in the SCEAM (Barnes et al, 2003) were developed from literature, analysis of the regulations and standards that apply to care homes, and discussions with the people involved in the design and running of care homes. Over 300 elements were identified, and allocated to one of ten resident domains of interest or one staff domain of interest. The resident domains of interest were clustered

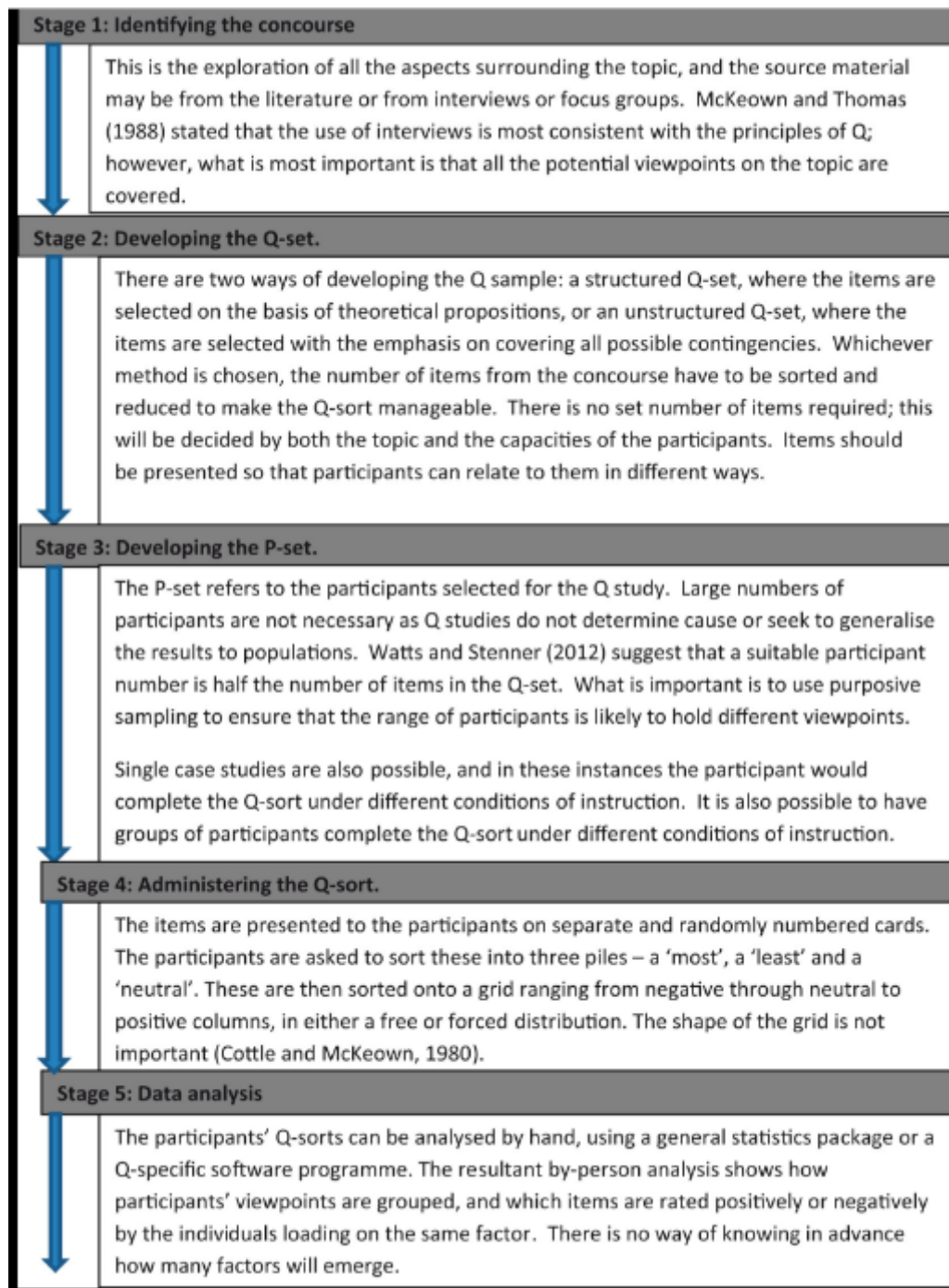
into three groups: universal, physical and cognitive. Suffice to say, this assessment, yielded a score which allowed the differences between design and use of the built care home environment to be discovered.

