EXPLORING THE CULTURAL SENSITIVITIES OF UK CARE HOME SERVICES TO THE OLDER NIGERIAN RESIDENTS

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EXPLORING THE CULTURAL SENSITIVITIES OF UK CARE HOME SERVICES TO THE OLDER NIGERIAN RESIDENTS

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Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is my own work.

Any ethical clearance for the research presented in this thesis has been approved. Approval has been sought and granted by the Northumbria University Ethics Committee. Date of original ethical approval -16/5/2017. Date of amendment request-21/02/2019.

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Abstract

Background: The older black Nigerian population in the UK has increased during the 20th century due to a combination of longevity and migration. As a result, the issue of preparedness of care home services to meet the needs of frail, ill and disabled individuals from a minority ethnic population is increasingly important.

Quality service provision includes acknowledging ethnic diversity, thus ensuring culturally-appropriate care for all older people, regardless of ethnic minority status. Few studies have investigated cultural sensitivity in care homes and also no study has been carried out in relation to cultural sensitivity to older Nigerians. This study aimed to explore the cultural sensitivity of English care home services to older Nigerian immigrants and examine practices and approaches within care home services to address the individual needs of residents and their families, and how those practices and approaches influenced the provision of culturally-sensitive care.

Methods: This study explored the sensitivities and barriers of using care home services by Nigerian older people through a constructionist framework. Four care homes and 19 participants took part in the study. Among these participants 7 were residents and 12 were care staff or managers. Two interviews were conducted. The first interview involved the use of semi-structured interviews for both the residents and staff, and focus group interviews with care staff and their manager, to investigate and gain in-depth understanding and insight on the cultural sensitivity of care home services to older Nigerians. The second interviews involved the use of semi-structured telephone interviews as a follow up to get more in-depth understanding on unanticipated responses and obtain nuanced answers which were not explored when the initial responses were received.

Findings: This study has provided a more nuanced understanding about culturally-sensitive practice in the care home. Findings revealed that some care homes were more culturally sensitive than others. It was revealed that these care homes were practicing under the synergistic and participatory stage of cultural awareness. Under the synergistic stage of cultural awareness, most of the staff were aware of the cultural differences amongst themselves and the residents, and they embraced this and chose the best way to provide for their cultural needs. This was either their way or that of the resident. Under the synergistic stage they sourced ideas from families, fellow staff and social workers. Some of the ideas were cooperative working, ongoing assessment, integrating with families, and extension of their roles. They used ideas and insight from staff of a similar background to the resident in core areas such as dietary needs, resulting

in staff working part-time in the kitchen to make ethnic food for the residents due to a lack of skills from their chef to prepare diverse cultural cuisine. To keep residents happy and active, some care homes incorporated celebration of significant dates such as each resident's independent day. Initiation of culturally-appropriate greetings were used as a mark of respect as well as an avenue to create trust in order to facilitate assessment of culturally-appropriate needs. Meanwhile, the participatory stage, which some of the care staff fell into, showed how they worked together with people of different cultures (care staff) to create a culture of shared meanings through teamwork and meetings. From the resident's perspective, it was found that their daily lives involved getting by and surviving or living passively, but they acknowledged that staff are commendable in some aspects of their everyday life. Also, some residents were reticent in disclosing their needs to staff, as they assumed that the staff are already aware. As a result, some of the care staff worked hard in finding out these needs. However, all care homes had some work to do in being culturally sensitive.

Conclusion: The research showed that services needed to improve to meet the key cultural needs of their diverse residents. Findings in this study revealed that care home staff might be culturally aware, but not culturally sensitive, and as such are not culturally competent. Research focused on cultural sensitivity in care homes is still at an early stage of development and therefore requires further elaboration. This study is however beneficial to understanding the needs of older Nigerians living in care homes and offers an insight into the existence of diverse needs for people from other ethnic minorities.

Contents

Chapter 1

1.1. Chapter overview

This study explores cultural sensitivity to the needs of older Nigerians who are living in an English care home. The introduction highlights the relevance of this topic to an ageing multicultural society. Within this introductory section, trends relating to the research problem are discussed, and the motivation for carrying out this study are presented. Following this, a brief description of how my personal experiences contributed to researching this topic is presented. The final section of this chapter provides an overview of the structure of the thesis.

1.2. Introduction

A diverse, multicultural population has become a defining feature of modern British society (Le Var, 1998; Panayi, 2014), which is a result of immigration-related factors (ONS, 2018). Net migration, according to ONS (2018) statistics, indicated that about 248,000 more non-EU citizens came to the UK than left in the year ending June 2018. This movement was the highest non-EU net migration since 2004. According to the ONS (2018), the reasons for this surge are predominantly for study and work, but they also cautioned that this information is not accurate because some people do not give a reason for migrating to the UK. Historically, Nigerians (the population of central focus of the study) contributed to the surge in migration following independence in 1960. Many Nigerians migrated to the UK to study (Hernández-Coss and Bun, 2007) as well as other countries such as the United States (Ogbaa, 2003). Upon completion of their studies, the majority returned to Nigeria (Change Institute, 2009; Migration Policy Institute 2010). However, civil and political unrest in Nigeria during the 1950s also led to many migrating as refugees (more likely to move with their families) along with skilled workers, often settling in London, Liverpool and other industrial cities (Waters, Ueda and Marrow, 2009; ONS, 2015). However, this population saw a significant rise in migration during the 1970s (from 28563 in 1971 to 31000 in 1981 (ONS, 2015)).

This significant rise was due to the collapse of the petroleum boom, making it more permanent than the pre-independence wave of temporary migration (Institude, 2010). Asylum applications from Nigerians peaked in 1995 when the repression associated with the military dictatorship of Sani Abacha (then president of Nigeria) was at its height (Pongou, 2010; Migration Policy

Institute, 2010). Also, the 2001 UK Census recorded 88,378 Nigerian-born people as residents in the UK (UK census 2001). Recent estimates by the Office for National Statistics (2014) put the figure at 181,000 in 2013. The United Kingdom Census in 2011 recorded 191,183 Nigerian-born residents in England and Wales, while the census of Scotland and Northern Ireland recorded 9,458 and 543 Nigerian-born residents, respectively (Scotland's Census 2011). More recent estimates by the Office for National Statistics put the figure at 215,000 in 2019 (ONS, 2020). In the council of Europe report, the board reported 100,000 Nigerians in the UK and predicted that this figure was an estimate because it excludes children born outside Nigeria.

Likewise, Nigerians with citizenship of another EU member state who then relocated to the UK are not included these statistics. The report suggests multiplying the figure by between 3 and 8 to reflect the size of the Nigerian community in the UK (Committee on Migration, Refugees, and Population, 2008).

1.3. Background

Many Nigerians who came into the United Kingdom (UK) as adults in their twenties and thirties in the 1950s and 1960s are now ageing (Felton, 1987; Wohland *et al*., 2001). The relationship between ageing and the need for long-term care is strong; therefore, it is highly likely that a proportion of this population will require both informal care and support from health and social care services. For those requiring long-term care, the predominant provision in the UK is residential and nursing care homes (Bowes *et al.,* 2012). In this era of transcultural nursing where professionals are to connect and care for people from different cultures, providing care that fits a person's culture and life patterns, values, and set of meanings are almost unavoidable. This is particularly important in the UK, given its diverse culture as highlighted above. Remarkably, also, many minority ethnic population in UK have different cultural needs and beliefs to those of the native population and some of these people require healthcare that is abreast to that of their diverse cultural needs (Narayanasamy, 2002; Cortis, 2003; Duffy, 2001; Holland and Hogg, 2001; Price and Cortis, 2000; Fletcher, 1997). The provision of diverse cultural needs was supported by the National Health Service (NHS) and Department of Health (DoH), who state that services should be reactive to the cultural aspects of people's lives (Cortis, 2003; Chady, 2001; Foolchand, 2000). This places emphasis on individual assessment and avoiding assumptions based on partial awareness of residents' ethnicity or culture. It

requires appreciation of both the diversity within minority groups and the limitations of basing care on fact-file approaches (Butt 2010). This is reflected in the UK nurses' regulatory body guidance, which recommends awareness of minority groups and individualized care centred on an individual assessment rather than on categories (NMC 2009). This is because a lack of knowledge of individual culture may limit the ability to offer appropriate and adequate care. This is particularly relevant when caring for individuals from a black minority ethic (BME) group.

BME is a generic term used to describe people of non-white descent (Bhopal, 2004). Africa is the world's second-largest/most-populous continent with considerable genetic, linguistic, cultural, and phenotypic diversity and more than 2000 distinct ethnolinguistic groups (Hille and Johnson, 2017; Jobling *et al.*, 2013). African countries are extremely diverse. For example, Nigeria has over 521 languages and over 1150 dialects (Adesola, Akinlabi and Orie, 2018; Ndimele, 2016). Moreover, African countries are rich and diverse in different aspects of culture including food, dress, language and etiquette. Each ethnic group has its own culture (Gansinger and Kole, 2016). For example, in respect to Nigerian cuisine, the ingredients in traditional plates vary from region to region (Kraig and D, 2013). In the south, crops such as corn, yams, and sweet potatoes form the basis of the diet (Thaker and Barton, 2012). These vegetables are often pounded into a thick, sticky dough or paste (Aboh, 2018). This is often served with a palm oil-based stew made with chicken, beef, goat, tomatoes, okra, onions, bitter leaves, or whatever meats and vegetables might be on hand (Aboh, 2018; Lin and Levy, 2014). Fruits such as papaya, pineapples, coconuts, oranges, mangoes, and bananas are very common in the tropical south. In the north, grains such as millet, sorghum, and corn are boiled into a porridge-like dish that forms the basis of the diet (Singh and Upadhyaya, 2015; Lin and Levy, 2014). This is served with an oil-based soup usually flavoured with onions, okra, and tomatoes.

The relationship between food and culture is strong and well documented (Kittler, Sucher and Nelms, 2011; Counihan and Van Esterik, 2013; Anderson, 2014). Food is an important and powerful symbol of cultural identity (Gabaccia and Gabaccia, 2009). Other cultural aspects of living such as etiquette or rule of conduct are important to Nigerians. Giving respect to elders is common practice. Age is considered golden and older people should be respected and admired. In the traditional Igbo culture much honour is attached to old age, so older people feel privileged and younger people look forward to becoming old. Parents educate their children about valuing old age, and respecting and assisting older people. Socially, greetings are considered very important in Nigerian culture. The way a greeting is fashioned varies from

region to region. A common practice is a handshake and a long list of well wishes for one's family are expected even on first contact, and this should be repeated even after you had met the person a short while ago.

Clothing is also culturally important in Nigerian society with considerable variation amongst ethnic groups and tribes. For example, in Yoruba, men wear sokoto and an agbada or buba while women wear iro and buba along with gele (head wrap) and ipele (sash) over their shoulder (Akanji, Amusan and Olubukola, 2019). In the Igbo region, men dress in isiagu (a shirt with large lion heads, crowns or other symbols) or a long shirt together with trousers or wrappers as well as caps and corals. Women dress in a blouse or skirt or dress (Moghalu, 2015). However, during special events Igbo women can be seen carrying horse tails. In Hausa, men dress in large flowing gowns called Babban riga made with elaborate embroidery around the neck and robes by the name of juanni and jalabia (Nweze, 2018). Hausa women wear zani (wrappers) that are made out of colourful cloth called atampa, along with matching blouses, head ties and shawls. They can sometimes be seen with beautiful body paint ornaments (Nweze, 2018). In Nigeria, certain cultural attire are worn during occasions. People are easily identified by their dress. This could also be worn for identification, especially for those with a traditional title. In general, clothing is a means of expressing individuality and culture.

Both Western and traditional forms of medicine are popular in Nigeria. Traditional medicine, also known as *juju,* is common in rural localities. Juju practitioners use a variety of plants and herbs in their cures. Most families also have their own secret remedies for minor health problems. Many rural people do not trust Western-style medicine, preferring instead to use traditional ways. The diagnoses and chosen methods of treatment in traditional African medicine rely heavily on spiritual aspects, often based on the belief that psycho-spiritual aspects should be addressed before medical aspects. In African culture, it is believed that "nobody becomes sick without sufficient reason" (*Onwuanibe, 1979).* Traditional practitioners look at the ultimate "who" rather than the "what" when locating the cause and cure of an illness, and the answers given come from the cosmological belief of the people.

Before modernization, the extended family served as a form of social insurance or provided the traditional safety net for those requiring support or care. Filial piety is widely accepted, requiring intergenerational transfers of social responsibility and obligations to provide support for older family members (Odimegwu, 2019). Children have rights and obligations towards

their parents, just as the parents do for their children (Izuhara, 2010). For many Nigerians, this is a system that works. However, for those in diaspora, this reciprocal care arrangement could be challenging. Providing care in the home may not be a suitable option for some people. Situations such as round-the-clock care, seven days a week for those with reduced mobility, frailty, or mild confusion may not be possible. In these situations, professional care may also be needed. This is where this unique individual is faced with care that is either different to or in disagreement with their cultural needs or beliefs.

Those who have migrated and lived in the UK have life experiences of living in different cultures. As they age, some make the transition to living in long-term care and bring with them their unique life experiences, personal history and blend of cultures to the care home where they will live. For care staff and home managers this is a phenomena that is being encountered on a regular basis and will become more frequent as the population becomes more diverse. Whilst this is not a new phenomena, yet it is certainly under researched. The consequence is that the evidence base for transcultural care home nursing is under developed.

1.4. Cultural sensitivity: being aware of cultural differences

In the UK the heterogeneity of the frail older people population highlights the need to offer a range of health and social care services that are culturally sensitive, and reflect language, cultural and religious differences (McSherry *et al*., 2012). Quality service provision includes acknowledging ethnic diversity, and ensuring equal access, delivery and continuous care for all older people, regardless of ethnic minority status. Service developments are, therefore, critical if present and future needs are to be met (Patel, 1998). Cultural sensitivity is the ability to recognize the differences (in beliefs, values, norms, and behaviours of persons who belong to a cultural or ethnic group that differs substantially from one's own) and to understand and react appropriately to them (Porta and Last, 2018). In order to recognise these differences some researchers have claimed that the individual must first be culturally aware, enabling the individual or organisation to avoid misinterpretation, and to help to understand and communicate effectively with the diverse groups (Halter, Pollard and Jakubec, 2018; Lynam 1992; Ramsden 1997; Mitchelson & Latham 2000).

To enhance and maintain sensitivity it is necessary to understand one's own biases, values and interests, as well as one's own culture. McMurray (2003) argued that cultural sensitivity requires transparency and respect for cultural differences. Similarly, understanding the

dynamics of other cultures is important as this gives professionals a clear knowledge of cultural behavioural patterns in patients from different cultural backgrounds which may affect their attitude towards management of health issues. In addition, Bennett (1986) emphasised that cultural sensitivity is an awareness of the importance of cultural differences and respect for the views of people from other cultures. However, culturally-sensitive practice does not mean that practitioners should lose themselves but they should have the ability to move into another's world, whilst keeping an open mind and embracing differences within a multicultural society (Hansen 2001).

1.4.1. Why culturally sensitive practice is important in care homes

The work of Hofstede (1984) explains that culture is a collective programming of the mind which differentiates one human group from another (Hansen, Panwar and Vlosky, 2013; Hofstede, 1984). According to Hofstede (1984), culture plays a significant role in the way an individual thinks and forming their beliefs of what is appropriate and inappropriate in terms of ethical behaviour. When older people move into nursing homes, they can lose their connection with their homes and cultural environments, thus the shift can be life changing for older people (Hutchinson *et al*., 2011; Brownie et al., 2014). It is also well documented that residents' preferences develop over a lifetime, but remain stable in late life, and are not necessarily associated with frailty or cognitive function (Runci *et al*., 2014; Van Haitsma *et al*., 2014; Abbey *et al*., 2015). It is therefore important to create a sense of home, maintaining self-identity and self-worth, and develop positive relationships with fellow residents and staff (Falk *et al*., 2013; Roberts & Bowers, 2015). Most importantly, staff understanding of a resident's culture and preferences are essential as they are continuously exposed to different cultures. Understanding of a resident's cultures helps them to embrace and appreciate the differences that exists, minimises stereotypes and enables them to think in diverse ways. In addition, communication, which is classed as a critical part of human interaction has been greatly linked to influences from cultural tendencies such as figurative language, speed and presentation (body language). Understanding these could enhance staff's understanding of residents and help provide supportive living in the care home, as well as being a way of optimising biographical continuity or personal life experience.

Incorporating and understanding these cultural themes, traditions, and customs into daily programming becomes important as this allows residents and staff to experience both their own and other cultures, thereby contributing to a sense of community in the facility. More importantly, the population of older black people aged 60 and above living in the UK predicted to rise to nearly a quarter of a million (Evandrou, 2000). Approximately 1% of the ethnic minority population live in care homes, in comparison to around 4.5% of white British (ONS, 2014). The predicted increase in ethnic elders has led to calls for further research into their needs and wellbeing if the present, and future, needs are to be met (Blakemore, 2000). Numerous research studies have been carried out about black ethnic minorities in America but there is a significant gap in the literature from the UK. Notably, also, service responses to the needs of black older people have been inadequate (O'Neil, 2004). According to Age Concern (2002), current levels of care are insufficient to meet the demands of this ageing population group. Most often, services have either failed to provide appropriate support within primary services or have turned to voluntary organisations in the community to ensure that support is provided (O'Neil, 2004). Though there is not sufficient evidence to date on whether integrated or separate services enhance effectiveness, there is a need for more culturally-appropriate and sensitive services (Social Care Institute for Excellence (SCIE) 2006).

Mastery of these cultural skills is critical if health and social care are to meet the need to offer a range of health and social care services that reflect linguistic, cultural, and religious differences (Swihart , 2019). Also, enhanced knowledge of cultural requirements may provide improved quality of care. Similarly, the provision of quality services must acknowledge equal access and delivery of care regardless of race or religion (Riekkinen *et al.,* 2015). This study contributes to providing new knowledge and data needed by policymakers, practitioners, and staff working in care homes to make services more culturally appropriate, accessible, and responsive, thus providing improved health care to ethnic minorities in the UK. The study aims to explore the sensitivity of care home services to the needs of older Nigerian immigrants in the United Kingdom through addressing the following objectives.

- ✓ To explore how daily life is experienced by older Nigerians living in a care home.
- ✓ To understand how care home staff respond to the needs of older Nigerian residents and their families.

- ✓ To examine practices and approaches within care home services to address the individual needs of residents and their families and how those practices and approaches enhance the provision of culturally sensitive care.

1.5. Justification of the study

The number of older people from BME communities has risen sharply over the past decades and is projected to continue to rise (Evandrou, 2000; Phillipson, 2013). Whilst there has historically been little utilisation of care home services by Nigerians and other BME groups in the past, this may change as this population ages. According to Evandrou (2000), service responses to the needs of black older people have been poor.

UK guidelines highlight the necessity of providing the best quality of care that includes promoting choice, autonomy, and dignity (Hartley, 2010; Reading and Webster, 2014). The absence of research and statistical data raises important questions regarding the implementation of such guidelines and care standards, and, more importantly, the development of long-term care services. The implications of this are that further clarification is needed to fully explore how services might adapt to acknowledge ethnic elders' culture and care expectations, and also the impact of these issues in the context of their wider social and economic background (Young *et al*., 2012). The predicted increase in ethnic elders has led to calls for further research into their needs and wellbeing (Blakemore, 2000).

1.5.1. The motivation for carrying out this study

Growing up as a Nigerian child under a strict culture and norms has affected the way that I accept what is right and wrong. The saying "first impressions matter" impresses the importance of greetings. Greeting processes are vital in Nigeria, and it is rare to greet someone in passing. You are required to take time to exchange pleasantries and ask about each other's well-being. Greeting is the first impression that determines how acceptable you are or will be. In Nigerian culture a greeting can deter a young girl from getting married. This is because greetings are regarded as a mark of respect, and many men can ascertain whether a girl is 'wife material' from the quality of their greeting. Greetings in the Nigerian context are not cursory but are a genuine desire to know the other person's news about how they feel, how they slept, how are

their families, and so on. These initial enquiries are followed by up to 10mins of laughter, backslaps and, finally, a hug or a handshake. When greeting someone much older, it is a sign of respect and deference to bow the head and you are required to address them as uncle or aunty, mama or papa. Even if the individual is not a relation this is the culturally-correct approach to signify respect.

Coming to the United Kingdom with these cultural norms meant that I needed some adjustment to some of my beliefs. For example, I came to terms with the experience of choosing whether to greet or not greet someone when passing on a road, and understanding that there would be no consequence of either decision. Sometimes, when I tried to greet, I found that it was somewhat surprising to some people and my greeting might not be accepted. I started to wonder how other Nigerians coped with this. After a few months of my stay in the UK as a student, I had a part-time job in a care home as a carer, and this was when the issue of cultural sensitivity became of great interest to me. Firstly, I noticed that there were few black residents in the care homes where I worked. I became aware that daily routines in the care home could be culturally sensitive. Greeting was one of the cultural sensitivities I noticed. You could choose to say hi to a resident, coupled with addressing them by their first name, on waking them in the morning. Secondly, the menu included mainly British food and some residents from ethnic backgrounds rejected this food. Also, there appeared to be limited activities relating to the residents' cultural backgrounds.

Becoming aware of these practices left me wondering what living in this situation meant to these older individuals. Being self-aware of one's experiences prompts an individual to consider their own thoughts and actions in light of different contexts (Finlay and Gough, 2008; Lumsden, Bradford and Goode, 2019). My experiences of working in English care homes motivated me to focus my PhD study on care home settings and how older Nigerians experienced lived in these environments. As a carer I have a strong belief that residents should enjoy their final years, regardless of their background. I recognise that my beliefs, previous life experience, migration to the UK, and experience of working in the UK informed the choice of my research topic and had potential to influence the entire research process. Reflexivity was, therefore, an important part of the research process. Lumsden, Bradford and Goode (2019) drew attention to the influence that a researcher's ongoing critique and critical reflection of his or her own biases and assumptions has on all stages of the research process, and warns that this needs to be recognised from the beginning of a research study. The continuous process of

reflection helps a researcher to recognise, examine, and understand how their social background, location and assumptions affect their research practice (Lumsden, Bradford and Goode, 2019). The key to reflexivity is "to make the relationship between and the influence of the researcher and the participants explicit" (Pretorius, Macaulay and de Caux, 2019). This process determines the filters through which researchers are working, including the specific ways in which our own agenda affect the research at all points in the research process (Pretorius, Macaulay and de Caux, 2019).

Growing up within a Nigerian context taught me respect and to value older people. In this study, the respect which is inbuilt shaped my understanding of how care should be given to the older person. This is why my work experiences served as a further driving force to researching this topic. The thought of having been there, and the belief of knowing what it's like to be a Nigerian as well as a care home resident, crown it all. However, this belief and experience is only a starting point to researching this topic. This is because my experiences in the UK as a carer and a Nigerian child are only within my horizon. As this study progressed, more knowledge about the experiences of older Nigerians living in care homes unfolded and only at that that stage were new insights gained.

1.6. Structure of the thesis

In this thesis, I aimed to capture the views of residents and staff on cultural sensitivity in the care home, while also giving a detailed account of the research process itself. The purpose of chapter one has been to introduce how the study aims were derived, together with a brief overview of the background highlighting the content and gap in knowledge of this study, thus showing why this study is needed as well as why this gap needs to be filled.

The subsequent chapter presents available evidence reviewed before the commencement of this thesis. The chapter begins with discussions of the process used to search for the related literature. In the search for literature, A qualitative synthesis (sometimes called a qualitative systematic review) was used, though this a relatively new field and methods are still developing. It was followed by a narrative analysis to interpret the findings within the related literature. This then identifies the gaps in the research and further provides the rationale for conducting this study.

Chapter 3, provides a detailed account of the chosen methodology, outlining the philosophical underpinning adopted in this research. This chapter provides a rationale for the chosen methodology, constructivism, which could enable the exploration of the research area, which is currently lacking in knowledge.

Chapter 4 shifts the focus from the research approach to the way the data were collected, described and interpreted. This chapter details how my participants were recruited and interviewed. Data collection was done using the semi-structured interviews which agrees with constructivism as the underpinning philosophy of the study. The major benefit of the semi-structured interviews was the interactional characteristics which are needed for co-construction of knowledge. I interviewed 12 staff and 7 residents in their respective care homes. I used thematic analysis to analyse the data derived.

Chapter 5 presents the data collected. Here the staff and the residents' data are presented. From the residents' data, immigration stories, as well as their daily lives in the care home, are detailed and presented. From these detailed experiences from the residents, their everyday living experiences are captured, and the cultural aspects of their lives unfold. In terms of staff data, the detailed description of their data gives a clear view on how they encounter the daily lives of these residents. At the end of the chapter staff and resident data are pulled together to understand their views. This is method is guided by the study chosen methodology (constructivism).

In Chapter 6 the study focus moves from description to interpretation, examining themes that emerge from exploration of both resident and staff worlds. Staff and resident data are closely examined to identify common themes, ideas and recurring patterns. This method offers rich and thick description of the data set and theoretically-informed interpretation of meaning. It explores explicit and implicit meanings within the data which focuses on the residents' subjective experiences and sense-making.

In chapter 7, an in-depth interpretation of the findings in chapter 5 and six are presented. The presentation of these findings are organised in themes, and explores how these relate to the wider body of literature Then the differences are discussed, showing how this insight can inform workforce development. To conclude, (chapter 8) the chapter outlines further discussions of the original contribution to knowledge including discussions of the study limitation and areas for further studies.

Chapter 2

2.1. Literature review

2.2. Chapter overview

In this chapter, scoping of the broader literature on transcultural nursing and person-centred care is presented to provide context to this study. Transcultural nursing addresses sensitivity to other people's culture. Following this, the body of literature relating to the research question is examined using a qualitative narrative synthesis approach to critically appraise and synthesise the findings of the literature review. This chapter is divided into six sections. Section 1 discusses the search strategy used to identify published research studies regarding cultural sensitives in the care home. Section 2 presents the inclusion and exclusion criteria used while selecting published research studies to include in the review. This is followed by section 3, which shows (in a tabular form) the details of all the identified studies to determine if they met the eligibility criteria. Section 4 assesses the quality of the studies retrieved using the CASP quality criteria for assessing primary studies. Section 5 details the data extraction method, and section 6 presents the synthesis of the findings from the mixed-method studies that are included in the review. At the end of the chapter the discussion highlights gaps in existing knowledge that have shaped the aims of this study.

2.3. Transcultural nursing

Both transcultural nursing and cultural sensitivity are indispensable in this era of global migration. Cultural awareness is a precursor to culturally sensitivity. Transcultural nursing therefore requires a level of awareness of other people's culture before becoming sensitive to providing the care that is needed. Thus, transcultural nursing care is the process of knowing other people's culture in order to provide care that is culturally sensitive and inclusive. Therefore, understanding the theoretical discourse about transcultural nursing is relevant to research concerning cultural sensitivity in any care context.

The extant literature suggests that the notion of culturally appropriate care was introduced by Leininger (1988), who was drawn to this subject by her nursing experience. She drew on the constructs of culture from anthropology and care from nursing, and redefined what has come

to be known as cultural care (Leininger, 2001). Leininger's innovation began with a theory of cultural diversity and universality and was presented in 1975 as a Sunrise model. In the mid-1950s, there were no cultural knowledge base practices to guide nursing decisions and actions that would help to understand cultural behaviour as a way of providing therapeutic care (Leininger, 1989). Transcultural nursing according to Madeleine Leininger, is:

> *"a substantive area of study and practice focused on comparative cultural care (caring) values, beliefs and practices of individuals or groups of similar or different cultures. Transcultural nursing's goal is to provide culture specific and universal nursing care practices for the health and well-being of people or to help them face unfavourable human conditions, illness or death in culturally meaningful ways." (Leininger and McFarland, 2002)*

This called for the need for all nurses to have sufficient and correct information about the cultural background of the individuals they care for. This has become increasingly important in healthcare practice today within multicultural societies where there is a demand for health care services that can meet the need of different cultures (Leininger, 1997; Seisser, 2002). This requires nurses to have knowledge of different cultures and customs to conduct holistic assessment for optimal care (National Center for Cultural Competence 2010). As a result, different models of transcultural nursing were developed to assist nurses in overcoming the overwhelming complexity of variations in culture in health care. Theorists posit that these models can be used to enhance care with any population (Raman, 2015). Significant models of transcultural nursing developed by Leininger, Giger and Davidhizar, Purnell and Campinha-Bacote have shaped this field, and according to these authors, these models are still at their foundational stage and developing to enhance the delivery of healthcare.

2.3.1. Models of transcultural nursing

Leininger's sunrise model developed from analysis of culture theory, and the relationship between anthropological and nursing beliefs and principles. This model is used by nurses when making cultural evaluations of a patient. The model connects the concepts of the theory with actual clinical practices, while offering a systemic approach to identifying values, beliefs, behaviours and community customs (Leininger and McFarland, 2002). The model is comprised

of several aspects of culture, including religion, financial, social, technological, educational, legal, political and philosophical dimensions. According to Leininger and McFarland (2002), these components, along with language and social environment, greatly influence the service delivery systems, whether traditionally or professionally. Traditional health care is based on conventional beliefs related to health, whereas professional systems rely on learned knowledge, evidence-based practice, and research (Leininger,2002). Understanding of the cultural needs promote the achievement of desired clinical outcome. Also, these goals are accomplished by the use of three concepts: cultural care maintenance/preservation, cultural care negotiation/accommodation, and cultural care restructuring/patterning (Leininger and McFarland, 2002). Cultural preservation refers to nurses' provision of support for cultural practices, such as employing acupressure or acupuncture for anxiety and pain relief, both of which are acceptable practices in some cultures prior to medical interventions. Equally, cultural negotiations refers to the assistance rendered to the patients and their families in carrying out cultural activities that do not pose threats to the health of the patients or any other individual in the healthcare setting (Leininger and McFarland, 2002). Lastly, cultural restructuring refers to nurses' efforts to deliver patient-centred care by helping patients modify or change their cultural activities. Cultural restructuring is proposed only in harmful cultural practices that could harm the patients or their surroundings (Leininger and McFarland, 2002). These conceptions inform nursing practice as well as achieve their ultimate goals (Leininger, 1997).

The application of Leininger's model into practice requires awareness of the culture of the individual. This is illustrated by a study carried out by Nashwan and Mansour (2013) in Doha Qatar on 'Caring for a Bedouin Female Patient with Breast Cancer titled; An Application of Leininger's Theory of Culture Care Diversity and Universality'. It was found that being able to access Bedouin culture over the internet using Leininger's model made a good start. The findings found that the initial reaction of the nurses was that Bedouin culture is different from them and valued it. The information derived from the internet acted as a starting point for them. This highlights the need for more evidence-based research on various cultures for easy access when needed. Most importantly, these seven factors identified by Leininger are seen to include predictable aspects of cultural needs. In practicality, deeper understanding might be needed to understand the nuances associated with individual culture. For example, Badger *et al.* (2012) found that more understanding was needed when providing culturally-appropriate food with some managers seeking training for their chef on how to make a particular ethnic food. The ability to understand the differences in a culture is a step to providing culturally-sensitive care,

which is why this study is needed to contribute to the necessary knowledge needed to care for Nigerians in care homes.

Transcultural nursing models have played a significant role in forming the basic foundations of nursing practice (Smith, 2019). However, despite their positive contributions, the transcultural models have been criticized for their limitations and failure to acknowledge certain issues related to the educational and practical components of transcultural nursing (Raman ,2015). According to these critiques, the model also overlooked the recognition that cultural diversity needs to go beyond group differences due to variations in socio-economic backgrounds, age group and types of community.

Also so much is being documented about transcultural nursing among health care providers and patients, with the ageing population almost left out of the context of the cultural group. It may be argued that nurses or healthcare professionals are more located in hospitals and other healthcare sectors. However, care homes are important part of healthcare industry. They strengthen the healthcare industry by providing specialised care to non-critical and critical residents, acting as an emotional and physical support system to senior citizens and improving their quality of life. Also, most of these critical and non-critical seniors' transit from the hospitals to the care homes where continuity of care occurs. The care home population is comprised of people from different ethnic minorities. It is therefore important to understand the influence of culture on these populations in order to achieve the goals of transcultural nursing as highlighted. Most importantly, the existence of the care home within or part of the healthcare industry is crucial, particularly within Britain because of its multiculturalism and growing life expectancy. However, these theories are argued to be applicable to all settings in both assessing and looking after patients. However, these are predictable aspects of care, and unexpected lifestyle change frequently occurs among older adults in cares home, meaning more understanding will be needed to understand how these models fit in. On the contrary, the model has been commended for its clear and simple method of evaluating professional and societal culture (Higginbottom *et al.*, 2011; Giger and Davidhizar, 2002) (Shen, 2014). Aside from Leininger's model, other scholars have developed their models in the field of transcultural care. For example, Giger and Davidhizar's transcultural assessment model was developed in 1988 as a result of the need to assess and provide care for patients and their families that is culturally diverse as well as assisting nursing students in an undergraduate level to assess and provide culturally appropriate care (Giger and Haddad, 2020). More recently, Giger and Davidhizar's

transcultural model posits that every person is culturally unique and should be assessed according to six cultural phenomena: (a) communication, (b) space, (c) social organization, (d) time, (e) environmental control, and (f) biological variations (Giger and Davidhizar, 2002).

The essence of Giger-Davidhizar's transcultural model is to create awareness on the key areas of people's culture. However, as mentioned above in Leininger's theory, the ultimate goal is to create awareness of the differences in culture and critical areas where attention is needed to assist nurses in assessing individuals who are culturally diverse in order to provide culturally-competent nursing care. The practicality, as already highlighted above, is that more awareness of other cultures is needed. Overall, the aim of these models is to provide care that recognises people's culture in healthcare delivery systems.

Critically, the aim of transcultural nursing is to ensure that people from different cultural backgrounds are treated appropriately regardless of their location. In addition to this, it was discovered that culture affects the way people respond to treatment and, as a result, transcultural nursing and its model were created to enable practices that are culturally sensitive in healthcare. However, looking at the meaning of culture and its concept, it was found that culture is often synonymous with race or used as a broad, monolithic term to describe people who are physically similar, come from same ethnic group, or have the same belief values, and behaviours. However, this has been found to be stereotyping rather than being culturally competent (Kagawa-Singer and Kassim-Lakha, 2003; Saha, Beach and Cooper, 2008). This argument is the fact that a person could come from same culture as another but may not necessarily agree with the same belief and values (Kagawa-Singer and Kassim-Lakha, 2003). For example this agrees with the point highlighted in chapter one about Nigerians. In Nigeria, there are 36 states and one territory, and each state is further divided into Local Government Areas (LGAs). Within it, there are 774 LGAs, with largest being Kano state (44) and the smallest being Bayelsa (9) (UN, 2004 and WB, 2015). The distribution of these local governments also varies in their culture. They are rich and diverse in different aspects of their culture (food, dressing, language, etiquette, etc.) (Gansinger and Kole, 2016). However, there are other aspects of culture which are similar in Nigeria. An example of this is the beliefs about respect, which are a reciprocal aspect of care. This now refers back to the aim of transcultural nursing to provide culture-specific and universal nursing care practices for the health and well-being of people. Treating every person (person-centred care) as an individual was also introduced and coined by Balint in 1969, particularly the belief that every individual is unique

and has to be understood as so. In 1984, person-centred care caught the attention of Lipkin and colleagues (Lipkin, Quill and Napodano, 1984)

2.4. Person-centred care

Person-centred care as an approach to care that sees each human being as a unique individual with their own story to tell (Crickmore, 2011). Lipkin, Quill and Napodano, (1984)added that person-centred care promotes trust and confidence, clarifies and characterizes the patient's symptoms and concerns, generates and tests many hypotheses that may include biological and psychosocial dimensions of illness, and creates the basis for an ongoing relationship (Lipkin, Quill and Napodano, 1984). However, since the creation of person-centred care, critics have arisen over how closely focused this is to the individual instead of the social and political context of care (Ryan *et al*., 2008). The effectiveness and meaning of this concept have recently been challenged by Boggatz's (2019) study demonstrating that over 20yrs since the birth of person-centred care it is yet to be practiced. This study stated that person-centred care is an ongoing process which is accompanied by organizational changes. Other scholars have also questioned the actual meaning of person-centred care and concluded that it is referred to as treating everyone as an individual, according them respect and finding out what is relevant to their care (M, 2018; Kreindler, 2015). However, Kreindler (2015) indicated that, in general terms, patient-centred care is care organized around the patient in which the providers partner with the patient's family in identifying their needs and preferences. In contrast, Hannan (2019) indicated that person-centred care is a care where the person is actively involved in their care (Hannan, 2019). Other studies also found barriers in implementing the practice of person-centred care, particularly traditional practice and structure. The study of Hannan (2019) found that professionals working according to traditional care pathways restrict the freedom to deviate from usual care. Time constraints were another barrier, and it was found that person-centred care was time consuming, especially in training, education and development of partnerships for professionals and patients. It found that person-centred care might be difficult to implement, especially in the fast pace of healthcare activities. However, one significant finding was that once person-centred care was embedded, it provided the opposite in that it saved time (Hannan, 2019). In addition, attitudes whereby professionals lacked interest, commitment or knowledge and consciously or unconsciously slipped back into their usual practice were found to be a barrier to person-centred care.

In response to these debates, the concept of relationship-centred care has arisen. This recognizes quality care as comprising of strong interdependence and reciprocal relationships within all care elements, particularly when it is inclusive of the older person, their families and staff (Ryan *et al*., 2008). However, McCormack and McCance (2016) argued that even with introduction of relationship-centred care, it has not stood the test of time as an alternative or have different dimensions compared to person-centred care (Boggatz, 2019; McCormack and McCance, 2016). To account for these concerns, cross-cultural approaches to healthcare were incorporated to create a balance between acquiring some background knowledge of the specific cultural groups encountered in clinical practice, and developing attitudes and skills that were not specific to any particular culture but were universally relevant. In recent times, the application of these theoretically-driven models of transcultural nursing is making slow progress in terms of application to practice. However, in order to provide quality healthcare, it is important to have an understanding of the group receiving care and how this group perceives and responds to health as well as the cultural implications surrounding their behaviours (Değer, 2018; Andrews and Boyle, 2002) .

This study arose from these concerns, and part of its contribution was to create awareness of cultural related behaviours of Nigerians; specifically those who are considered a vulnerable group and live in a care home.

2.5. Search strategy

Identification of a topic area and prior assessment of potential size and scope of research literature is an important step that maps the key concept underpinning a research area (Grant and Booth, 2009; Arksey and O'Malley, 2005; Carter and Lubinsky, 2015). This step helps to maintain motivation throughout the research project also and ensures no work has been done on the same topic to inform the development of new research (Carter and Lubinsky, 2015). Scoping research allows the researcher to synthesise and analyse a wide range of published and unpublished research materials which provides greater conceptual clarity of a topic (Davis, Drey and Gould, 2009). This contextualises knowledge by identifying what is already known and not known. A well-defined search strategy determines the quality and quantity of studies retrieved and missed. In this review, the first step was a systematic search of relevant bibliographic databases to ensure broad coverage of areas of interest, across medical,

psychological and social science literatures. These databases were useful in retrieving studies specifically related to this research. Keywords and Mesh terms were derived from the research questions to search the databases (see table 2). A list of alternative terms was generated from a dictionary search and examination of original articles. The searches were intended to identify, quantify, and summarise available evidence around areas of interest for a general understanding of the research area.

Databases search	Search strategy	Hand search of journals	Summary of key concepts alternative search terms (synonyms)
Web of knowledge (all databases)	Using basic search operators ((AND, OR, NOT, NEAR, SAME). Wildcards such as (* $?)		**Sensitivities-** susceptivity, vulnerability, AND OR perception. **Care home** OR nursing home, OR assisted living facility OR convalescent home, OR Residential care **Minority** OR outnumbered group, OR opposition, less than half, AND OR, splinter group (see appendix for details). **culture** Civilization OR, society, OR way of life, OR lifestyle OR customs, OR traditions OR heritage, OR habits OR values . **Ethnicity** Nation OR Nationality OR Race OR Clan OR Family OR Folk OR House OR Kindred OR Tribe. **Ethnic background** Ethnic affiliation OR Ethnic origin OR Ethnical background OR Racial origin OR ethnic group OR Racial backgrounds OR Their ethnic origin **Immigration** Migration OR Migrant OR immigrant Minority OR Minority OR
ASSIA (ProQuest)	PRE, NEAR, AND, OR, NOT Truncation (*) and wildcard (?) were used		The same alternative and keywords as above were used with the application of (*)(?) and PRE, NEAR, AND, OR, and NOT. For example Using wildcard Sensitiv? OR Awk?rdness, OR AND OR percept? Using truncation Sensitivity* OR Awkwardness*, OR susceptivity
Medline (using EBSCO platform) was used to cross search with others in EBSCO	Using the search options, the following were chosen. Search modes: using the search expander Boolean/phrases were selected		Same as above. (find the details in the appendix)

collection			
Science direct	Science direct database allowed me to explore scientific and medical research Search such as peer-reviewed journals, articles, book chapters also to search words using Keywords, author name, journal /book title, volume, issue, and page.		Same as above but without Truncation.
Scopus	Scopus as one of the core database was used to search for words using their search strategy below: for example ALL(" ") AND AUTHOR-NAME() TITLE-ABS- KEY(*?) AND PUBYEAR AFT 1993 SRCTITLE(**) AND VOLUME( ) AND ISSUE( ) AND PAGES( )		Similar to the above but with inclusion of: (" ") AUTHOR-NAME( ) TITLE-ABS-KEY(*?) AND PUBYEAR AFT SRCTITLE(**) AND VOLUME( ) AND ISSUE( ) AND PAGES( )
Social care online	An option to type a search into the search box, use your own words, register and login in was available in this database.		Some of the authors derived from other databases were searched in the Social care online database, which yielded the same results but also listed similar related articles which was helpful. Also, " " (speech marks) was used which indicates that a phrase search will be carried out, e.g., ‘‘dementia care.’’
Zetoc	Zetoc is one of the core social work databases which was used in search of the literature. Zetoc alert and RSS feeds option was used to track the latest articles or journal titles related to my work and interests		Search options such as : All fields, e.g., “care home.” Titles, e.g., “cultural sensitivities.” Author ISBN/ISSN Year published were used
National archives	The National Archives is the official archive for England, Wales, and the central UK government, containing 900 years of history from Doomsday Book to the present, with records ranging from parchment and paper scrolls through to recently-created digital files and archived websites.		National statistics database was used to search for immigration history of black ethnic minorities in the UK using the listed synonyms

Table 1: Databases and search terms

2.5.1. Inclusion and exclusion criteria

Published studies eligible for inclusion were quantitative, qualitative, mixed methods and systematic review studies that investigated cultural sensitives in care homes. It was difficult to impose restrictions on the searches due to reasons stated earlier; however, minimal limits were applied to the dates of publication. The publication date was set at not less than 10 years old, as outdated data are not good representations of recent findings. Much has changed since the introduction of Equality and Diversity Act 2010. This Act replaced the previous Race Relations Act 1976 in providing a legal framework to protect individuals and advance equality for all. The Equality and Diversity Act seeks to ensure everyone has a fair chance in life. Older black minority ethnic people were included in the search because this term supports the identification of studies with a sample that may include Nigerians. All selected items were restricted to the English language and no restrictions were placed on geographical coverage.

2.5.2. Search results

The search for primary research using the above strategy yielded 3500 studies. 20 were duplicates across these databases, reducing it to 3480. These articles were further screened on the basis of title and abstract, resulting to further rejection of 3,000; this included various studies, many of which were not related to this study, research work included as newspaper or magazine publications and studies relating to learning disabilities. These 480 articles were further screened to assess relevance, thus reducing the records to 10 articles. Full text copies of these papers were reviewed using CASP quality criteria, resulting in the final selection of 5 studies for systematic appraisal (Harden *et al*., 2004; EPHPP, 2009; Critical Appraisal Skills Program (CASP), 2013; Evans, Lasen and Tsey, 2015).

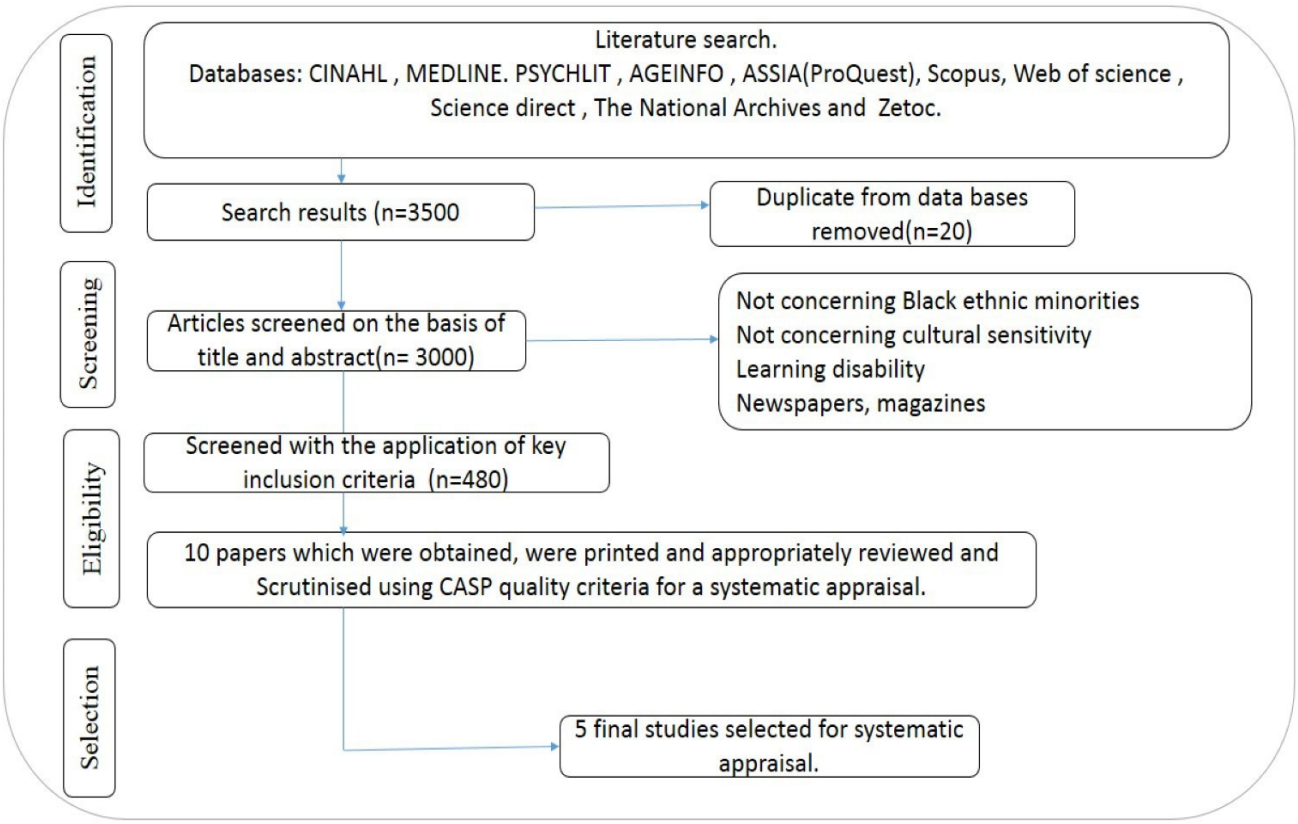


Figure 1: Summary of search results.

2.5.3. Data extraction and synthesis

Extraction of data is an essential but challenging exercise; this is because primary studies to be used come in various formats and use different styles of reporting and important information is often missing. The same information may be reported inconsistently within a study. However, some scholars have provided various useful guidance on how to approach the process (Gaziulusoy and Boyle, 2013; Garland, 2001; Naoum, 2012; Aveyard, 2014; Wellington, 2005). According to Wellington (2005), having a lot of literature to report on can feel overwhelming, but it is essential to keep the focus on the scope of your study rather than the literature, hence the use of key criteria checklist is important. This makes it easier to score each criterion and also screen out those studies that do not meet the criteria. For this qualitative narrative synthesis, a standardized data extraction form for quantitative, survey and qualitative research was used (Please see table 3 below).. The scores are derived based on the criteria (see criteria column in the table).

Criteria	Fully met Score yes	Partly met Score no	Not fully met score Can't tell	Weighting/score of the review papers					
				SRP 1	SRP 2	SRP 3	SRP 4	SRP 5	SRP 6
Clear aims, relevant and clear research questions	Yes			80%	90%	90%	95%	70%	60%
Qualitative methodology appropriate	Yes								
Research design (research appropriate and justified appropriateness of research design	Yes	no							
Sampling –: Who was included in the study? Who was excluded from the study? How was the sample selected? Were there any factors that influenced how the sample was selected What is the size of the sample and groups comprising the study? What is the size of the sample and groups comprising the study?	yes		weak						
Data collection- appropriate setting, method justified and explicit and if so why	yes								
Reflexity (relationship between researcher and participants)	yes	Partially met							
Ethical issues (sufficient details, issues raised, ethical approval)	yes	no							

Data analysis (rigorous – in-depth description, how themes derived, data selection, sufficient presented, contradictory data, own role, data analysis systematic)	yes	Partially met	Can't tell.
Findings – clear – for/against, credibility, related to aims	yes		
Value – relation to current knowledge, new	yes	Partially met	
areas, transfer/use Worth or relevance			

Table 2: The quality of the studies appraised

No.	Reference	Aims and objective	Methodology	Research design	Sampling	Data collection	Reflexivity	Ethical issues	Data analysis	Findings	Value
S1	Likupe, G., Baxter, C., & Jogi, M. (2018). Exploring health care workers' perceptions and experiences of communication with ethnic minority elders. Quality in Ageing and Older Adults, 19(3), 180190	To explore health care workers' (HCWs) perceptions and experiences of communication with EMEs. In this paper the term HCW includes qualified nurses and health care assistants.	A descriptive qualitative study design using semi-structured interviews was employed. Ten HCWs, who had ethnic minorities in their care were individually interviewed to explore their perceptions and experiences of communication when caring for EMEs	A descriptive qualitative study design	A snowball approach was then used to identify those individual HCWs in these institutions who had EMEs directly in their care. These were targeted as they had the experiences that the researcher wanted to study. Purposive sampling is directed by the question being asked	The qualitative approach as described by Sandelowski (2000, 2010) was adopted for the study using semi-structured interviews with HCWs, which lasted between 30 and 50 min.		The relevant Research Ethics Committee granted ethical approval for the research under reference number 13/W A/009 6. After being provided with written information followed by a verbal explanation about the study, participants indicated their voluntary participation by signing a consent form	A thematic approach using an iterative and interpretive technique was adopted in analysing the data	Analysis of data revealed that in common with all older people, EMEs experience stereotyped attitudes and difficulties in communication. However, EMEs face particular challenges, including cultural differences, different language and stereotyping of care based on misunderstood needs of EMEs. Facilitators of communication included appropriate training of HCWs and appropriate use of interpreters.	Great value

2	Badger, F., Clarke, L., Pumphrey, R., & Clifford, C. (2012). A survey of issues of ethnicity and culture in nursing homes in an English region: Nurse managers' perspectives. Journal of Clinical Nursing, 21(11-12), 1726-1735.	A survey of issues of ethnicity and culture in nursing homes in an English region: nurse managers' perspectives	Mixed methods	A postal survey	All nursing homes for older people in one English region were sampled. The region was representative of the UK, having a diverse population and a range of inner city, urban and rural areas. Nursing homes (n = 303) were identified from the CSCI website (now CQC; http://www.cqc.org.uk).	Semi-structured telephone interviews. This two-phase study adopted a mixed methods approach, appropriate for exploratory work. Phase 1 was a postal survey of managers, and in Phase 2, a subsample of managers participated in semi-structured telephone interviews		The study was appraised by the relevant university committee. The managers' information sheet addressed issues of confidentiality, and no inducements were offered. Each questionnaire had an identification code, but no other identification. Managers who agree d to be interviewed provided their contact details	Culturally sensitive care delivery varied. Some homes had established systems that were responsive to residents' diversity, while others responded to the needs of black and minority ethnic residents on an 'as required' basis	Managers' underlying philosophies of care were to treat each resident individually and not by category. It was felt that individualised care plans resulted in residents' needs being met appropriately. Culturally sensitive care delivery varied. Some homes had established systems that were responsive to residents 'diversity', while others responded to the needs of black and minority ethnic residents on an 'as required' basis. Managers' identified advantages in having staff from diverse backgrounds, although prejudice from residents towards staff emerged as a theme and managers' responses varied. Staff training in the provision of appropriate end-of-life care was identified as a need	Great value

3	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*(1), 354	This study addresses a lack of literature on the use of formal services for dementia by people from CALD backgrounds by examining the experiences and perceptions of dementia caregiving within four CALD communities – Italian, Chinese, Spanish and Arabic speaking – in south western Sydney, Australia.	Qualitative design	The methods included focus groups with family carers and one-to-one interviews with bilingual/ bicultural community workers, bilingual general practitioners and geriatricians.	A total of 121 family carers participated in 15 focus groups and interviews were held with 60 health professionals	In total, fifteen focus groups and sixty interviews were conducted.	Appropriate for the study	The project received approval from the University of Queensland Human Research Ethics Committee and the Sydney South West Area Health Service (Western Zone) Human Research Ethics Committee.	Transcripts were stored and managed using the NVivo 7 software programme. Content and thematic analyses were undertaken	People from 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. CALD communities often have limited knowledge of services. There is a preference for services that will allow families to keep their relative at home, for safety as well as cultural reasons, and they are particularly reluctant to use residential care	Great value

4	Evans, N., Meñaca, A., Andrew, E.V.W., Koffman, J., Harding, R., Higginson, I.J., Gysels, M. (2011). Appraisal of literature reviews on end-of-life care for minority ethnic groups in the UK and a critical comparison with policy recommendations from the UK end-of-life care strategy. *BMC Public Health, 11*.	Aims to review and evaluate literature reviews on minority ethnic groups and EoL care in the UK and assess their suitability as an evidence base for policy.	Systematic review		Searches were carried out in thirteen electronic databases, eight journals, reference lists, and grey literature. Reviews were included if they concerned minority ethnic groups and EoL care in the UK. Reviews were graded for quality and key themes identified.	Thirteen reviews (2001-2009) met inclusion criteria. Seven took a systematic approach, of which four scored highly for methodological quality (a mean score of six, median seven).	The majority of systematic reviews were of a reasonable methodological quality.		Articles were managed in Endnote X2. Titles and abstracts were initially assessed by one reviewer (NE) to eliminate those not related to EoL care. All remaining titles and abstracts were then assessed for relevance in regular team meetings (minimum three participants). Reviews that took a systematic approach were appraised for methodological quality (table 3) using a grading scheme adapted from Russell, et al. [41]	The literature reviews concerning minority ethnic groups and EoL care in the UK described a range of social, institutional, epidemiological and cultural reasons for low service use and identified some distinct EoL preferences and needs. In light of this evidence, in order to improve the use of, and satisfaction with palliative care services by such groups, it is necessary to recognise the complexity of factors leading to low service use and sub-standard provision of care and implement a systematic, organisation wide, approach to tackling these multiple and inter-related factors.	

5	Sury, L., Burns, K., & Brodaty, H. (2013). Moving in: Adjustment of people living with dementia going into a nursing home and their families. *Internation al Psychogeriatric, 25*(6), 867-876.	The adjustment to this new caring environment by both residents and their family caregivers and the factors that influence this are the focus of this review.	Systematic review.	A literature search of Embase, Scopus, and Medline databases of articles published in English between 1990 and 2011 using specified search terms was performed to examine this transition		174 titles located were screened and reference lists hand searched resulting in the 49 relevant articles included in this review			Not clearly stated. However, the article used a systematic review of Embase, Scopus, and Medline databases from 1990 to 2011 using their stated MeSH terms	This decision and the subsequent adjustment period is a difficult time for people with dementia and their family caregivers. Admission has been linked to increased behavioural symptoms and in particular depression and agitation, decreasing cognition, frailty, and falls in people with dementia. For caregivers, guilt, depression, feelings of failure, and continuing burden but also improvement in quality of life have been variously reported	

Table 3: Data extraction form for quantitative, survey and qualitative retrieved

2.6. Narrative synthesis

Considering the study aims and the scarce yet diverse nature of the literature included in this review, a narrative synthesis approach was adopted to combine evidence from quantitative, qualitative and mixed-methods studies (Pope and Mays, 2006; Popay *et al.* 2006). Narrative synthesis in this study is intended to provide reflection on the literature and also create an avenue where the few available primary studies are brought to light in a more robust manner through a story-telling method. The following **elements of narrative synthesis were used in this study**:

1. Develop a theory of how the intervention works, why and for whom
2. Develop a preliminary synthesis of findings of included studies
3. Explore relationships in the data
4. Assessing the robustness of the synthesis

2.6.1. Element 1: Develop a theory of how the intervention works and why

No theory development will be undertaken in this review as it is an exploratory one. However, as earlier stated in chapter one, no research has been done on older Nigerians living in the care home. The data derived from this review are related to people from black ethnic minorities. The information derived from this review will provide further understanding about how widely applicable this is.

2.6.2. Element 2: Develop a preliminary synthesis of findings of included studies

The preliminary synthesis involved the extraction of the primary studies using a descriptive characteristic presented in a table (see table 3 above). This gives a textual summary of the results of the studies, giving a clear initial description of the included studies. This process allowed for a clearer view and identification of patterns across the retrieved studies. This has already been illustrated above in table 4 with headings of study design, results of study quality assessment, outcome measures and other results. Tabulation of the descriptive synthesis makes

it easier to review and compare results between studies. In addition, study design, differences in study population, method of data collection and analysis is presented for quick referral when needed.

2.6.3. Element 3: Explore relationships in the data

By exploring the relationship within and between studies, various factors on culturally-sensitive practice are highlighted, including the impact of an intervention, or explanations of how or why a component has an effect. Patterns across these findings were subject to rigorous evaluation to identify and explain differences of culturally-sensitive practice in care homes. Close attention was paid to the heterogeneity, research methods, methodologies, participant characteristics, interventions and other unknown sources across the studies, using narrative synthesis methods. For example, restriction was placed on the date of publication to ensure that up-to-date information was reviewed. Narrative methods are considered to be an important tool for investigating heterogeneity across primary studies, highlighting components of an intervention which may account for its success or investigating the possibility that study variation is due to theoretical variables.

2.6.4. Element 4: Assessing the robustness of the synthesis

The robustness of the synthesis was assessed using critical reflection. This included assessment of the strength of the evidence for drawing conclusions on culturally-sensitive practice or care in care home and assessment of the transferability of the synthesis findings to different population groups or contexts. The key to clear identification of robustness of the synthesis is the methodological quality of the included studies and the analytical methods employed to develop the narrative synthesis.

2.7. Summary of method of selected studies

A range of methodology and methods were used in the selected papers. These included 1 mixed method, 2 qualitative studies, and 2 systematic review studies. Only Badger *et al.* (2012) and Evans *et al.* (2011) touched on cultural sensitivities in the care home. Cultural sensitivity is a set of skills that enable understanding and relates with people from a different cultural background (Goossens and Murata, 2019). In essence, culturally-sensitive care is meant to be

equipped with both theoretical (knowing that) and practical knowledge (knowing how) (Goossens and Murata, 2019). Sury *et al.* (2013) and Likupe *et al.* (2018) reported issues around moving into or accessing healthcare by the black ethnic minority. Also, the limited literature on cultural sensitivity reflects the paucity of research around the black ethnic minority. Likupe *et al.* (2018) conducted a qualitative study using individual semi-structured interviews involving ten healthcare workers who had ethnic minorities in their care to explore their perceptions and experiences of communication when caring for ethnic minority elders (EMEs). Badger *et al.* (2012) employed a survey method to explore issues in ethnicity and culture in nursing. This two-phase study included a postal survey and a subsample of semi-structured telephone interviews. They sampled nursing homes for older people identified through the CQC website (n=303). Of 303 care homes that were selected, a total of 101 participated in the study. The data were analysed using SPSS (Version 14). Evans *et al.* (2011) conducted a systematic review on end-of-life (EoL) care for minority ethnic groups in the UK and a critical comparison with policy recommendations from the UK end-of-life care strategy. Thirteen databases were searched and those studies that concerned minority ethnic groups and EoL care in the UK were selected. Reviews were graded for quality and key themes identified. Data analysis was done using a grading scheme adapted from Russell *et al.* (1998). Five areas of reporting were graded: specifying the objectives; searching the literature; selecting relevant and valid studies; critical appraisal of studies; and synthesis of data and presentation of findings. Reviews were graded independently by two reviewers (NE and MG) and then compared. Differences were discussed in team meetings (minimum 3 people) and resolved by consensus. Shanley et al. (2012) conducted a qualitative study into the use of formal services for dementia by carers from culturally and linguistically-diverse (CALD) communities. They used a qualitative design where fifteen focus groups and sixty interviews were conducted. Focus groups were with family carers and one-to-one interviews with bilingual/bicultural community workers, bilingual general practitioners and geriatricians. A total of 121 family carers participated in 15 focus groups and interviews were held with 60 health professionals. All fieldwork was audiotaped and transcribed. Transcripts were stored and managed using the NVivo 7 software programme. Content and thematic analyses were undertaken. Sury *et al.* (2013) carried out a literature review on the topic 'Moving in: adjustment of people living with dementia going into a nursing home and their families'. Databases such as Embase, Scopus, and Medline were searched. From these databases, 174 titles were screened and reference lists were hand searched, resulting in the 49 relevant articles included in this review. The method of analysis was not clearly stated.

2.8. Practicing culturally-sensitive care in the care home

- ✓ Language and communication and awareness
- ✓ Religion and ethnicity,
- ✓ dietary needs
- ✓ Prejudice
- ✓ Individualised care
- ✓ Staffing

2.8.1. Language, communication, and awareness

Language, communication and awareness were reported in the selected primary studies as a significant hindrance to black ethnic minorities' decisions to moving into and living the care home (Badger et al., 2012; Sury, Burns and Brodaty, 2013; Shanley et al., 2012; Evans et al., 2011; Likupe, Baxter and Jogi, 2018). Some of the studies were restricted to certain areas such as end-of-life care (Evans et al., 2011). In these studies, there was a particularly useful focus on awareness and communication. According to Evans et al. (2012), good communication skills are important to understanding both verbal and non-verbal communication, stating that there were key problems with communication. This included a lack of information in appropriate language and format, inadequate provision of interpretation and advocacy services, and in understanding verbal and non-verbal communication. Also, this study addressed cultural competency in care homes, stating that negative perceptions about care home services were considered a significant impediment to increased utilisation, but they also added that some services were identified as culturally insensitive. There was no clear indication about what culturally sensitive care should be in Evans et al.'s (2012) findings. Evans et al, (2012) appraised literature relating to end-of-life care and the source of this claim was a report by the House of Commons health committee on palliative care carried out in 2003-2004. A lot may have changed since this report referenced by Evans et al. (2012), due to the implementation of the Race Equality Act 2010. To be culturally sensitive is to be culturally aware of the differences in culture and, according to Evans et al. (2012), the consequence of being insensitive to culture is low use of care homes by these populations.

According to Badger et al.'s (2012) findings, language and multicultural belief would be a barrier for residents from other ethnic minorities coming into the care home, stating that most

of the care home managers participating in this study emphasised that this was an important pre-admission assessment consideration which meant that residents and families are as fully informed as possible. For example, certain questions are usually asked so they can determine at the initial stage whether a certain home is suitable for their relatives and their cultural beliefs.

For those residents who had communication problems, families were asked to write cards with words or whole phrases in the resident's local language as well as English as an approach to tackle communication problems. Thus, Badger *et al.* (2012) explained that the care homes had measures in place to tackle the problem. These measures included family as well as ethnic staff involvement in facilitating communication. However, these authors did not indicate the effectiveness of these approaches. Another approach was to make a CD that included information relating to family lives and family names which the care home can play for the resident at mealtimes or during activities. Badger *et al.* (2012) added that other care homes who did not have access to an interpreter asked families to help. However, these approaches appear to be restricted to predictable aspects of care, as highlighted above, such as mealtime communication phrases. These approaches could pose a problem, for example, in symptom assessment or emergency situations where the absence of staff or family interpreter would require an interpreter (Badger *et al.,* 2012). Another measure was used by the carers was the use of ethnic staff members. Some managers from Badger *et al.'s* (2012) findings expressed that they had multilingual care staff who communicated in the residents' language, but expressed that if there were difficulty regarding the use of multilingual staff, external services were always sort. Though Badger *et al.* (2012) indicated that only 13 managers were interviewed, they did not clearly state which and how many managers spoke about issues relating to language and communication as well as details of the questions posed to determine the suitability of a care for a resident.

Evans et al. (2011) concluded that though translations were given there were always issues surrounding the format of the information provided. According to Evans et al. (2012), lack of information in an appropriate format, negative perceptions and low awareness were identified as barriers to utilisation of care home. They stated that a good communication channel meant that residents and families could understand themselves more. However, Likupe et al. (2018) stressed the importance of appropriate communication in the care homes, pointing out that communication that is appropriate to the population should be every manager's concern. They indicated that staff should focus on using some honorific terms such as sir or madam, which are classified as a norm in traditional African and Asian cultures. Likupe et al. (2018) affirmed

that training staff in culturally-sensitive communication is a need and asserted that such training should focus on how care staff should address residents They also argued that this was consistent with the findings of Age UK's (2012) recommendations. For example, Likupe et al. (2018) indicated that staff should always ask residents how they would want to be addressed and that mangers should recruit care staff who are openminded and willing to be trained in culturally-sensitive communication. Also, Likupe et al. (2018) pointed out that institutions should provide an informal curriculum which enables care workers to provide culturally-competent care using culturally-sensitive communication at the individual level. However, Likupe et al. (2018) did not indicate how this could be achieved.

2.8.2. Dietary needs

Provision of culturally-appropriate food and how this was delivered varied across the selected papers. According to Sury *et al.* (2013) there was a lack of access to traditional ethnic foods that might hinder the process of adaptation to residential care for both the residents and their families, which can affect the quality of life of the resident. However, according to Badger *et al.* (2012) (a survey of issues of ethnicity and culture in nursing homes in an English region: nurse managers' perspectives), it was identified that three managers had never had residents who required anything other than a British diet, and the only variations were because of residents' health needs. However, it was not clear if these care homes had diverse ethnic residents within their care. Despite this, according to Badger *et al.* (2012), other home managers indicated that in most cases, an individual arrangement was always made. They added that one of the managers interviewed explained that one lady in the care home who ate little food but loved to eat chicken on the weekend had this need met thus displays the home's ability to respond to the resident's requests. In another home a family usually bought food for their Muslim relative. Participants explained that the pre-admission forms which each resident completed helped them understand residents' likes and dislikes, and they always tried to create menus on that basis. It was also added that they have residents from diverse ethnic backgrounds, such Asians and whites (which is the majority), and as such they cater for their needs. Also, Badger *et al.* (2012) expressed that managers sometimes seek training if they have people with particular needs that they are not used to providing for. In this case external support is accessed to train their catering staff on how a specific food is made, thus aiming to meet that particular need of the individual resident. However, Badger *et al.* (2012) found out that these

arrangements varied from one-off to more structured approaches depending on the number of BME residents in a home.

2.8.3. Religion and ethnicity

Only two studies mentioned how religious needs are addressed in care homes. According to Badger *et al*. (2012), most managers emphasised their support for residents from various religions. They stated that residents were free to participate in all or none of the faith-based activities. One manager, according to Badger *et al.* (2012), ensured that Muslim residents could have their room facing Mecca if required and that families could access a prayer room. They added that another manager stated that if residents had religious needs, they ensure they are met. For example, a manager expressed that if this was related to a minister or a priest, there was provision available for a home visit. Other aspects of religious-related care were noted, for example helping African Caribbean residents to follow skincare regimes and ensuring that a female Muslim resident's wishes to be attended by female staff were respected. Finally, Badger *et al.* (2012) reported that steps were taken to ensure that staff appreciated that a resident's response to a bereavement reflected their culture and religion, and that this should be respected. The second study which highlighted religion stated that there were concerns about deterministic links between cultural, ethnic or religious factors in relation to preferences in end-of-life care of black ethnic minorities (Evans *et al.,* 2011). Evans *et al.* (2011) stated that some of the approaches already in practice were a cookbook, and caution was needed to avoid stereotyping. Also, Evans *et al.* (2011) stated that minority ethnic groups merely present information about rituals and beliefs, and that there was a need for training in care that is sensitive to cultural differences. In contrast, however, Evans *et al.* (2011) concluded that despite frequent recognition that services need culturally-competent care, few reviews provided recommendations about how to achieve this.

2.8.4. Perception and action

Prejudice is a form of attitude that influences the way we interact with the world, including our day-to-day experiences with other people, groups, and issues (Bissell and Parrott, 2013). We hold explicit attitudes or subjective views of which we are cognizant. We also hold implicit attitudes and associations that we might not even recognize because they are unconscious or automatic. Badger *et al.* (2012) found that having ethnically diverse staff was regarded as

positive; however, three managers who took part in their study spontaneously described incidents of discrimination and prejudice: for example, they described a situation when they took a male agency worker, a staff nurse, and the family responded by stating 'it comes to something when my mother has to be cared for by a black man'. The manager noted that the home was a rural location, and overseas nurses had been appointed relatively recently. Also, there was another incident according to Badger *et al.* (2012) in which a resident felt upset relating a similar issue about a black nurse and the nurse in question was advised to be careful when dealing with such a resident. Badger *et al.* (2012) also stated that this same manager expressed that sometimes they tried to work around things so that staff are protected from this problem.

In contrast, Badger *et al.* (2012) added that another manager expressed that in situations like this (discrimination), they usually have a word with the resident, stating that every staff in the care home is entitled to look after them whether white or black due to lack of staff. They also stated that if they refused, either they get taken care of or they get referred to another home t. They indicated that families are contacted if this happens repeatedly. In all, Badger *et al.* (2012) found that prejudice was infrequent from the responses received from the managers and, most often, the attitude changed once the resident got used to the staff. This is an issue according to Badger *et al.* (2012), however, as they revealed that there was support for staff in incidences of this nature, indicating that this was inline with equality legislation. However, Likupe *et al.* (2018) found that for some migrant workers in the UK and Ireland, cases of discrimination were always occurring, especially care workers from African origin. In their findings, some migrant care workers recounted occasions where their older residents preferred white or Irish workers and even refused care at some point. According to Likupe *et al.* (2018), this occurred mostly as a result of grievances about language proficiency or issues around national accents.

2.8.5. Individualised care

Badger *et al.* (2012) and Likupe *et al.* (2018) were the only authors who had addressed individualised care. According to Badger *et al.* (2012), the managers treated all residents as individuals in relation to factors such as diet, religion, end of life, and cultural practices. For example, residents who required anything different from British food were provided with such, or training was sourced to address this need. Meanwhile in terms of religious needs, especially

for Muslim residents, beds were placed facing Mecca if required and families could access prayer when needed. However, most managers spontaneously mentioned that they expected to have more BME residents in the future, noting the impact of a cohort effect.

Meanwhile, Likupe et al. (2018) explored healthcare workers' perceptions and experiences of communicating with ethnic minority elders and found that care assistants expressed that one significant way to promote individualised care was by understanding one's culture They highlighted that some healthcare assistant often cared for people from different ethnic backgrounds and cultures, which can be challenging in terms of understanding their individual cultures and values in terms of religion, form of personal address and manner of speaking. Likupe et al. (2018) added that training in these basics needs of their ethnic residents serves as a good starting point to base their care.

In contrast, Likupe *et al.* (2018) also discovered that though knowledge of culture was an important factor, ethnic older people required individualised treatment as no two people are the same. They stated that cultural knowledge should be regarded and used as a guide, and older people's wishes and needs should be respected. They that culture is a dynamic concept and things are always changing.

2.8.6. Staffing

Staffing and their competency towards the provision of culturally appropriate care were also identified as one of the contributory factors to cultural sensitivities in the care homes. According to Badger *et al.* (2012) and Sury *et al.* (2013), homes were more likely to have staff who did not speak English as a first language than residents. However, Badger expressed that all managers felt that their staff spoke good English, and staff who experienced initial difficulty later became fluent. Evans *et al. (*2011) indicated the need for training staff in care to increase their awareness of and sensitivity to the cultural background of the resident, stating that monolingual workers could provide better care by learning some essential words in the client's language.

Although the outcomes from these research studies differed considerably, they were all completed in a care home context. In this small body of literature there was a clear indication that services needed to improve culturally to meet the needs of older black minorities in the care home. However, they indicated that there is a variable range of alternatives in place in care

homes to meet the needs of the black ethnic minority, and some studies indicated that although there may be low numbers of black minority people living in care homes, establishing systems to meet the needs of all was essential.

2.9. Discussion of results

2.9.1. What is known?

This review has uniquely taken an approach to the identification, appraisal and synthesis of the peer-reviewed research about cultural sensitivity in the care home in the UK. Though there were a limited number of peer-reviewed articles relating to this study, those which were included provided insight into a range of cultural and institutional reasons leading to culturally-sensitive as well as quality living in the care home. These include language, communication, awareness, staffing, religion, dietary needs, and prejudice. The discussion around these topics varied across the appraised literature in the way they understood and practiced culturally-sensitive care. As indicated earlier, cultural sensitivity involves both theoretical (knowing that) and practical knowledge (knowing how) (Goossens and Murata, 2019). The findings of Badger *et al.* (2012), Sury, Burns and Brodaty, (2013), Shanley *et al.* (2012), Evans *et al.* (2011) and Likupe, Baxter and Jogi (2018), however, contributed to the body of knowledge needed to understand how these issues are tackled and how they affect care home life and quality of life of residents. In all the appraised literature, there was evidence of 'knowing that' cultural differences exist, which is why several adjustments in the care provided was made. For example, In the case of language and communication, Evans *et al*. (2012) found that good communication was core to understanding residents from black ethnic minorities. This included a verbal and non-verbal type of communication, stating that problems were not just centred on having information in a correct format but understanding that non-verbal cues exist. Meanwhile, Badger *et al*. (2012) expressed that family played an important role in facilitating communication. They stated that most of the care home managers showed the importance of preadmission assessment as a good facilitator to meeting the specific needs of residents.

Another noteworthy example of 'knowing that and knowing how' was identified in the provision of culturally-appropriate food. According to Badger *et al.* (2012), not all care home manager participants had residents who required any diet which differed from the offer of British food. However, other care home staff who made adjustments to the food adopted a

personalised approach. Some went as far as accessing training to make a particular food available for their residents with ethnic backgrounds when needed. Others also explained that this is where preadmission assessment comes into play, particularly through the identification of likes and dislikes and required adjustments made. In terms of religion, it was seen that some care home staff used their knowledge about cultural needs of their ethnic by responding to them. For example, according to Badger *et al*. (2012), religious support was available in some care homes for those from other ethnic minorities. Residents were allowed to make a choice of whether or not to attend faith-based activities. According Badger *et al.* (2012), more training and awareness is needed to provide culturally-sensitive care. Sury *et al.* (2013),indicated some of these factors (e.g. food) could hinder the process of adaptation to residential care for both the residents and their families.

2.9.2. Referring to the broader literature

Evidence suggests that culture and ethnicity are among the most important global challenge (Salway *et al.*, 2016; NHS, 2013; Randhawa.G., 2007). The reason is because culture and ethnicity create a unique pattern of beliefs and perceptions as to what "health" or "illness" or access to services actually mean, and this is not limited to Nigerians (Malik *et al.*, 2017; Anderson, 1997). In Nigerian culture, the fear of moving into the care home is identified as of one of the challenges faced, according to Okereke, (2012), and particularly the feeling of being dumped to die in care is seen as a culturally unacceptable. As a result, most Nigerians see care homes as a last resort (Okereke, 2012). However, living in a care home is not entirely negative, as it can also be a positive choice. An example of this is in cases of safety where vulnerable older adults cannot look after themselves, and they could in turn be a hazard to themselves (Phelan, 2015). Furthermore, for some older people, choosing to move into the care home serves to pre-empt change when their condition deteriorates or to provide a social environment (Cook *et al*., 2003). Care homes provide 24/7 services from care staff and qualified nurses who are readily available when needed. It could also serve as an avenue for an opportunity to socialise with people of a similar age group, especially for those who have experienced loneliness at home. Also in care homes there are opportunities to have whole meals, which very beneficial for frail older adults who need help with this aspect of care (Merrell *et al.*, 2012). In addition, those who need help with medication are offered and supervised when the need arises (Odberg, Hansen and Wangensteen, 2019). In particular, this can serve as a positive

choice for some families as this gives them peace of mind knowing that their loved ones are not on their own. Help is always available for those that require specialised care, such as mental health care, respite care, palliative care, elderly care, physical disability care and dementia care.

However, culture and beliefs can affect how one adapts or transitions in the care home. Therefore, the ability to recognise cultural differences in people remains an important factor in an organisation (Patrick and Kumar, 2012). This includes perceptions, cultural meanings, cultural meanings, identity issues, health beliefs, socio-economic issues, and service-related barriers (Malik *et al.*, 2017). However, the nature and magnitude of these barriers vary both within and across cultures (Sawrikar and Katz, 2008). Sarwrika and Katz (2008) found that such barriers are interrelated, interact with, and reflect barriers that arise from the families' own situation or factors about the specific service. Notwithstanding, the literature indicates that, broadly, the barriers are common to ethnic minority families (Sawrikar and Katz, 2008).

2.10. Strength of the studies appraised

The appraised literatures that utilised systematic appraisals were an added strength in that systematic reviews are an excellent review method that carries out research in an unbiased systematic method to provide evidence for policy makers and practice and to identify gaps for further research (ten Ham-Baloyi and Jordan, 2016; Williamson and Whittaker, 2019). One of the weaknesses identified was from Evans et al.'s (2011) research. Evans *et al.,* (2011) study managed to cut across the inclusion criteria due to their date of publication (2011), and this implied that all the references of their research were 2007 and earlier, which was within this study exclusion criteria due to the introduction of race equality act as already discussed above. As a result some of the evidence highlighted by Evans et al. (2011) were seen to be outdated.