### *Q methodology*

Q methodology is considered suitable for establishing, analysing and reporting on viewpoints, attitudes and perceptions of different stakeholders concerning a specific topic (Watts and Stenner 2012). Q methodology uses a prescribed process, which is illustrated in Figure 1 and typically utilises statements from stakeholders. These statements are then used in a card-sorting task in order to explore patterns of individuals' thinking/feeling/attitudes surrounding the topic area. The following advantages of Q methodology are:

- Participants are involved in devising the items (the concourse) for the card-sorting task.
- Lack of response, as may be found with surveys, is not anticipated due to the interactive nature of the participation.
- Rather than the rating of a Likert scale, participants in Q methodology are asked to rank items in relation to each other, producing a hierarchical ranking.
- Q methodology is viewed as being appropriate for complex issues, as it facilitates the identification of similarities, the construction of broad categories or dimensions of the phenomenon being investigated and the exploration of patterns and relationships within and between these dimensions (Shinebourne and Adams, 2007).
- Q methodology is reported to facilitate groups of people who may be reluctant to complain.

FIGURE 1. Stages of Q methodology.



## Method

In this Q methodology study there were two groups of participants: the first group (from 2 x statutory sector, 2 x private sector and 2 x third sector providers) who completed the

interviews which contributed to the statement development ( $n = 16$ ), and a second group of participants ( $n=16$ ) (2 x statutory, 2 x private and 1 x third sectors homes) formed the Q-set (4 residents, 5 staff and 7 relatives). All participants were recruited using a convenience (local to the lead researcher), snowball sample (participants recommended others to speak to). Following the advice contained within Watts and Stenner, (2010), Brown, (1993) and McKeown and Thomas, (1988) that Q-methodology is biased towards low person samples due to its intensive orientation, a P-set size of  $n=16$  was determined as shown in Table 1. An initial invitation to participate in the study was made by letter, and this was followed up by a phone call. The lead author met with participants to explain the study, who were then given two weeks to consider whether or not they wished to participate. At each stage of the study participants were reminded that they could leave the study at any time without penalty and this served to ensure ongoing consent to participation.

TABLE 1 Actual P set ( $n = 16$ ).

Care home provider	Type	Relative/carer	Resident	Staff	Total
Statutory sector	2 × Purpose build	1	1	2	4
Third sector	1 × Conversion	1	3	2	6
Private sector	2 × Conversion	1			1
Associates		4	1		5
Total	5	7	5	4	16

### Development of the Q set

In this study, concourse development (see Figure 1) began with the identification of eight key themes from the literature and standards. This served to ensure full coverage of the subject area, using themes from the literature to prompt interview questions with participants. The interview responses, the eight themes from the literature review and the

domains from the SCEAM (Barnes et al, 2003) were used to develop the concourse which was then thematically analysed into twenty-two free nodes using NVivo v9.1. Tables 2 and 3 show how the statements relate to the literature review, environmental assessment domains and free nodes generated from the interviews. In this way the three areas of investigation (the literature, the SCEAM (Barnes et al, 2003) and the interviews) served to make up the 30 statements.