2.11. Limitation

Despite the use of qualitative review process which uses rigorous and explicit methods to draw reliable and accurate conclusions, this review still has some limitations and weaknesses. This study required more in-depth research relating to cultural sensitivity in the care home, but only one study conducted qualitative research and others were systematic reviews. Systematic reviews could be argued to be the best method of gathering available evidence but the studies

appraised are usually secondary sources, limiting the volume of new insights usually gathered from primary studies. Also Badger *et al.* (2012) and Likupe *et al.* (2018) carried out primary studies speaking to managers and care workers respectively. This raises the issue for selection bias indicating that the population selected are not representative of the information needed to address cultural sensitivity used by the residents. Also it could be augured that the telephone interview method used by Badger *et al.* (2012) may be to the advantage of the managers to disclose only positive clear information, further questioning the content of their responses.

2.12. Gaps identified

This review clearly demonstrates that research on cultural sensitivity to the needs of care home residents is underdeveloped. Few studies met the inclusion criteria to be included in this review. The findings from these appraised studies tend to focus on predictable aspects of cultural needs, though one care home reported by Badger *et al*. (2012) additional measures in terms of food (getting training for their chef on ethnic food). More nuanced approaches to other cultural needs will enhance the credibility of the predictable aspect of care mentioned. Also, the limited amount of appraised literature proved the dearth of information or research around black ethnic minority groups in the UK. The systematically searched journals only sampled either care staff or the manager, so the residents' voice was completely lost even when they are the recipient of care. However, it was seen that most of the research was conducted based on end-of-life care which could be argued as one point for interviewing the carers. Thus, little is known about living in a care home in relation to this topic. Furthermore, most of the research carried out on black ethnic minorities is not representative of the diverse cultures within this group, making difficult to group and offer uniform care.

Within this African population, there are diverse linguistic, cultural, political, and religious factors which make it complex and difficult for anyone to group them nor assess their care together as a singular black ethnic minority group (Hille and Johnson, 2017; Jobling *et al.*, 2013). Caution is therefore advised, according to Badger *et al.* (2012), not to assume that care could be provided based on general knowledge of ethnicity, culture or religion. This is where this study comes into play; can the Nigerian community be grouped and cared for as people from the Black ethnic minority? They come from different cultural backgrounds, and have distinct values and beliefs. Therefore, researching them separately is important to understand

their needs. Much research has already been done on the Chinese population with this same notion of not wanting to be grouped (Chau and Yu, 2010; Dong *et al.*, 2011; Miyawaki, 2015). The same caution was also advised by the UK nurses' regulatory body guidance, which recommends awareness of minority groups and that individualized care should be centred on an individual assessment rather than on categories (NMC, 2018). The care home is an important health care sector, and respecting residents' cultural needs is fundamental to affording care (Gunaratnam, 2007).

2.13. Expected contribution to the body of knowledge

To improve the use of and satisfaction with services by black ethnic minorities it is necessary to recognise the complexity of factors surrounding diverse ethnicities and cultures. As a result, this study is conducted by exploring some of these complex issues, but with a focus on Nigerian residents to understand cultural sensitivities that arise in care home contexts and how care staff attempt to address the cultural needs of these residents. Another contribution this study is intended to make is to construct knowledge about cultural sensitivities through the staff and residents to gain an in-depth knowledge of cultural sensitivity in practice through their voices, which is missing in the existing literature. Practicing cultural awareness enables the individual or organisation to avoid misinterpretation, and helps to understand and communicate effectively with diverse groups (Halter, Pollard and Jakubec, 2018).

This study will also make an important contribution to knowledge by providing insight into how to make services more culturally sensitive to the needs older Nigerians specifically, and will contribute enormously to the areas that need attention which will be channelled towards attracting and contributing to already highlighted government policies which claimed to be committed to "delivering real social reform".

Chapter 3

3.1. Research methodology

3.1.1. Exploring ways to gain knowledge: underpinning philosophy, an overview of the method and research design

The purpose of this chapter is to present a detailed description of how this research was carried out. This includes a discussion of the study's research paradigm, as well as presenting the underpinning philosophy and detailing the methods by which knowledge was be gained. The aim and objectives of this research will be re-iterated as this, according to Miles and Huberman (1984), posits that knowing what you want to find out leads inexorably to the question of how you will get that information.

In chapter 2, I found that that the majority of the research seems to represent the voice of the staff rather than both resident and staff. This meant that that the findings are viewed from staff perceptions of resident's care home life in predictable aspects of care provided (which includes language, communication, awareness, staffing, religion, dietary needs and prejudice). This study seeks to address this gap in knowledge by exploring resident perspectives through the adoption of a methodology that gives access to the resident world. Care homes are places where residents live and staff work, therefore the selected methodology also addresses the need to take into consideration the world view of others that has substantial influence over daily life in this setting. The adopted methodology was a vehicle that addressed the following aims:

- To explore how daily life is experienced by older Nigerians living in a care home.
- To understand how care home staff respond to the needs of older Nigerian residents and their families.
- To examine practices and approaches within care home services to address the individual needs of residents and their families, and how those practices and approaches support the provision of culturally-sensitive care.

The process of getting to know or obtaining knowledge and understanding of a research topic is based on the researcher's positionality and paradigms concerning beliefs, values, ontology, epistemology, and relationality (Sikes, 2004). According to Kincheloe and Berry (2004), these

shape the outcome of the research and choices made about research methodology deeply affect what is found.

3.1.2. Following the route of qualitative research

Considering the issues raised within the appraised literature in chapter 2 and the nature of the research question, a qualitative approach was the best fit. Various circumstances influence the choice of research approaches. According to Corbin and Strauss (2008), it is recommended that rather than using philosophical positions, research questions should inform the selection of the methodological approaches used to conduct research. While quantitative methods focus on obtaining numbers and statistics, qualitative research, due to its exploratory nature, aims to uncover (under the surface) and gain an in-depth and interpreted understanding of the social world (Creswell, 2017). It tends to gain an insight into the way people live, what they do and what they need in their everyday lives (Corbin, Corbin and Strauss, 2008). Analysis of qualitative data can reveal valuable attitudes and perspectives that cannot be accessed through a quantitative approach (Creswell, 2017). The exploratory nature of qualitative research makes it easier for gathering new information for a specific area of study, often through an intense, detailed interview and dialogue between the researcher and the researched (Cresswell, 2017). Therefore, due to the exploratory nature of qualitative research, it was chosen as an approach to understand the residents' and staff world and to explore the 'why' and 'how' cultural sensitivities are addressed in care homes. Moreover, there is a dearth of information about older Nigerians who are living in English care homes, and qualitative research would enable insight into the lived experience of this population. This approach does not claim that results are universally right, statistically correct or can be reproduced. It is intended to provide deep insight into the phenomena being studied.

Among different qualitative approaches, phenomenology was chosen because of its unique aim and way of researching a subject. Phenomenology aims to understand the essence of a phenomenon from those who experience it (van Manen, 2016). This implies that research within this approach is not focused on the participants themselves or the world they live in, but rather the meaning of the interrelationship between the two (van Manen, 2016). The task of the phenomenological researcher, therefore, is to discover the essence of the problem under study, thus inductively generating theory for practical applications (Ellis, 2013).

3.2. Phenomenology

Phenomenology explores the structures of consciousness in human experiences of relating to a concept (Polkinghorne, 1989). The term phenomenology became prominent during the enlightenment period when philosophers such as Immanuel Kant 1724-1804 and William Hegel 1770-1831 began using this approach (Smith, 2016). However, phenomenology, in its philosophical stance, started with the German philosopher Edmund Husserl and has continued until the 20th to 21st century (Smith, 2016). Modern philosophical phenomenology seeks to understand how things appear to our conscious awareness and ultimately how the world appears to individuals in their subjective experience (Mckenna, 2012). In other words, phenomenology involves reflecting on everyday experience of its underlying order, structure and coherence (Mckenna, 2012). This approach was selected for this study to offer insight and enhance understanding of the experience of older Nigerians living in a care home. Phenomenologists are more focused on the first-hand description of a phenomenon than in resolving why people experience life in the way they do (Sherman, 2012). For instance, a phenomenological study on cancer may focus on the experience of what it feels like to have cancer, focusing on the individual's point of view and trying to describe how the individual interprets their everyday world (Ugalde *et al.*, 2019). It endeavours to capture the nature of the experience rather than measure or define the causes of cancer (Ugalde *et al.*, 2019). Phenomenologists are more interested in every aspect of human experience because they perceive that humans' experience of the world is a valid way to interpret the world (Beck, 2019). Therefore, scientific, empirical traditional approaches are rejected as the superior method of research. Phenomenology varies from other approaches of qualitative research because it aims to understand the essence of a phenomena from the point of view of those who experience it (Beck, 2019). The task of the phenomenological researcher therefore is to discover the essence of the problem under study.

3.2.1. Choosing between different approaches of phenomenology

There are a number of phenomenological approaches, notably transcendent phenomenology and hermeneutic phenomenology. Choosing between these two major approaches posed a significant decision for the study. Husserl's (1859-1938) approach, transcendental

phenomenology, focuses on people's meaning of a lived experience of a phenomenon or concept (van Manen, 2016). The purpose of transcendental phenomenology is to describe the essence of experiencing a phenomenon that is being studied (van Manen, 2016). Husserl believes that the empirical or scientific approach is not applicable to human subjects because humans attach meaning to external factors and, therefore, will not respond automatically (Moustakas, 1994).

Husserl argued that the lived experience of an individual should be reflected on, therefore this method captures both the way a person experiences their world as well as their interpretation of reality (Mortari and Tarozzi, 2010). Husserl proposed that one could not be studied in isolation from each other, and such a transcendental phenomenon remains a valid alternative to the scientific method of research (Moustakas, 1994). Therefore, using the transcendental reduction process, according to Husserl, helps to gain an in-depth understanding of consciousness and uncover the underlying structures of a phenomenon. Reduction or bracketing focuses on the technique of epoche, whereby a researcher could purposely set aside his or her own beliefs or previous knowledge to have a clear understanding of the problem under study (Eddles-Hirsch, 2015). Others have criticised Husserl's claim of setting aside their previous knowledge and argued that it is difficult to understand a phenomenon without the use of previous knowledge (Zahavi, 2005). Likewise, Dilthey (1989), indicated that human previous experiences are necessary pieces of knowledge that become clearer when new knowledge is sought or gained. This argument was supported by Merleau-Ponty (1973) who found that in order to gain in-depth understanding and clarification of a current phenomena, previous experience is needed. This is because humans live with a ceaseless flow of experiences and are capable of attributing a meaning to his/her experience and through reflective thinking, thus making sense of his/her life.

At this point, Husserl's descriptive method was rejected because previous knowledge of the phenomena under study enriches the description of the problem in a most reliable way. More so, according Heidegger (1927/1962), pre-understanding is a structure for being in the world, and it is the meaning of a culture that is present before we understand and become part of our historical background. According to Heidegger (1927/1962), it is not something we can put aside, as it is understood as already being with us in the world. Heidegger further explained that nothing can be encountered without reference to a person's background understanding. Filtering and clouding the researchers' pre-understanding of the problem may

capture the essence of a participant's experiences but there are possibilities that they could cloud the truth within the data.

Researchers are often interested in research topics that are derived from their expertise, professional interests, beliefs, and experiences (Råheim *et al.*, 2016). In this study, the researcher's experience of working in a care home environment, and as a Nigerian who knows and understands the culture of Nigerians, influenced the choice of the research topic. The researcher's previous experience influenced all aspects of the research process. For example, the development of the interview guide took into consideration the perspective of Nigerian culture. When addressing the topic of food the nuances of the cultural importance of eating together and the significance of food as a way of celebration were included. This process ensured that contextuality, or sensitivity to structural conditions that contribute to participants' responses and to the interpretations of situations informed by experiences by validation of perceptions and a careful review of existing knowledge, was embedded in data collection processes (Im *et al.*, 2004) .

Distancing or being passive in the research process is difficult to achieve whilst giving a full, rich description of the phenomena. Thus, transcendental phenomenology was rejected and hermeneutic phenomenology was considered as the approach for this study. Husserl claimed that knowledge is connected to conscious awareness, whilst Heidegger's hermeneutic phenomenology focused on interpretation and developing meaning from being. This led to rejection of Husserl's transcendental phenomenology approach to bracketing of previous experience (Giorgi, 2012).

Heidegger rejected the phenomenological epoche, arguing that interpretation is needed before understanding. From a Heideggerian perspective, researchers are vital components of a research study as 'being-in-the-world' of the participants, pointing out that the act of knowing is formed by active involvement as well as interacting with the environment (McConnell-Henry, Chapman and Francis, 2009). Also, if to be is to be-part-of-the-world, then understanding is not achieved by phenomena speaking for themselves, as argued by Giorgi, but with what a researcher unreflectively brings to a study when they approach a phenomenon (pre-understanding) (Giorgi *et al.*, 1985), However, this does not imply that research is centred on what it is to be in the world, but by opening up to, and learning from, the world via the process of dialogue with the phenomena of the world, and also critically considering that understanding, so that limitations, contradictions and conflicts in views can be understood

(Gadamer, 2008). In relation to this study, the experience of being in the world brings cultural knowledge and professional experience to the research, which shaped the research aims and objectives. Great care was required not to dwell nor rely completely on this experience as this could lead to bias within the study. The professional experience and cultural background of the researcher led to an interest in the topic, however it was recognised from the outset that the experience of older Nigerian residents could be very different both in their personal experience and cultural affiliation. However, the researchers' background knowledge in this research area (a Nigeria and carer) was particularly important as this helped reflect on the topic, data and emerging findings. Past experiences and cultural background influenced the research process as well as facilitating sensitivity to what was being studied. Mruk and Breuer (2003) argued that researchers must talk about their experiences and reflect on them as this could influence the data collected and interpreted. They also argued that it helps others understand the research perspectives and the conclusions drawn. For example, in chapter one it was stated that greeting is an important aspect of Nigerian culture and could be viewed as being disrespectful if not provided. The manner in which a greeting is made is important to avoid it being interpreted as rude rather than congenial. Having this knowledge could be an advantage to a researcher as there is existing understanding that would support dialogue between the researcher and the researched during data collection and ongoing interpretation of the data. Furthermore, professional experience and related communication competency could offer advantages when conducting research with vulnerable populations, such as care home residents. Understanding of the challenges that exist with regard to recruitment, consent and assent are important in care home research. Reflecting on these issues is important throughout the research process, and this requires open-mindedness, transparency and readiness to explore by the researcher. For this reason pre-understanding, personal experiences and awareness of intersubjective exchanges with research participants (Bazeley, 2013; Finlay, 2002) were presented in chapter one.

3.3. Inductive approach

Decisions about the use of inductive or deductive approaches in research should underpin a study because this influences the understanding of the phenomena (Altinay and Paraskevas, 2009). For example, the inductive approach consists of using specific prepositioning to infer general principles, while a deductive approach is aimed at using general principles to infer a

specific preposition. An inductive approach begins with a research question and the collection of empirical data which are used to generate hypothesis and theory. Meanwhile, the deductive approach starts with a theory-driven hypothesis which guides data collection and analysis (Altinay and Paraskevas, 2009). An inductive approach was used in this research as this approach is concerned with new emerging theory from the data (Altinay and Paraskevas, 2009). This study is more concerned with understanding 'why' rather than 'what-'type questions and in generating new theoretical insights. This approach is not without weaknesses, such as being more effective with a small sample, being time consuming as ideas are generated over a much longer period of data collection and analysis, and also the risk of yielding no useful data (Denzin and Lincoln, 2011a). However, the strengths of using the inductive approach overcome these issues, and support exploration of how care home residents and staff experience and interpret their social world (Kumar, 2002).

3.4. Determining a stance

Due to the broad nature of qualitative research, Miller (1997) hints that stance taking when using qualitative methodologies are dependent on the researcher's way of observing settings and the relationships within those settings (Miller and Dingwall, 1997). As a result, the way researchers describe social reality and interpret it will vary depending on the observational and analytical position chosen (Miller and Dingwall, 1997). Those positions are further dependent on the paradigm on which the research is based (Miller and Dingwall, 1997).

3.5. Research paradigm

A considerable amount of literature has been published on research paradigms (Lin, Oxford and Culham, 2016; Killam and Carter, 2013; Guba, 1990; Denzin and Lincoln, 2011b; Lincoln and Guba, 2016; Blaikie and Priest, 2017; Kuhn and Hacking, 2012). According to Denzin and Lincoln (2000) and Kuhn and Hacking (2012), research paradigms are a set of shared common beliefs and agreements about ways to address and understand a problem. The word paradigm became current with American philosopher Thomas Kuhn's *'the structure of scientific revolution' (1962)* (Lincoln, 2000; Denzin and Lincoln, 2000), where it was seen to mean a philosophical way of thinking, or a set of common beliefs and agreements shared between scientists about how problems should be understood and addressed (Kuhn and Hacking, 2012). The word paradigm originated in Greek to mean pattern, while other scholars such as Tracy

and Tracy (2013) described it as a preferred way of understanding reality, building knowledge, and gathering information about the world. Lin, Oxford and Culham (2016), amongst others (Geis, 2010; Chambliss and Eglitis, 2018; Eglitis and Chambliss, 2017; O'Leary, 2007), explained that a paradigm is like the lens on a pair of glasses. Chambliss and Eglitis, (2018); went further to give an example of this using the same pair of glasses and to think of a paradigm as looking through coloured glasses. If you put on red glasses, everything looks red. If you put on pink glasses, the world looks pink. So, the lens (paradigm) researchers choose changes the way they see the world. It directs everything that researchers see (O'Leary, 2007). The preferred way of seeing influences preferred ways of understanding, building knowledge, and gathering information. A researcher's paradigm can differ on the basis of ontology (the nature of reality) epistemology (the nature of knowledge) (Eglitis and Chambliss, 2017), axiology (the values associated with areas of research and theorising) or methodology (strategies for gathering, collecting and analysing data) (Chambliss and Schutt, 2012). A particular paradigm may be associated with certain methodologies (Chambliss and Schutt, 2012). Factors influencing the choice of these paradigms are illustrated below.

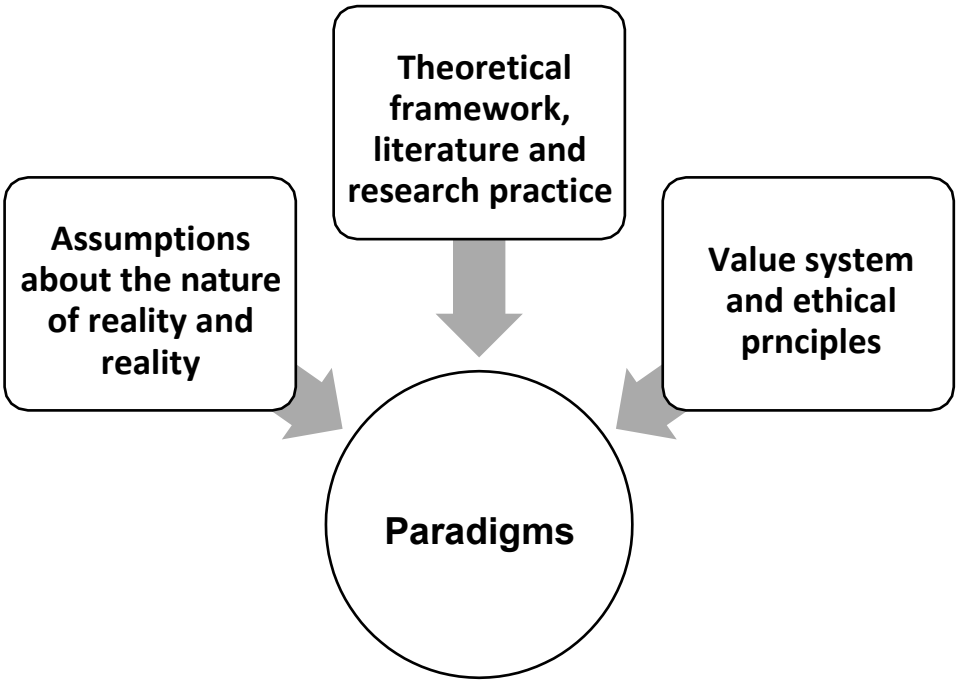


Figure 2: Factors influencing the choice of a paradigm.

Source Chilisa, B., & Kawulich, B. (2012). Selecting a research approach: paradigm, methodology and methods. University of Georgia.

3.5.1. Elements of the research paradigm

Qualitative researchers such as Lincoln and Guba (1985) have identified that there are four elements of research paradigms, which are epistemology, ontology, axiology and methodology. Knowledge and understanding of these elements are important as they make up the basic assumption of norms, beliefs and values that each paradigm holds (Denzin, 1989). Each research paradigm includes the research methods and research philosophies. This combination helps the researcher to develop the understanding and knowledge about the topic of the research.

3.5.2. Paradigms considered and rejected

Research paradigms begin with choosing a topic as well as developing a research design that mirrors the framework of values and beliefs for researching a topic (Creswell and Creswell, 2017; Conrad and Serlin, 2011). According to Denzin and Lincoln (2011a) there are several questions researchers need to ask in the process of selecting a paradigm and methodology. Questions include: 1) what is the nature or essence of the phenomenon being investigated 2) are social phenomena objective in nature or created by the human mind 3) what is the basis of knowledge corresponding to the social reality and how can knowledge be acquired and disseminated and 4) what is the relationship of an individual with her environment, is she conditioned by the environment or is the environment created by her?

Based on the answers to these questions, a researcher is able to determine which paradigm fits best to address their research question and aims and, in turn, determines which methodology will be most appropriate (Denzin and Lincoln, 2011a). In assumptions about the nature of reality (ontology), knowledge (epistemology) and value (axiology), positivists believe that there is only one tangible reality that is relatively constant across time and setting (known as naïve realism) and that part of the duty of the researcher is to discover this reality (Chilisa, 2012; Chilisa, Preece and Education, 2005). Positivists also believe that data can be measured and also broken down into variables (Chilisa, Preece and Education, 2005). The nature of knowledge (epistemology) for positivists is deep rooted in the paradigm of natural science (Mertens, 2010). Positivists view knowledge as that which can be derived empirically and verified or disconfirmed, thus allowing it to be generalised (Eichelberger, 1989; Chilisa, 2012; Ediger, 2003). Knowledge is made up of hard data, is objective and is therefore independent of the values, interests and feelings of the researcher and researched (Chilisa, Preece and

Education, 2005; Chilisa, 2012). Research approaches within this paradigm are quantitative in nature, and include quasi-experimental, correlational, causal comparative, experimental and surveys (Holder, 2016; Kirby, 2000; Phillips and Burbules, 2000; Morris, 2006). The methods of data collection are mostly questionnaires, observations, tests and experiments (Morris, 2006). Within this context, the main aim of research is to discover principles and laws that govern the universe and predict behaviours and situations (Heppner *et al.*, 2015; Chilisa, 2012). In addition, in the paradigm of axiology, the positivist belief is that all enquiries should be value-free and researchers should collect data using scientific methods to achieve objectivity and neutrality during the inquiry process (Berkes, 2017; Chilisa, 2012; Denzin and Giardina, 2016).

In summary, positivism and post-positivism are understood to be objective, be knowable, be free from values and believe that authentic results are only derived from observations and verifiable measurement. Designing research within this paradigm includes quantitative approaches such as quasi-experimental research, causal comparative research and correlational research. As a result, a positivist parardigm was discounted because this study believes that there are multiple realities which are socially constructed. Also, reliable knowledge is subjective and nomothetic, and truth is dependent upon context. Also,value is accepted because it is believed that value affects how one thinks or acts as well as what is found to be important. Most importantly, the research design proposed for this study is qualitative research as it is conducted in a natural setting.

Furthermore transformative/emancipatory and postcolonial indigenous paradigms were critically examined because they had elements that could address the research question. The transformative paradigm is a research framework that centres the experiences of marginalized groups and includes analysis of power differentials that have led to marginalization, and links research findings to actions intended to mitigate disparities (Chilisa, 2012; Riazi, 2016; Mertens, 2008). The study population, Nigerian residents living in an English care home, may be classed as less privileged due to their immigration history, race and ethnicity, or as those who have witnessed historical evidence of power differentials from their colonizer. However, the researched are not those oppressed on the basis of their cultural values nor does the study address social justice (Mertens, 2005; Mertens, 2010; Mertens and Ginsberg, 2009). The outcome of this research however is intended to offer knowledge on how to improve the life experience and wellbeing of ethnic care home residents.

On the other hand, a postcolonial indigenous paradigm was also examined because it is seen to analyse and explain the cultural legacy of colonialism and imperialism (Reviews, 2016; Said, 2016; Young, 2016). It speaks about the hidden consequences of external control and economic exploitation of other people and their lands which, according to history, can be traced back to Nigerians and their colonial masters. A postcolonial paradigm was discounted because the study was not aiming to challenge deficit thinking and pathological description of the former colonized, but was looking to explore cultural sensitivities in the care home for those who are being cared for through co-construction or, rather, jointly constructing meaning and understanding through their story (constructivism).

Hence, constructivism is applied in this research as it believes that reality is socially constructed and knowledge is best derived from those who experience it. This is why data collection within this paradigm is dependent on the researched and analysis of data obtained is based on the voices of those who took part in the study.

3.5.3. Following the Constructivist route

Having detailed the route to researching this topic and the consideration of various qualitative approaches and research paradigms, it was concluded that a constructivist approach was the best fit with this study particularly because:

- It accepts that there are multiple realities, which is particularly useful to this research because of the aim to explore the experiences of care staff and residents within different care home settings.
- It is a subjective epistemology in which the researcher and the researched jointly construct meaning and understanding.
- It fits with hermeneutics which agrees that knowledge and meaning are co-constructed.

Although constructivism and interpretivism are related concepts that appear regularly in the lexicon of social science philosophers and methodologies, their specific meaning lies in the purpose of their use (Schwandt 1994). These methodologies address the understanding of the world as others experience it (Fosnot, 2013; Teater, 2014; Hirokawa, 2014). Having discussed the aim of this study above, the intention is not solely to give new insight which will be

beneficial to understand the care home life of residents, but also to make an original contribution to knowledge that would inform policy change and practice development. Constructivism offers various ways of knowing and guarantees meaningful knowledge to inform practice. Based on this context, the primary purpose of the inquiry is to provide new insights that allow an individual to make an informed choice that could lead to effective change (Rodwell and O'Connor, 1998).

Rodwell's description of constructivism appeared the right fit to this study since it aims to explore older Nigerians' experiences and staff perspectives in meeting cultural needs, and the results are intended to inform policy and change in practice. To achieve this aim, it was based on interaction with the older women and men, and care workers, to construct meaning or reality from the data derived. This is in line with Fosnot (2013), Teater (2014) and Hirokawa (2014) where it is argued that individuals seek understanding of the world in which they live and work. It allows the study to generate complex insights to the issue rather than narrowing the meaning into a few categories or ideas. This is important as it will further direct the study interest to rely as much as possible on the participant's view of the situation. This will be derived through interaction, where other aspects of life histories, including cultural norms that affects the life of participants, are captured.

However, it is impossible to achieve this without an ontological and epistemological stance. Beliefs of what is true, what exists and what is real (ontology) will be explored. This in line with Ritchie et al. (2014) and Creswell (2013), who defined ontology as the nature of social reality, the kind of things that exist, the conditions of their existence and the relationships between these things. Constructivists believe that knowledge is multi-constructed and oppose the idea that there is single methodology to generate knowledge (Given, 2008b). The constructivist approach can be traced back from great scholars such as Edmund Husserl's philosophy of phenomenology (the study of human consciousness and self-awareness) (Mertens and Wilson, 2018; Mertens, 2005) and German philosopher Wilhelm Dilthey's philosophy of hermeneutics (Eichelberger, 1989; Chilisa, 2012).

Constructivists argue that reality is socially constructed and mind dependent, and that there are multiple realities as well as people who construct them, which is why it was chosen as an underpinning philosophy in this study (Creswell, 2003; Mertens and Ginsberg, 2009; Denzin and Lincoln, 2011a; Silverman, 2018). In essence, this simply means that meanings do not exist independently; rather human beings have to construct the meaning. Constructivists assert that

ontological beliefs (what exists) are continually being accomplished by social actors which are not only produced by social interaction but in a constant state of revision based on one's belief.

Ontology concerns one's underlying belief system as a researcher about the nature of being and existence (Blaikie and Priest, 2017). This is concerned with the assumptions a researcher makes in order to believe that something makes sense or that something is real, or the nature of the phenomenon that is being investigated (Blaikie and Priest, 2017). Throughout this study methods were used to support getting as close as possible to the researched to ensure that evidence was assembled based on individual's views and their subjective experiences.

Furthermore, what counts as knowledge (epistemology) for constructivists is that it is subjective, because it is socially-constructed and mind-dependent (Coghlan and Brydon-Miller, 2014; Keengwe and Byamukama, 2018). Also, constructivists accept that the world is constantly changing and meanings are continually shifting and contested. This implies that there are no objective, pre-existing truths out there waiting to be discovered; meanings are constructed. The word epistemology originates from Greek word episteme, meaning knowledge and logos, implying reason, to understand or to know (Killam and Carter, 2013; O'Brien, 2006). Sometimes it can be challenging to differentiate between epistemology and methodology, however the only distinguishing feature between these two is the fact that epistemology is more philosophical in nature than methodology (Killam and Carter, 2013). Epistemology examines the relationship between knowledge and the researcher during discovery (Zagzebski, 2008; Grimm, Baumberger and Ammon, 2016). In totality, it refers to how we know what we know and what to know. Applying this in research requires reflecting on questions such as "is knowledge something which can be acquired on the one hand, or, is it something which has to be personally experienced? What is the relationship between me, as the inquirer, and what is known?" In answering these questions, the ontological belief cannot be completely left out. This means that ontology influences the epistemological stance. As stated earlier, ontology examines one's underlying belief system as a researcher about the nature of being and existence. In the first chapter the researcher's professional experiences, personal migration experiences and cultural background were presented with an indication of how these influence perceptions and understandings. However, there are many other factors that remain unknown (multiple realities) that exist prior to and alongside this research. For example, participants may hold similar or different cultural beliefs to that of the researcher, and this influences their understanding of the phenomena of interest in this study. Influencers can be fully understood through dialogue with people that share the same cultural background

in neutral, open and transparent circumstances. Hence, through dialogue understanding is shaped and insight to a phenomenon is gained.

Whilst there is debate as to what the truth is, what is known and whether there is any such thing as truth (Striker, 1996; Lepore and Ludwig, 2013), this study does not aim to discover truth. This research seeks to discover the multiple truths that lie within the human experience of what the residents and staff tell. Since reality is mind-dependent and constructed, social inquiry is in turn value-bound (Keengwe and Byamukama, 2018). According to Ritchie *et al.* (2014), the use of reality will clear assumptions through intuitive knowledge, widen the horizon through authoritative knowledge (information received from people) and gain logical knowledge through reasoning from (a) that which is generally accepted and (b) that which is the new knowledge. In addition, this study acknowledges that research is value-laden (i.e., axiological belief). This points back to chapter 1, which discussed how my personal experiences drove my interest to research this population, my experiences working in the care home and my cultural background, including some core cultural values such as greetings which are non-existent in the care home, I was left wondering how the Nigerian population cope in the care home. In this research, these values guided data collection processes, and the approach to the participants.

Axiology originates from the Greek word 'Axia', based in concepts of value, worth and logia, which means science, and all combined are closely related to the idea of positionality and reflexivity (Hammond and Wellington, 2013). The term axiology was first applied by Paul Lapie (Logique de la Volonte, 1902) and E. von Hartmann (Grundriss der Axiology, 1908) (Marcum, 2008). Axiology is concerned with values, including aesthetics and ethics (Denzin and Lincoln, 2017; Gutek, 2013), but also includes the process of research (Collins, 2010; Cassell, Cunliffe and Grandy, 2017). Ethics investigates the concept of right and wrong in individual social conduct, while aesthetics studies the concept of beauty and harmony (Cassell, Cunliffe and Grandy, 2017). One cannot talk about ontology or epistemology without axiology in qualitative research because values directly determine our daily life decisions and views. This is to say that value affects all human dimensions (Klenke, 2008; Creswell, 2014; Creswell, 2007). Although some philosophers do not consider axiology as one of the four main branches of philosophy, especially the philosophers of science (Weinberg, 1992; Handoyo, 2015), scholars such as Honer *et al.* (2005) and Handoyo (2015) put axiology into three main branches of philosophy alongside epistemology and ontology. Axiology considers the philosophical approach to making decisions, rights and value (Finnis, 1983), and also examines attributes to different aspects of our research including participants, the data and the audience to which we

disseminate our research results (Handoyo, 2015). In a simple terms, it addresses questions such as:

- What is the nature of ethics or ethical behaviour, and what values will you live by or be guided by as you conduct your research?
- What must be done to respect all participants' rights, and what are the moral issues to be considered?
- Which cultural, intercultural and moral issues arise, how will I address them and how can I secure the goodwill of participants?
- How shall I conduct the research in a socially just, respectful and peaceful manner?
- How shall I avoid or minimise risk or harm, whether it be physical, psychological, legal, social, economic or other? (Shermer, 2015; Nakray, Alston and Whittenbury, 2015).

The implementation of ethical considerations focuses on four principles, which the researcher needs to consider when dealing with participants and data (Hurka, 2014). These principles are privacy, accuracy, property and accessibility (Hurka, 2014).

To summarise, constructivism was chosen as the underpinning philosophy of this research because it is believed that knowledge is socially constructed by people active in the research process and that researchers should attempt to understand the complex world of lived experience from the point of view of those who live it. Also, the constructivist philosophical paradigm is compatible with qualitative research and that of the phenomenological approach which was used in this study (Paley, 2016). This is the case because the paradigm seeks to generate understanding of a phenomenon through engaging with the experiences of the participants using different data-collecting agents.

3.6. Research design

3.6.1. Sketching the plan

It is inappropriate to establish in advance an exact process for a constructivist inquiry (Rodwell, 1998). The study adopted key aspects of constructivist research, including to manage its

complexity with flexibility within an emergent research design. However, there are elements of an emergent design which can be specified in advance(Lincoln and Guba 1985). These are

- Conducting design in a natural setting.
- That the emergent design is central to constructivist stance, involving an interactive approach.
- That the emergent design is central to constructivist research, involving an interactive approach both in data collection and analysis.
- The implicit knowledge is required to understand the nuances and reveal meaning.

Therefore, the overall design of this study reflected these components to give it a coherent and logical approach, thereby ensuring that the research aims and objectives were addressed. For instance, qualitative research was the chosen approach and this was conducted in a naturalistic setting and constructed to elicit multiple realities, which aligns with a constructivist conceptualisation of knowledge. Data collection (semi-structured and telephone interviewing) used interactive methods which aligned with constructivism (see below for details). Thematic data analysis was used to pull together the data derived from these interviews.

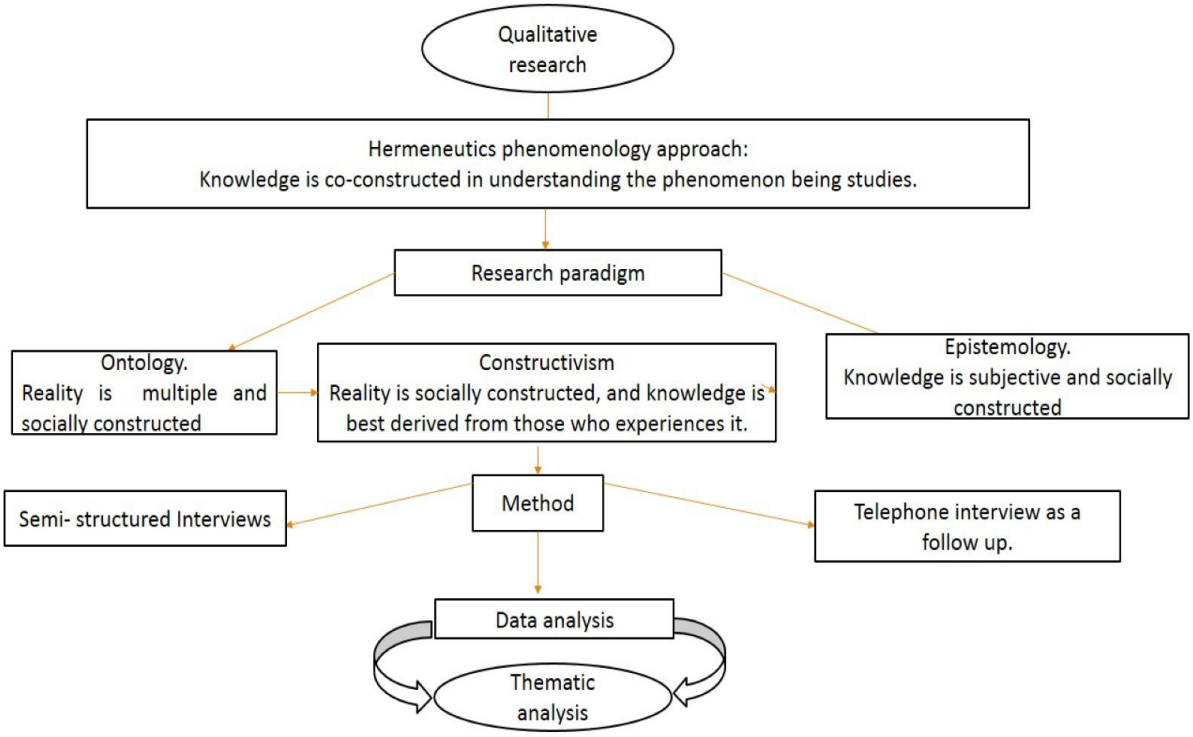


Figure 3: Research design

3.7. Data collection

As stated above, one of the aims of adopting constructivism was to establish reciprocal (interactive) and communicational ground between the researcher, older Nigerian residents and staff to gain an understanding of cultural sensitivities in the care home. There are different approaches to carry out an interview, although the dominant characterisation of interviews is based on the dichotomy between structured and unstructured interviews (Collins 1998). However, other interview styles have been acknowledged (e.g. May (2003)) such as semi-structured interview, group interview and focus group interview. These interview styles also vary in the way they collect data. Each one of these interview types follows their own approach to conduct an interview and to collect the research data. A clear difference between each type of interview style is seen in the way the interview questions are formulated and the amount of freedom given to interviewees in their replies to each interview question (Bryman 2012).

This also resonates with hermeneutic approaches that involve a process where the researcher and the participants work together to explore and develop their understanding of the phenomenon being studied. According to Koch (1995):

> *"Hermeneutics invites its participants into an ongoing conversation. Understanding occurs through a fusion of horizons, which is a dialectic between the pre-understandings of the research process, the interpretive framework, and the sources of information*."

According to Gadamer, there are several ways to develop a horizon of understanding. These are: pre-understanding, fore-conceptions, and openness to meaning (Gadamer, 2008). This explains the notion that we cannot stick blindly to our own fore-meaning if we want to understand the meaning of another, and goes on to state that all that is asked is that we remain open to the meaning of the other person as it leads us to the next stage of understanding. In this study, I found that fusion of horizon is not straightforward and can only be achieved through interpretation, which develops throughout research process. Interpretations may be complete but never end, as I found that new understanding emerges after each interpretation. However, Koch (1996) suggested that fusion occurs through reporting of research, thus indicating how the researcher participates in the research, provides understanding of social and historical context of the research, and how the horizons of the interpreter and the interpreted are fused. This research followed various processes to gain an understanding of cultural sensitivity in care homes, and as it progressed towards its underpinning

philosophy, consideration was given to creating the avenue for joint interaction to occur through the use of semi-structured interviews and during said interviews. Interactions were established between myself and the older residents and staff to move towards a fusion of horizon, and this was expedited by going back to resident and staff accounts of daily experiences to examine the interpretations that emerged from the experiences. At the conclusion, I found that fusion of horizon derived from this study was based on various contexts. In terms of care home life, residents were found to be in a world of their own even though they lived in the same care home settings. Some of these resident's world was greatly influenced by their immigration histories, educational background and lifestyles. These factors affected how they viewed, lived and coped within care home as an older Nigerian. As the interpretation progressed I found that a common topic with cultural concern was related to food, with half of them talking about greetings and respect. At this stage, I found that my understanding about older Nigerians and care home settings widened. The fusion here was that person-centred approaches were key to culturally-appropriate and sensitive care. This is because people's way of life (culture) is influenced by a lot of factors, as found in this study**.** Also, the way people interpret and view life differs. This connects back to the transcultural nursing model and person-centred care presented in chapter 2. This study provided new insight for myself that the complexity in providing culturally-sensitive care begins with knowing that differences exists between people from different cultural backgrounds (cultural awareness), and subsequently seeking understanding of the group receiving care and how these groups perceive and respond to health as well as the cultural implications surrounding their behaviours (Değer, 2018; Andrews and Boyle, 2002). This is then followed by person-centred care, where the person is actively involved in their care (Hannan, 2019). This is summarised by Gadamer's findings that in order to gain insight into a new horizon we must be open to their understanding of past and present horizons (Gadamer, Weinsheimer and Marshall, 2004).

The implication for hermeneutic inquiry is that research participants are also giving their self-interpreted constructions of their situation (Koch, Webb and Williams, 1995, p. 835). This process of co-construction and understanding occurs when the researcher indulges in repeated circular reading between the part and the whole text. This is to decode the author's intention and establish a relationship between the text and the context (Gadamer, 1989). This permits the researcher to engage the participants in a collaborative process of understanding the phenomenon. This not only involves the participants in a collaborative conversation but also

engages them in an ongoing discussion around reflective writing and modifying based on participants' feedback until the interpretation fully encapsulated their lived experiences. To get the participant's viewpoint, the study used semi-structured interviews. More so, the use of semi-structured interviews to engage in more conversational mode helped participants revisit their experiences. This is because the participants were invited to discuss topics around their immigration story, and their move to and life in the care home. It was anticipated that these participants needed prompts to enable insight into their story. As a result, the semi-structured method for interviewing was used to structure the questions. These questions were explorative and predictive in nature, as highlighted in chapter 4, to enable participants to reconstruct and discuss their experiences Also, within hermeneutic phenomenological methods, van Manen (2016) describes interviewing as having two purposes: (1) as a means to explore and develop a rich understanding of the phenomenon; (2) to develop a conversation around the meaning of an experience. Thus, van Manen (2016) encourages more conversational interviewing.

Data collection within hermeneutics phenomenology has two purposes (van Manen 2016). The first is to explore and develop understanding while the other is to develop an understanding of the meaning of experience through a more conversational interviewing. According to van Manen (2016), this is seen as a more interactive interview format compared to structured interviews. Conversational interviewing, which is also known as semi-structured interviews, helps participants to revisit their experiences. Details of how this was used in this study are detailed in the method chapter.

3.8. Data analysis

In analysing the data retrieved from this study, I considered that I needed to remain true to the constructivist concepts which assert that researchers must rely upon the participant's view of the situation which is derived from co-construction (Creswell 2003). As a result, thematic analysis was chosen because it features participants' accounts and perceptions, is not tied to any single methodology, provides a highly flexible approach that can be modified, and is specifically used to provide a rich description of the findings rather than a fine-grained analysis, which agrees with Braun and Clarke (2006).

Notably also, thematic analysis is a common interpretive strategy used to synthesize the meanings of a studied phenomenon (Benner 1985; Van Manen 2014). Thematic analysis is a

tool as well as a strategy used to detail and provide a rich and complex account of data (Braun & Clarke 2006). It goes beyond description in that it involves the process of recovering the theme that is embodied in the evolving meaning and imagery of the work (Van Manen 1997, p. 78). The thematic analysis, which was used in this study, helps us to reflect on daily taken-for-granted understandings and to unravel the surface of these realities, which we use to explain the phenomenon under metaphysical traditions (Benner, 1985; Braun & Clarke, 2006; Van Manen, 2014).

3.9. Methodological challenges

Every methodology used in research, including hermeneutic phenomenology, has some challenges attached to it. One of the major challenge of hermeneutics is the fact that participants are the primary sources of their own experiences (Phillion, He and Connelly, 2005; Balani, 2000). This implies that they can choose what to share, how to share it or what to omit (Qu and Dumay, 2011). In addition, Qu and Dumay (2011) posit this could lead to participants presenting themselves as mobilised in situations rather than giving more mundane but factual accounts. In other words, there is a possibility that participants do not mean what they say or say what they mean. Also, because participants own and decide what they share and how they say it during data collection, it then means that these narratives from the participants have been filtered twice by the participant and then the researcher's interpretation, which could be interpreted as a source of bias in the research. However, this cannot be completely avoided in that we are not in control of participants original experience. Also, language is in itself a representation of meaning and meaning and its significant are sometimes not entirely in agreement (Bass, 1982) This, according to Bass, (1982) implies that language may display deficit or surplus over the actual meaning or intention of the speaker. This, however, does not mean that the instability of language as a conveyor of meaning does not render speech as unrepresentative of meaning, Bass (1982) acknowledges. This, however, can be guarded by the concept of 'shared intelligibility' (Yacobi, 1985; Zerweck, 2001; Thompson, 2018). This is a process where the researcher utilises shared knowledge based on the experiences and pre-understanding of the phenomena which, according to Yacobi (1985), Zerweck (2001) and Thumpson (2018), can serve as a safeguard against unreliability. In this study, shared intelligibility between the researcher and researched existed in relation to aspects of Nigerian culture and the experience of migration. Language, cultural norms, beliefs, symbols, values,

and approach to food were all backgrounding issues that facilitated conversation about care home life. For example, use of terms from a shared native language enabled participants to articulate experiences and describe events that would otherwise would have been difficult. The shared intelligibility in language, including verbal and non-verbal cues, was also useful to understand when not to continue or when a sign meant a word which will not need to be revisited. Thus, shared intelligibility was advantageous in the conveyance of meaning between the researcher and the researched.

Also, pre-understanding of the phenomenon occurred due to the researcher's previous experience working as a carer in a care home looking after older adults similar to that of the age of older Nigerians living in the care home involved in this study. Having worked with different older people in care home settings, my understanding about care home routines and the pattern of daily life resulted in sharing of meaning throughout the interviews. From a researcher perspective this use of shared intelligibility about the research setting allowed conversations to flow with minimal interruption.

3.10. Chapter Summary

Overall, this chapter has presented and detailed various major research paradigms which guided research. Each has been unpacked within a framework of its ontological, epistemological axiological and methodological assumptions, including its data collection methods. Interpretivism or constructivism views reality to be socially constructed and states that there are multiple realities. Reliable knowledge is subjective and nomothetic and truth is determined upon context. In interpretivist and constructivist paradigms, value is accepted as affecting how one thinks or acts as well as what is found to be important. Hermeneutic phenomenology was used in this study to allow for a deeper understanding of the participants' experiences and how their lifeworld is pre-reflectively experienced. The next chapter will present detailed practical steps and discussion on the process used.

Chapter 4

4.1. Methods

4.1.2. Introduction

This chapter presents a detailed account of the research methods to give the reader insight into the research process. This discussion begins with the strategy and process for the selection and recruitment of care homes that provided services to older Nigerians. This is followed by a description of the processes for identifying, selecting and recruiting residents and care home staff participants. Qualitative data collection methods in the form of face-to-face and telephone semi-structured interviews were selected to generate rich data about the participants' experiences. The approach to thematic analysis is presented, and the chapter concludes with a detailed discussion of the ethical considerations that were addressed when carrying out this research.

4.1.3. The research fields

National care home data sets do not include information about ethnicity of residents and this proved to be a challenge in identifying and selecting the research field. The office of national statistics (2011) highlighted that London had an above average proportion of ethnic groups including those of black African ethnicity (7.0 per cent), with southern boroughs being home to the largest Nigerian community in the UK. This information directed the initial search for research sites in London. A search of the CQC database and website, and housing.org, led to identification of 11,783 care services. On further scrutiny it was identified that there were duplications and services that were not relevant to this study (such as children's services and ambulance services). Following removal of duplications and false hit a total of 653 care homes (329 nursing homes and 324 residential care homes) were identified.

4.1.4. Recruitment of care homes as research settings

The sampling strategy aimed to recruit at least four care homes that were providing services to older Nigerian residents to ensure that the sample was diverse and relevant. Of the 653

identified care homes, 12 were located in the southern boroughs of Lewisham (n=9), Peckham (n=2) and Woolwich (n=1). The care home managers of these homes were contacted to explore if Nigerian residents were living in the home or if they could suggest care homes where older Nigerian residents were likely to be living. This process is known as respondent-driven recruitment and is often used to recruit hard-to-reach populations (Johnston and Sabin, 2010; Bonevski *et al.*, 2014; Badowski *et al.*, 2017). This approach resulted in four care homes being recruited where individuals with experiences of the phenomena under consideration lived. Criterion sampling was then applied to ensure that individuals that met predetermined criteria were identified and invited to take part in the study.

4.2. Description of care home sites

Care home 1 is registered with CQC and had received a care quality rating of overall good. This home was registered to provide nursing and residential services for up to 33 residents. At the time of data collection, only 29 residents lived in the home. Many of these residents had lived in the local area throughout their lives, so the care home was a familiar place prior to moving in as a resident. The home is located in a residential area close to shops, amenities and public transport services. People are accommodated in single bedrooms over three floors served by two lifts. There are en-suite bathrooms but communal facilities are sufficient (kitchen, laundry etc.). There is a large garden to the rear of the home and car parking is available.

Care home 2 is registered with CQC and had received a care quality rating of overall good. Care home 2 is a home that provides residential services for up to 15 adults with only 12 occupants at the time of data collection. All the residents in this care home had lived in the local area for more than 20 year prior to placements so the home was a known building prior to moving there. It is located in a large city near to a few shops, restaurants and a school. Care home 2 has 15 bedrooms, all en-suite, and arranged over three floors. The ground floor has five single en-suite rooms with WC and wash basin, whilst the first floor has seven single rooms with same settings as ground floor. The second floor has two large single rooms with en-suite WC and hand basin, and two large single rooms en-suite with WC, hand basin and shower. Care home 2 also has a garden, and communal dining area/lounge area.

Care home 3 is registered with CQC and had received a care quality rating of overall good. Care home 3 is a home that provides residential services for 56 residents, all occupied at the

time of data collection. Up to half of the residents in this care home had come from various locations of the city but the remainder had spent the majority of their life in the local area. This care home was located in a residential area of a large city, close to several shops, and provides direct access to different areas of the city. Care home 4 has 56 bedrooms, all en-suite. The care home is designed with a welcoming lounge area, a light and airy dining room, beautiful gardens and cosy bedrooms, which provide a warm place for residents to rest and relax. The care home also includes a place of worship, a cinema room and an activities room, as well as a hairdressing salon.

Care home 4 is registered with CQC and had received a care quality rating of overall good. Care home 4 is a purpose-built care home that provides residential services for up to 48 residents, with 28 occupants at the time of data collection. The majority of the residents in this care home lived in the area all their lives with a few who were referred from other places. The care home is located in a residential area close to shops, amenities and public transport services. People are accommodated in single bedrooms over three floors served by two lifts. There are no en-suite bathrooms but communal facilities such as kitchen and lounges. There is a large garden to the rear of the home and car parking is available.

4.3. Recruitment of resident participants

The care home resident population is regarded as vulnerable due to high levels of frailty, multimorbidity, cognitive problems and disabilities. Thus, gaining access to residents requires negotiation with gatekeepers to ensure that they are protected from harm, but at the same time their right to take part in research is upheld (Holloway and Wheeler, 2002). In this study, care home managers were gatekeepers, both to the care home service and residents (Schreuders, Spilsbury and Hanratty, 2019). Negotiating access to care homes can be challenging for researchers, particularly for those researching sensitive topics such as culturally-sensitive care. Some of the managers declined the opportunity for the home and residents to participate in the study. Some managers suggested that the residents' families would not support the research. Other managers were supportive and recruitment of participants started as soon as potential care homes were identified. Within each research site a meeting was held with the care home manager to provide general information about the study and offer an invitation to residents to participate. This was to ensure that all potential participants were aware of the study and were

given ample time to consider their involvement. It took 3-4 weeks to identify participants in each care home.

4.3.1. Inclusion criteria for resident participants

- Older black Nigerians resident living in a care home
- Older resident who is willing to take part and has capacity to make a decision about participation
- Able to take part in a lengthy discussion
- Aged 65 and above

4.3.2. Exclusion criteria for residents

- Older residents who did not have capacity to consent were not included because they potentially were unable to articulate their views
- Older people from other black ethnic minority groups.

Of 33 residents in care home 1, only 2 residents were Nigerian and were identified by the manager to meet with the study criteria. One resident was male (65 years old) and the other female (75 years old). The female resident had lived in the UK for 20 years and in the care home for 3 years. The male resident had lived in the UK for over 28 years and resided in the care home for 4 years. In care home 2, of the 15 residents one female resident (67 years old) met the study criteria. Throughout her life she had lived in different parts of Europe and settled in the UK in the 1990s. At the time of recruitment to the study she had been living in the care home for 5 years and previously had lived in other care homes.

In care home 3. one male (68 years old) and one female (70 years old) Nigerian resident were recruited to the study. The male resident had lived in the UK for over 25 years, and the woman had been living in the UK since her early 50s. Both of these residents had lived in the care home for over 4 years. The manager also reported that they had previously lived in supported accommodation prior to moving to the care home. In the fourth care home, two female residents were recruited (aged 70 and 75). They had lived in the care home for just over 2 years at the time of recruitment. The 70-year-old resident had lived in the UK for over 29 years, and the

other resident had lived in the UK since she emigrated from Nigeria in her late 30s. A total of 7 participants were recruited from the four participating care homes (see table4).

4.4. Recruitment of care home staff and managers

During the initial meeting with the care home manager, options about interviewing the residents' key worker and other care staff were discussed. The managers then informed staff about the research. Potential participants were given an information sheet prior to the day of the interview and informed consent was gained on the day of the interview. In care home one, one carer and one manager took part in one-to-one semi-structured interviews. In care home two, six care staff and one manager took part in a focus group interview. In care home three, one carer and one manager took part in one-to-one semi-structured interviews, with the same occurring in care home four. Whilst there was interest in the study, there was limited time and high work demands on staff and these pressures reduced the number of staff and managers able to take part. A total of 12 staff took part in the study (see table4).

4.4.1. Inclusion criteria for care staff and managers

- Care workers involved in the care of participating residents
- Care home manager of the participating care home

4.4.2. Exclusion criteria for care staff and managers

- Other staff not directly involved in the care of participating residents such as the domestic staff.

Participating care homes	participant	gender	Age band	Marital status	Year of immigration on to UK	Where they lived	Duration of stay in care home	Type of accommodation.
Care home 1	Ms. Joy	Female	75	Single	1968	Peckham	2 years	Nursing/ Residential
	Mrs. Joan	Female	80	Married	1978	Peckham	3 years	

	1 manager 1 carer	Female Female						
Care home 2	Mrs. Nneka	Female	67	married	1990	Peckham	3 years	Residential
	1 manager 1 carer	Female Female						
Care home 3	Mr. Peter Mrs. Jane	Male Female	81 75	Married Married	1976 1975	Peckham Peckham	5 years 3 years	Residential
	1 manager 5 carers	5-Female 1-Male carer						
Care home 4	Ms Juliet Mrs. Amaka	Female Female	79 80	Single Married	1970 1968	Lewisham Lewisham	3 years 4 years	Residential
	1 manage 1 carer	1 female 1female						

Table 4: Overview of the resident's profile and staff participants

Total number of participating care homes = 4

Total number of residents = 7

Total number of care staff = 8

Total number of managers = 4

Total number of residents and staff participants =19

4.5. Data collection

Resident and staff data collection involved 2 interviews: the first a face-to-face individual interview and then a second telephone interview. The first interview was carried out face-to face with residents and care home staff at a time that was convenient to the interviewee. Staff were offered the opportunity to take part in either an individual semi-structured interview or focus group interview to optimise participation in the study whilst generating a rich data source. The second interview was via telephone due to the distance between the researcher and researched, and the need to be very flexible with the scheduling interviews. Other reasons for combining different types of interviews included the need to generate different participants' perspectives (parallel use) and striving towards data completeness or confirmation of findings (integrated use) (Rees, Ford and Sheard, 2003; Taylor, 2005).

4.5.1. Rationale for use of semi-structured interview

As earlier indicated in the methodology chapter (chapter 3), this study was underpinned by a constructivist approach. This approach emphasizes the generation of data generation that enables understanding of the perspective of those experiencing the phenomena of interest. This also requires researchers to understand the context, therefore familiarity with the research setting is important. Knowledge is constructed from the meanings attributed to phenomena and the context where phenomena exist, so dialogic interaction between the researcher and researched through data generation efforts such as interviewing can deepen understanding (Cohen & Manion, 1994; Galbin, 2014). The use of semi-structured and focus group interviews is consistent with the study's underpinning philosophy. Semi-structured interviews allow depth to be achieved by providing the opportunity on the part of the interviewer to probe and expand the interviewee's responses (Rubin and Rubin, 2005). Though semi-structured interviews are a managed verbal exchange, they also allow informants the freedom to express their views in their own terms (Newton and Newton, 2010; Menter *et al.*, 2011). This type of interview allows reciprocity between the interviewer and the participants (Galletta, 2012), thus giving room for the researcher to improvise follow-up questions based on participants' responses (Hardon *et al.*, 2004; Rubin & Rubin 2005; Polit & Beck 2010). This approach also allows space for participants' individual verbal expressions (Robert Wood Johnson Foundation 2008). Importantly, semi-structured interviews are appropriate for studying people's opinions and

perceptions of complex or sensitive issues, which is core to this study (Barriball and While, 1994).

4.5.2. Semi-structured interview guide for resident participants

The semi-structured interview guide provided a framework for the interview to ensure that the research questions were addressed. Research questions are not the same as interview questions (Johnson and Christensen, 2013). Research questions describe the issue to be explored but rarely can be addressed by literally asking the same questions (Johnson and Christensen, 2013). Thus, the interview guide that was designed for this study included explorative, predictive and interpretive questions. The guide also enabled the researcher to direct conversations towards the research topic during the interviews (Blandford, 2013; Whiting, 2008). The guide was particularly helpful in deciding whether emerging topics from the participants were worth exploring, when to end or open a new topic or reintroduce something mentioned earlier in the interview and when to probe for more detail (Kelly, 2010).

Gaining trust and building rapport, as well as making the participants comfortable, were important considerations to support interviewees to discuss their experiences and views. Small talk at the beginning of the interview was conducive to opening the discussion and obtaining demographic information. This also enabled the researcher to get to know the participant. This was followed by explorative questions that opened up the discussion. For example, “how is daily life in the care home?” This question is explorative and allows the interviewee to discuss any aspect of life.

In contrast, predictive questions, such as “in what ways has this life affected your health and wellbeing?” focused on predictable outcomes of the phenomenon being studied (Miller, 1998; Johnson and Christensen, 2013; McBride, 2015). The interpretive questions were used throughout the interviews to double-check what the participant meant and to compare with emerging findings as well as offering opportunity to share more information about issues and topics (Merriam, 2009). For example, one of the participants stated that a carer is “on the high shoulders with her.” When asked what that meant she replied, “she is rubbing shoulders with me”. It was important that any ambiguous statements were clarified with the participants to ensure that their meaning was understood.

The interview guide was initially prepared in pidgin English and further in English in anticipation that these older Nigerians did not have English as their first language. The topic

guide was formed using the topics identified through the literature review that was presented in chapter two. These were based on the predictable aspects of care highlighted by the included authors. As a result, it lacked the nuances and insights that could potentially be gained if the interview moved beyond these predictable aspects of care. Separate interview topic guides were prepared for staff and resident participants to provide a framework that allowed for exploration of both working and living in a care home.

4.5.6. Conducting the interview with residents

Prior to the interview, I had booked an initial visit to the care homes to discuss the possibility of participation. During this initial visit, the manager took time to show me round the care home and introduced me to the residents and the staff. During this time, I engaged in friendly discussion with residents, as this was important to establish familiarity and also contributed to my understanding of life in the care home. On the day of the interview, I considered that the setting used in conducting interviews can affect the interaction and further influence the type of data generated (Angelelli and Baer, 2015; Edwards and Holland, 2013). These effects can be the most general, including the influence of places and spaces on identity, perceptions, memories and emotions, and the interaction of hierarchies of power at different levels associated with individuals, institutions, organizations and society. In addition, these can be very specific and may affect face to-face interaction, such as noise, interruptions, and distractions (Edwards and Holland, 2013). It was important to ensure that the participants experienced privacy. Some residents wanted the interview to be held in their bedroom with the door shut. They felt that this setting would enable them to tell their stories without any interruption from other residents or staff. When first meeting the residents, I introduced myself and referred to them as mama or papa. I was aware that this is a culturally-acceptable introduction prior to discussing the study and gaining informed consent. Three resident participants were particularly thrilled to be addressed in this way and they spontaneously told me about family and life in the UK. In contrast, one participant was uneasy and not willing to take part in the interview despite all the culturally-required formalities being provided. She then changed her mind when one of the care staff provided further explanation about why I was visiting the home.

Each interview commenced with a question such as "mama or papa, could you tell me how you got into the care home?". In response some spoke of their journey into the care home, while others began talking about family issues, illness, lack of family support, and children moving away from home. They all discussed what they experienced when migrating to the UK. This provided the opportunity to explore in-depth their migration stories. As the interviews progressed it was clear that these individuals had had very unique migration experiences. Their experiences of moving to and living in the care home also varied. As the interview proceeded, reflecting on the constructivist orientation of the interviews, these individuals were encouraged to discuss the things that they considered to be most relevant. On many occasions when a participant discussed a broad topic or experiences, they were encouraged to give an example of something that had transpired which influenced this perception. This strategy was useful to enhance understanding of what the participants were trying to tell, thus minimising misinterpretation during the analytic process.

The duration of the interviews ranged between 45 to 60 minutes. The recorder was paused occasionally when the participant was emotional or when they required a break. Thus, the interview was conducted at the pace set by the older resident. Those that became emotional were happy to continue with the interview after a short break. Toward the end of the interview, key points were revisited to check understanding and clarify anything that was vague or ambiguous. At the end of the interview notes were made in a reflexive diary to capture initial thoughts and observations.

4.5.7. Telephone follow-up interview

A telephone follow-up interview was conducted with 6 out of 7 residents after initial analysis had been completed to gain further understanding of the older resident's views and experiences of living in the care home, and to clarify any issues that were vague or ambiguous. On the day of the interview, the manager was initially telephoned to explore if the resident was well enough and willing to take part in the telephone interview. The discussion commenced with further exploration of general topics that had been mentioned in the first interview. Mrs Amaka barely shared anything during the initial interview, stating *"not a lot, even though I live here, I know how ..... not a lot"*. When asked if she could explain further, she said *"I hope I meet someone*

that I can love and trust. At the moment I live here. I know that lady next door. and the lady who brought me. I can't tell you (quite)".

However, her responses during the telephone interview were totally different. She was relaxed and more open and willing to have a discussion:

Researcher:

Mama it is nice to have you back. How are you today?

Amaka:

Fine my daughter

Researcher:

Mama I don't know if you can remember, the last time l came there to see you, we had a very Small chat about life in the care home. Can you tell me a bit more about that?

Amaka:

It is strange if you ask mmmmhhh that's all I can say

Researcher:

Strange? How mama?

Amaka:

Well since I moved to England it is been problem here and there. You know coming to UK really helped me. My husband's people were bad I will say. They hate me with so much passion, but my husband was very good. When we came here I think.....was it 196……7 (asking the daughter)

Rose:

(Talking to her mum) mummy you should know we were little then, but I remember it was around the 60s

Amaka:

Hold on, it is around 1968 because my elder sister died just two months after we left.

Researcher:

Aww mama I am so sorry to hear about your loss

Amaka:

My daughter thank you. That is life.

This illustrates the value of generating data through an initial face-to-face interview and then further discussion during the telephone interview. Familiarity between the researcher and researched developed throughout the two interviews. Returning to these key participants enabled them to move past a superficial account of their life (Fujii, 2018) and enhanced the quality and richness of the data.

4.5.8. Semi-structured interview guide for care staff

The interview guide included open-ended questions to avoid yes or no answers. For example, "Can you tell me about caring for residents from ethnic minority groups including Nigerians? How do you know what they need?" The phrasing of questions ensured that they were presented in simple, easy-to-understand language. The participants were asked about how they responded to the needs of older Nigerian residents; what practices and approaches were adopted within care home services to address the individual needs of residents and their families, and how those practices and approaches support the provision of culturally-sensitive care. The interview guide served as a framework for the discussion and, according to Silverman (2013), departures from the guide are not a problem and should be encouraged. This ensures that unexpected yet relevant topics emerge, reflecting the reality of the participants views and experiences.

4.5.9. Conducting the interview with care staff and manager

Twelve care home staff and managers were recruited to the study. The interviews were arranged at a time convenient to the participants, and structured to enable them to fulfil duties to the residents. They were assured that they could leave the interview to attend to residents if needed. The interview commenced with brief introductions. After the participants introduced themselves, I introduced myself as a PhD student who had worked as a carer in a care home as well as a support worker with people with mental health issues. This conversation enabled the discussion to flow. Topics were then discussed according to the interview guide. Participants discussed caring for people from different ethnic backgrounds, what challenges they experienced, what approaches they used, and what worked well and what did not work. The interview was in the form of a casual conversation to ensure that it was a pleasant, neutral experience, whilst balancing this with a professional but detached approach. Participants were encouraged to talk by paraphrasing what they said, constructively restating their viewpoints, and reflecting back their own words. These techniques ensured that they were aware of the active listening that was occurring. They were also asked to clarify issues that were unclear or expand on points that they had made. At the conclusion of the interview, they were thanked for their contribution. The duration of the interviews ranged between 50 and 60 minutes.

4.5.10. Planning the focus group interview

A focus group discussion had been planned to be undertaken with all care staff and their managers. However, due to time constraints and demands of work, only one care home staff group took part in a focus group interview. The purpose of the focus group interview was to gain a broad range of views on the research topic and to create an environment where participants felt comfortable to express their views (Hennink, 2011). Focus group discussions lend themselves to a wide range of research applications. As with other qualitative research methods, focus group discussions can be used for exploratory, explanatory or evaluative research, as well as policy-oriented research (Creswell, 2014). In this study, the focus group topics were prepared and reflected the questions of the semi-structured interview guide that was used for the one-to-one individual interviews. The focus group interview included 6 carers and their manager. Though the size of the group was small, this was advantageous because it

gave every participant an opportunity to share ideas. For example, during the interview, most of the staff had the opportunity to speak more than once and all gave their contributions, something that would have posed a challenge in a larger group composition. According to Kruger *et al.* (2000), the most significant part of a small group is that it gives everyone in the group an opportunity to share insights and yet is large enough to provide diversity of perception.

4.5.11. Purpose and rationale for using focus group interview

As earlier stated, focus group interviews aim to collect high quality data in a social context which is intended to help understand the phenomenon under study (Khan and Manderson, 1992; Patton, 2002). Therefore, the study used focus group interviews to explore a range of ideas and feelings care staff and managers had about culturally-sensitive care. It was aimed at exploring the differences in perspectives amongst care staff about culturally-sensitivity care and the approaches they used to address this issue. The purpose was to uncover factors that influenced opinions, behaviour or motivation and gain more insight into complicated views, especially the participants' opinion on the phenomenon. Focus group interviews tend to yield a rich and detailed set of data about perceptions, thoughts and impressions of people in their own words (Stewart, Shamdasani and Rook, 2009). This was significant as it helped to find out their understanding and thoughts on cultural sensitivities in the care home and possibly how they could meet the cultural need of residents from other ethnic minorities. Also, focus group discussions have been used in researching sensitive topics and with vulnerable populations. The concept of sensitivity highlights the inherent threat to those involved, stemming from the private or personal nature of the issues under study as well as the potential for embarrassment or social censure on disclosure of associated attitudes and/or behaviours (Jordan *et al.*, 2007).

4.5.12. Conducting the focus group interview

The interview commenced with exploration of ground rules for the discussion to ensure that everyone had an opportunity to express their views. The topics reflected the semi-structured interview guide and were structured using Anderson's (1990) guidelines for constructing focus group interviews. Then the session started with a general topic which was related to care of residents from ethnic minority groups. The manager had provided a tea trolley and this had the effect of creating a relaxed atmosphere. The conversation flowed, and probes were used to facilitate depth of discussion (Anderson, 1990). The interview took an hour and forty-five

minutes. At the end of the interview, the participants were appreciated for their contributions and time.

4.5.13. Planning the telephone follow-up interview

After the initial data collection, contact was maintained with care home staff. Only those staff who took part in the one-to-one semi structured interview were able to take part in a follow-up telephone interview. This interview enabled further discussion of issues relating to culturally-sensitive care, new ideas, and issues that appeared contradictory or vague:

Researcher:

During my interview with the residents you had a different viewpoint regarding provision of culturally appropriate food which I believe differences sometimes do exist. This was the idea that residents eat all that they are given and are used to the local food because they have lived in the UK all their lives. Also, you added at some point that some get food brought over by family. Would say that there is a high level of involvement of family in terms of food, and the type of food families are allowed to bring to the care home?

Deputy manager care home 3:

Yes, the family was highly involved especially in both bringing food in and teaching us how to cook them. What we do most times is, if we notice that family tends to bring specific food for their loved one more often, we seek advice on how to make the same dish to the resident. So yes, we learn from them and we do our best to make the same type of food they bring in. Like I said, they have lived here all their lives and are used to the local food.

In addition, missing information was also explored with care home manger 3. This was because after the initial interview it was evident that there were topics that were inadequately explored with care home 3 manager and thus required further exploration. For instance, during the first interview with the manager about the provision of activities, it was not clear whether the activities that were discussed were identified through assessment of a resident or through discussion with family and staff. Subsequent data collection led to clarification of this issue as illustrated below:

Researcher:

I remembered on my last visit that you provide home-based activities and even culturally related activities like celebrating the independent day of every resident tribe in the care home. Are these residents assessed based on this or …. I mean how did you come up with it?

Deputy Manager Care home 3:

Well, I believe during your last visit, you saw that most of the staff here are Africans and some British. This has helped a lot to understand our resident's cultural needs. During our meeting, we discuss ways to do better than we are doing (Pause for 30 seconds). My staff shares useful ideas base on their experience with residents and we look into it. In terms of activities, we assess and re-assess based on what we have and normally our activity coordinator takes care of that. As I said our residents like what we offer them.

Researcher:

Would you say that these activities reflect cultural diversity?

Deputy Manager Care home 3:

Yes, I would say because celebrating each tribe's independent day I believe reflects cultural acceptance. So yes!

In summary, the data derived from the second interview added to the richness and depth of the data. In total, 2 interviews were conducted (semi-structured face-to-face interview and telephone interview) in this study.

4.6. Data analysis

Following each interview, a brief field note was made detailing significant impressions and events that occurred during the discussion. As soon as possible after the interview, the audio recording was listened to and transcribed verbatim. This process was important to identify if further information could be attained in a later interview. Also, this was an opportunity to reflect on the interview process. Once transcription was completed across all of the data set, data analysis commenced. Braun and Clark's (2006) 6 stages of thematic analysis was adopted to remain true to the tenets of the constructivist approach. This approach is a guide to

harvesting, analysing and synthesising data. Thus, the six systematic steps were intertwined all through the analysis.

During the initial transcription, familiarisation with the data was achieved as the transcript was read repeatedly, searching for meanings and patterns across the data and marking ideas for codes. These codes were generated by identifying important sections of the text and attaching labels to index them as they related to the issue. During the coding process, some text was coded in multiple different codes and some data was initially un-coded until meaning was later determined. According to Savage (2000), qualitative coding involves a process of reflection, thinking and interacting with the data. Also, during the initial coding, memos were recorded to identify interesting aspects in the data and emerging impressions that may form the basis of themes across the data set. Also, as this study has 2 data sets these were initially coded separately.

Following initial coding development, the data was revisited and reviewed to determine if a coherent pattern was apparent. During this review process it was easy to spot inadequacies in the initial coding (King, 2004) which required recoding. Also, it was noticed that some of the codes contained a chunk of text that had relevant issues which contradicted the category it was attached to, and so they were broken down in a new code. This process was required as coding is an ongoing organic process (Braun, 2006). Also, the reviewing process was to ensure that the themes were refined in such a way that they are specific enough to be discrete and broad enough to capture a set of ideas contained in text segments. At the end of this process, it gave a clear idea of the content of different themes, how they fit together and the overall story they tell (Braun, 2006), including testing the referential (raw data) adequacy by making sure these themes were firmly grounded in the data and represented the participants' voices (Lincoln and Guba, 1985). Once all the themes were developed using the above strategies, the write-up process began with the individual data sets (resident data and staff data)

Each theme was analysed using quotes from the participant as a reference of the source. This was in agreement with King (2004), who states that quotes from the participants are an important component of the final report. Making references to the original source of the data aids understanding of specific points of interpretation from the participant's point of view as well as the prevalence of the themes. Following this, an in-depth description of the data was done and further interpreted to gain in-depth understanding of its broader meaning and implication. This is in accordance with King (2004), who stated that simply reporting codes,

categories and themes that appear in transcript will only offer a flat descriptive account with superficial knowledge, thereby doing less justice to the richness of the data. Ideally, according to Braun & Clark (2006), before the researcher progresses with the analytical process it is recommended to progress from description, where data are simply organised and show patterns, to interpretation, as this attempts to theorise the significance of the patterns and their broader meanings and implications, often in relation to literature. Critically also, within s constructivist worldview, it is acknowledged that individual experiences are subjective, differ and are multiple from one individual to the other. However, great care was taken to ensure that in-depth understanding and the complexity of the participant's individual experiences were well represented.

4.7. Data management

Data management is an important, integral but challenging part of qualitative research which is crucial to a successful study (Lewis-Beck, Bryman and Liao, 2004). Good planning and management of data has been identified as necessary for facilitating the coherence of a project (Huberman & Miles, 1994). Careful planning for data management at an early stage in the research process not only facilitates interpretation but also positively affects the final result of a study which can make a significant contribution to the rigor and success of qualitative research (Haisler, 2011; Lewis-Beck, Bryman and Futing Liao, 2004). Managing data involves performing a series of tasks, ranging from identifying and locating potentially useful data sources to collecting, organizing, reducing, and processing them, to generating informative documentation for them and to storing and preserving them (Thestrup and Kruse, 2017; Hoffmann, 2017). It is therefore extremely important to initiate this plan from the outset of a study to prevent confusion as a result of poor data management which can severely limit the amount of information that can be processed or remembered (Lewis-Beck, Bryman and Liao, 2004; Krier and Strasser, 2014; Briney, 2015). In this study, the following steps were adopted to manage the data.

- Create a file naming system
- Back up regularly
- Check if data was of sufficient quality and accuracy before conducting the final analysis

4.7.1. Step 1: Create a file naming system

File naming has a huge impact on one's ability to identify, locate and understand (what they contain) those files when needed (Hsia, 2015; Bannister and Remenyi, 2013). Without proper file management, documents can be lost or can be inappropriately deleted, needing rework which is timewasting (Hsia, 2015; Bannister and Remenyi, 2013). To ensure that this problem was completely avoided a clear and short directory structure was used that included information about the project such as, date and a unique identifier:

- Participant Name (anonymised)
- Type of data collection method
- Site of data collection
- Interviewer
- Date of data collection

For example, the first care home interviewees were 1 male and 1 female resident alongside 6 staff. The two residents participated in semi-structured interviewing while the care staff took part in a focus group interview. These participants were interviewed by the researcher. File naming for those that took part in the study from the first care home were labelled using the following convention as described above.

Peter_ST_interview_notes_FS_.05/05/2017

Nneka_ST_interview_notes_FS_05/05/2017

Staff_FI_interview_notes_FS_05/05/2015

According to Johnson, Mims-Cox and Doyle-Nichols (2009) and Bishop (2012), using these file naming conventions (descriptive name that reflects file content, removal of spaces from file names, punctuation such as underscores and hyphens to separate words) is a good practice. Naming conventions are rules which enable the titling of electronic and physical folders, documents and records in a consistent and logical way (Disselkamp, 2013). This ensures that the correct records can be located, identified and retrieved from a filing system in a timely fashion, and that they are stored in an appropriate secure location (Gupta, 2016; Cardoza *et al.*, 2004; Stephens, Plew and Jones, 2011). This is also beneficial because naming records

consistently, logically and in a predictable way will distinguish similar records from one another at a glance, and by doing so will facilitate the storage and retrieval of data (Cardoza *et al.*, 2004; Stephens, Plew and Jones, 2011).

4.7.2. Step 2: Anonymise all sensitive information

Doing qualitative research is about putting oneself in another person's shoes and seeing the world from that person's perspective (Conway, 2014; Sachs, 1996; Holstein and Gubrium, 2011; Jespersen and McNamee, 2013). The most important part of data analysis and management is to be true to the participants (Harris, 2012; Taylor, 2017). It is their voices that the researcher is trying to hear, so that they can be interpreted and reported on for others to read and learn from (Pitney and Parker; Jones, Torres and Arminio, 2013; Denzin and Lincoln, 2011b; Crouch and Pearce, 2013). To illustrate this point, during transcription, personal information such as the individual's name and age which was discussed during the interview as part of the interview process was anonymized through the use of pseudonyms. All files and folders used to save the transcript was encrypted and password protected to ensure that they were secure.

4.7.3. Step 3: regular back-up

Back-up of useful documents is as important as the document itself, and highly essential to avoid the risk of losing data through accidental deletion, hard drive failure or theft (Remenyi, 2013). All the academic activities including transcribed data were done on the Northumbria University desktop and all files saved in the university U-drive, which provides back-up. The back-up is done each time any activity is carried out on the files.

4.7.4. Step 4: Checking for accuracy before conducting a major analysis (accuracy)

Audio-taped interviews and fieldnotes are major data sources in qualitative studies (Polit and Beck, 2010) which are either transcribed verbatim (record all interjections, signs of emotions coughs, sighs, chuckles, etc.), word-for-word (these transcriptions capture the text as it is spoken but eliminate all filler words) or general and grammatically correct transcriptions (in this type of transcription, filler words are eliminated, false starts and self-corrected words are not included, and grammar and mispronounced words are corrected). Whichever method used, transcription of audio-tapes remains a critical step in preparing for data analysis and care is needed to ensure accuracy and validity of the totality of the interview.