TABLE 2. The development of the Q-set 1-15

No.	Statement	Relates to free node from interviews	Relates to environmental assessment domain	Relates to literature review
1	Keeping up my interests	Activities, settling in, male needs, what makes a care home homely	Choice and control, physical support, cognitive support	Home as space, home and identity, specific rooms
2	Doing new things	Activities, what makes a care home homely, emotion	Choice and control, community, awareness	Home as space, home and identity, specific rooms
3	Being in the same neighbourhood	Care home selection, what makes a care home homely, power	Choice and control, community	Home as place, home and identity
4	Choosing the home after visiting it	Care home selection, what makes a care home homely	Choice and control, community	Home as place,
5	Being involved in planning the future	Power, what makes a care home homely	Choice and control, physical support, cognitive support, safety and health	Home as place, homeliness
6	Knowing what's happening	Power, what makes a care home homely	Choice and control, awareness, community.	Home as place, homeliness
7	My wishes are respected	Power, staff attitude, activities, what makes a care home homely	Privacy, choice and control, comfort	Homeliness
8	Staff are there for the whole family	Staff attitudes, what makes a care home homely, settling in	N/A	Homeliness
9	Staff take time to talk with me	Staff attitudes, what makes a care home homely, settling in	N/A	Homeliness, home and identity
10	Feeling comfortable	Emotion, power, staff attitudes, environmental control, what makes a care home homely	Comfort, personalisation, privacy, normalness	Home as space, homeliness, home and identity
11	Feeling there are people to talk to	Compatibility, connections, emotion, what makes a care home homely, settling in	Choice and control, community, awareness	Home as place, homeliness, home and identity
12	Having peace and quiet	Spirituality, what makes a care home homely, connections, compatibility	Privacy, choice and control, comfort	Home as place, the outdoors, home and identity
13	Feeling part of a community	Connections, compatibility, role, what makes a care home homely	Community, choice and control, awareness	Home as space, the outdoors, home and identity
14	Being able to see what's going on	Outdoors, connections, favoured design features, what makes a care home homely	Awareness, safety and health	Home as place, design features, the outdoors
15	Being in a fresh, clean environment	Hotels, favoured design features, what makes a care home homely	Comfort, safety and health	Design features, home and identity, homeliness/domesticity

TABLE 3 The development of the Q-set 16-30



No.	Statement	Relates to free node from interviews	Relates to environmental assessment domain	Relates to literature review
16	Having good food	Hotels, food, quality of life, what makes a care home homely	Choice and control, comfort, physical support, cognitive support	Homeliness, homeliness/domesticity
17	Keeping up my own routine	Power, staff attitudes, quality of life, what makes a care home homely	Choice and control, privacy, community, awareness	Home as place, home and identity, homeliness/domesticity
18	Feeling the staff are able	Quality of life, staff training, staff attitudes	N/A	Homeliness
19	Having big rooms	Favoured design features, quality of life, possessions	Privacy, personalisation, comfort	Design features, home as space, dementia design
20	Having own things around	Possessions, favoured design features, what makes a care home homely	Personalisation, cognitive support	Home as place, homeliness, homeliness/domesticity, home and identity, dementia design
21	Being seen as an individual	What makes a care home homely, staff attitudes, staff training	Personalisation	Home as place, homeliness, home and identity
22	Feeling at home	What makes a care home homely, quality of life	Privacy, personalisation, choice and control, normalness	Home as space, homeliness, the outdoors, home and identity
23	Being able to be myself	What makes a care home homely, quality of life	Choice and control, personalisation, physical support, cognitive support	Home as space, homeliness, the outdoors, home and identity, homeliness/domesticity
24	Getting outdoors	Settling in, outdoors, role, spirituality, male needs, what makes a care home homely	Choice and control, physical support, cognitive support, awareness	The outdoors, home as space, design features, dementia design
25	Being included	Settling in, activity, role, connections, what makes a care home homely	Awareness, community, choice and control, safety and health	Home as space, home and identity
26	Complaints are dealt with	Concerns, power, staff attitudes, staff training, standards	Cognitive support	N/A
27	Rules can be bent	Connections, power, emotion, settling in	N/A	N/A
28	Seeing the same faces each day	Connections, emotions, settling in	Awareness	Home as place, home and identity
29	Offering refreshments to visitors	Connections, emotions, power	Community, normalness	Homeliness, home and identity, specific rooms
30	Open visiting hours	Power, emotion, settling in, connections	Community	Homeliness

Brown (1993) states that although statements are derived from initial categories, it is rare for any statement to be exclusive to only one category. The statements developed for the Q-set in this study (n= 30) were found in a minimum of two free nodes and a maximum of five free nodes following analysis of the interviews. The number of statements chosen was arbitrary, however when thinking about the population from which the participants (P-set) would be drawn, it was important to keep the Q-set small. Following a pilot study participants were asked to rank the statements under the condition of instruction “What is most important in making a care home homely?” and “What is not most important in

making a care home homely?”. The Q-sorting grid used a plus three to minus three scale for responses (see Tables 5, 6 and 7.)