Also, transcription errors are almost inevitable, and crosschecking is extremely important during and after transcription, such as listening to the taped interview and crosschecking with transcribed data (Polit and Beck, 2010; Lewis-Beck, Bryman and Liao, 2004; Dixon, Singleton and Straits, 2015). This is because certain errors during transcription can cause misinterpretation or change the meaning of the actual word used by the participants, such as (Polit and Beck, 2008) "this was totally moot" but the transcription might read "this was totally mute." To verify the accuracy of transcribed data in this study, audio-taped interviews were transcribed verbatim by the researcher a day after it was collected, thus ensuring that nonverbal cues which can be easily forgotten were remembered. Also, extra time was created for another listening of the audio-taped interview in order to crosscheck with the transcribe data. During this period errors that were detected were corrected and now saved for data analysis.

4.8. Ethical considerations

As stated previously in chapter 3, this research is value-laden and ethical issues were unavoidable due to the nature of the study (cultural sensitivity) and the method of data collection. This research valued communication and the giver of the information (co-construction). Also, as stated in chapter one, my personal experience of working as a carer in a care home, as well as my cultural background, drove my interest in researching this topic. Some of the cultural views were centred on respect for the older person and value for culture, hence they required ethical consideration. Ethics is rooted in the ancient Greek philosophical inquiry of moral life (Fouka and Mantzorou, 2011). It refers to a branch of philosophy that addresses questions about morality (Wiles, 2012). Research in social science is often concerned with collecting data from people, and this almost inevitably raises questions about the way in which people who provide data should be treated by researchers (Oliver, 2010). However, irrespective of where research is conducted, almost all research must receive both ethical and governance approval, and all must meet the legal requirements of the Mental Capacity Act 2005 (ENRICH, 2013). As such, this research proceeded with ethics approval from the Faculty of Health and Life Sciences Research Ethics Committee, Northumbria University. This was followed by data collection with guidance of ethical principles of researching a subject. The ethical guiding principles influenced the way participants were treated throughout the research (Hinton and McMurray, 2017). These guidelines addressed:

- ✓ Not to cause harm
- ✓ Informed consent
- ✓ Anonymity and confidentiality ✓ Right to withdraw.

4.8.1. Not to cause harm

Not to cause harm to participants (residents, care staff and managers) is one the ethical issues considered by every researcher (Lichtman, 2013; Sibinga, 2018; Wiles, 2012). Harm comes in different forms and from different directions, depending on the topic of the research and the data collection methods. Participants may be harmed physically, psychologically, socially, economically or legally (Sibinga, 2018; Wiles, 2012). Also, audio interviews are interventions. They affect people. A good interview lays open thoughts, feelings, knowledge and experience, not only to the interviewer but also to the interviewee. The process of being taken through a directed, reflective process affects the person being interviewed and leaves them knowing things about themselves that they didn't know, or least were not fully aware of, before the interview, all of which falls under physical, psychological and emotional harm.

Though it is not possible to avoid every theoretical possibility of harm or to be sure that a project will cause no adverse consequences whatever to any individual, it is extremely important that direct harm to the reputation of the feelings of a particular individual is avoided at all cost (Chambliss and Schutt, 2012; Lichtman, 2013; Sibinga, 2018). The risk of such harm can be minimised by maintaining the confidentiality of research subjects and by not adversely affecting the course of events while engaged in settings (Chambliss and Schutt, 2012). Also, participants should be respected at all times and be in the same emotional and physical state at the end of the study as they were at the start of the study (Chambliss and Schutt, 2012).

However, there is an inconsistency with this argument posed by Chambliss and Schutt (2012). Qualitative interviewing involves entering the life-world of participants (Elmir *et al.*, 2011) and most often researchers are focused on learning about people, and their deeply meaningful and emotionally-laden personal experiences (Knapik, 2006). In most cases when this occurs emotional occurrences during research may not be completely avoidable or discouraged and in any instances when they occur no particular responses are needed (Seidman, 2015) as it is entirely up to the participant to make the decisions of contributing or not (Prior, 2015). Also,

if the interviewee becomes too emotional to continue it may be ethical to allow a few minutes for the individual to gain some composure and be in a stable position to decide whether to continue or not (Prior, 2015). This was considered throughout the planning stage of this thesis, data collection and data analysis. Though it has its own risk, this was minimal risk for both participants and the researcher. For the researched the study focuses on their experiences and views about care home life and they had the opportunity to express their views about daily life in the care home. Through this process sensitive information was unavoidably discussed, which was quite upsetting for both the researched and the researcher.

4.8.2. Intrusive threat (physiological or emotional harm)

Exploring sensitive issues in this research was a risk that could not be completely avoided. This is because this research addresses topics that are private (decisions and journey into a care home) and sensitive which may cause distress, upset, annoyance, or negative memories. However, there are large variations in what people perceive to be private, and this varies across different ages, cultures and situations. In this research stories about the decision and journey into care for the resident evoked memories and feelings and some of the participants were quite emotional during the interview. However, the questions around the journey into the care home and the life experiences in the care home were discussed in the middle of the interview because of the likelihood to cause emotional distress. Discussing sensitive topics around the middle of the interview gives the researcher and the interviewee time to develop trust and rapport and also allows time to deal with any unexpected outcomes (Alston & Bowles, 2003). Furthermore, it will be disastrous to raise emotionally-laden topics towards the end of an interview and then finish abruptly, leaving the interviewee distress. This is because research participants voluntarily participated, and leaving them feeling a little bit better at the end of the interview is a positive experience and ethically appropriate (Chambliss and Schutt, 2012). On reflection, however, some questions were explorative and addressed sensitive topics, for example discussion around care home life might provoke observations which are not favourable to the participants which might induce an emotional outburst. Thus it was important to ensure measures to tackle them were considered and in place. During data collection, however, two of my participants became visibly upset, but at different times. Mrs Joy was upset while she recounted her experiences about the care she received in the care home. However, just as discussed earlier, I offered the opportunity to stop the discussion or take a break at some point,

and I offered to get care staff who knew Mrs Joy well if she consented. However, she declined and was happy to continue. Meanwhile, the other participant needed her family around, and said she wanted to go home or to be left in peace and quiet.

The decision to interview people about sensitive topics stems from the epistemological and ontological stance that knowledge and reality can only be sought from those who experience it (Crotty, 1998). Knowledge about a particular phenomenon may be gained through face-to-face interviews. Face-to-face interviews involve human interaction and are a way of exchanging information that can be difficult to obtain through other methods, such as questionnaires or surveys (Creswell, 2007). Demonstrating care and empathy during research is essential in eliciting information from participants (Dickson-Swift *et al.,* 2007). This is particularly important when studying vulnerable participants and sensitive topics (Kavanaugh *et al.,* 2006).

4.8.3. Voluntary participation

This was one of the potential risks / harms anticipated in this research, especially where the gatekeeper had given permission to meet with participants. It was anticipated that these individuals may find it difficult to refuse; they are unintentionally caught in the 'web of consent' (Farimond, 2013). However, this issue was clearly explained and addressed before, during and after meeting up with the gatekeepers and the participants. This study was very transparent with gatekeepers that participation is completely voluntary and individual residents' consent will be sought. The voluntary nature of participation was reiterated at the point of data collection with participants. Also, the rights, safety, and wellbeing of participants were considered prior to and during the data collection period. This included vulnerability as a result of their age and the nature of the information being required by the residents to provide. Although ageing does not intrinsically make one vulnerable, vulnerability is context-specific and can be related to cognitive, communicative, social and psychosocial vulnerability. In this research the intention was to recruit older residents to tell their story. It was recognised that they may be vulnerable as a consequence of their living arrangements and their need for care. Every effort was made to ensure that participants were not put in any additional stress by giving them every opportunity to make their own decision about participation and to withdraw from the study if required. This was detailed in the information sheet about what the research was all about and encouraged to ask questions. Participants were given respect for individual

autonomy even when they have signed a consent form, and they were made aware that they were free to withdraw from the study at any time, without giving a reason and with no subsequent impact on their care in the care home.

Furthermore, participants were encouraged to read the information sheet and consent form thoroughly and write down questions for the investigator, if they were able. Participants were given the time to discuss the study with family, friends, or their personal care staff if they wished. If they did not understand any portion of the consent form, they were provided the opportunity to request assistance from a representative or advocate in this process or to ask the investigator to further clarify the information. Also, a safety protocol was observed throughout the study (appendix 6), which was an extremely important part of ethical consideration for both the participants and the researcher. Consent was never taken for granted, and as such was revisited at every stage of the research process to ensure that participation was purely voluntary.

4.8.4. Anonymity and confidentiality

Participants need to know that their participation in research and the information they provide will remain confidential and not be shared beyond the research (Wiles, 2012). For example, this research was carried out in care homes and about resident daily lives, meaning it was important to reassure residents that every information was confidential even if it involved the care home manager or the care staff, and this gave the participants security of answering the question honestly. The study ensured that privacy was maintained at all levels throughout this project. The participants were interviewed in a comfortable environment free from possible distractions, which encouraged discussion. All forms of misinterpretation were avoided throughout this study, such as false interest, or saying one thing and meaning another. Participants were assured that anonymity and confidentiality would be maintained at all times during the study and in any publications arising from it.

4.8.5. Informed consent

In this study, residents and staff who took part were given the opportunity to meet and discuss the study with the researcher. This included explaining the nature of the research, what the participant would be required to do, what the findings of the studies will be used for, and answering any questions (Creswell, 2014). Participants were assured of confidentiality and

what the study will be used for, including the estimated length of the interview. They were provided with an information sheet and given time to decide if they wished to take part in the study. During the meeting, the option of both written and audio recorded consent were provided. Written and audio recorded consent options were provided in anticipation that they may be some residents who might struggle with the written English version.

4.8.6. Right to withdraw

Following informed consent, all participants who took part in the study were clearly told that if there is any reason they were no longer willing to participate, they were not obliged to give reasons or contact anybody in order to withdraw. Also, if they had any concerns regarding the information provided or the study they should feel free to drop a few lines to the university / supervisors at the address provided. Following successful ethical consideration and data collection, this study proceeded with management of the data collected.

4.8.7. Second ethical approval

After the initial data collection, I maintained contact with the participating care home staff and this led to telephone discussion with the older residents and, during these conversations, the participants were aware that the conversations they provided were going to be used for research purposes and they gave their consent prior to that conversation. However, as some time had elapsed, I needed to revisit the participants who originally consented to my recording their phone discussion to ensure that I still had their consent. However, as second interview was unintended and not covered by the original ethical approval chair's action was needed to amend the original ethical approval to accommodate the new data collection method. This was applied for and approved.

4.9. Demonstrating rigour

As a concept, rigor is perhaps best thought of in terms of the quality of the research process. In essence, a more rigorous research process will result in more trustworthy findings.

Trustworthiness is considered a more appropriate criterion for evaluating qualitative studies. In order to ensure the process is trustworthy, they propose the research should satisfy four criteria (Guba and Lincoln, 1989). They are credibility, transferability, dependability, and confirmability.

4.9.1. Credibility

Credibility deals with how researchers clearly link the research findings with reality in order to demonstrate the truth of the findings (Merriam, 1998). This study ensured credibility through triangulation, peer scrutiny of the research project and verification of emerging themes (Carter *et al.*, 2014; Sheldon and Rasul, 2006). Triangulation is an important aspect of qualitative research which involves using multiple methods or data sources to gain more complete understanding of the phenomenon being studied (Carter *et al.*, 2014; Sheldon and Rasul, 2006). Method triangulation was used in this study, which involved using different data collection methods to check the consistency and accuracy of the findings. After the first visits and a follow-up telephone call, familiarity was built up with older Nigerians and staff, creating more trust and rapport and yielding more data during the follow-up telephone interviews. This was particularly effective for staff participants after they showed concern about allowing access to external researchers due to potentially unknown outcomes. During follow-up, these staff were already considering putting plans in place based on the positive outcome of the initial interview.

Furthermore, peer examination was also used to ensure credibility, including intensive discussions with supervisors and presentation of initial findings at conferences. At the end stage of analysis, triangulation was used within the supervision team to review the findings, which was very helpful at illuminating the blind spots and led to further data collection.

4.9.2. Transferability

This refers to the degree to which results of research can be generalised or transferred to another context (Firestone, 1993; Guba and Lincoln, 1989). Transferability was ensured by thorough description of the study context and the assumptions that were central to the research. This involved thorough description of sampling, recruitment, data collection and analysis and is

presented to allow the reader make comparison with their own context and develop the transferability of the study.

4.9.3. Dependability

This can be defined as the stability of data across conditions and time. Dependability is suggested to be closely related to credibility and compared to reliability in quantitative studies (Lincoln *et al.*, 1985). In other words, they are an evaluation of the quality of the integral process of data collection, analysis and theory generation. Dependability in this study was enhanced through the code-recode procedure, which the researcher conducted throughout the analysis to evaluate results. Also, the use of triangulation was used to make sure the weak points of one approach to data collection was reimbursed by the use of alternative means.

4.9.4. Confirmability

Confirmability refers to the degree to which the results of the study could be confirmed by others (Lincoln *et al.*, 1985). This study ensured confirmability by thorough documentation of the research process and how results were achieved, based on the experiences and ideas of the informant rather than that of the researcher. Detailed methodological description of the study has been given in the previous chapter to establish confirmability.

4.10. Conclusion

This chapter has presented a description and rationale for the research design and methods. The challenges encountered in recruiting research participants have been discussed in detail, including the search for research sites, encounters with gatekeepers, and methods of data management and analysis. Overall, the journey towards this process of co-construction between the resident and staff was challenging and insightful. Qualitative research methods provided the opportunity for resident, staff and researcher to interact, thus exploring our views and individual experiences. When conducting the interview from the constructive stance, I remained reflective and flexible in my interview approach, as already discussed. I was mindful that the interview was considered a means of knowledge construction between me and my participants. The next chapter will shift the focus towards description of the full account of

what was derived from residents' daily lives in the care home and staff accounts of their experiences in meeting their cultural needs. This gives the reader a clear view of the two accounts. Providing these accounts helps me as a researcher to keep track of my influences and bracket any bias or emotional attachments.

Chapter 5

5.1. Findings

5.2. Getting to know the participants

5.3. Introduction

This chapter focuses on presenting the findings by detailing a full account of both the residents and staff data. The aim is to give insight into the world of the participants and their experiences of care home living. The full account of residents' stories reflected their unique life experiences among which exists some differences across all participants' immigration history and daily life experiences. These stories included the drivers for their move into the care home, adjustment and life experiences in the care home and some interesting stories about how care staff meet their cultural needs as Nigerians in the care home, which is core to this research. From the staff data, it captured various views and perceptions about the provision of culturally-appropriate care and ways they attempted to provide services based on residents' cultural needs. Within staff and residents' stories, it was captured that the resident and staff shared a common topic of discussion because the environment which they live in shared a common routine. The aim of giving a full account of these participants' stories is to give insight to the world of the participants and their experiences of care home living and working.

5.4. Structure of the chapter

The structure focuses on presenting each participant's story one after the other, according to their lived environment. As earlier indicated in the previous chapter, I interviewed two residents from each care home, except in care home 2 where only one resident was interviewed. In presenting their stories, each individual within the sample is presented, beginning with a brief description before detailing their experience of nursing home placement. At the beginning of each resident's story, quoted words and phrases from their own words are used to bring the content of their stories to life. The aim is to illustrate an idea and illuminate their lived experiences. This aim is supported by Corden and Sainsbury (2006), who suggest that quoting deepens the understanding by means of registering the informant's voice. Descriptions and

direct quotations provide the basis for qualitative reporting and allow the reader to enter into the situation presented (Patton, 2002). Thus, entering quotations could be understood as a validation process (Matt, 2004). Even so, if the quotations are presented without an interpretive commentary, the reader is forced to take on the task of the analyst, with a very small and limited data set (Brinkman & Kvale, 2015; White et al., 2014). This is followed by a detailed presentation of their immigration history journey into a care home and their daily life experiences of care home life, as told by the residents. The presentation of their immigration stories in this study was needed because the process of immigration is a change in itself and can affect people's expectations, behaviours and reciprocities (Ahmad, 1996). Also, this will give a clearer view about their lives, then and now, and how this has impacted on their well-being. Through their stories, we capture their daily life experiences as well as practices and approaches by staff to enhance the provision of culturally-appropriate care. Then staff data from each care home are presented, detailing how care is provided for older Nigerians, beginning from their assessment to the actual care provided. This is attempting to understand the experience from their point of view. Towards the end of the chapter, both resident and staff data are pulled together in an attempt to illustrate the shared understanding of the complex world of lived experience from the point of view of those who live and experience it. This idea rests on Gadamer's supposition that understanding between two differently situated beings occurs through a fusion of their horizons. This is the range of vision that includes everything that can be seen from a particular vantage point. This chapter concludes with a summary giving a concise viewpoint of their care home life and how their cultural needs were met.

5.5. Care home 1

5.5.1. Introduction to the resident participants

Ms. Joy (resident 1 care home 1)

> *"Sometimes, I sit down and ask God 'why you don't take me'."*

Ms. Joy was 75 years old at the time of data collection. She came to the UK in 1968 and lived in Peckham. She migrated as a single mother with her son when he was only a year old. She indicated that she migrated from Nigeria to the UK to escape the humiliation she faced for

having an illegitimate child. Prior to her arrival in the UK, she worked as a support worker for a Catholic charity organisation in Nigeria. She indicated that she had a good knowledge of how to read and write in English and so did not have much problem socialising nor applying for a job in the UK. She worked in the area as a carer.

Sadly Ms. Joy lost her only son seven years after their arrival in the UK. She also lost her parents who lived in Nigeria in the subsequent years. She continued to live in the UK with her sister who is married with two sons:

> *"I came to England in 1968, you know in Nigeria how they treat people with children and without a husband, very bad, but when I came here then worked as carer for Peckham. For Nigeria, I worked for a Catholic charity organisation. My mother died, later my father died only my sister and her husband, her sons are left. I had one son, and he died when he was eight years old. God knew what he was doing. He took that boy, knowing that I would come to nothing after my parents are gone. Sometimes, I sit down and ask God why you don't take me, but he is not ready for me yet." (Ms. Joy Care home 1 Resident 1)*

Here Ms. Joy expressed her grief at losing close family members. However, she continued to focus on her career as a carer in the care home before she took ill. The illness was related to a fall in her home that led to an emergency hospital admission. On admission to the hospital, Ms. Joy was treated for injuries. Following rehabilitation, she had limited mobility and was confined to a wheelchair. She was assessed by professionals to determine her ability to live independently. The outcome was a decision that she required continual support which could be provided by residential care services. Ms. Joy indicated that she couldn't understand why she was asked to leave her flat but added that a decision had been reached that she was unable to live independently.

> *"I got a call that I cannot do anything for myself. They said I can go. The doctors have found out I cannot do nothing for myself. I cannot cook, I cannot do nothing for myself and they said I have to go" (Ms. Joy Care home 1 Resident 1).*

For Ms. Joy, the decision to move into the care home was not an active personal choice. She preferred to remain in the environment that she knew but said this was no longer possible as a result of her limited mobility:

> *"Before now I was living in a council house, it was the council flat, and if I want to go back, I can't because sometimes I plan to go back but I can't" (Ms. Joy Care home 1 Resident 1).*

However, it was evident that there was no further choice for Ms. Joy as a team of professionals had assessed the need for Ms. Joy to consider alternative care in a care home setting.

> *"They sent me to the hospital, and my doctor says I must go, look at the place and if I like it. They drove me down here." (Ms. Joy Care home 1 Resident 1).*

When asked about her daily life in a care home, Ms. Joy indicated that although the staff were initially very attentive, this changed:

> *"When I first came here, in the morning somebody will come and wake me and get me ready for tea. I have not seen that written in my notes at all". No one gets me up in the morning, I could sleep from morning to night to daylight. No one comes and says Joy daylight" (Ms. Joy Care home 1 Resident 1).*

Ms. Joy addressed this by reaching out to someone she called 'sister' in the care home. According to Ms. Joy, there was a need to ask to be helped because of her inability to do this by herself.

> *"One morning, one sister is here, and I said I have something to tell you and she says yes, Joy, I said to her, could I have a wash, yes you can have a wash. And the sister said there is somebody who can help here. And I say I have never asked anybody for something like this, but since I can't manage it and she asked that lady to give me a quick wash, and the lady gave me a quick wash"(Ms. Joy Care home 1 Resident 1).*

While Ms. Joy talked about a lack of help getting up and dressed in the care home, she also spoke about how she had observed some staff calling her 'sister' by her name, which she thought was inappropriate.

> *"One morning, one sister is here, I call her sister nobody call her sister. Where I was working, they had sister and matron but here they have no one call you sister they address you with your name. I don't think it is fair. Yesterday she came today she is here again and I say sister. Here everybody calls you Joy, Jane, Nancy (sighed). I don't think it is right. It is a question of sister or matron in the place that they called healthcare; I don't know. I say this is not healthcare, I told them. It is somewhere else because if it is, you can call sister, you can call matron not Nancy, oh dear. Some of them, joy, some of them 'dinner is ready. You saw one of them come and call me joy for dinner as I say I don't know which one comes. They call you what they like" (Ms. Joy Care home 1 Resident 1).*

In this account Ms. Joy stressed the importance of being appropriately addressed when staff speak with residents. She gave an example of what she meant about how people should be addressed. Ms. Joy considered that greeting people with their titles instead of their names is appropriate. She also commented on her observation of how staff addressed other people in the care home. She indicated that some staff called her by her first name, whereas others used different names or focused on the task without any introduction. For example, Ms. Joy indicated that some care staff expressed this when alerting her for dinner by merely saying *"dinner is ready",* without adding a prefix to it. Ms. Joy indicated that this lack of social etiquette was not respectful. When discussing food choices and her preferences Ms. Joy indicated that the food served in the care home was "ok but she does not like it". Ms. Joy was concerned about getting repeated meals every day, which irritated her and sometimes made her regurgitate.

> *"I have been here for more than one year, eating bread morning and evening, eating bread, breakfast, and dinner, and lunch for supper bread oh. It gets on my nerves but what can I do. Too bad bread all the time. Sometimes I vomit, when I go to the toilet, I cannot keep it, I have to let it out." (Ms. Joy Care home 1 Resident 1).*

Nonetheless, Ms. Joy emphasised that she had different experiences of living in the care home. She indicated that these experiences varied with the home's manager. Specifically, she described the way that the previous manager provided residents with a choice of food, whereas the current manager did not do this.

> "*We had a … a lady who was here, we were not eating bread morning and night but this one comes eating bread from morning afternoon and dinner" (Ms. Joy Care home 1 Resident 1).*

Ms. Joy appreciated having choice or something different from bread being provided at each mealtime. She suggested that she would like something relating to familiar foods. Also, Ms. Joy expressed that occasionally she had to eat unfamiliar food.

> *"Just something different, tomatoes, sometimes I get all kinds of vegetables that I don't know, but I eat them" (Ms. Joy Care home 1 Resident 1).*

Most importantly, Ms. Joy indicated that this issue was not something she would complain to the management about because they are fully aware of these issues and have failed to act, stating "they know but haven't bothered yet so don't worry". Not only were this, according to Ms. Joy, there no alternatives once food was refused except a cup of tea.

> *"When they put dinner before me and I say what is that and they say dinner and I say I can't eat that and they take it away and give you a cup of tea." (Ms. Joy Care home 1 Resident 1).*

Consequently, she indicated that she:

> *"H mmm, if you don't want it, you leave it and you suffer inside" (Ms. Joy Care home 1 Resident 1).*

Ms. Joy expressed a strong mixed feeling towards almost everything since she was moved into the care home. Ms. Joy continued to argue about staff awareness of the situation and insisted no further action was needed about this. She then added that this concern was rather personal and emphasised that caution be applied on issues like this.

"Well, not directly, not directly for everything you said to one person you said it to all. You have to be careful what you say or…" (Ms. Joy Care home 1 Resident 1).

Ms. Joy also spoke about the activities in the care home. She explained that the care home offered a range of activities including exercises, in which she participated if she felt comfortable with them.

"The activities they do here is exercise, activities, (quiet for 2 mins) I do the exercise only the one I like." (Ms. Joy Care home 1 Resident 1).

Ms. Joy further indicated that she preferred calming activities. She believed that activities should be calming, not noisy, and this impacted her participation.

"Sometimes I get up and walk away, I said I don't like. If I decide to do sometimes I do it plainly; I don't do it ahhahahahahah, so noisy (quite)" (Ms. Joy Care home 1 Resident 1).

Ms. Joy added that sometimes during one of the monthly parties, which she did not enjoy, she had to join in. This required her to drink and dance:

"Every month they have parties here, which I don't like but I come along, and I listen to what they have to say, they drink, they dance." (Ms. Joy Care home 1 Resident 1).

Sadly Ms. Joy's loss of close family members led to her receiving minimal visitors. Ms. Joy relied on occasional visits from her nephew that she had to arrange. This nephew travelled from Sheffield for a visit.

"If I want somebody, I just pick up the phone and phone him when he can come, and they said how he can come so far, I say he lived so far away. He lives in Sheffield" (Ms. Joy Care home 1 Resident 1).

Ms. Joy explained that knowing that the only surviving members of her family were her sister and nephew made her emotional and that she sometimes wished God could come and take her life, as highlighted above. Nothing, however, was said about her second nephew and their relationship. However, when asked how she managed all these, if going to church was a good

a support system. Ms. Joy expressed that she worshipped at a particular church before moving into the care home and had struggled to keep up with her faith since.

> *"I joined the seven-day Adventist church and I go there once in a week. Sometimes twice, I go there because the church is a good journey from where I live now (care home) so I can't find the church if somebody don't come for me and take me there. I had one lady who lived in 173 where I live, she lived they, she comes for me, every Friday she come to ask me if I would like to go to church and she takes me and I have to pay for her for taking me and bringing me back but I don't know what happened, I want to see her, I cannot see her" (Ms. Joy Care home 1 Resident 1).*

When asked if the care home made the provision or if the lady could not be reached over the phone she said:

> *"If I want her, I have to phone her and ask her if she is coming and she says get ready, and after breakfast here she comes" (Ms. Joy Care home 1 Resident 1).*

Ms. Joy loved to attend church, as she earlier stated, to keep in touch with her faith community. However, since losing contact with a church member that came to take her, she expressed feelings of unhappiness.

> *"yes, if she comes, that day I feel happy, very happy the day she do come because if she don't come, I lay down in the bed and I sleep all day, hmmmmm, so I am still there by Gods mercy(quite)I haven't got a son, I haven't a daughter, with my poor mother gone and left me… I had one son, and he died when he was eight years old. God knew what he was doing. He took that boy knowing that I would come to nothing after my parent gone." (Ms. Joy Care home 1 Resident 1).*

Ms. Joy was still bitter about losing her son and parents, and talked about them in almost all her conversations and concerns. This was mostly mentioned when a specific need wasn't met which continued to indicate her ongoing grief. Ms. Joy has had a tough life from moving to the UK to living in a care home. Firstly, the move to the care home was not a choice Ms. Joy made.

Secondly, almost all aspects of her daily life were not favourable. Thirdly there is virtually no close family to call upon without extensive prior organisation. In all Ms Joy would rather keep all her concerns private, away from the care staff who are looking after her. Her judgment and understanding regarding this was that the care staff were aware of every situation in the care home.

Mrs. Joan (care home 1 resident 2)

'I have had a very glorious past.'

Mrs. Joan was 80 at the time of data collection. She worked as a nurse in a catholic hospital in Abuja Nigeria, before migrating to the UK in 1968 at the age of 30 with the help of her poor parents. While in the UK, she settled in Peckham for further professional development. Mrs. Joan then studied nursing and worked as a nurse in a local hospital. Later she gained additional qualifications as a social worker, which she held until her retirement. Mrs. Joan was married with two children, both of whom are now married and lived with their own families. While in Peckham, Mrs. Joan made friends with both her work colleagues (fellow nurses in the UK) and other Nigerians residing in the region. She enjoyed her life as a professional in the UK and believed she broke a record by proving that people of colour could achieve something great. She was even interviewed by the BBC regarding this.

> *"I came to the UK when I was very young, 30 years precisely. My parents sent me here because I was the only member of my family, who was bright. I studied nursing and got work after that. I had another interest in social work. I went ahead and did it and worked as one. I am 80 now, but I had a very glorious past and also known to the BBC due to my achievements. During some of my interviews with the BBC, they could not believe anything good could come from a black person" (Mrs. Joan care home 1 resident 2).*

Following the death of her husband, and her children moving away from the family home, she indicated that she felt lonely. She had difficulty attending to some of her daily personal activities and chose to move into a residential care home. All Mrs. Joan needed was company and someone to help with the cooking of her meals, and thus her choice of care home was residential. Mrs. Joan expressed that she understood that she was getting older and accepted this. However, all she wanted was a regular visit from her children.

"ehm, my husband is dead. My children are still alive. They live around the corner; my daughter is a teacher and my son an engineer. But I don't need them to look after me; I get on with it. I said to them you have your own life; I will like to stay in a care home. I told them that I would like them to come and visit me regularly. I am 80 years old and I can't forget that I am 80, I am here for the meal and company"(Mrs. Joan care home 1 resident 2).

Mrs. Joan made an active choice to move into the care home. Mrs. Joan spoke about her personal care, which she said the staff assists with every morning and night: "I live here and every morning the staff help me with getting washed and dressed." She then added "something I used to do before without problems, I am more than 80 I know… I get on with it". Also, she indicated that help with personal care was needed after she had a fall which resulted in a loss of mobility.

"After that fall I had in the bathroom… you see I did everything myself but I slipped and fell… ever since then, I almost need help with everything". (Mrs. Joan care home 1 resident 2)

Mrs. Joan also added that since the fall, her lifestyle has changed and she needs more support from care staff.

"*That fall changed my life, unlike my normal active person. Right now, I feel like a vegetable (laughing), I have to be wheeled to everywhere I need to be and I don't quite get it." (Mrs. Joan care home 1 resident 2)*

Despite this, Mrs. Joan indicated that she still had confidence and mentioned that she chose to move into the care home as a result of her current condition.

"Not really, because I have confidence. Nothing can stop me. I have done it all. I am here due to circumstances" (Mrs. Joan care home 1 resident 2.)

Mrs. Joan emphasised that company and meals were two significant problems that led to her move into the care home. About meals, she expressed that she was not getting Nigerian cuisine

that she loved while at home, but added that life must go on: “When I was at home, I have my choices, especially Nigerian food but here I am”. The absence of these Nigerian food preferences was not a significant concern for Mrs. Joan. She indicated that professionalism, as well as acculturation, played a vital role.

> “*I am a trained nurse, and I have lived here for many years, I eat whatever is available I eat mainly British food”. (Mrs. Joan care home 1 resident 2)*

Also, Mrs. Joan explained that her current food choices and preferences have changed since she lost her mobility. She said it was hard to know what she would prefer as sometimes she rarely had an appetite but ate because of the need to comply with her medication.

> “*Like I said before, that fall has changed my life… do you know that sometimes I don’t even know what I want to eat, I just eat because I need to take my medication… it is that bad”. (Mrs. Joan care home 1 resident 2).*

This change in appetite did not wholly deter the craving for the unique Nigerian cuisine she loved. For example, she expressed that occasionally she yearned for Moi Moi, which will not be forthcoming in the care home.

> *’Yes, sometimes I miss Moi Moi… but I know that is something I will not expect to receive here.” (Mrs. Joan care home 1 resident 2)*

Furthermore, Mrs. Joan stressed that such special cuisine was not likely in the care home because she had received nothing but British food.

> “*Yes, because they have never served anything except British foods, so why ask” (Mrs. Joan care home 1 resident 2).*

Next, Mrs. Joan spoke about her faith needs, noting that though she believed in God she was not very religious even before she moved into the care home. She indicated that she would not inconvenience anyone to attend to this need.

"Don't get me wrong, I believe in God, but I would not bother anybody to take me down to the church where I worship". (Mrs Joan care home 1)

In addition, Mrs. Joan said sometimes her daughter comes with a pastor and they prayed together, which she enjoyed but thought that this was enough when coupled with her private prayers.

"I don't know if I have told you this, but sometimes my daughter comes with a pastor to pray with me which feels nice and most times I pray quietly on my own… it is enough. (Mrs Joan care home 1).

When asked about activities she enjoyed in the care home, Mrs. Joan re-iterated that her choice of activities also changed following the fall. Previously nothing is was exciting as having a chat with fellow residents and staff members: "I can't stop talking, I enjoy people's company". She added that she was mostly sitting with other residents, listening to the radio, watching TV, and glancing through the papers: "all I do now is sit, listen to the radio, watch telly and listen to music". Yet Mrs. Joan said care home life was an inactive life in which eating and sleeping were more prevalent: "it is a life of just eating and sleeping*"*. However, Mrs. Joan expressed that before care home life, she loved her professional job, chatting with friends and traveling freely.

"Good old days… I loved shopping, chatting, shopping, and loved my job because I spent time with my colleagues chatting about life. I love to move around but here I am". (Mrs Joan care home 1)

Mrs. Joan also received regular visits from her family, as she expected (as indicated above).

"I told them that I will like them to come and visit me regularly and they are doing it". (Mrs Joan care home 1)

In brief, Mrs. Joan lived a life she expected, as illustrated by her stories. Her immigration history to care home life and experiences remained unique as compared to Ms. Joy. Mrs. Joan was at least partly satisfied with the care she was receiving from the team, including her dietary needs. Though she talked about missing her favourite Nigerian food, the impact of this was minimised because she has lived in the UK for so many years. Her expectation from her children regarding visits was also met.

5.5.2. Staff perspectives

The manager and care staff spoke about various care strategies employed to look after their residents, including their understanding of the diverse cultural needs of their residents. This included knowledge about the existence of differences between people from other countries or backgrounds. This was highlighted in the care home manager comment about the presence of ethnic minorities in the resident population.

> *"We do get people from other ethnic origin but in very small number" (manager care home 1).*

More understanding surrounding this was explored, and the manager expressed that adaptation was one of their initial concerns but that everything seemed to go well. This manager revealed there were some occasions where they thought that Mrs. Joan would experience adaptation difficulty. This was expected when the daughter took her home for a visit, but surprisingly they said resident goes home and comes back to them without any problem. They added that duration of stay in the care home may have played a significant role.

> *"As you would expect, even Joan, when she came here, we thought we will have challenges but she settled well. If she goes out with her daughter, she will like to come back, we have no challenges, and they have lived here for so many years, so we don't have any challenges." (Manager care home 1).*

Also, other needs, such as dietary needs, were always addressed during admission into the care home. According to the manager, this is the time when nutritional needs are assessed and if the resident needed ethnic food they made provision for it.

> *"We take it from the beginning. In terms of nutrition, this is where if you are from ethnic origin, you know, we provide ethnic food, if it is often. We do a dietary summary of peoples foods, likes and dislikes it is picked up from the assessment stage when they are coming in". (Manager care home 1)*

Additionally, the manager expressed that acculturation was also taken into account when meeting this need. They specified that despite this acculturation, there was a structured approach in place. This included providing Nigerian food one or two times a week.

> *"But like you said, most of them have lived here for so many years so they are used to the food, so they don't really mind. But once or twice in a week, the kitchen, make rice and plantain and order yam so that they can make dishes for the residents from other ethnic origin" (Manager Care home 1).*

Additionally, from the subsequent manager comment, she continued to emphasise that, despite initial assessment, ethnic food alternated with globally-eaten food and, as such, residents get a mix of everything

> *"Okay, first, we assess their food needs, then we match up similar choices and tend to alternate them with globally eaten food like rice, potatoes, and chicken, even beef which is a Sunday meal. So they get a mix of everything, but in the meantime, we are looking into having a treat for our residents." (Manager care home 1)*

Then the manager added that plans were already in place about giving the individual resident a treat of their favourite meal:

> *"We are looking into treating each resident to their favourite meal once in a while. As I said, we are doing the much we can" (Manager care home 1).*

When asked how these would be achieved, either via daily changes or specific resident menus, the manager said it wouldn't be regular but they are still at the planning stage.

> *"Not on a daily basis as such, as I said, we are still looking into it" (Manager Care home 1).*

Moving on, care staff in this care home indicated that other needs, such as faith, need were not an issue. They noted that most times residents prefer to arrange such activities themselves, and added that there is provision for access to a minister if they needed it, even though some residents were not keen.

"We do, but sometimes our residents prefer to arrange for themselves. Some don't even bother and we also have a minister of God that comes here every now and then, but some of them rarely show interest" (care staff care home 1).

Following this, the manager went on to speak about the provision of activities and how these were also picked up from the assessment stage. From her comment, the activity coordinator assesses and organises the activities on a weekly basis, and this included dominos, painting and dancing. She stated that provision of activities was made available for those who preferred to stay in their bedrooms

"The activity coordinator when somebody comes, they go and meet the person and find out what their needs are, have a chat with them as to what type of activity they will like to do. The activity coordinators have a weekly planned activity of what they do every day or what they have to do for the day. It could be gentle exercise; it could be painting, dominos, singing and throwing balls. Sometimes they do one –to one activity for those who cannot come out of their bedroom, depending on what their needs are. Funny enough, we have quite a few who don't have dementia; there are some that doesn't want to come out; they prefer to stay in their room" (Manager care home 1).

Not only this, the care staff added that these activities were based on what they enjoyed doing, but also said that they were mostly based on availability, expressing the difficulty of providing individual culturally-related activities. They cited an example of a Chinese lady and the associated language challenges to meeting her choice of activities. They added that residents like this are compensated to make up for their unavailable options.

"Mmmmh! Well, we assess them by asking them what they enjoy doing, which most times are based on what we provide in the care home. It is a kind of difficult to provide some of the culturally related activities on individual needs. For example, we had a Chinese lady whom the family told us likes playing Cat Catching Mice and Xiangqi (Chinese Chess). First, we had the issue of language; if we had this activity in place for her, we will lack the staff to engage in it because of the language barrier.

In her case, we organized something different like outings during Chinese New Year and she loved it." (Care staff Care home 1)

In summary, the story that these residents told about their daily lives in the care home varied. It is clear that there is a mismatch in resident and staff stories, especially on issues relating to food. The manager expressed that they provided ethnic food twice a week, while one of the residents (Ms. Joy) said this was no longer the case. The other resident seemed content with whatever she received. In terms of activities, the manager spoke about the assessment done by the activity coordinator and how the resident choice of activities is known, but this was based on what was available in the care home. This meant that if a resident wanted something different, it might pose a challenge, as seen from the illustration of the Chinese lady.