Appointments were made to complete the Q-sorts at the participant's convenience, and took place in various venues within the nursing/care homes, and in some relatives' houses. The average time taken to complete a Q-sort was 75 minutes.

## **Results**

The results have been presented under headings from the different parts of the study:

### *Results from the literature review*

The review, published earlier (Fleming et al, 2017) sought to critically appraise the existing literature with regard to the design of 'homely' nursing/care homes. Mallet (2004) acknowledges that homeliness is a 'multiconceptual' issue, and is critical of many studies for being uni-disciplinary in nature, and focusing only on one issue. Whilst Mallet refers to the 'dream home', 'actual home', 'ideal home' and 'haven', the lead author of this paper found that themes from the literature consisted of:

- home as space (Sinha and Nayyer, 2000; Cutler and Kane, 2005);
- home as place (Fitzgerald and Robertson, 2006; Zborowsky and Kreitzer, 2009);
- design features (Dickinson, Shroyer, Elias et al, 2001; Barnes, 2002);
- homeliness (Mallet, 2004; Shenk, 2004);
- home and identity (Lipsedge, 2006, Lees-Maffei, 2008)

- dementia and nursing homes (Low, Draper and Brodaty, 2004; Wilkes, Fleming, Cioffi et al, 2005), and
- specific rooms (McDaniel, Hunt, Hackes et al, 2001; Nagy, 2002).

Throughout the literature there was a great deal of complexity and uncertainty surrounding how to achieve a homelike environment. The default position appeared to be that a place was 'homely' if it was not institutional and was small in scale (Lundgren, 2000; Calkins, 2009).

#### *Results from the SCEAM*

The SCEAM (Barnes et al, 2003) was used to quantify the characteristics of the building to assist with exploring what features of the care homes if any, contributed to the creation of homeliness in the care home environment. The six care homes were evaluated. The features which most supported homeliness were, in descending order, those which supported personalisation; safety and health; privacy, community, comfort and awareness. The features which were least supportive were those of choice and staff accommodation.

#### *Results from the Q Methodology*

Data analysis using PQMethod Version 2.2 (Schmolck, 2011) was carried out: three factors were extracted using a centroid analysis and a varimax rotation. The outcome of this is shown in Table 4. This solution explained 52% of the common variance.

Outcome	Q sort(s)	Q sorters	Identifier
Confounded	9	1 × Relative (female)	Rel 1/6
Non-significant	4, 7, 15	1 × Resident (female)	Res 1/6
		1 × Resident (male)	Res 2/6
		1 × Relative (female)	Rel 4
Factor 1	3, 6, 10, 13	1 × Staff (male)	S1/1
		1 × Staff (female)	S1/6
		1 × Relative (female)	Rel 1
		1 × Relative (male)	Rel 3
Factor 2	2, 5, 11, 12, 14	1 × Resident (female)	Res 2/1
		2 × Staff (female)	S1, S2/6
		2 × Relative (female)	Rel 1/1, Rel 1/4
Factor 3	1, 8, 16	1 × Resident (female)	Res 1/1
		1 × Staff (female)	S3/6
		1 × Relative (female)	Rel 2

TABLE 4. A 'best' solution.

It was not the individual statements themselves that developed an understanding of what is meant by 'homely' in this study, but the factor arrays that derived from analysis of the participants' Q-sorts. These factor arrays described the placement of each statement in that factor (and it could be traced back to which participant had placed it) which expressed the viewpoint contained within the factor. These factor arrays had to be interpreted, named and a short factor descriptor developed. It can be seen from the factor arrays below (Tables 5, 6 and 7), that there were three viewpoints attached to what was meant by 'homely' by the participants in this study. While there were similarities in some statement placements between the three factors, there were also significant differences.