5.6. Care home 2

5.6.1. Introduction to the resident participant

Mrs. Nneka, (care home 2 resident 1)

("I just have to behave and try to understand them")

Mrs. Nneka was 67 years old at the time of data collection. Mrs. Nneka left Nigeria and went to Italy in her 20s. She then travelled and lived in France, Sweden and Spain. Her frequent migration from one country to another was as a result of the humiliation and difficult lifestyle she experienced. Before her migration to these countries (France and Sweden), Mrs. Nneka was the first child of her parents and worked as a farmer and a hairdresser with her siblings. She said she could barely speak English but was able to speak Pidgin English. While in these countries, Mrs. Nneka worked as a house cleaner. She married and had her first child while living in Spain. In this country, Mrs. Nneka lost her husband to another woman and decided to flee to the United Kingdom in 1990, alongside her son, and the circumstances surrounding this move were not well understood. Prior to this, Mrs. Nneka was unable to secure any citizenship from these countries she had lived in because she was uneducated, could not speak English or the languages spoken in these countries, and, as well, could not secure a decent job. When living in the UK, she married a British man and had two more children. She is now a British citizen.

"My sister, I have lived in so many countries. I lived in France, Sweden, Spain, and the UK. I had a child for one man in Spain, you know how bad men are, he followed another woman. So, my sister, I moved on, went to the UK after because of immigration problem. 'You know even our heavenly father, you won't believe me when I return from Europe with my child, and I started having babies with my oyibo (white man) husband. Husband dey or husband no dey (Pidgin English meaning whether there is husband or no husband). God has created me to have children. I like to look after my children' 'I am 67 now but I am happy because I have children" (Mrs Nneka care home 2).

While in the UK, Mrs. Nneka expressed that her husband suffered from cancer and passed away, leaving her and her teenage children. However, during Mrs. Nneka's stay in the UK, she learned how to speak English from her husband, who was a British man, and worked as a cleaner in a care home. At the age of 60, Mrs. Nneka suffered from mental health problems. She had difficulty complying with her treatment regimen and the effect of the medication was that Mrs. Nneka required care at all times. It was learnt that she had episodes where she did not comply with medication and relapsed to the point of interfering with other people's property. The psychiatric team further reviewed Mrs. Nneka and, with her children's decision, she moved to the care home.

"Yes, I have big children. My children brought me here, I have been sick since I was going from hospital to hospital, going to… What is it called ehhh going to different homes…? At the long run, my children brought me here say (mama come, come go this place) (Pidgin English). They brought me here my own children, so that is the thing. And they always come to see me." (Mrs Nneka care home 2).

Mrs. Nneka's limited ability to self-care and mental health problems meant that she required long-term care, and this is why her children made a choice of care homes for her continuity of care. Mrs. Nneka spoke about various areas of her life in the care home which included personal care (help getting out of bed), meals, activities, religious needs, and family visits. According to her, when she was moved into the care home, the carers did everything for her: "*they use to do everything for me"*. Mrs. Nneka explained that this was because of her ill health at the time: *"I wasn't well enough, you see I was sick that's why".* At the point of data collection, Mrs.

Nneka said she had improved and can self-care with minimal support from care staff. Before living in this care home, Mrs. Nneka lived in a few care homes and finally ended up in care home 2, which she says suits her and her family, although Mrs. Nneka didn't explain the reasons surrounding this. Since living in care home2, Mrs. Nneka said she liked it there and all she needed to do was to behave herself and understand the staff.

> *"They are different ones, Yes, different homes which I have been, but this one, is ok and I wouldn't go anything against it. It is ok. Mmmmm, I just have to behave, try to understand them" (Mrs Nneka care home 2).*

Although Mrs. Nneka liked her current care home abode, she expressed concern about a member of care staff whom she said liked to do things her way and got on her "high horse" with her: "*Only we have one carer here, she like to do things the way she like.* Mrs. Nneka was asked what she meant by "*high horse"* and she replied, *"she goes on a high shoulders sometimes I mend with her yea".* When asked if she had raised the issue with the management, she said:

> *"Mmm, not really, I didn't need to. The manager herself is seeing things happening; I rather not report anything for now. I will just leave it" (Mrs Nneka care home 2).*

Further to this, Mrs. Nneka also expressed that some of the care staff addressed her using her first name, which she did not like but was now adapting. Also, Mrs. Nneka indicated that greeting an older person using a prefix such as an aunty was proper, and she also practiced this.

> *"Did you see the lady who came in? Did you remember I called her aunty, because she is older than me, and she calls me Nneka because she is older than me? You see, I wouldn't. I am getting on; there are things I would also accept to live with." (Mrs Nneka care home 2).*

Meanwhile, Mrs Nneka also talked about her food choices and how this was provided. She expressed that she enjoyed and appreciated all efforts made by the care home to provide her choice of food. Mrs. Nneka got varieties of Nigerian cuisine she liked, such as Moi Moi, beans, rice and swallow (called swallow because of the method of eating it, i.e., using your fingers, take a morsel of paste, dip it in soup and swallow without chewing it).

"Yes, I am not allowed to cook, Yes, I like Moi Moi and if they are unable to make Moi Moi, they cook black eye beans, they are the same protein. Occasionally, the person I mentioned go and cook the food I eat. That is the food we end up having. Sometimes they cook ladies' fingers which I like so much (stew goes with rice)." (Mrs Nneka care home 2).

In addition, Mrs. Nneka spoke about how the care home manager, who was also a Nigerian, went as far as giving out money from her income to provide her with her favourite Nigerian food.

"The manager came to a point that she gives her money to go the market to buy the food we like to cook for us. So many things. Anything we like to eat we tell them they try, they try to do it for us". ***(Mrs Nneka care home 2).***

Mr**s.** Nneka also added that staff sometimes cooked Nigerian food from their home and brought in for them to eat. As a result of this extra effort by care staff, Mrs. Nneka would not hold any grudge against the staff team.

"Sometimes the staff cook from their houses and bring them for us, so I can't not complain. I hold nothing against them". (Mrs Nneka care home 2).

Also, Mrs. Nneka expressed that there were other areas of care home life she enjoyed. This included card making, which was taught by the activity coordinator in the care home. She said the activity coordinator showed them how to do different activities, including card making, which she loved.

"The lady who is teaching us, she does, come up with different things and we do them like Christmas cards (showing me the cards she made) we do quite a lot of it and some patterns we make patterns Mmmmm like dress pattern. I love them" (Mrs Nneka care home 2).

Sadly, however, these favourable activities were only available seasonally, but Mrs. Nneka stated that there were other forms of activities that she engaged with available in the care home.

"Like now Christmas is finished, nothing yet is only the Christmas period, maybe more to come during next Christmas. But within ourselves, we do silently what we love to do" (Mrs Nneka care home 2).

Specifically, Mrs. Nneka said she also enjoyed watching her favourite TV channel and some exciting American movies.

"Apart from this, if I see something I like on the telly. If East Enders is showing and ehhhhh, coronation street. English and American films if they are nice, I watch them." (Mrs Nneka care home 2).

Apart from these activities mentioned by Mrs. Nneka, she also added that the care home manager organised and marked special events, such as mother's day, in the care home. During the occasion, Mrs. Nneka said they enjoyed eating and listening to music.

"Like those you mention, in most cases is the food we cook, they cook food for us, we play music" (Mrs Nneka care home 2).

Apart from this, Mrs Nneka indicated that she and a friend named Rosemary usually loved to keep up not just with going to church every Sunday but also with the particular groups she belonged to in the church. Mrs. Nneka explained that Rosemary did come to the care home to take her to church for church activities which she enjoyed, yet when she was unavailable the care home organised someone to take her to church on Sundays or to attend any activity organised by the church.

"We do only go to church on Sundays, and if there is any place whereby church people are organising, they may invite us, and we go. I like to attend church activities, and this lady I mentioned (Rosemary) always like to go" (Mrs Nneka care home 2).

Since moving and living in the care home, Mrs. Nneka enjoyed family visits from her children.

"At the long run, my children brought me here say (mama come, come go this place) (Pidgin English). They brought me here my own children, so that is the thing, and they always come to see me" (Mrs Nneka care home 2).

Mrs. Nneka's immigration story and daily life highlight both the drivers for choosing a care home and the experience while in it. It was seen that her underlying health condition mostly led her to move into the care home. However, throughout her story, it was seen that this did not interfere with her enjoying daily life. Food and choices and preferences were met, with the result that she would hold no grudges against the staff team. Also, the current care home where she lived seemed to meet all her needs and she applauded it by saying that among her previous placements, this appeared to be the best.

5.6.2. Staff perspectives

It was learned from the responses of the care home 2 manager that the care home recognized individual differences which related to race, ethnicity and age, and acknowledged that they admit people from different cultural background but only those with residential needs.

> *"Yes, we have people from here (British) we used to have a Chinese, but at a time she needed nursing care and was referred. We have people from other African country as well. But now only two African ladies and the rest is British people". (Manager care home 2)*

The manager went further to explain that they get these residents through their social worker, and these residents are mostly unable to manage on their own at home**.**

> *"We get most of our residents through their social worker who is normally in cases where the residents are no longer able to manage themselves at home"(Manager Care home 2).*

Furthermore, the care staff explained that when these residents are referred to them by the social worker, they do a further assessment, which then acts as a guide to meeting the specific needs of the residents.

> *"They get referred to us, so they would have their assessment done by the social worker which is normally the basis of own assessment. This will be a guiding principle shaping our own assessment also based on resident specific need." (Care staff care home 2)*

Also, the manager added that even though re-assessments are usually done, they do recognise that residents' needs often change while in their care, but continuous assessments are generally done to ensure residents get the best possible care.

> *"Though many of them tend to change sometimes when they live here for some time. Our assessment is constantly reviewed to match each resident's needs to ensure they are comfortable" (manager Care home 2).*

Following assessment, the care staff emphasised that in food-related needs, residents' ethnic food was prepared and stored in the freezer. This frozen food was mainly served during lunch to meet this need. Also, the care staff expressed that the food was always double-checked by the dietician to make sure there were right for their residents.

> *"For example, two ladies from Africa here, we give them African food. We ask a dietician to come and check to make sure the food is right for them. We prepare the food and freeze it, and we feed them during lunch and that's all they get for the day. We make them stew, fufu, beans, garri" (Care staff care home 2).*

To maintain to this method of food provision, the manager stated that their ethnic diverse care staff are part-time in the kitchen and involved in making native local dishes for the residents. In addition, the manager explained that this was easily achievable because of the small number of minority groups.

> *"Like I told you before, we assess the resident individually to accommodate their food needs. However, one thing we have noticed over the years is the small number of people from Nigeria coming to live in the care home. Right now, we have only one Nigeria while the other ethnic minority resident is a Jamaican, therefore meeting their food needs will not break the bank. Coming to your question about how the catering staff explores the food preferences with residents. First, I will like to mention that some of our care staff (both white and black) are also part-time or what you call the bank shift as a kitchen assistant. So most times during their time in the kitchen, they play a major role by*

assisting our chef to make these meals and then store them away in the freezer" (Manager Care home 2).

In addition, the manager added that care staff were able to know the residents' ethnic food choices through continuous assessment. They explained that despite adding local ethnic food to the menu, weekly assessment was usually done to understand when choices have changed.

"Your second question about how staff knows which food the resident wanted… well, despite our initial assessment of individuals resident food preferences at the beginning when we introduced native local foods in our menu, we still continue to do a weekly assessment to find out which of their choices or preferences have changed" (Manager Care home 2).

Interestingly, the care home manager also mentioned that some of the residents enjoyed their favourite food when it was brought in by their families when they come to visit them.

"Some of their family also bring food when they come to visit them". (Manager Care home 2)

However, these strategies or approaches, according to care home 2 staff, were only possible because of the manager's ethnicity, indicating that in previous employment all residents were served the same food. This staff suggested that their African residents should be grateful for the food adjustment and wondered how they would react if this was their situation.

"If not that this care home is managed by Africans, they will not be getting any African food at all. Where I worked before, we had African residents and there is no African food been made or Africans. They make the same kind of food for all the residents. So they should be thankful for receiving it at all, because if they find themselves in that kind of situation, what will they do?" (Care home 2 staff)

Nevertheless, tensions around supporting and provision for dietary preferences were also picked up from the care home 2 staff comments**.** This carer explained that due to the nature of Nigerian food, there was sometimes debate on reducing the number of times Mrs. Nneka got the food she preferred due to lack of physical activity shown by this resident. They were concerned she might put on weight, which was not good for her especially with her existing condition of diabetes.

"We try not to give them African food morning afternoon and night, because they are not going anyway. Though some of the staff object to this, but I think it is not fair on them because they are sitting all day and eating those heavy food is not good for them. For example, Nneka (Nigerian resident) refuses any exercise, even with the dietician intervention, she has diabetes, and Nneka can walk. She refuses to move. Asked to move around once in a while she get very upset about it" (Care home 2 staff).

The adjustment made on the provision of African food according to the care staff was in agreement with the dietitian due to Mrs Nneka's health. Staff also suggested that Mrs Nneka's consumption of Nigerian food was important as, due to its high sugar content, it had previously resulted in increased blood sugar and a subsequent hospital admission.

"In Nneka's case, we had to ask the dietician to come in and help after she was admitted to the hospital for a high blood glucose level. While in the hospital, she did not have access to Nigerian food and after a few days, she was discharged back to us. When she came back, we had no choice than to get the dietician in to ensure that we are doing the right thing. We were then advised to adjust her food with lighter options at a certain time of the day. You are a Nigerian and you know that most of the food can be heavy at times. Funny enough Nneka's favorite Nigerian food is mostly the heavy one (laughing). She still gets most of them but only once a day". (Care staff care home 2)

In addition, the manager claimed such an adjustment needed to strike a balance between addressing personal preference and the provision of a healthy nutritious diet.

"Yes, I would say, but mostly for health-related reasons". (Manager Care home2).

Furthermore, more understanding was needed on why Mrs. Nneka refused available activities. The manager started by explaining that the home provides a basic form of activity to keep the residents active and stimulated: "*we offer them painting, films, dominos, newspapers every morning".* Also, the manager gave an explanation that additional activities were offered, including trips to a local day centre and church activities: *"they go to day centre, including*

Mrs. Nneka. They go to church". However, there were challenges with certain activities. The manager outlined that both a monthly dance class and bi-weekly art and craft class were available by visits from external tutors.

> *"One man comes once a month for a dance, one other lady come to do art and craft every Thursday and comes every two weeks and for some time now they have not been. I think it was to see if government could fund it". (Manager Care home2).*

However, despite all these activities provided by the care home, some of the residents preferred not to indulge in any and instead preferred to sit and rest, something which the manager felt was absolutely normal.

> *"Some of them are not bothered with any activity at all. They refuse almost everything offered. They prefer to sit and rest. Even some of them when the entertainer comes they walk off when you ask, they say because he is stupid. And some of them don't like dancing. Sometimes they don't want to do anything. It is normal" (manager care home2).*

In summary, these findings demonstrate that staff in this care home tried to provide ethnic food for their ethnic residents through the use of different approaches. Firstly, despite assessment, the ethnic staff played their part to bring food from home to show residents how deep their understanding of cultural needs was. Secondly, the manager strategized with care staff by allowing them to work part-time in the kitchen as a method to diversify the menus on offer. Lastly, residents were assessed weekly because the care home staff and managers understood needs always change. The effect, as seen from Mrs. Nneka, was that staff were kind and inclusive of residents' need the care home, and this held the possibility of improving relationships in the care home.

5.7. Care home 3

5.7.1. Introduction to the resident's participants.

Mrs. Jane (care home 3 resident 1)

*(**"**I am an Igbo woman')*

Mrs. Jane was 75 years old at the time of data collection. Before her arrival to the UK, she worked as a farmer and was popularly known and called an 'Igbo woman' (meaning a typical Igbo woman, deeply rooted in Igbo tradition). Mrs Jane arrived in Peckham UK at the age of 33 alongside her husband and two of her young children in 1975. While in the UK, Mrs. Jane and her husband had two more children. Mrs. Jane worked as a cleaner in people's houses alongside her husband. Life in the UK since arriving from Nigeria for Mrs. Jane and her husband was stressful and challenging due to their lack of formal education. She and her husband worked around their children to keep the family going. Communication was one of their biggest challenges, particularly as she communicated in Pidgin English, which was only partially understood by the British people. Though Mrs. Jane and her husband were interested in learning English, they both had limited opportunity to gain access to study in British colleges due to the demands of childcare. However, their children went to British schools and were able to learn and speak English fluently and, as a result, the couple settled to look after their children. Twenty-five years on, at age 65, Mrs. Jane's husband died and she lived alone with her children as a single parent. Two years after she lost her husband, she also lost her father who lived in Nigeria. She said her father who was a wealthy man and was killed by some people who never liked him in the village.

> *"I was only 33 years when I come to England. I carry my two children with my husband come. Since then, I had another two children. My daughter, it was hard to go anywhere. When I go out, my husband will stay with them or if my husband goes out, I will keep them. Since we don't speak English well, it was hard to get a good job but thank God my children are all educated now. I work as a cleaner to get money and my husband too. We live here for a very long time. 'Too much killing my daughter, after around 25 years my husband died my father died, he is a big man, but they killed him, that's how they do it. If they don't like something, they kill you for nothing" (Mrs. Jane Care home 3).*

After her children grew up and left, Mrs. Jane was on her own for a long period. As a result of this, Mrs Jane was vulnerable to loneliness and social isolation, which had an impact on her nutrition and health**.**

"Her children felt she wasn't feeling well even when her favourite meals were made; she still left them untouched" (manager care home 3).

Also, because her support and care needs required close proximity, the fact that Mrs. Jane's children had moved out meant that she felt it was necessary for her to live in a care home.

"None of my children lived permanently with her and as a result, her children felt it was right for her to stay in a place she will be looked after" (manager care home 3).

She moved into a care home located in Peckham at the age of 72. Mrs. Jane needed several prompts to tell the story about her daily life experiences in the care home; as such, she spoke in short phrases. For personal care, Mrs. Jane said, *"the girls are getting better"* and, when asked if she could explain a bit further, she said *"if they are good they are good, if they are bad they are bad"*. However, in talking about her food preferences and choices, she spoke very little. Mrs. Jane expressed that she had no problems with the food provided by the care home: "*The food is not bad".* However, Mrs. Jane indicated that she would have preferred to be offered Nigerian food which was not provided by the care home where she resided, although she did believe she will get it someday.

"I love swallow (pounded yam), with soup like egwusi, ogbono. I love it… I prefer eqwusi. I haven't got it, but I will get it … if you don't eat well, you will be like a nonsense woman." (Mrs. Jane Care home 3)

In terms of activities, Mrs. Jane spoke briefly about her choices. As earlier stated, Mrs. Jane required a lot of prompts to engage in the interview. However, she did mention that among all the activities offered in the care home, she enjoyed writing, knitting and chatting with fellow residents and staff.

"From everything they give us here, I like to write, knit and talk with people here." (Mrs. Jane Care home 3)

Since living in the care, Mrs. Jane enjoyed visits from her family, especially her children.

"My children do come to visit me, and even my sister." (Mrs. Jane Care home 3)

Mr. Peter (Care home 3, Resident 2)

("I am being looked after")

Mr. Peter was 81 years old at the time of data collection. He arrived in the UK in 1979 to study engineering. On completion of his studies, he secured a job as a graduate engineer in south London (Greenwich) and was able to invite other members of his family over to live in the UK. They formed strong family ties in London, where he later married to a Nigerian woman he met in the region. Mr. Peter, alongside his wife, had three children, all of whom were born, lived and enjoyed close family in the UK. Mr. Peter's children were all studying; the youngest was still in the college, while the others were both at university. Mr. Peter had retired from his engineering job and moved to Peckham with his wife and children and re-settled there. However, he subsequently lost his wife.

> *"I came here when I was very young. I think it was in 1979 to study engineering. I finished and thankful; I got a job. Once I started to get some salary, my family came over from Nigeria to live with me in Greenwich. I met my wife here we lived together, had three children all grown now, the last boy still in the UNI. When I retired, I left for Peckham because most of my friends and Nigerians lived there but it wasn't the best decision because a few months after we moved down, I lost my dear wife. Horrible" (Mr. Peter Care home 3, Resident 2).*

Since losing his wife, whom Mr Peter relied on for most social activities and domestic chores, he was now left with doing most of this basic task which both enjoyed doing together. Mr. Peter expressed that the impact of this significant loss and grief led him to experience considerable loneliness, which further led to a refusal to eat or drink. Thus, as Mr. Peter was ill, his children all away studying in the local university and his parents long deceased, it became a necessity to explore other options. As a result of Mr. Peter's ill health, he was taken to hospital where he was treated and referred to the care home where he now resides**.** However, Mr. Peter said the choice to move into the care home was his because it came to a point where he knew he had to move. While in the care home, Mr. Peter stressed that life was acceptable: "*everything is fine".* Mr. Peter said he was being looked after, that the staff are kind to him

and, most importantly, that his main aim (help with getting dressed) for moving into the care home had been achieved.

> *"I am being looked after. Nice staff as well. The problem I had was… I cannot get dressed sometimes but the staff are always there to help me. Every morning the staff come in and it's done. I am happy. I like this place" (Mr. Peter Care home 3, Resident 2).*

Mr. Peter also spoke about his food choices and preferences, in that he liked the food offered by the care home. However, he admitted that at times he had to eat whatever was provided, even if it wasn't his particularly choice, because after living in the UK for so long food had become a compromise.

> *"I like the food and the staff, I have no problem at all. Even though sometimes, I get to eat whatever is made which oftentimes is not my favourite but I can manage because I have lived in this country for so long. Sometimes you have to eat and survive" (Mr. Peter Care home 3, Resident 2).*

Explaining further, Mr. Peter stressed that eating to survive in this context meant that food was not his priority, rather being looked after was.

> *"I mean that I don't mind the food. I am not really concerned about the food most of the times because I am being looked after. Helping me get washed and dressed was my problems and they are helping out on that." (Mr. Peter Care home 3, Resident 2).*

Despite stating this, although Mr. Peter would love his favourite Nigerian cuisine as he had experienced it before he arrived in the UK and when his wife prepared it, the urge for it diminished since he moved into a care home. Mr. Peter then added that the kitchen staff cooks and serves everybody and that he will eat whatever he receives as food.

> *"Oh yea, I will love Nigerian food. Fufu and soup. I love them back in the days when I was in Nigeria, and when my wife was alive. All those died away as soon as I moved in here. They cook food in the kitchen and serve everybody; I will eat whatever I am given" (Mr. Peter Care home 3, Resident 2).*

Also, Mr. Peter appreciated all efforts made by the care home to provide what he called a modified version of African food to meet his culturally-appropriate food needs, although he believed this was not the same as the main Nigerian cuisine.

> *"The kitchen staff make the modified version (laughing) something they call rice and stew, but you will know they are not the same, but I am happy" (Mr. Peter Care home 3, Resident 2).*

In terms of activities, Mr. Peter spoke very little about his choices. He said he said he is quite happy sitting and relaxing while listening to music: "*nothing special, I just like to listen to music"*. He then added that sometimes the staff take the residents out for a walk. Mr. Peter was asked if he could remember a place he has been to with staff and he said he couldn't remember but they usually walk around the home premises*: "no, the staff take us for a walk and back. Just around here".* Mr Peter also shared his cautious concerns about care home life. In his story he re-iterated the reason for moving into the care home and expressed that it remained his ultimate goal. He stressed that he had not deemed it necessary to take note of other concerns because his primary aim was achieved, as discussed above. This is included how he was addressed, as he stated that staff could call them whatever they wished as long as he primary support needs were met. As such, he only cautiously engaged with further discussion about the care home meeting his wellbeing needs.

> *"Like I told you, it got to a point where I needed help to do everything for myself, and all I cared about was to receive help to look after myself. Like getting washed, food, and maybe someone to talk to. Since I have come in here, I have not really looked into those kinds of things because I got exactly what I wanted from here. The staff helps me to get a wash and dressed. They cook food in the kitchen and serve everybody, I will eat whatever I am giving and I don't like to complain about little things like the way I am being addressed. Some staff calls me whatever they want and I have no problem with it. You see my daughter, they are helping me to a lot of things, and I am happy about it." (Mr. Peter Care home 3, Resident 2).*

Mr. Peter would not complain but stressed that if someone addressed him as papa, like the way the researcher addressed him, or even used Mr as a prefix before his name, he would like it.

"Smiled, it is alright, my daughter. But if someone called me papa like you addressed me all the time or Mr before my name, I will love it. But this is not what I will complain about like I told you before" (Mr. Peter Care home 3, Resident 2).

Though there was caution shown by Mr. Peter in talking about the way he would like to be greeted, it was also evident that this could be an important issue to him in terms of wellbeing. Also, Mr. Peter said he enjoyed an occasional visit from his children and sometimes from his social worker: *"Sometimes my children visit me and sometimes my social worker"*.

In summary, as Mr. Peter told about his daily life in the care home and immigration story, several key points emerged. Mr. Peter was focused on achieving his goal of moving in into the care home in order to receive support with personal care. Once this was achieved, Mr. Peter remained focused and thankful, and would not address other areas of his daily life that were not right. Also, Mr. Peter applied caution when discussing some of his concerns, re-iterating the impact the care staff had made regarding his initial goal.

5.7.2. Staff perspectives

It was learned from the deputy manager's response that both the staff and resident population of this site were ethnically diverse.

"We do get residents from all ethnic minority, India, Nigeria, China. It is highly diverse, we have quite a variety from different culture, we have Nigerians and Africans working here, some are French-speaking and staff from various ethnic group but we lack from the Chinese group. We put up job advert but you can only expect certain people coming to apply" (Deputy Manager Care home3).

The deputy indicated that diverse residents are referred to them from either the hospital or through the social worker. They emphasised that there were criteria for accepting them, which included *"assessment to ensure their needs are met".* In addition, the manager expressed that hospital assessment are only a starting point indicating that a more nuanced and comprehensive assessment are required to achieve their cultural needs.

"You know the assessment they do at the hospital is more straightforward than the assessment we do later in the care home. In the hospital, you know it is like a tick box type of thing but when they come here you see a lot of changes. Some difficult to manage and different from what they assessed at the hospital." (Care home 3 manager)

In addition, the deputy manager explained that their assessment included dietary needs and that opinions were usually sought from families and residents to ensure an appropriate balance was maintained. This indicated the importance of obtaining information about the individual resident from other professionals and people such as family to ensure quality of life is maintained.

"Actually, apart from assessing basic things like food and the rest of it we seek opinion and feedbacks from resident families and social workers putting the residents at the centre of it all. These were some of the ideas that we found interesting and has contributed so much to maintaining resident health and wellbeing" (Deputy Manager Care home 3).

Following the assessment, the deputy manager indicated that there were no issues regarding dietary needs. They stated that the residents ate all that is offered, primarily because some of them have lived in the UK all their lives and are used to British food**.**

"No, when it comes to food, they all eat it what we give them. We have no problem with the food; some residents get food brought to them by their families. A lot of these older people have stayed here all their lives; they have come here in their early days. I have been here for more than 20 years. They are used to all the local food in the shop. So, they are used to the kind of food cooked here. They lived here all their lives" (Deputy Manager Care home 3).

In addition to this, the deputy manager maintained that adjustment was not needed around food because some food is eaten globally. Also, the manager added that family members were fully involved in teaching staff how to make residents' preferred food.

"Some of the food is eating universally such as chicken and potatoes, so some of them are already used to the food … we sometimes ask family

to teach us how to make residents favourite dish to suit their personal needs" (Deputy Manager Care home 3).

Furthermore, the deputy manager expressed that other areas, such as activities, were also assessed and met. They stated that the purpose of the pre-assessment was to identify and meet the specific needs of the resident. They added that some of the residents who are used to specific activities were able to continue with them. Also, the deputy manager specified that there are some residents, regardless of assessment, who choose to do nothing even when families has been consulted about their preferences. Responses from families, according to the deputy manager, often included what was already offered in the care home. However, the deputy manager indicated that there was always music playing in the background throughout the day and the residents enjoyed this.

"When it comes to activities such as knitting or may be music, we tend to do pre-assessment to identify specific needs of a residents 'most at times for some residents that has knitted all their lives they tend to carry on while some of them prefer not to do anything. 'We have spoken to their family about it. We tried to find out what they enjoyed doing and some of the answers we got back are the activities we do here, and still, you can't get them to do it. They just like their quiet time. But most times, most of them love music so we tend to play different types of music throughout the day, so at some point, during the day, some residents tend to hear the music they like" (Deputy Manager Care home 3).

The manager also added:

"We have different kinds of activities for the residents, depending on their interest. Sometimes some of the residents rarely partake in any of these activities; they sometimes prefer to sit nice and quiet. We play dominos. They have brain testing exercises where they are giving certain things to identify. Some residents don't like to do anything. Sometimes we get some residents who don't want to engage in anything" (Manager Care home 3).

Also, the care home manager expressed that there were a variety of activities used to engage residents, giving dominos and brain testing games as examples. Despite providing these activities, the manager indicated that engaging some of the residents posed a challenge. Aside from this, another member of care staff added that the activities mentioned by the manager and her deputy were not the only ones provided. Sometimes residents were taken on a short trip as a form of leisure, or parties and external entertainers could also be offered.

> *"We take them to the park, castle they eat nice launch. They go out sometimes twice a week if the weather allows. They go to tea parties. Some schools come here to sing for them. People come from outside to entertain them" (care staff 1).*

The deputy manager added that they also engage residents in other meaningful activities in different ways. She said they marked several occasions, such as Jamaican Independence Day where they had a band and colourful outfits, whilst also developing a playlist to blend each resident's choice of music.

> *"Today is Jamaican Independence Day, and we had a band and dressed in different attire. We try to blend in with everybody based on music and other activities. For example, not all resident like soul music and so on, so we blend in different types of music based on what each resident enjoys and put them on as a playlist, so this makes it possible for everyone to enjoy the music depending on the one they like. (Deputy Manager care home 3).*

It was further picked up from the manager's comment that music on the playlist included the residents' local traditional music which had been given to the care home by the residents' families. Also, the manager said special occasions were graced with barbeques with staff dressed in colourful attire and more music reflecting the residents' backgrounds. She added that residents had shown their enjoyment by dancing and hugging each other.

> *"Just in addition to what the deputy manager has said about entertaining our diverse residents and even British residents. We have barbeques stuff, and we tend to do barbeques sometimes in the evening or even during these festive periods. Our residents enjoy it so much. For example, when it was Jamaica Independence Day, we got all the staff to*

dress up like Jamaicans both the residents. It was so colourful and entertaining with music playing in the background which included resident's local traditional music and you could see so much joy with the residents dancing and hugging each other and some sit and enjoy the barbeque. There is another one coming up" (Manager Care home 3).

To achieve this idea, the manager expressed that ethnically diverse staff were the key. The manager revealed that meetings are held with care staff and useful information about activities was shared and acted upon. They also stated that marking such occasions reflected cultural acceptance.

"Most of the staff here are Africans and some British. This has helped a lot to understand our resident's cultural needs. During our meeting, we discuss ways to do better than we are doing (Pause for 30 seconds). My staff shares useful ideas base on their experience with residents, and we look into it. 'Celebrating each tribe's independent day reflects cultural acceptance. In terms of activities, we assess and re-assess based on what we have and normally, our activity coordinator takes care of that." (Manager Care home3)

The deputy manager added that the recruitment of staff that reflect the diversity of the resident's population were very important to achieving their diverse cultural needs. However as seen from the deputy managers comment above (at the beginning of this section), the recruitment of these ethnically-diverse staff also poses a challenge. Then then manager noted that "*once a needed staff comes through the door for employment, it makes all the difference" (Care home 3 manager).* For other popular activities, such as bingo, the manager argued that although these were not necessarily culturally specific to Nigerian residents, their lengthy period in the UK meant they were now acculturated to them and this made them enjoyable.

"Not really, but most of our residents have lived here all their lives, and when we offer these activities, they tend to join in." (Manager Care home3).

In addition, the manager indicated that the variety of choice available for residents meant that residents were unlikely to request activities that were not already offered.

> *"Not really, maybe because we provide lots of choices available and ask them to choose what they like and we also do ask what they like doing, and we always try to provide that." (Manager Care home3)*

Other events that had recently been marked with activities were Father's Day and the Queen's birthday. These were seen as brightening the home's environment, and more likely to include visits from family members, including those from ethnic minority backgrounds

> *"Even we do Father's Day party for them as well. We do different kinds of party including Nigerians party, Queens's party. They brighten the residents up…… it is like a united nation (smiles)" (Care staff 1 care home 3).*

> *"Families seems to like us, it is amazing, and some of the family members of people from other ethnic minorities who visited during the entertainment loved it" (Manager Care home 3).*

In addition, another member of care staff noted that a homelike environment was a need to be considered. They stated that stories heard about the state of care homes in the UK were not encouraging. They felt that activities and interventions offered in this home were essentially in combatting this, and had been noted by residents' families.

> *"Having been a carer for years before I came to work here, I can confirm that something needs to be done to make care home a home for the residents. People do share interests and stories, and I have heard a lot about the state of care home in this country. This home is one of the homes that is doing so much to engage people from other ethnic minorities especially the entertainment part of it. It is amazing and some of the family members of people from other ethnic minorities who visited during the entertainment loved it. Residents enjoy it and they feel as if they are enjoying their lives" (Care staff 1 care home 3).*

Also, the manager expressed there were other upcoming events that will be celebrated in this fashion, the aim of which were to improve the mood and wellbeing of residents.

"We are planning an upcoming party where everyone would dress up according to places people come from. We are planning on making it colourful because colours motivate people and cheer them up. We like to keep our residents happy all the time" (Manager Care home 3).

These ideas included advice and guidance from families, staff, and social workers in search of views to maintaining resident health and wellbeing.

"*Actually, we did not start it from the start, it started from constant review of the proper management of the care home putting the residents at the centre of it all. We started to seek opinion from relatives, staff and social workers. These were some of the ideas that we found interesting and have contributed so much to maintaining resident health and wellbeing. It might interest you to know as well if you look around the staff dress the way they like; it's more of a home instead of an institution. This makes residents relax and feel like it's their own home. It makes the staff feel at home and relaxed to take care of the residents. We have staff from various ethnic groups; we arrange a get-together party within the home for all staff every year where all staff comes in their attire. Celebrate and dance with the residence. Every residence ethnicity is celebrated" (Manager Care home 3).*

In addition, another member of care staff added that they tried to respect every resident in this care home by greeting them the way they choose to be greeted, indicating that greeting is essential for communication, triggers positive conversations and can help connect people on a more personal level.

"I think greeting is one of the most important things I would consider. (Nodding) first impression they matter, and greeting is one of them. If I am not greeted I feel I am being ignored or disrespected. So yes, I would rate people according to how they greet people" (Manager Care home3).

Significantly, the following care staff member stated that the importance of greetings could not be overstated. They added that failure to greet might mean being disrespectful, while positive greetings can help form positive long-term relationships.

"In fact, in my country greetings could hinder a young girl from getting married. Yes, it is that serious. If you want know a respectful woman, find out if she greets people which can earn her a good husband" (Care 1 staff care home 2).

This care home staff member further added that greeting an older person can be a sign of humility, and this can make a remarkable difference in an initial meeting with an older person.

"Our older parents regard greetings as a sign of humility and respect, and even initial meeting with a nice greeting could make all the difference" (Care 1 staff care home 2).

Another care home staff member explained that he applies this with residents by greeting them and spending time with them in the morning; talking about their families and how they spent their night. He added this was well received by residents.

"I do that with older Nigerian residents, , and other staff have also learnt to do it because they see that it makes them happy. in the mornings we spend time talking about yesterday or about family visits, and they love it." (Care 1 staff care home 5).

At the end of his comment, he concluded that greeting people nicely in the morning can have a huge impact and also portrays respect.

"Apart from the older people, nice warm greetings in the morning makes all the difference to me as a person. It shows me acceptance and respect, and I don't take it for granted" (Care 1 staff care home 5).

Also, another staff member who was originally from Jamaican acknowledged that greeting was crucial for every African, and described how to achieve it:

"Yes, like greeting, every African value greeting more than anything else including me. In Jamaica, even other country, knowing how to greet someone is very important. You should always acknowledge a greeting by returning the greeting. When meeting someone for the first time, a handshake with a cheerful greeting such as 'how do you do' or 'good afternoon' can change a lot of things. May be sometimes, women may

start by greeting men and other women with a handshake and once you get to know the person, a hug and kissing on the cheeks will usually replace it and of course using formal titles, such as Mr, Mrs, Dr, and what have you. Ordinary hello and hi greetings won't work especially for Jamaicans" (Care 1 staff care home 4).

Another care home staff member raised issues about the importance of understanding cultural norms and how these norms influence people's values, humour, hopes and loyalties. The manager then highlighted the broader benefit of the interventions already discussed, including entertainment, indicating that these had helped the resident to adjust to care home life.

"Most of the residents who never liked to stay here at the initial stage, tend to adjust within days and they feel good because they see we are here to look after them" (Manager care home 3).

In brief, the responses and ideas emerging from both residents and staff varied. However, there was a clear indication that staff were trying to attend to cultural needs of residents through various means. It was interesting to see that most of the ideas were coming from the staff, social worker or the family, and not from the resident who is the recipient of care.

5.8. Care home 4

5.8.1. Introduction to the residents participants

Ms Juliet (care home 4 resident 1)

("If I want something I ask the staff, and they will bring it")

Ms. Juliet was 79 years old at the time of data collection. She migrated to the UK as a single lady in 1970 at the age of 32 in search of a better life, but could neither read nor write. Ten years after she arrived, her father, who had been in the army, migrated to the UK to join her. Since then, Ms. Juliet had lived with her father who is now deceased; she did not marry or have children. She worked as a cleaner in Lewisham in the city of London. Before migrating to the

UK, Ms. Juliet said she tried to go to school but could not manage this as she kept failing courses and never advanced.

> *"I have been here since I was 32, still young then, but now I am an old woman. I have reached almost 79, I think. When I came here, I live for Lewisham, our black people full there. But before that time, you know for Nigerian nothing, everywhere was dry so I wanted to come here for a change was a daddy's girl so when I came here ten years after my dad who used to work for the army joined me, but he is dead now. Since I was not that sharp with education, I just did not worry. When I write exam, I will fail so I just stopped. I just focused on my job here, cleaning for people, no children, no husband" (Ms Juliet care home 4 resident 1).*

Three years after Ms. Juliet retired as a cleaner, she lived alone without issue. However, on several occasions Ms. Juliet was found by the police to have been missing either because she had set off to get something from the shop or could not locate her home. Her last trip before she was found and moved into a care home was when she embarked on a restless search for where her father had gone, and she was reported to the police by a man whose door she regularly knocked on in order to find him. Also, due to a lack of close family and friends to offer support, Ms. Juliet moved into a residential care home following assessment by her social worker.

> *"You know my sister, I still believe my dad is alive, sometimes I go to look for him where we live, and the police said it was wrong, they took me away. One time I forgot where I was going to buy something when I tried to ask neighbours they called the police. When I sit and think of this, I cannot understand, this life can be lonely. One day social worker came to me and said if I need someone to talk to she can arrange. So I came here" (Ms Juliet care home 4 resident 1).*

Ms. Juliet spoke about her care home life, stating that the staff were quite helpful, especially with getting up in the morning: *"The staff here is very good…when they come in the morning, they make it so easy to get up. They are good my daughter.*" She commended the staff for doing an excellent job when attending to her personal care needs.

"The girls here are very nice, in the morning when they come, they clean me up, clean my bed. Very nice place" (Ms Juliet care home 4 resident 1).