Factor 1 consisted of Q-sorts 3, 6, 10 and 13, which had an Eigenvalue (EV) of 5.97 and explained 37% of the common variance. Factor 1 was given this descriptor of *Standards Driven* as a number of the highly valued statements could be found in the National Care Standards (Scottish Government, 2007). Examples include 'Being in a fresh, clean environment', 'Knowing what's happening' and 'Having good food'. In this factor, many of

the more neutral and lower ranked statements were concerned with interaction and individual choice for example, 'Choosing the home after visiting it', 'Keeping up my own routine' and 'Being included'. It is of interest that no residents shared this viewpoint; however it was unsurprising that staff did because these care standards inform the service staff deliver and are used to measure their performance.

TABLE 5. Factor 1 array.

Not most important						Most important
-3	-2	-1	0	1	2	3
8	10	1	2	6	7	15
11	25	3	4	14	12	22
	27	18	5	16	20	
	28	21	9	19	23	
		30	13	26		
			17			
Table 5. Factor 1 array			24			
(Standards driven)			29			

Factor 2 consisted of Q-sorts 2, 5, 11, 12 and 14 which had an EV of 1.26 and explained 8% of the common variance. Factor 2 was given the descriptor of *Making the Most of It* as the most important statements were about participants being actively involved with their environment. Examples include, 'Keeping up my interests', 'Being able to see what's going on' and 'Getting outdoors'. Lower ranked statements were more related to the standards, and there was less emphasis on individuality compared to feeling part of the home as a whole. Staff, residents and relatives shared this viewpoint.

TABLE 6. Factor 2 array.

Not most important						Most important
-3	-2	-1	0	1	2	3
6	3	9	2	5	4	1
10	11	17	0	8	22	14
	27	18	12	15	23	
	28	25	13	19	30	
		29	16	24		
			20			
Table 6. Factor 2 array			21			
(Making the most of it)			26			

Factor 3 consisted of Q-sorts 1, 8 and 16 which had an EV of 1.13 and explained 7% of the common variance. Factor 3 was given the descriptor of *A Sense of Belonging* as the two most important statements were 'Being seen as an individual' and 'Feeling at home'. The rest of the distribution was interpreted as individuals picking and choosing what things they wished to do, such as 'Doing new things' while maintaining established routines such as 'Offering refreshments to visitors' and valuing familiarity with the home – 'Seeing the same faces every day'. There was less emphasis on feeling part of the home as a whole. Again, staff, residents and relatives shared this viewpoint. This factor resonates with supporting statement 1.20 in the National Health and Social Care Standards (2017) which states '*I am in the right place to experience the care and support I need and want*'

TABLE 7. Factor 3 array.

Not most important						Most important
-3	-2	-1	0	1	2	3
8	3	6	4	1	15	21
25	13	7	5	2	23	22
	24	9	11	14	26	
	27	10	12	16	29	
		18	17	19		
			20			
Table 7. Factor 3 array			28			
(A sense of belonging)			30			

## Discussion in relation to the results

The findings from the data analysis of the Q-sorts are discussed in relation to the research aims below.

*Research Aim 1: To develop an understanding of what is meant by ‘homely’ in the care environment.*

The staff group of participants were evenly spread over the three factors, while the resident group of participants were spread over Factors 2 and 3 only. Interestingly, three staff participants from the same care home each loaded on a different Factor. This could be viewed as a positive indicator for that care home. The fact that the staff both held and expressed different opinions about homeliness despite being all female, of similar age, and having a similar length of caregiving experience suggests that this care home encouraged individuality, rather than institutionalisation in the staff group. Such individuality assists in the avoidance of ‘total institutionalisation’ described by Goffman (1961) as having three main features: collective or communal living, isolation from the wider community and being forced to live to a set of enforced and formal rules.