She then added: *"the only thing is …. this place is too boring nowhere to go, just sit (smiles)".* Other than the quiet nature, Ms. Juliet added that the care home was good at including the residents, whom she called friends.

"This place is good, everybody here is very good even my friends who live here. It is a nice place"(Ms Juliet care home 4 resident 1).

Further on, Ms. Juliet indicated that once personal care was completed, breakfast was served, and this included food that she enjoyed, such as toast.

"*In the morning when I wake I eat toast for breakfast...I like it" (Ms Juliet care home 4 resident 1).*

She went on to explain that most often, the staff served snacks to everybody in the care home.

"Sometimes in the afternoon, staff come here with tea and biscuit and give everybody".

Then Juliet added that during lunch there were choices, such as rice and stew, which she also enjoyed.

"During lunch, they serve rice and sometimes stew with something for lunch" (Ms Juliet care home 4 resident 1).

However, rice and stew were not the only served cuisine in the care home, but Ms. Juliet indicated that it was her only favourite food served there. She noted that other foods such as mashed potatoes with vegetable were also served.

"Sometimes, they serve mash with vegetables which I don't like much, but when I get rice and stew, I feel happy" (Ms Juliet care home 4 resident 1).

Ms. Juliet added that though she doesn't like mash and vegetables when she sees other people eating it, she eats them as well: *"But if I look and everybody is eating, I will eat also….*

(Smiles)". Ms. Juliet said that despite this; she would prefer foods like swallow, which she had not had for a long time.

> *"Yes, of course, like swallow, it has been a long time. Swallow with bitter leaf soup. Very nice"(Ms Juliet care home 4 resident 1).*

However, although Ms. Juliet's food preference was not available on the menu she was thankful for food she also enjoyed, like stew and rice: *"No, not yet, but I get rice and stew. I like it".* She concluded by saying if she wanted anything she *"will ask the staff and they will bring it."* In terms of activities, Ms. Juliet said there is usually "*nothing to do"* most of the time in the care home, but she liked to sit and read the newspapers and watch television*:* "*I like to read papers and watch the telly to know what is going on".* She also indicated that it was not the only thing she did daily as sometimes entertainers came to dance and play music: *"no, sometimes some people come here with loud music …dancing".* Ms. Juliet stated that this music was not enjoyable or to her taste. Later, Ms Juliet clarified that she preferred to listen to people playing drums.

> *"Well, I love that kind of music where people play bongo (drum)… you know when people tie wrapper and shake the bum? …it is very nice." (Ms Juliet care home 4 resident 1).*

However, this kind of music was not available in the care home according to Ms. Juliet. Meanwhile, although Ms. Juliet indicated that she was still happy living in the care home, she would not expect extended families to come all the way from Nigeria to visit.

> *"I don't expect my people from home to come here… it is too far… I thank God I have a place like this" (Ms Juliet care home 4 resident 1).*

She then added, *"Sometimes, the social worker comes to see me as well."* In talking about her religious needs, Ms. Juliet spoke little about how her faith needs in the care home were met. She said she was very religious when she was in Nigeria but not now: *'I go to church very well back home… but not now".* She explained that it was challenging to keep up with her faith needs, particularly because of the distance she would have to travel to attend the church.

> *"Very hard sometimes because the church place is far from my house. I just feel tired to go" (Ms Juliet care home 4 resident 1).*

She then concluded that despite this, she would require no further intervention in maintaining her faith needs.

> *'No, don't ask. I am fine." (Ms Juliet care home 4 resident 1).*

Mrs. Amaka (Care home 4 resident2)

("Dear heavenly father, I am in your hand, please dear father hear my cry")

Mrs. Amaka was 80 years old at the time of data collection. Mrs. Amaka migrated to the UK with her husband and three children in 1968 to look for a better job while her husband wanted to further his studies. While in Nigeria, Mrs. Amaka worked as a traditional birth attendant alongside her older daughter, while her husband worked as an interpreter for the missionaries. On arrival to the UK, Mrs. Amaka settled in the city of Lewisham with her family and worked as a cook and kitchen assistant. Mrs. Amaka's husband finished his studies and travelled back to Nigerian while she remained with her children. At the age of 75 years, Mrs. Amaka lost her husband as a result of an unknown illness in Nigeria and it was harder to move back home because of her previous difficult relationship with her in-laws.

> *"Before we left home, I think in 1968, my husband's people never liked me. So when we moved to England I wasn't ever going to go back but my husband died and nobody could tell what killed him. Even with his death, I was not still ready to go home because nobody likes me'. I am old now, 80 you know. Before we lived in Lewisham, I delivered babies for women in the village and my husband was interpreting for people. When we came here, my husband went to school and cooked for people" (Mrs. Amaka Care home 4 resident 2).*

Mrs Amaka added that since after she lost her husband, everything seemed to fall apart, including her relationship with her children.

> *"But then the worst happened, it looked like my husband died and my children decided to turn away from me .....Only my second daughter sitting beside me now, stood by me all the time" (Mrs. Amaka Care home 4 resident 2).*

She insisted that it was an evil act to be let down by her children: "*nothing but the devil.* She added that her only obedient daughter was in employment and the circumstances surrounding her job made it difficult to see her. Consequently, she became lonely and thriving alone in the care was an increasing challenge.

> *"My children moved away, my daughter who was always beside me had to go to work and sometimes her job need sleepover, so nobody at home, it was so lonely, with the problem of my husband's relatives and my children's trouble….it was hard for me." (Mrs. Amaka Care home 4 resident 2).*

One day while at home, Mrs. Amaka had a fall while using the stairs and was suddenly rushed into Accident and Emergency before being admitted to the hospital ward.

> *"One day I don't know, but I can remember coming down the stairs, and then that was it, nobody was around when except for sister who came visiting… then I found myself in the hospital and the doctors said I had a fall" (Mrs. Amaka Care home 4 resident 2).*

During her stay in the hospital, Mrs. Amaka said life had been very difficult because she can't walk and her only daughter who came to see her lived far away due to her job.

> *"My only problem now is my leg. I can walk well. The doctors said I have to use the wheelchair. My daughter who normally come to help when she can live far. I don't know how I am going to manage" (Mrs. Amaka Care home 4 resident 2).*

As Mrs. Amaka got better and was ready to be discharged from hospital, she could no longer return home because there was nobody to look after her and she had lost her mobility. This decision was compounded by Mrs. Amaka's complicated relationship with her children, resulting in her being heartbroken.

> *"When I got better, I was worried how I was going to cope at home, but my daughter said I they will get a new place for me when I asked where she said care home. I cried. I had children who does not care about their mother. That is life" (Mrs. Amaka Care home 4 resident 2).*

She then added, "*If not for this, my daughter. I don't know. She will call me and ask about me every time".* Mrs. Amaka then further explained that they then held a meeting in the hospital with her daughter and then she was moved into the care home.

> *"The doctor came to me and said they have found somewhere where I will be looked after; then my daughter came with me to see this place I live now. Since then, I have been living here" (Mrs. Amaka Care home 4 resident 2).*

Since moving into the care home, Mrs. Amaka said she felt better off in her home compared to a care home: "*There is nothing here, I was more comfortable in my home*." She explained that life had been so unfair and indicated that living in her own home was preferable to her current situation. She stressed that the routine of the care home was the main issue.

> *"I don't know why my life has become this way when I was at home, I have the way I do my things but this place is just different"(Mrs. Amaka Care home 4 resident 2).*

She then added, "*The time they wake up, music and television noise everywhere, I don't like a life like this".* Mrs. Amaka would have preferred to spend more time in bed in the morning but added that she remained grateful for the good job the staff team was doing.

> *"Yes, at least they should allow people have a rest in the morning before waking them up … I am not against them, they are doing a good job to help me get out of bed but if they can let people get up in their own time, it will be good" (Mrs. Amaka Care home 4 resident2).*

In explaining her favourite music, she indicated that Christian songs were most preferable as compared to the disco music played in the care home, and also added that food was part of her concern.

> *"I am a Christian, and I don't like any other music that is not Christian music in the morning, I like to listen to Nigerian Christian music not disco… even the food. I don't know" (Mrs. Amaka Care home 4 resident2).*

In terms of food, Mrs. Amaka spoke at length about her food choices and preferences, stating that her dietary needs had been a key part of her discharge plan from hospital to the care home. However, in the three years since her arrival, she felt these needs had not been met.

> *"I don't know if this is a way to get rid of me. The doctors made me believe that all everything I need will be taken care of, but that is not happening. It has been over 3years but still nothing" (Mrs. Amaka Care home 4 resident2).*

As a result, Mrs. Amaka's daughter became concerned, and advised her to complain to the management. However, Mrs. Amaka was reluctant to follow this route and insisted on waiting patiently.

> *"My daughter keeps saying, make complain, but I don't think it is right. I said to my daughter, you are not here all the time, be patient, let us wait and see. Till today, I am still waiting" (Mrs. Amaka Care home 4 resident 2).*

According to Mrs. Amaka, her familiar food included "*rice, stew, pounded yam not bread".* However, her daughter was unable to provide them for her due to work commitments.

> *"My daughter lives far away if she has to come to visit me, she will come straight from work with just snacks. So you see." (Mrs. Amaka Care home 4 resident 2).*

However, the management had previously observed an issue with her food choices, and had asked her for her preferences. However, when her favourite food was prepared and served she did not enjoy it, indicating that the taste was primarily the issue.

> *"One day, the manager came to me and asked what I want to eat, I told her rice and stew, and she said ok they were going to make it for me. I was shocked when they brought it; I couldn't even swallow it. They tried but I didn't like it. The taste is different" (Mrs. Amaka Care home 4 resident 2).*

Mrs. Amaka also spoke about the activities she enjoyed in the care home; she said the care home offered a range of activities yet sometimes she felt like doing nothing.

> ***"****There is always something here to do all the time, either they play that noisy music or they bring games, sometimes colouring things, but sometimes I just like to relax somewhere.****"*** *Though there were varieties of Activities in the care home, this was not a priority for Mrs. Amaka. Pointing out that she was not used to doing any of those available activities. "The problem I have is… I don't do all these games even when I was at home, so that is all I can tell you. They are trying, but I will like to go someone quite to have my rest, not games" (Mrs. Amaka Care home 4 resident 2).*

In addition to this, Mrs. Amaka expressed that other family-related issues were her concern, not games. She also shows a great deal of unhappiness when stating that following the passing of her husband and the disintegration of the relationship with her children, life had become very unfair.

> *"I have been through a lot, and games will not make my condition better. My husband is dead, my children all apart, only my daughter who cares about me. I don't know why it is like this" (Mrs. Amaka Care home 4 resident 2).*

Though Mrs. Amaka's situation was a concern to her, she said she was a Christian who believed in God regardless.

> *"I believe in God. I trust God even though I am like this" (Mrs. Amaka Care home 4 resident 2).*

She stressed that there was provision for a minister if she needed it, and added that the care home provided a pastor who usually visited every Sunday.

> *"When I came here, the care home said they will bring somebody every Sunday to pray with me if I wanted. The pastor comes every Sunday. He will pray and bless me" (Mrs. Amaka Care home 4 resident 2).*

Because of the issues impact her family life discussed earlier, Mrs. Amaka said life feels like she is now childless despite having four children. She expressed that all her children turned their backs on her, except one of her daughters who has always been there.

"Visit mm, do you know I have four children, and it looks like I have no children. The children God gave me is now a problem for me, only this my daughter even if she is far she calls on the phone but others don't." (Mrs. Amaka Care home 4 resident 2).

In all, this was not a concern Mrs. Amaka wanted to share as she said: "*don't bother; it is a long story."*

5.8.2. Staff perspectives

In this care home, the manager expressed that BME residents usually came in small numbers and added that they currently have only two Nigerian residents.

"We hardly get black people here, and if we do, they were usually small numbers. At the moment, we have just two black people and they are all Nigerians" (manager care home4).

In managing this population, the manager explained that this is reflected in their assessment and care of the resident. They indicated that, once assessed, provision of appropriate activities were always provided, stressing that bingo was common.

"Based on the assessment, we formulate activities in the home. We do exercises, quizzes, bingo is the most popular, cards, knitting, dance /music as a form of exercise" (Manager Care home 4).

Most of these activities, according to the manager, reflected cultural diversity: *"yes most of them"*. They indicated that even Nigerians join in and enjoy the same activities other residents do, but also acknowledged that they do decline some of them. As such, most often they ensured that residents were offered a choice of activities based on both safety and preference.

"Well, partially, yes. Our white residents enjoy it the most and most times other residents from other ethnic minorities join in including Nigerians. But what we have noticed is that some of them at the mention of 'activities' decline instantly. We had a lady here who said she likes swimming which we don't offer here. We looked out the possibility of

arranging it, but the risk was too much. She can't walk and sometimes she goes out of breath which is normal for her. So I would say the assessment covers both safety and choice" (Manager Care home 4).

The manager clarified that though safety and choice were a priority in providing activity, limitations around affordability were still taken into consideration.

"It is based on both. Yes, because we provide what we can afford, but as I said, we assess them based on both criteria you mentioned and make changes where necessary from time to time" (Manager Care home 4).

Also, care staff highlighted the importance of having these varied activities, indicating that this enhanced resident health and wellbeing.

"It helps the residents to unwind and improve their health and mental wellbeing" (Care staff care home 4).

In terms of food**,** the care staff said that adjustments were made, particularly when compared to other areas of care.

"Yes, yes, with food, yes, we do make adjustment, but with care and other things, we don't" (Care staff care home 4).

In terms of food adjustment, the chef prepared the residents' choice of food while the staff served it.

"*Our chef cook their food, and we serve them" (Manager Care home 4).*

During further clarification about the meaning of the above comment, the manager indicated that plans were already in progress to include diverse ethnic food in the care home menu. They stated that the plan was due to a realisation that their Indian chef could not make Nigerian cuisine. As a result, a Nigerian domestic staff member offered to help in preparing Nigerian dishes to meet this need. According to the manager, this was a welcome suggestion waiting to be put in place.

"Actually, we have improved since the last time you visited, but it has nothing to do with our new resident (I mean the Nigerian lady) in particular, though she will be benefiting from it. You know what, I have

to tell you this after we spoke I thought we need to do more for our residents from other ethnic minorities including Nigerians. At the moment, we are looking at how we can achieve this. Before, we could make something like rice and stew which they call curry rice here, but we have noticed that it did not make much difference. The reason is that curry and stew work out almost the same way, maybe a different taste and once we serve this to our Nigerian residents, and they will eat very little and sometimes turn it down. Even when we ask why they did not eat much, they mostly complained about the taste. Our chef is Indian and has little knowledge of how to make Nigerian food, but the good news is that one of our new domestic staff is a Nigerian and she worked as a kitchen assistant in her previous job. She has suggested that she could cook Nigerian meals every Friday and we are looking at considering that because it might help. I feel for them as well, but you know it cost a lot of money to make Nigerian dishes here" (Manager Care home 4).

Furthermore, the manager expressed that culture remained a vital issue for older Nigerians accessing the care home. According to the manager, the best solution was for people to abandon their cultural beliefs to avoid consequences.

"We have Nigeria resident the one you interviewed, speaking from the one you we have. From your question, culture is one of the main problems why we don't put our loved one in the care home. If I may say, I think we should move away from that culture. People might end where they don't like" (Manager Care home4).

Also, the manager wondered why black ethnic minorities did not access home, stating that other minorities thrived well in that environment.

"If other people can live in the care home, I see no reasons why black people cannot" (Manager Care home4).

Clarifying this, the manager expressed that this was an ongoing difficulty in the home. They that black ethnic minority people were problematic in that she had previously been in a dispute with a black resident's relative who disagreed with her management style.

"This is the problem I am having at the moment. I will prefer to have white people in the care home than black. The black will give you more trouble. They try to bring trouble where there is no trouble. So demanding. Wanting everything done for them. One certain one came for respite. As soon as she saw I was a black manager, she decided to mess up, asking for flowers. She said the last care home their mother went they were welcomed with flower. I told her, I am here to care not to give a flower. She went to report me that I did not receive her well" (Manager Care home 4).

Aside from this, the manager suggested that the only way to solve this was by people moving away from their culture or opting for homecare. The manager expressed that this would work well for this population, and added that the government is currently suggesting this.

"I think they should move away from that culture and better still keep their people in their home. Government is trying to encourage people to remain in their homes; I think that option is what black people are going for. It is best for them" (Manager Care home4).

In summary, the services rendered in this care home for older Nigerian migrants showed an awareness of differences in ethnicity and culture. However, the approach to meeting the cultural needs remained a challenge. The care home manager expressed that efforts were made, and these did not seem to work well. New plans were still under consideration to achieve dietary needs. This included using domestic care staff with cooking skills to develop a more diverse menu of food choices. The challenges, however, led to the manager speaking out and suggesting alternative care at home for older black people. Within her suggestions, older Nigerians should only abandon their culture if they needed to live a care home life.

5.9. Building understanding of staff and resident worldviews

This section draws on a socially-constructed perspective of staff and resident data to build understanding from the stories they told. The aim was to bring together opinions and experiences by focusing on the richness and contextual nature of the data collected, and by drilling deeper into the narrative. From these groupings, the first-hand accounts of participants

and how they described their daily lives, as well as how staff met their cultural needs, are re-examined. It was important to present the interview transcript in a polished and logical manner as a professional courtesy and as a mark of respect for the intellect of the participant, while still retaining the rich data of the opinions and experiences shared. This "re-presentation" of the raw interview data was a crucial first step in the analysis as it demonstrated to the participant that the researcher understood the context of what the participant had said (Gibson and Brown, 2009, p110). Also, re-representation of raw data agrees with epistemological and constructivist view that knowledge is subjectively interrelation between the researcher and participant in the co-construction of meaning (Hayes and Oppenheim, 1997, Pidgeon and Henwood, 1997). The process of building meaning used in this chapter is a multidimensional concept that includes my level of insight into the research area, which agrees with not bracketing my previous experience as a Nigerian and a carer who has worked in the care home sector. This is to assure the reader that the researcher is well attuned to understand the nuances and complexity of the participants' words and actions, able to reconstruct meaning from the data generated with the participant, and have capacity to "separate the pertinent from that which isn't" (Strauss and Corbin, 1990, p.44).

The resident participants' description of their life in a care home gives insight into their unique experiences and the complex interactions with staff. The analysis of the stories that were retold in this chapter by the residents showed the cultural variety and cultural differences that exist within this group of Nigerian resident. The diversity was particularly visible in their immigration histories and cultural needs. Within the staff population was diversity in perception and opinion about provision of cultural needs. However, staff displayed varying differences in provision of cultural needs of their Nigerian residents, including instances where they attempted to address those needs. Such perceptions meant that care home 3 deputy manager felt that some of the residents had become acculturated to British food because of their duration of stay in the UK and, therefore, no adjustments were needed. However, what was picked up from other care homes was a detailed process of providing for cultural needs. This approach began with getting to know the residents' preferences, aspirations for living in the care home and needs. This was a continuous process as needs do change. Specifically, care home 2 manager and care home 3 deputy manager indicated that this requires comprehensive assessment to gain a nuanced understanding of a resident's background, values, beliefs, cultures and preferred lifestyle. Care home 2 manager indicated that this was one of the most crucial aspects of their care home. For example, they found that food choices varied and were

based on individual preference, rather than being specifically related to ethnicity. For example, in care home 3, where two Nigerians participated (Mr Peter and Mrs Jane), Mr Peter indicated preferences for a particular Nigerian food called swallow (swallow is widely used in Nigeria to describe starchy foods that are cooked to a dense paste and eaten with various soups) with his favourite Nigerian soup or rice, as this had traditionally been a favourite dish of his. Meanwhile, Mrs Jane preferred the same swallow but with a specific Nigerian soup called 'Egwusi soup'. Also, in Care home 2, where Mrs Nneka resided, the care staff mentioned that there are other residents from other black ethnic minorities, meaning that provision of favourite ethics foods was regularly made. In care home 2, the staff (ethnic) achieved this by working part time as a cook to ensure that the right food and taste is achieved for their ethnic residents. These staff were skilled in preparing the required cuisine and this enhanced the service provided by the home. Also, care home 2 staff indicated that through informal interactions with these residents, important things such as food choices and preferences were identified and acted on. This approach was particularly welcomed by Mrs Nneka as she expressed the extra effort that the staff go to in terms of food when compared to her previous placement.

> *"They are different ones, Yes, different homes which I have been, but this one, is ok and I wouldn't go anything against it. It is ok. Mmmmm, I just have to behave, try to understand them".*

> *"Sometimes the staff cook from their houses and bring them for us, so I can't not complain. I hold nothing against them" (Mrs Nneka Care Home 2).*

In addition, staff indicated that they ensured that the Nigerian food provided was right for the Nigerian residents by inviting the dietician to ensure that they met each individual's needs. Then this food is prepared and frozen in readiness for lunchtime. This strategy, according to the manager in care home 2, is possible because of her ethnicity (African). This care home team was keen to try different ways to address the residents' food choices and preferences. However as stated above, the approach to culturally-appropriate food was diverse and, as a result, differed in other care homes who made other attempts to provide for this need. For example, in care home 3 family members were actively involved, particularly in bringing food for their loved one and teaching care home staff how to cook Nigerian cuisine. Meanwhile, in care home 4 the chef prepared food for all residents including Nigerians. However, this approach in care home 4 came with difficulty, as the residents reflected on the chef's lack of

skills in making diverse cuisines. Nevertheless, care home 4 team was sensitive to the difficulty associated with meeting both culturally-appropriate food and taste. To address this issue in the care home a Nigerian domestic staff member was offered additional hours to work in the kitchen to prepare Nigerian food.

In terms of activities, the approach differed across the four care homes. For example, in care home 3 the manager indicated that they sourced ideas from feedback received from resident's families and staff on how to engage their ethnic residents. This included suggestions for occasions and celebrations such as independence days. The traditional way to mark this occasion was through music and dressing up. In this care home residents wore colourful clothes and a band played music that the residents had selected. This music consisted of each resident's local traditional music. Families were also involved in ensuring that traditional music was played. This manager from care home 3 highlighted that staff ethnicity plays an important role towards understanding the diverse needs of the residents. They indicated that these staff share their knowledge or views within the staff community. Other care homes, such as care home 2, practiced differently. Care home 2 manager mentioned how their residents are taken to day centres, schools are invited to sing, mothers' days are celebrated and other forms of activities such as card making, etc. are included. In care homes 1 and 4 similar approaches were used, such as residents being assessed by an activity coordinator and the offer of varied activities such as dancing, throwing balls, dominos, monthly parties, etc. In all these care homes, the approach towards residents' cultural needs were seen not to be perfect. For example, care home 2 resident (Mrs Nneka) received all the ethnic foods she loved but complained that the activity was seasonal (card making). Whereas in care home 3, care staff in the process of learning to make residents ethnic foods, but were proficient with activities that their ethnic residents loved. Also, in care home 3, the view about the importance of greetings were shared by ethnic staff in order to meet the preference of Nigerian resident, but this was not practiced in the other participating homes.

The second factor which was highlighted initially at the beginning of this discussion is staff willingness to embrace the differences that exist, and how this is influenced by economic impact and individual belief systems. The belief or assumption that residents are used to the environment was particularly seen in care home 3. Though care home 3 staff were committed to providing culturally-appropriate food and activities as a team, there were individual beliefs about their Nigerian resident which were shared by the deputy manager. This belief was particularly related to food, as she believed that most of their residents have lived in the UK

for so many years that they are used to the environment. As a result, no adjustment was needed in terms of food. In care home 4, the manager expressed their desire to provide ethnic food but indicated the economic impact of doing so. However, this did not deter the manager from offering a part-time post for the domestic staff (Nigerian) to ensure that Nigerian meals are cooked for their Nigerian residents. This perhaps was as a result of the repeated complaint about the taste of the food made by the chef as indicated earlier in this section. Within these categories of staff, minimal or no adjustments were made in terms of culturally-appropriate activities. Efforts that were made were related to activities which are commonly available in the care home. For example, dominos, throwing balls, gentle exercise, knitting, painting and dancing.

However, for residents, their experiences varied and were seen to be based on the staff level of awareness of their cultural and daily needs, as well as staff willingness to adjust and meet these needs. For example, in care home 1 (Mrs Joy) and care home 4 (Mrs Amaka), residents referenced staff's partial commitment to their initial assessed needs, and they expressed that the initial assessment raised their expectations of care home and was a guiding principle over their decision to live in that particular home. Particularly Mrs Joy in care home 1 expressed that the initial assessment (prior to moving into care home) detailed that her needs would be met in the care home, but was then devastated how it all turned out. Meanwhile Mrs Amaka commented on how her hopes were raised by the doctors regarding the care home, but the reality since moving there had been different.

> *"I don't know if this is a way to get rid of me. The doctors made me believe that all everything I need will be taken care of, but that is not happening. It has been over 3years but still nothing".*

> *"The doctor came to me and said they have found somewhere where I will be looked after; then my daughter came with me to see this place I live now. Since then, I have been living here". (Mrs Amaka Care Home 4 Resident 2)*

However, those care home staff in care home 2 who were sensitive to residents' cultural needs reflected on the resident feedback about care home life (for instance Mrs Nneka, in care home 2 as highlighted above in p 47.). Some of the residents (Mr Peter) who were either not happy or satisfied remained cautious about their demands for cultural needs (specifically food) and

preferred not to speak out about anything. In relation to food they had concerns about the limited choice (Mrs Joan p9), the taste of some food (Mrs Amaka 4 p41) being offered and unfamiliar food (Mrs Joy p4-5). Some residents, who neither complained nor received their ethnic food, remained hopeful that such dishes would be available in the future. For example, Mrs Jane indicated that she would have preferred Nigerian food and hoped to receive this. However, the staff participants from this home did not indicate that they were aware of Mrs Jane's views and hopes.

Other aspects of their core cultural values were highlighted by the residents. This was in relation to how staff addressed them as Nigerians. They indicated that staff did not ask for their preference on how to be addressed, but they felt they had little choice but to accept this. For example, residents who would have preferred to be referred to as papa did not complain if they did not receive this. Meanwhile, the majority of the residents were happy with how their faith needs were met, although others would not elaborate on this topic. In terms of activities, residents acknowledged that though there were range of activities available in the care home they often lacked their own personal choices. Others who did not comment on the choice of activities were happy to sit and watch television or participate only when they felt like it. Overall, these residents have accepted the differences from the life they lived at home and expressed a willingness to cope with their current circumstances and understands that life is now different.

Overall, the staff level of awareness and willingness to make changes played an important role in how ethnic residents adjusted to care home life. The benefit of this level of cultural awareness and willingness to accept change gave rise to various practices, such as continuous assessment (getting to know the resident), getting family involved, and shared views from the staff community. On the other hand, these residents based their hopes on the initial assessment and, as a result, further communication between them and the staff about their cultural needs were limited if not initiated by staff. This indicated that staff had to work extra hard to identify these needs and how they were being met, as some dissatisfied residents did not think it was appropriate to speak out.

5.10. Chapter summary

This chapter has provided insight into the lived experiences of the participants, and offered insight into their immigration stories, journey into the care home and daily life experiences. In all four participating care homes, there were Nigerian residents, as well as staff from other ethnic minorities (cultural diversity). The vital dominant issues were related to food, and its impact on both residents and staff. It revealed some of the residents were not communicating their food needs to staff. As a result, staff diversified their approach in meeting their culturally-appropriate food need. This included working with resident's families / social workers, and staff cooking and bringing food from home for their ethnic residents.

This also provided insight into how staff worked to provide culturally-appropriate care. It revealed through ongoing assessment that staff worked hard to find the differences that existed between Nigerian residents and other residents. It revealed that ongoing assessment aided staff to gain deeper understanding of the individual resident's cultural requirements. This approach helped them build understanding about diverse cultures in the care home. Another approach which staff found helpful was ethnic staff contributions and suggestions. This approach, as mentioned by the care staff, was helpful because these staff have underlying knowledge about similar ethnic residents. In the next chapter these findings are presented thematically, in order to understand the life experiences and challenges to the provision of culturally-sensitive care in a more robust manner.

Chapter 6

6.1. Making sense of the stories told by the participants

6.2. Introduction

The previous chapter provided a descriptive presentation of resident and staff stories and highlighted the varying differences in the way the residents lived their daily lives in the care home. In resident stories, they described the way they lived their lives invested with personal meaning. These meanings were an important illustration of how their previous lives before immigration has impacted their current life. Consequently, this affected the way they lived and interacted with the care staff while under their care. Some were reticent about their needs, some were going with the flow and some found modes of adaptation. From staff perspectives, the residents' reluctance to disclose their cultural needs was a difficult situation which they are unaware of. However, some staff were willing to build and deepen their understanding of residents' cultural needs and they achieved this in different ways. This included ethnic staff upskilling other staff, working with residents' families /social workers, and individual assessments which were obtained informally and then incorporated into daily routines. One interesting finding derived from the staff efforts was that no particular care home met all cultural requirements to the satisfaction of the residents. However, finding the differences that exist and the willingness to build understanding from these differences was more important for most of the care home staff. Through this analysis the following themes (illustrated in the table below) were identified and will be discussed below, moving away from description as presented in the previous chapter to interpretation, in order to echo and assign meaning to these diverse experiences.

Main themes	**Subthemes**
Cultural diversity	-individual differences in living requirement -distinctiveness in immigration stories
Cultural awareness	- finding the differences that exist -understanding cultural requirement
	-knowing cultural requirement

	-willingness to build understanding about diverse culture
Approaches, practices and strategies	-working with residents' families / social workers -ethnic staff upskilling other staff -incorporating skills into daily routines -spiritual needs

Table 5: ***Themes identified***

The themes presented will reflect both the staff and the residents' views, which agrees with the constructivist methodological approach used in the study as a way to construct meaning from both the staff and the resident data. At the end of the chapter, a summary of the findings is presented, highlighting how these key dominant features impact the residents' quality of life in the care home and how staff responded to these concerns.

6.3. Main theme 1: Cultural diversity

This main theme discusses the multiculturalism that exists within the Nigerian residents. Cultural diversity in this context is the quality of diverse or different cultures, and the attributes that people use to confirm themselves with respect to others, as well as their values and cultural norms. These includes more obvious cultural differences in their food choices and preferences, perceptions about religious belief, traditions and lifestyles. Lifestyle in this context is the way of life of these older Nigerians. This covers their immigration stories as well as the uniqueness in their cultural requirements, which further aids in understanding different perspectives within their world and their daily needs. This gives a clearer picture of the descriptions of other themes and how staff recognize the presence of such diversity. The link between culture and lifestyle as found in this study is that a lifestyle is part of culture, while from people from single cultural backgrounds can have different lifestyles. The findings in chapter 5 (see details in each resident's data) revealed the different cultural needs and lifestyles that exists within these older Nigerians. This illustrates that these Nigerian residents have different lifestyles based on their background. For example, a lifestyle of Mrs Joan in care home 1 from that of Mrs Juliet as they

both had significantly different educational backgrounds. This showed that though these individuals are Nigerians (cultural background), their lifestyle differentiated their cultural needs. The details for the description of this theme are organized into two sub-themes: individual differences in living requirement and diversity in immigration. These are now explored in more detail.

6.3.1. Sub-theme 1: Diversity in immigration stories

This theme looks at the varying differences in the immigration stories of the Nigerian residents in more details. This is recognizing the uniqueness and differences in these individuals. Learning these differences aids in understanding the different perspectives within the world they currently live. The reason for recognition of this stage of their life was observed as it appeared to affect the life they lived in their various localities, the job they did and the life they currently live in the care home. The process of their immigration was understood to occur in different stages. The first stage, as seen from the findings, were pre-migration, which involved the decision and preparation to move to the UK. This stage for all the participants was a remarkable stage. Mr. Peter and Mrs Joan immigrated for *further studies* with the full support of their *families,* while Mrs Nneka *moved from Nigeria to Spain and subsequently the UK due to relationship difficulties and resulted in a low-paid job.* Mrs Joy was humiliated *for having an illegitimate child in Nigeria and had to move for a better life.* Since living in the UK, life was a rollercoaster from being a *carer to losing her only child* and then being *asked to move into the care home in later life.* Then, Mrs Amaka was *fleeing poverty in Nigeria with her children and husband and, since being in the UK, she highlighted that she had spent the majority of her life looking after her children*. Subsequently, she lost her husband and eventually moved into care because all her children now live on their own. However, there were similarities to these stories, as they were all within their middle age and had spent significant time in Nigeria before they immigrated, making them heavily influenced by Nigerian culture. What is now significant within this subtheme is the second stage of their immigration, which is their absorption within the social and cultural framework of their new society. The absorption process, as seen in chapter five, was influenced by their educational level as well as personality factors. For example, Mrs Joan, having moved to the UK at a young age said she *had a very glorious past and had been known to the BBC due to her achievements*. She went on to express that since her husband's death she has made a choice to move into the

care home for the *meals and company*. Mrs. Joan added that despite having two children who lived around the corner, she didn't need them to look after her. As a result, she expressed that she is happy with the meals and would not expect otherwise. This contrasts Mrs. Joy, who migrated to the UK as a result of the way she was treated due to having no husband coupled with losing her only son. Mrs Joy expressed that sometimes she *sits down and asks God 'why you don't take me*, but said *God was not ready for her.* Mrs. Joy showed concern on the effect of refusing food that is not her choice, by stating "*if you do not want it, you leave it and you suffer inside."* One remarkable thing picked up from these narratives is that staff were unaware of these distinctive issues and the impact of their immigration lives on their current living condition.

Staff understood that assessment was an important stage and tool for understanding their residents' individual needs. For example, the manager from care home 1, as Mrs Joy and Mrs Joan showed, had knowledge of the differences in cultural need and expressed that through assessment resident choices and preferences were picked up and *addressed where required.* For example, in terms of food, common food choices such as rice, potatoes and chicken are eaten globally, but this showed no awareness of the impact of the non-provision of ethnic food choices, as already highlighted here. However, the findings in chapter five showed that individual assessment during care home placement was mostly related to the physical needs of the residents. Although care staff expressed knowledge of residents' previous life before moving into the care home, they did not reflect on their assessment of their needs and the impact this might have in the current choices they make. These experiences affected their identity and perception of self, and how they view themselves as unique from others.

In summary, these diverse experiences and distinctiveness in immigration stories provided a unique understanding of each resident's life and roots. This gave insight into how they perceive their current living situation as well as how their immigration stories affect the choices they currently make. However, staff relied on assessment as a major way to understanding their needs. In care home 2, the care home manger indicated the importance of continuous assessment due to changes in their living requirements. The same manager highlighted the importance of individual assessment to meeting their needs. This further connects to the next subtheme which will discuss how this affected their living requirement in the care home.

6.3.2. Sub-theme 2: Individual differences in living requirement

The subtheme above provided the uniqueness of the immigration stories of the Nigerian residents. In this subtheme, individual differences in living requirements will be discussed. Among the most important kinds of individual differences are food choices, personality traits, and values. This theme will discuss these individual differences, and how they contribute to the shaping of behaviour and the individual's sense of self. These individual differences distinguished one person from another and, thus helped to define each person's individuality. It was discovered that some of these residents construct their choices of food based on life-course experiences and various contextual influences. For example, Mr Peter expressed love for fufu and soup, which he said were not provided in the care home. According to Mr Peter, *he had loved these dishes while in Nigeria, but this had died away since moving to the UK.* Furthermore, when staff tried to provide Mr Peter's choice of Nigerian food, he commented that it *tasted like a modified version of his favourite food* and added that *sometimes you have to eat to survive.* A similar comment was picked up from Mrs Juliet, who loved a different kind of Nigerian cuisine called *swallow and bitter leaf soup* and expressed that *they are not available in the care home.* The important revelation seen from these residents was that they were reluctant to share their thoughts about food preferences with staff because they felt that "*they know but haven't bothered yet, so don't worry" (Ms Joy).* They made the assumption that staff were already aware of their preferred food choices and so did not need to actively share this.

Individual requirement based on activities were also picked up from Ms Juliet. Ms Juliet indicated a love for a type of Nigerian drum dance which isn't offered in the care home but also would not share this with the care staff. Some of the residents would love to do a certain activity, but would not reveal this to the care staff and even though they did not enjoy what the care home offered in its place. This was picked up from Mrs Joy's comment when she explained that noisy activities offered in the care home are quite uncomfortable and that she would like table activities which are quieter.

> *"I don't like noise. If you are having an activity you have to make up your mind that you want to do a table or something else" (Ms. Joy).*

The argument from the manager of this care home was that the activity coordinator hired by the care home assessed and organized all activities. These *activities are planned on a weekly*

basis and included dominos, panting and dancing. The manager highlighted that *all planned weekly activities were carried out on daily basis.* However, Mrs. Amaka in care home 4 expressed that the pressure of family-related issues are more worrying compared to making choices about activities. Findings in chapter 5 (page 147) revealed that Mrs. Amaka had a concern with family support since moving into the care home and has remained emotional on how some of her children have abandoned her.

> *"I have been through a lot, and games will not make my condition better. My husband is dead, my children all apart, only my daughter who cares about me. I don't know why it is like this." (Mrs Amaka)*

While personal factors affected Mrs. Amaka's desire to accept activities, some of the residents expressed concern on other living situations, such as greetings. The desire to be addressed in a certain way as a way of living in the care home was picked up by Mrs. Joy, Mrs. Nneka and Mr. Peter. They expressed the effect this had on the day-to-day living in the care home. This particularly triggered a feeling of unease and a lack of respect from the care staff once they did not receive it the way they expected.

> *"One morning, one sister is here, me call her sister nobody calls her sister. Where I was working they had sister and matron but her they have no one call you sister they address you with your name. I don't think is fair." (Ms. Joy)*

> *"Did you remember I called her aunty, because she is older than me? People were calling me my name, when I first came, but now they call me mama. But initially, they called me Jane and I didn't like it. But you see, I am getting on." (Mrs Nneka)*

> *"Some staff call me whatever they like but if someone called me papa like you addressed me all the time or Mr before my name I will love it." (Mr Peter)*

Others however, found a semblance of equilibrium with their host culture as a result of the unavailability of their cultural requirements. This was relating to food, where Mrs Joan and Mr Peter expressed that the duration of their stay in the UK had influenced their views about food. Mr. Peter expressed that "*sometimes you have to eat and survive"* while Mrs Joan said she is a trained nurse and eats *"whatever is available mainly British food"*. However, the same resident

gave further reasons why they ate mainly British food, which was mainly because her food choices were *not available (Mrs Joan).*

What was remarkable from these residents was that, although they identified their unmet needs, they were reluctant to come forward themselves due to personal and subconscious fear. For instance, Mrs Amaka, when expressing her dissatisfaction of the food she received in the care home, stated that despite the management intervention on preparing what was supposed to be her favourite food it was only her daughter who advised her to complain when it did not meet her preference. This resident's response was that she would rather not tell the staff about it as she thought *it is not right* (Mrs Amaka). She continued by saying: "*I said to my daughter, you are not here all the time, be patient, let us wait and see. Till today, I am still waiting".* Mrs Amaka's analysis of the taste of that food was not that it did not taste good, but her argument was that it did not match the taste she was used to (culturally). In summary, it was evident that these Nigerian residents are unique in their needs, both in terms of culture and daily life. These residents seem to find it uncomfortable in relating their individual needs to the staff team, even with some level of awareness that the management are open and willing to listen to their needs. Most of them had a negative perception about relating these needs to staff. One perception was that the staff were aware of their needs but chose to do nothing. In terms of activities, they was variation in what they wanted to do, and when this was not met, they reacted differently. Some walked away while other sat quietly to enjoy some relaxation time. The next theme explores what level of awareness staff had about these resident needs, as indicated by the residents, and how they found and met these needs.