The literature review demonstrated that defining 'homely' is a difficult task, due to the dynamic nature of the concept, the changing patterns of use of the home, and the varying models of family living. Rybczynski (1986) describes how the concept of home changed from that of a communal place of shelter for both people and livestock in the Middle Ages, to a domestic environment for family units. Similarly he describes the changes in patterns of family living over the centuries from the home being primarily a female domain, where children were cared for, to a place of both work and domesticity. There was more agreement in the literature concerning what was considered homely in the care home environment, but often these studies looked at only one particular aspect of the care home, such as the use of communal areas (Hauge and Heggen, 2007; Olin and Jansson, 2008). These communal areas are particularly challenging in fostering a homelike environment as the residents of a care home may span more than one generation, have different levels of dependency and have conflicting ideas as to what constitutes homeliness. Decor for communal areas is often decided by consensus, potentially meaning that no one is actually pleased with the outcome. Also, residents generally keep their personal possessions in their own rooms, so the communal areas can reflect a lack of personal meaning such as might be found in the communal areas of a household. Some care homes have tried to overcome this problem by adopting different styles in different communal areas or in different units of the same facility. An example of this is Hogewey in the Netherlands, which is built on a village model with houses reflecting the styles of different decades.

*Research Aim 2: To explore if a homely care home is a priority in the expressed needs/wishes of care home residents, staff and relatives.*



The findings clearly demonstrated that 'Feeling at home' was considered to be important to all of the participants in this study. This statement was ranked most important in Factors 1 and 3, and second most important in Factor 2.

Heathcote (2012:7) asserts that the very idea of home is so linked with one's identity that it is almost inseparable from one's being: that it is an individual's base, one that provides permanence and stability from which to build a life within and around it. Bachelard (1994:4) states "our house is our corner of the world". Both these definitions suggest that there is a sense of belonging attributed to the definition of home. For this reason Factor 3: 'A Sense of Belonging' is the key finding relating to this research question. Factor 3 was produced from the Q-sorts of one resident, one staff member and one relative, so can be said to be small, however Brown (1980:192) states that a Q methodology study requires only enough participants to establish the presence of a factor and to allow comparison between one factor and another.

The relevance of Factor 3: 'A Sense of Belonging' to this research question was supported by examining the underpinning themes behind the statements ranked as most important to the participants (statements 21 and 22), which included 'Home as Place'; 'Home as Space'; 'Homeliness' and 'Home as Identity'. Other high-ranking statements supported the view that the balance of power between staff and residents should be equal, as these participants valued retaining their own identity, participating in activities (new and old) in either an active or passive way (statements 2, 10, 11 and 29,) while knowing that the environment was supportive (statements 15, 26 and 28). It did not matter to one female resident that she, herself, was not keeping the environment clean nor offering refreshments, only that these features were present. This is similar to a householder having repairs or decoration carried out, rather than he or she doing it themselves.

The results suggest that satisfaction with standards of care had to come first, but that only meeting the standards of care was not necessarily enough, as demonstrated by extracts from the interview transcripts of the following relative:

*Rel 2/1: "But eh, so, the home was clean, it was tidy, there was no untoward smells. Eh, that was it, when we talked to people in the home, they seemed happy. And I think that's quite a good gauge. It's all very well saying 'Oh, here's a report from the Care Commission, here's this, here's that.' I worked in the Health Service for twelve years in quite a senior post and eh, commissions and eh, things look at, they've got a checklist to check, they'll check the checklist and yes they do go round other fringes: but a checklist can, if you know there's going to be an inspection, and you know what the inspection is going to be on, that's what you'll concentrate on to pass the inspection."*

This extract expressed a cynicism, or suspicion, about the standards. It was clear that this relative wanted to believe that the standards of care for their relative were there, but that over and above that they required a friendly or warm environment. None of the 'significant others' used the word 'homely' to describe what they were seeking, but it is clear that the attitude of the staff, and the relationships between the staff and residents were equally as important, if not more so, than a fresh, clean environment or a feeling that the staff could demonstrate competence.

None of the residents who participated in the study had visited the home before choosing it. One female resident had a 17 year long relationship with the care home as her husband had been resident in it, so she had not looked at anywhere else. Two other residents had previous experience of the care homes they were in,

and also had not looked anywhere else. Only one female resident stated she was not given any choice about giving up her home, this was because she had been ill at the time her family had chosen the care home for her.

For other participants the expectation for more than just standards of care came through their sorting strategy, as explained by the following extract:

*Rel1: "Top 4, out of these, OK. It's funny how these are all quite important. See I think if you get these right, then this will happen. If that makes sense? So 'being seen as an individual' em, 'being included' , 'Being involved in planning the future', 'being in a fresh, clean, environment' has to be very important, although eh, it's a completely different point to the rest of these, I still think at this point that's important."*

For the participants using this logic during their sorting strategy, if they felt at home, it followed that the environment was satisfactorily clean and fresh; there was good food and there was a positive relationship with others in the building.

Fitzgerald and Robertson (2006) and Robertson and Fitzgerald (2010) explore the relationship between a management approach ('corporate, organised, uniformed, task orientated' or 'more relaxed, no uniforms') and ambience and describe the creation of ambience within the care home as a complex interplay between the physical and social environments. They particularly highlight the interplay between the physical building and the management approach in the creation of a home like or hotel like residence and the different patterns of behaviour resulting from this interplay. Yet, as the care home

population are becoming increasingly frail on admission and in care (Green et al, 2017) it would be timely to add 'a hospital like' residence.

It is interesting to observe the findings in a paper by Wiles et al, (2011) where the team pointed out the resilience of the frail old as they negotiate and renegotiate their circumstances in order to give themselves a place in which to age. We argue this could be at home, in a 'homelike', 'an hotel like' or 'a hospital like' environment. The key is where the individual feels they *belong* in order to feel safe and secure and this is the essence of ageing in place.

*Research Aim 3: To explore which features, if any, contribute to the creation of homeliness in the care home environment.*

As suggested by the literature review, key features appeared to be the view from the windows, the size of the rooms, being able to get outdoors and to be able to provide refreshments to visitors. Opinion on these was however divided among the participants in this study. Some participants reported room size to be very important while others reported this as not important at all. This appears to be dependent on whether or not the care home was regarded as home, or the individual's room was considered home. Examples from the transcribed interviews and Q-sorts are provided:

*Rel2/1: "No! [emphatic] I don't think her room is her home, I think the home is her home, because she spends time in her room every day, but she spends time in the lounge talking to other people. Or she goes out, or she goes downstairs to the general rooms and she does her yoga, she does her keep fit, she does her singing for*

*her memory, she does reminiscing, there's all those things. It's all part of the home. I think if you say "yes your room is your home", you might as well make them cells, and lock them up in their own little private cell. And say "That's your home, in you go, bye-bye. I'll put your food through a slot in the door."*

*Rel1/4: "I think, I think of her flat as being her home; the whole space, no. I can't honestly say that and I'm not being derogatory about the home, but no I actually think it's her flat, as we call it, is more her home for her. Outside of that, then that's where the atmosphere and everything happens, and it has made it a better home for her. But I think it's her wee flat that's made it for her."*

From the participant responses, room size seemed to become an issue when the individual's' room was viewed as the entirety of their home, and if this was the case then 'Having big rooms' was of greater importance. It could perhaps also relate to the functionality of the room: smaller rooms are rapidly dominated by assistive equipment such as walking aids, hoists and wheelchairs, reducing the 'usable' space, detracting from the effects of personalisation and presenting a more clinical appearance. Overall 'Having big rooms' ranked at +1 in all the factor arrays (a consensus statement) suggesting that large rooms in a care home environment are quite highly regarded.

The daughter of one resident reported that an en-suite was one of the things she had thought she would insist on when choosing a care home for her mother, but in fact her mother felt it was of no importance to her at all. This difference in desire for an en-suite may be a reflection of what people have been used to, and therefore may indeed be influenced by age. Residents in their eighties and nineties may not have any expectation of an en-suite bathroom.

Statement 14, 'Being able to see what's going on' elicited several responses involving windows, which facilitated being able to observe activity within the care home, as well as external events. Windows were also seen as important because they permitted natural light:

*Res2/1: "Being able to see what's going on'. Oh yes, I suppose that's a very important thing."*

*Rel1/1: "My Mum's got a lovely room, looking out to the garden..."*

Some statements provoked more response than others. For example, statement 29 'Offering refreshments to visitors' provoked some interesting discussion about kitchen provision. Whilst many participants were happy that staff offered refreshments on the residents' behalf, some participants thought it would be a good thing if there were basic kitchen facilities available to those residents who could use them. Other participants felt that the provision of kitchen facilities was too much of a health and safety risk. In an Irish study, Morgan-Brown, Newton and Ormerod (2013) suggest the development of a Homemaker role as being a means of creating a more homelike environment. This role provided a consistent staff presence in the communal areas and the post holder was expected to engage directly with residents, and to carry out cleaning and cooking duties in these areas. There is a risk however that the creation of this role would encourage staff to see homemaking as the role of one person, in the same way that the role of Activities Coordinator can lead to staff feeling empowered to be task driven. Perhaps these roles, Homemaker and Activities Coordinator, should include a champions element as the Champions model has been used successfully in many areas of healthcare, for example dementia (NES, 2011), arthritis (Arthritis Research

UK) and compliance with personal protective equipment (Hennessy and Dynan, 2014). The successful creation of a Homemaker role would assist in meeting the new Health and Social Care Standards (Scottish Government, 2017), particularly the supporting statement 1.38 *If appropriate, I can choose to make my own meals, snacks and drinks, with support if I need it, and can choose to grow, cook and eat my own food where possible.*

Overall, those who loaded on Factor 3: 'A Sense of Belonging' felt it was important to be able to offer refreshments to visitors, those participants loading on Factor 2 did not, while those participants loading on Factor 1 had less strong opinions. This suggested that being able to offer refreshments to visitors added to 'Feeling at home'. Again, some examples of these responses are provided:

*Rel2: "..... And I'm definitely neutral about refreshments for visitors, they can bring their own."*

*Res1/1: "Well the visitors can go and help themselves in here. I mean they don't allow us to make cups of tea, I mean we might scald our hands or something and then the carers would get into trouble. [Talks about female resident who does this] They can go and make themselves cups of tea and for me as well."*

There were no indications in the factor loadings that the design of the care home impacted on what the participants considered to be 'homely' features. Participants from a purpose built care home loaded on the same factors as those from a converted care home. The influence of the organisation appears to have been negligible also, as the purpose built care home was run by the Local Authority and

the converted care home by the third sector. No participants were recruited from the private sector at the Q-sort stage of the study, and it would have been interesting to see if this would have made any difference to the results. The fact that those participants with no affiliation to any particular care home loaded on different factors suggests that the inclusion of a care home from the private sector may not have altered these findings.

### *Limitations*

Whilst Q methodology was extremely effective in overcoming participants' potential reluctance to complain as reported in the literature, it did have limitations. While this methodology clearly captured three viewpoints from the participants Q-sorts, this does not mean that other viewpoints cannot be held. Additionally, the viewpoints obtained were only a snapshot in time as indicated by the following quote from one of the participants:

*Res2/6: "A different time I might have sorted them a bit differently."*

Longitudinal studies using Q methodology acknowledge this point, and have been used to discover what event/experience has brought about the change in viewpoint. It may have been useful to broaden the participant groups, to include commissioners, inspectors and design professionals. The inclusion of these groups may have provided a more complete coverage of the potential viewpoints held about the features which make a nursing/care home homely, or may have reinforced Factor 1: Standards Driven as being the strongest factor present.

### **Conclusion**



Home is an emotive word and homely conjures up different things to each individual. The authors suggest that Factor 3: A Sense of Belonging best encapsulates what makes a care home homely. This underlines the importance of the concept of ageing in place. To feel a sense of belonging implies that individuals feel they are in the right place, at the right time, and that they are safe, secure and socially connected and this will, owing to the increased frailty of care home residents, be in relation to their state of health.

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