6.4. Main theme 2: Cultural awareness

This theme discusses the staff level of awareness and understanding of the differences between themselves and the Nigerian residents. Especially in terms of needs, attitudes and values. As highlighted above, resident unwillingness to reveal their thoughts and feelings about their current living condition to the care staff meant that staff had to diversify their search for best practice to care for them. The areas explored by the care staff began with finding the differences that exist (assessment), and included ethnic staff contributions and suggestions and deepening understanding through informal communication. As discussed in chapter five, the care home population is made up of people from diverse ethnic backgrounds and, as such, this population

varies in their daily requirements. Therefore, finding the differences in this population, as seen from the data, was to gain insight into their cultural requirements. The data for this theme is organized in 3 subthemes (knowing about cultural requirements, understanding cultural requirements, and willingness to build understanding about diverse culture), which are now discussed in more details.

6.4.1. Subtheme 2.1: Knowing about cultural requirements

This theme signals that assessment should be diverse and ongoing throughout the residents' everyday living experiences. It was found that the initial assessment is not always sufficient for people in long-term living arrangements. Within the four participating care homes, standard formal assessment relating to the resident's basic needs prior to care home placement were echoed. This includes gathering information concerning the resident's individual physical, cultural (food, religion and activities) and daily needs, plus other information. They all indicated that the aim of the formal assessment was to guide their decisions whether or not to accept the residents based on the facilities and type of services provided, and this sets the pace for an ongoing assessment.

> *"The way the admissions happens is when somebody is coming from the local authority, they send us an assessment and we read and re-assess. From there we learn more about the person, see if we can care for the needs of the person." (Care home 1 manager)*

However, the managers in care homes 1, 2 and 3 emphasised the need for ongoing assessment, revealing that this approach is always, needed specifically on food (ethnic food). They indicated that the initial assessment serves as a starting point and once the resident starts to adjust to care home life needs do change.

> *"But you know not everything is picked up from the first day, so during our meeting, we discuss ways to do better than we are doing (Pause for 30 seconds) because needs do change" (care home3 manager).*

"We assess and re-assess based on their needs" (care home 2 deputy manager).

"We take it from the beginning. In terms of nutrition, this is where if you are from ethnic origin you know, we provide ethnic food, if it is often. We do dietary summary of peoples foods, like and dislikes it is picked up from the assessment stage when they are coming in" (manager care home 1).

In care home 2, specifically, residents were assessed individually based on their needs. According to care home 2 manager, special arrangements were usually made in cases where they get people from ethnic minorities, including Africans. These special arrangements included care staff preparing ethnic food, asking a dietician to check the food and storing specialised dishes in the freezer to serve them when needed.

"*We try as much as possible to assess the resident individually to accommodate their food needs For example two ladies from Africa here, we give them African food. Then we ask a dietician to come and check to make sure the food is right for them. We prepare the food and freeze it and we feed them during lunch and that's all they get for the day. We make them stew, fufu, beans, garri". (Care home 2 manager)*

Equally, Mrs Nneka in care home 2 acknowledged that the care staff usually enquire about her food choices, and revealed that the manager made every effort to achieve this, even at her own personal cost. However, this manager indicated that such efforts were because of her ethnicity as a black African. She emphasised that this type of practice is rare in some of the care homes, especially in her previous employment.

"The manager came to a point that she gives her money to go the market to buy the food we like to cook for us. So many things. Anything we like to eat we tell them they try, they try to do it for us" (Mrs Nneka).

The manager's effort indicated that initial assessment and real care home practice differs based on the management and philosophy of care. For example, a care staff in this care home indicated that the manager, due to her ethnicity, believed that culturally-appropriate food was

a core need for ethnic residents. This resulted in all the effort she made, and based on her previous experience working in care homes this was uncommon.

> *"If not that this care home is managed by Africans, they will not be getting any African food at all. Where I worked before, we had African residents and there is no African food been made or Africans. They make the same kind of food for all the residents. So they should be thankful for receiving it at all, because if they find themselves in that kind of situation what will they do?" (Care staff care home2).*

Regarding the provision of ethnic food, another the manager in care home 1 revealed that, following the assessment, those with specific food needs, including ethnic minorities, were identified and provided for. However, as already highlighted above in (see chapter 5 page 116), the residents residing in this care home revealed that only British foods were available on a daily basis and the only variation they received was with the previous management.

> "*We had a… a lady who was here, we were not eating bread morning and night but this one comes eating bread from morning afternoon and dinner" (Ms. Joy Care home 1 Resident 1).*

> *"If we can we equally inform them so that they can make the necessary arrangement. So one of the things we look at and then… I don't know if you saw one of my colleagues looking at the folder. It is called the personal plan folder. so if resident has got, their needs in that plan and how their needs can be met, what can they do for themselves their personal needs and what we can do for them is document in there, their nutritional needs how can they eat, what kind of food do they like, how can they eat All these needs are assessed and documented so that the carers will know how to care for the person. In terms of nutrition, this is where if you are from ethnic origin you know, we provide ethnic food" (Care home 1 manager).*

These varying practices, as indicated by this manager, were also seen in care homes 3 and 4. These two care homes stressed that the initial assessment was always easier than ongoing assessment. They indicated that ongoing assessment is where the realities and challenges are

more eminent. This is when the reality of care home life sets in and residents try to make meaning of their current situation.

> *"You know the assessment they do at the hospital is more straightforward than the assessment we do later in the care home. In the hospital, you know it is like a tick box type of thing but when they come here you see a lot of changes. Some difficult to manage and different from what they assessed at the hospital." (Care home 3 manager)*

However, the managers indicated that once the needs changed and differed from the knowledge they originally have, then further ideas are needed to meet their ongoing needs. One of the ways indicated was to seek help from the families of Nigerian residents to help them. This could be in terms of food or activities, and is discussed in more detail later on this chapter. In care home 3, the manager specifically indicated that care staff share ideas in an ongoing assessment. This involved holding meetings with care staff, in which ideas are shared and implemented. These ideas particularly related to areas such as food and other complex needs of their residents.

> *"But you know not everything is picked up from the first day, so during our meeting, we discuss ways to do better than we are doing (Pause for 30 seconds) because needs do change" (care home 3 manager).*

In care home 2 staff had a different approach to doing ongoing assessment, which involved the social worker or the family member of the said resident. This care staff indicated that these are the channels they explore when they need understanding of residents' needs.

> *"Actually apart from assessing basic things like food and the rest of it we seek opinion and feedbacks from resident families and social workers putting the residents at the centre of it all. These were some of the ideas that we found interesting and has contributed so much to maintaining resident health and wellbeing" (deputy manager care home 3).*

Another interesting approach highlighted in care home 2 was establishing a more informal way of assessment which focused on retrieving some of the needs that are not easily disclosed

during formal assessment, one of which was food. This was highlighted by one of the care staff in care home 2. The aim according to this care staff was to gain mutual understanding via relationship building, which was a daily commitment, and then using this avenue to explore this need. This care staff revealed that this method of assessment was effective with their Nigerian resident. They stressed that enquiries relating to ethnic food needs required relationship building to develop a better knowledge of their food values and traditions. Similarly, it was important to draw on the staff's own experience (this staff member knew how to cook the food). The outcome according to this member of care staff was that it helped to solve culturally-appropriate food problems.

> *"Well for example food. The Nigerians I have met in this care home enjoy their stay because the staff who are Nigerians are quite close to them. Before, I came here to work I heard there were always problem with food with some residents especially black people. But I come to realise that by the time we get close to them, chat about their life before now, what they enjoyed doing, when they came to the UK and why they came here it helped us to know what they like. So because of this sometimes I will make that favourite food to them from home and they will thank me. So when the manager say they don't eat what they cook in the care home, I had to suggest the food the resident have told me they like during our chat. I remember the manager asking me who was going to cook it and I suggested that I could. So since then, staff get to make food for residents even our Jamaican staff. It is one of the things that make them and even our manager happy." (Care staff 1 care home 3)*

A similar approach was seen in care home 1, where the manager expressed that staff get to know what the resident wanted through ongoing assessment. This was a case where resident food preferences was picked up at in the first instance and native foods are introduced in the menu. In addition to this approach, the manager in care home 1 added that continual "*weekly assessments were done to find out which of their choices or preferences have changed"*. As stated in the quote above, there was evidence of an understanding that cultural differences exist and an interest in obtaining the knowledge needed to achieve a positive result. Such results

would include gaining clear knowledge of the resident's food preferences. In brief, this theme has highlighted various challenges faced by the care staff from the four participating care homes. Each of these care homes expressed a mismatch between the initial and ongoing assessment, highlighting the challenges they face trying to remedy the situation. This mismatch particularly related to food, as care staff highlighted the difficulty in meetings the residents' tastes and preferences. Each of these care homes devised ways of knowing how to continue to look after the residents from Nigerian backgrounds. Care home 3 sought help from the family while care homes 2 and 4 used ideas from the care staff. In all, these practices showed the acknowledgment of cultural differences between the Nigerian residents and the other residents in their care. The effectiveness of these strategies also varied. Care home 2 were more successful as they paid attention to every detail. This included informal ways to obtain the knowledge, the care staff's ability to capture the needs as well as making the initial move of preparing the food, and positive feedback from a resident who commended them for meeting both their taste and choices. The next theme highlights the efforts staff made outside their standard care routine to meet the needs of their Nigerian residents.

6.4.2. Subtheme 2.2: Understanding cultural requirements

The assessment discussed above in subtheme 2.1 has discussed how knowledge of the residents' diverse needs is gained. This theme signals the difference between knowing the cultural needs of the Nigerian residents and understanding these same needs. For example, the majority of the data indicated that ethnicity and diversity of staff is one of the key factors in understanding and providing culturally-appropriate care. The argument behind this was that ethical similarities portray both knowledge and understanding of these needs. Within the data, three out of the four participating care homes' staff strongly believed that ethnicity of staff played an important role, especially with residents of a similar ethnic background. This involved how staff use their insights from their cultural background to shape the care they provide to the residents. These ideas used by these care homes, according to the data, have solved a significant culturally-appropriate need surrounding food, activities and social interactions. The starting point for care home 3 manager was to achieve the right mix (diversity) of staff, which they hoped would reflect the diversity of the residents in order to understand and meet their needs.

"We do get residents from all ethnic minority, India, Nigeria, China. But we lack from the Chinese group. We put up job advert but you can only expect certain people coming to apply" (care home 3 manager).

However, as seen from this manager's comment, the recruitment of these ethnically-diverse staff also poses a challenge. This was attributed to the availability of the needed *ethnical diverse staff, as it is obviously challenging to recruit a staff group which reflects the makeup of the resident population*. The manager noted that "*once a needed staff comes through the door for employment, it makes all the difference" (Care home 3 manager).* Though this effort was only made in care home 3, care home 4 also shared a positive impact of having a diverse workforce. This was already highlighted in chapter five where ideas shared by Nigerian domestic staff had an impact on the provision of culturally-appropriate food, which was a current challenge faced by their Nigerian residents (see chapter 5 page 153 for data sources). Other areas such as activities and greetings are discussed below as part of the approaches used to enhance cultural need.

In summary, the theme understanding cultural requirements exposes the effort care staff make to gain deeper understanding of residents' cultural needs. This ranges from similar ethnic staff to welcoming ideas from other sources to meet residents' needs and includes care home 3 manager recruiting staff from diverse workforce, highlighting the usefulness of such practices. This unique way of recruitment, according to the manager, was a potential solution but also had its challenges, stating that achieving this was not always possible. Care home 4 manager was particularly open to suggestions from members of care staff and stressed the importance of finding new ways of working. While others shared great ideas about knowing and understanding the residents' needs, one of the staff in care home 3 made a striking comment about her views in meeting their resident's cultural needs. Details of this will be detailed in the next subtheme: willingness to build understanding.

6.4.3. Subtheme 2.3: Willingness to build understanding about diverse culture

This theme describes staff willingness to adjust to residents' cultural needs. The understanding and interpretation from one of the staff was that there was no need to prioritise provision of culturally-appropriate food because they believed most of their residents had lived in the UK all their lives and are used to local food. This was evident in care home 3. The deputy manager

here suggested that most of their *residents had no problem with food because they have lived in the UK all their lives, including herself.* In addition, this deputy manager expressed that most of the residents arrived in the UK in their early years and, as such, are used to local food. They consider that *some of the foods are eaten globally, such as chicken and potatoes (Care home 2 deputy manager).* The deputy manager was the only staff participant who shared this view. Her views were different from those of the staff team. Participating staff from same home highlighted effort made in provision of cultural needs. This included having a diverse workforce, partnering with families to ensure residents enjoy their cultural cuisine and recognition of diversity through celebration of significance. *Residents from the same care home (Mr Peter and Mrs Jane) commended staff effort in cooking their favourite Nigerian food, though Mr Peter indicated that the taste remained a difference*. However, no data retrieved showed it made any negative impact in the provision of culturally-appropriate food. The deputy manager's argument was that *these residents' duration of stay in the UK, as well as their contact with the host culture, have been significant influence.* Her views remained that their period of stay in the UK could have *influenced their cultural beliefs.* However, as seen from the theme individual living requirement it was evident these had has not given up their cultural needs, especially their preferred food choices. Also, the main theme cultural awareness highlights that this aspect of cultural need (food) required skills and understanding as care staff sourced for ideas from multiple avenues. However, in care home 4, the issue faced was frustration as a result of the complex needs of the Nigerian residents in relation to food. Care home 4 particularly expressed that they had assumed that all similar cuisines could be supplemented. For example, according to care home 4 manager, they used to make something like rice and stew, which is popularly known as curry in the UK, only to discover that this was not consumed by Nigerians.

> *"Before, we could make something like rice and stew which they call curry rice here, but we have noticed that it did not make much difference. The reason is that curry and stew workout almost the same way, maybe a different taste and once we serve this to our Nigerian resident, they will eat very little and sometimes turn it down Even when we ask why they did not eat much, they mostly complained about the taste." (Care home 4 manager)*

The manger expressed the need to build understanding in relation to this challenge. They understood that taste was an issue and the chef cooking for their residents had limited knowledge of other cultural cuisines. They welcomed ideas from a new domestic Nigerian staff member who had worked as a kitchen assistant in her previous job. The said new Nigerian domestic staff opted to *cook Nigerian food for the Nigerian residents every Friday* and, according to the manager, *this will make a huge difference to their Nigerian residents*. Then she added that *she feels for them even though Nigerian cuisines can be expensive to make (Care home 4 manager).* Though the same manager made comment on the economic impact of providing each Nigerian culturally-appropriate food, she was flexible and open to make changes whenever required.

In care home 1 however, the issue was that a resident's health condition formed the basis of their ability to adhere to their culturally-appropriate food. The care home manager of care home 1 explained that *Nigerian food can be heavy and most of these heavy ones are the ones the Nigeria residents request*. As a result, these Nigerian foods are provided once a day as agreed with the dietitian. According to further comment from care home 1 manager, *provision of ethnic food met both taste, choice and preferences (Care home 1 manager).*

In summary, this theme revealed staff willingness to know and accept other people's culture and identity. It revealed that in care home 3, a deputy manager's views and perception differed from the other staff in the team. The deputy manager's views were that most of the residents have acculturated and no adjustments were needed. However, as someone in a managerial post, comments of this nature could impact on further care if more awareness is not created. Other care homes made effort to work through their difficulties to meet the complex needs of the residents.

6.5. Main theme 3: Approaches, practices and strategies

This theme discusses the approaches, strategies and practices used to incorporate these skills into the daily routine of the resident. This includes working with residents' families / social workers, as they expressed that family plays an integral role in areas relating to food. The staff demonstrated that family members provide them with hands-on assistance on how to make certain cuisines of their loved one. The idea was to meet the cultural food needs of their

relatives. Another approach to practice was celebration of diversity which involved recognition of cultural occasions. The strategy worked via the ideas shared by the staff team about each resident's cultural occasions. The care home management used the information to plan events for their diverse resident population. They marked the occasions by cooking local cuisines, playing diverse music and seeking costumes and decorations to fit the event. Another approach was ethnic staff upskilling other staff. This was particularly related to greeting residents in their preferred cultural way. The ethnic staff indicated that they do this because it makes their Nigerian residents happy. These approaches are discussed in details as subtheme below.

6.5.1. Subtheme 3.1: Working with resident's families / social workers

The previous themes highlighted how care staff were sourcing for ideas from themselves as well as social workers to develop their skills in looking after their ethnic residents. The family was another source of ideas. The care staff expressed how families have been actively engaged in areas such as food, as well as sharing useful information about the president's choice of activities. In terms of food, family played a role in bringing food as well as teaching them how to make the same food for their loved ones. This was evident in care home 3 where the deputy manager, as well as the manager, mentioned that most residents get food brought in by their family who also teach them how to make the same food for their loved ones, and "*it works like magic.*"

> *"Yes, the family was highly involved especially in both bringing food in and teaching us how to cook them." (Care home 3 manager).*

Once this was working for both the residents and their families, the care staff played a significant part in bringing this to light in the care home. They monitored what was brought for the resident, the frequency of a particular food and the resident's reactions when the food was brought. This is the point where the manager expressed that they approached the family of the resident to teach them how to make the food. This move portrays commitment and willingness to learn and improve, as well as showing the residents and their family that they are aware of their cultural needs.

"What we do most times is, if we notice that family tends to bring specific food for their loved one more often, we seek advice on how to make the same dish to the resident. So yes, we learn from them and we do our best to make the same type of food they bring in." (Care home 3 manager)

Although Mr Peter termed it a "*modified version",* as stated in chapter 5, the effort from the care staff was appreciated and Mr Peter would not go into detail about this issue. In summary, this approach highlighted that staff were looking for the best way to meet their culturally-appropriate food needs. Again, the resident voice was lost in the whole idea, however, and the effort to do this was remarkable as seen from Mr Peters comment.

"The kitchen staff make the modified version (laughing) something they call rice and stew, but you will know they are not the same, but I am happy" (Mr Peter).

Care staff paid close attention to their residents' needs and likes by monitoring what their family brought over during visits, documenting this and seeking to take the challenge of providing it for them in the future. However, this was not a widely discussed topics as only care home 3 found this a useful technique. Family involvement was only evident in care home 3 and, according to this care home, was a method for the care home staff to get to know what the resident enjoys and go out of their way to learn to make the same food.

6.5.2. Subtheme 3.2: Recognition of cultural occasions

Other areas such as entertainment were indicated as part of the ideas harvested from their ethnic diverse staff which were apparent in care homes 2 and 3. In this theme, staff spoke widely about how they mark the specific important dates and occasions in the care home as part of meeting the residents' cultural needs. Staff in care homes 2 and 3 expressed that they host events as part of incorporating and responding to the cultural needs of residents. According to care home 2 staff and her manager, these celebrations included Mother's Day, Father's Day, and Independence Day of each resident ethnicity.

"We do everything here like Mother's Day celebration, Father's Day, independence day, and many others." (Care home 3 care staff 5).

"Today is our Independence Day, and we had a band and dressed in different attire." (Care home3 manager)

According to the manager of care home 3, celebrations such as Independence Day were popular, and staff usually dressed in different attire to make it colourful with entertaining music playing in the background. The outcome, according to the care home manager, was that residents were usually overjoyed, dancing and hugging each other while others sat and enjoyed a barbeque.

"It was so colourful and entertaining with music playing in the background, and so much joy with the residents dancing and hugging each other, and some sit and enjoy the barbeque. There is another one coming up." (Care home 3 care staff 1)

However only Mr Peter acknowledged the effect of this intervention, expressing that nothing was unusual about this celebration, but rather it was an opportunity to listen to music he enjoyed.

"Nothing special, I just like to listen to music." (Mr Peter)

Despite Mr Peter's muted reaction to the event, he enjoyed the musical aspect of it, which the manager had deliberately sought out via communication with residents' relatives. This music was played all day on the event, and even during everyday activities at other times. Once each resident heard the sound of their traditional music, their joy was usually not contained. However, Mr Peter's comment was the only time was noted in the resident interviews.

"I remember telling you that those who love music, we compiled a playlist and played it for them according to their choices and preferences, and some of the music is in their local language. So, yes, we try to meet up with their needs." (Care home 3 manager)

The manager aimed to reflect each community's Independence Day as a measure to indicate cultural acceptance and inclusion, as well as making the resident happy. Something the manager acknowledged was that the home was "*like a united nation."* Even the deputy manager from care home 3 expressed that some of the *families of the residents who are able to attend marvelled at the occasions and tended to like them, both their British and non-British families*. Also, the deputy manager expressed that more events were planned, where everyone would dress up according to places people come from.

> *"It is going to be colourful because colours motivate people and chairs them up, we like to keep our residents happy all the time". (Care home 3 deputy manager)*

There were a number of things evolving from these ideas from care staff. Firstly, the care staff were harvesting information from themselves as well as the social worker, as seen from the evidence presented below.

> *"We seek opinion and feedbacks from resident families and social workers putting the residents at the centre of it all. These were some of the ideas that we found interesting and has contributed so much to maintaining resident health and wellbeing" (deputy manager care home 3).*

Secondly, the effectiveness of these efforts from the resident's point of view were not encouraging, as indicated in Mr Peter's comment of "*nothing was special"* about the occasions marked. There was no mention of resident involvement in decisions about what entertainment they enjoyed, or feedbacks as to the effectiveness of this intervention. However, responses from Mrs Nneka regarding these occasions were that it is usually graced with food and music. Meanwhile, the manager portrayed the colourfulness of this occasions.

> *"We celebrate things like mother's day, father's day, and even we take them out especially Nneka to a church event. Most times during this event we cook food, play music… So they like it." (Care home 2 manager)*

"Like those you mention, in most cases is the food we cook, they cook food for us, we play music." (Mrs. Nneka CH2)

Also, Mrs. Juliet from care home 4, where none of these forms of activities were mentioned, yearned to enjoy one of her favourite local drum dances which the care home did not provide. She described it as bongo music, usually danced with a particular waist movement. However, she stated that bingo and watching television is still ok.

"Well, I love that kind of music where people play bongo (drum)… you know when people tie wrapper and shake the bum? …it is very nice."(Ms. Juliet)

The care home 4 manager revealed that the provision of culturally-related activities was influenced by availability and health and safety, as well as choice. She highlighted that these factors are considered first before any activities are provided. In brief, recognition of essential dates according to these care homes was seen to portray a way of meeting the cultural needs of the residents. The aim according to care staff was to keep residents active and happy, as discussed above.

6.5.3. Subtheme 3.3: Ethnic staff upskilling other staff

This theme discusses how staff of similar ethnicities to the residents upskilled other staff on greetings and how they should be delivered. It covers how care staff initiated greetings as a form of interaction with their Nigerian residents. The care staff indicated that the reason for upskilling in greetings was that Nigerians value greetings as it makes an excellent first impression and sets a positive tone for any conversation.

"I do that with older Nigerian residents, and other staff have also learnt to do it because they see that it makes them happy. In the mornings we spend time talking about yesterday or about family visits, and they love it." (Care staff 2)

This was an idea the staff team found useful in interacting with their Nigerian residents. Being aware that this was an important part of the resident's cultural value underpinned their effort

to practice it and, in practicing this, the care staff indicated that the idea and its application were gathered from their Nigerian staff. The Nigerian staff expressed that his knowledge about greetings in the Nigerian context drove the interest to initiate it. It was particularly driven by the fact that older Nigerians see greetings as a mark of respect and humility. In practicing this, they paid close attention to the way it is sent out and revealed that getting it right counts.

> *"Our older parents regard greetings as a sign of humility and respect, and even initial meeting with a nice greeting could make all the difference. I do that with older Nigerian residents. In the mornings, we spend time talking about yesterday or about family visits, and they love it." (Care staff 2 care home 3)*

As shown above, importance was placed on not hurrying a greeting. The staff indicated that it starts with chat about issues of the previous day, before progressing to enquiries about families and visits. This approach was welcomed by their Nigerian residents. Care staff 3 acknowledged that greetings were essential in African culture, and that she also valued them herself. She added that in Jamaica knowing how to greet is essential.

> *"Yes, like greeting, every African value greetings more than anything else, including me. In Jamaica, as with any other country, knowing how to greet someone is very important." (Care home 3 care staff 1)*

In addition, she added that greeting with a cheerful smile, and including the person's title, is an absolute need. She also suggested that using an ordinary hi was unacceptable.

> *"With a smile, ask, how do you do. In Jamaica, a hug and kiss on the cheeks are normal. Or even adding Mr, Mrs. Dr. just saying ordinary hello and hi can be a nightmare for Jamaicans." (Care home 3 care staff 1)*

This attracted contributions from the care home manager about how she valued greeting and how she felt when she received one. The care home manager expressed how much she valued greeting and how it makes a good first impression on her.

"I think greeting is one of the most important things I would consider. (Nodding) first impression they matter and greeting is one of them. If I am not greeted I feel I am being ignored or disrespected. So yes, I would rate people according to how they greet people." (Care home 3 manager)

Care staff 2 continued by explaining that, in Nigerian culture, greeting was so important and could earn anyone good favour. They also added that greetings could hinder a young girl from getting married.

"(Nigerian) ships in, in fact, in my country greetings could hinder a young girl from getting married. Yes, it is that serious. If you want to know a respectful woman, find out if she greets people which can earn her a good husband" (care staff 2).

Greetings could take any form or shape; however, as stated above, at the beginning of this theme, the details are crucial. It is easy for care staff to approach residents using their first names for dinner or medication to ensure they are speaking to the right person. Mr Peter, the resident participant in this care home, revealed that not all the care staff practiced this. He stated that some care staff address him as they wished, indicating that papa would be more ideal.

"But if someone called me papa like you addressed me all the time or Mr before my name, I will love it. Some staff call me whatever they like." (Mr Peter)

However, accepting the feeling that accompanies inappropriate cultural greetings could be challenging for certain cultures and people. For instance, Ms. Joy was devastated that carers in the care home addressed people the way they liked. This resident worked as a carer in the care home but was now retired, and she felt that people should be addressed with respect, preferably with the titles before their names.

"One morning, one sister is here, me call her sister nobody call her sister. Where I was working, they had sister and matron, but here they

have no one call you sister they address you with your name. I don't think it is fair." (Ms. Joy)

"Some of them, Edina, some of them 'dinner is ready.' I don't mind at all. You saw one of them come and call me Nancy for dinner as I say I don't know which one comes. They call you what they like." (Ms. Joy)

Equally, Mrs. Nneka from care home 2 expressed dissatisfaction with how care staff addressed her. She revealed that this began when she moved into the care home and noticed that the care staff addressed her by her name. This method of approach remained unacceptable to Mrs. Nneka, and she highlighted an example of how it should be done.

"People were calling me my name when I first came, they called me Nneka and I didn't like it. Did you remember I called her aunty because she is older than me?" (Mrs. Nneka)

Another prominent point seen in this theme was that care home 3 were the only care home who spoke about this topic. Other care homes revealed the presence of a Nigerian care staff and the contributions they were making to understand their ethnic resident's needs. It is not understood if this is practiced and not talked about elsewhere. However, the findings in this theme emphasises how the understanding of people's culture can make a difference in attending to their preferences.. Showing sensitivity to this aspect of residents' cultural needs, according to the staff, allows one to accord respect and value to other cultures. Residents in care homes 1, 2 and 3 showed that this aspect of their cultural need was very vital to the point of offering examples of how it should be done.

Subtheme 3.5: Spiritual needs

This theme discusses how care staff meet the faith needs of the residents and what the residents are saying about this need. It remained rather a sensitive issue to discuss, even during the interview, as residents almost declined to go into details on this topic. Among the four participating care homes, it was noted that the religious needs of residents were not an issue.

All four care homes made provision for a minister, but only a few residents showed interest in accessing this.

> *"Some don't even bother, and some of them rarely show interest even when we ask." (Care home 2 manager)*

> *"We also have a minister of God that comes here every now and then, but sometimes our residents prefer to arrange for themselves". (Care 3 home manager)*
> *"Even when they brought their mother here, they said they will bring someone every Sunday to pray for their mother. We have ministers that can visit at any time, so is not a problem" (care home 4 care staff 1)*

An example of the residents who rarely showed interest was Ms. Juliet in care home 4. When asked about how the staff meet with her faith needs, at first she did not understand the question. Once it was explained that this was about going to church she immediately cut in and said she knows where I was going and that she was not that religious even before she moved into the care home. Thus, she had never been concerned with visiting church.

> *"(Cuts in) I know where you are going, I am not that religious (20 secs pause)… even before I move in here and would not bother anybody to take me down to the church where I use to worship." (Ms Juliet)*

Also, another resident who expressed that faith need was not much of a problem expressed that her daughter brings someone to pray for her. In her opinion, this and her own quiet prayers were enough to meet her needs.

> *"I don't know if I have told you this, but sometimes my daughter comes with a pastor to pray with me which feels really nice, and most times I pray quietly on my own…..it is enough (laughing)." (Mrs. Amaka)*

Another participant who will not engage in-depth about her faith needs briefly explained that the distance was an issue, but then added that he used to go to church regularly in the past.

"Very hard sometimes because the church place is far from my house, I just feel tired to go. I go to church very well back home… but not now." (Mr. Peter)

Only one resident expressed difficulty and concern about faith needs. She explained that she had to make a telephone arrangement with someone to take her to her usual place of worship. She indicated that if this person failed, she felt unhappy.

"I have one lady who lived in 173 where I live; she lived there, she comes for me, every Friday she comes to ask me if I would like to go to church and she takes me. If I want her, I have to phone her and ask her if she is coming and she says get ready and after breakfast here she comes. If she did not come, I feel very bad." (Ms. Joy)

However, care homes 2 care staff said their residents enjoy their preferred place of worship with the care home making extra effort to take their residents to their preferred minister. This included a Nigerian resident who enjoyed going to church on Sundays.

"When you say religion, this care home provides it. I will use Mary as an example. She likes to go to the Catholic Church and even church group prayer meetings." (Care home2 care staff 1)

They added that they sometimes take their resident to extra religious outings hosted in the church, which the resident enjoyed so much.

"Now Mary goes to church, group prayer meetings, and some ceremony organised in the church." (Care home2 care staff 1)

In summary, none of these care homes mentioned if the residents would like anything else except a minister. In all, faith needs were seen not to be an issue as these care staff stated, and there was provision for it whenever needed.

6.6. Summary of the chapter

Through co-construction of knowledge of residents and staff ideas and thoughts, insights that answers the research questions has begun to appear. This has unveiled the participants' life experiences as a Nigerian in the care home, offers more insight on individual living requirements as well as how care home staff respond to the needs of older Nigerian residents and their families, and gives more knowledge on how some practices and approaches within care home services addressed the individual needs of residents and their families. It can thus highlight how these enhance the provision of culturally-sensitive care. Significantly, it was evident that there was substantive variation in the way these care homes approached their resident's needs. Some care homes were more responsive to the needs of the Nigerian residents through the use of flexible approaches and blurring of role boundaries than the others, and this was specifically evident in care home 1 and 3. The use of a flexible approach and blurring of role boundaries were dependent on the staff level of awareness and how sensitive they found the need of the resident. Others, however, were making assumption that the residents are used to the environment as well as its culture, and thus adjustments were not necessarily needed. However, evidence from the residents contradicts this claim. Also, residents were making assumptions that the care staff are aware of their situation and were thus reluctant to disclose them. In all there were many negotiations and ideas flowing from the direction of the care staff, social workers and resident families, rather than the resident themselves. In terms of activities, some care homes seek ideas from staff on the best activities that recognize the resident's ethnicity, while some care homes provided those they had within their facilities. In turn, responses from the residents varied, and some enjoyed activities that included their ethical background while others refrained. The next chapter discusses the significance of these findings and how these are related to the wider literature.

Chapter 7

7.1. Discussion

7.2. Introduction

The findings presented in the previous chapters showed the varying ways participating older Nigerians live and adapt in care homes. These were stories included and were influenced by difficult immigration histories and living and settling in the care home. While in the care home, they struggled to cope with living conditions not meeting certain needs. Some were cautious with disclosing their needs, while some understood that this is now the life they have to live. Some staff, however, worked hard to respond to their needs as they were aware that these were not always disclosed by the residents. In doing this, each care home had varying approaches and strategies to respond to their needs. This included cooperative working (teamwork), as seen in care homes 2, 3 and 4, all of whom supported all staff to share their ideas. Some recruited a diverse workforce to match the residents' ethnicity, as seen in care homes 3 and 4. Meanwhile, care home 3 utilised family involvement strategies to meet the culturally-appropriate food needs of their residents. In this chapter, a deeper interpretation of the findings is presented. To do this, the findings are organised into themes, and then explored in relation to the wider body of literature.

7.3. Key findings

One of the key findings of this study was how complex cultural awareness is within the context of care home practice. Staff participants provided insight to the necessity for a deep knowledge and understanding of residents' cultural needs. This is gained slowly and over time through interacting with residents and a continuous process of assessment and reassessment. An initial assessment only provides a baseline and broad understanding of the individual, and the findings clearly indicate that a nuanced understanding is important to the provision of culturally-acceptable care. Another complexity is the gap that exists between residents' expectations, assumptions and understandings of their care requirements, and how the service can meet their needs. The residents were reticent in relaying their needs to staff because they made an assumption that they had been assessed prior to moving into their care and that the staff knew what they needed. The comments from most of the residents were that they would rather not raise issues or provide further details. As a result, the staff faced a difficult situation in trying

to know and understand their needs. All care home staff expressed utilising ongoing assessment strategies to identify these needs, but these were often very complex. For example, when they identified each resident's appropriate food needs, the difficulty they experienced was in having to also meet the resident's individual taste and specific expectation. In this instance it included knowing and understanding how to prepare food with the flavour that the older person is anticipating as vitally important. It is the attention to such detail that was important to these older participants to enable them to live their preferred lifestyle. This requires supporting the older resident to be able to articulate and negotiate their wants and needs, and for staff to be able to respond. However, care staff were practicing according to what knowledge they have about the cultural needs of their individual residents and, according to staff, this knowledge is in constant development and reassessment as they get to know the residents and react to their changes over time.

In the literature, it was revealed that cultural awareness and practice are located in four different stages (Douglas, Pacquiao and Purnell, 2018). The initial stage, which is the parochial stage, is where one is unconsciously unaware of cultural difference and lacking any understanding of cultural diversity (Douglas, Pacquiao and Purnell, 2018). The individual in this stage does things their way and believes this is the right and only way. The second stage is the ethnocentric stage; the individual is aware of other forms of doing things but still considers their way as the best way (Douglas, Pacquiao and Purnell, 2018). This includes the individual viewing cultural differences as a problem, but remaining unsure of the significance of the problem and tending to ignore the challenge (Douglas, Pacquiao and Purnell, 2018). The third stage is known as the synergistic stage. Here, the individual knows cultural differences and practices exist and believes these differences can be valuable. They are therefore able to choose the best way to do things according to the situation, whether it is their way or the others' way. This final phase is also known as the participatory third stage. This stage brings people from different cultures together for creating shared meaning. It suggests that since a new culture has transformed you, you instinctively do the right thing, and this makes it easier to be culturally sensitive.

The findings revealed that across the four participating care homes they were largely either at the synergistic stage or the participatory stage. In the synergistic stage, how care home staff participants demonstrated that they recognised differences was evident in the various

approaches that they used, including their efforts towards ongoing assessment to gain nuanced understanding of resident's needs, balancing and managing workforce requirements (managers changed the role of staff), ensuring availability of Nigerian daily culture (some staff made Nigerian cuisine at their own home for their Nigerian residents), and managing the context of care (managers sometimes giving out extra money to ensure that they meet the cultural needs of the residents). This was the awareness that not all staff understood the needs and preferences of the older Nigerian residents, and the introduction of approaches to develop their competencies. Management were also recruiting diverse ethnic staff to match the residents' ethnicities and harvesting ideas shared among the staff team. These approaches, as found in this study, are beneficial for their ethnic residents as well as contributing to providing culturally appropriate care. These approaches also highlight some elements of the participatory stage, especially in a long-term care environments, which will be detailed later in the chapter.

In practicing under the synergistic and participatory stages of cultural awareness, some staff expressed that resilience and flexibility was the key, using every approach within their reach to provide the care that suits the resident's needs. For example, the findings revealed that staff in care home 4 at some point were enquiring from one of their Nigerian residents about her food choices because of repeated refusal of the food offered. Eventually, when her choice of food was provided, she was unhappy with the taste. This did not discourage them from seeking ideas to enhance their understanding. Through shared supportive meeting within the staff team, combined experiences were shared to use the cooking skills of their Nigerian domestic staff to remedy the situation. This was achieved through offering a flexible role in the kitchen. Staff showed their flexibility and resilience through shared support and ideas, talking about what they went through and seeking collaborative solutions. This effort by the care staff built on the understanding of effective communication, which is the process of exchanging ideas, thoughts, knowledge and information such that the purpose or intention is fulfilled in the best possible manner (Information Diffusion Management and Knowledge Sharing, 2019). In other words, through shared ideas staff were able to build understanding as to why the food was refused by the resident.

Staff in care home 3 also found that effective communication could be enhanced through culturally-appropriate greetings. This study found that first impressions make a significant difference and pave the way for further communication. For example, some residents were

unhappy with the way staff approached them. This was found to hinder conversations from proceeding. This study found that effective communication is a first step to gaining knowledge about another people's culture. Finding ways to create an arena for culturally-sensitive conversations to happen can be built on understanding how to make a culturally-appropriate first approach. For example, the way residents are approached, and how they are greeted, can demonstrate awareness and respect for their cultural background. Being sensitive to these issues can also demonstrate readiness to learn more about them as an individual. Findings also revealed that not all care home staff teams addressed all aspects of culturally-appropriate needs to the residents' satisfaction. This explains the synergistic stage of cultural awareness indicated earlier, illustrating both an awareness of cultural difference but also a lack of knowledge of its specific details. However, they were conscious of the need to behave in culturally-sensitive ways. All care homes had some work to do in development of residents' needs as instead they seemed to be more focused on routine aspects of daily care.

Cultural awareness, competency and sensitivity are common terms used in healthcare when referring to the care offered to people from different cultural background, and have been widely represented in the literature (Hultsjö et al., 2019; Kaihlanen, Hietapakka and Heponiemi, 2019; Holland, 2017; Thomas and Cohn, 2006; Miller, 2011). Providing care for the multicultural care home population brings both opportunities and challenges for care home providers to create and deliver culturally-competent services. As a result, cultural awareness, sensitivity and competence poses a huge challenge for service provision that addresses and takes note of such differences. According to Kirmayer (2012), cultural awareness and sensitivity are complex terms that require unpacking in relation to the individual culture of a group. Cultural sensitivity is an appreciation, respect, and comfort to the cultural diversity of people. Practicing it requires both theoretical (knowing that) and practical (knowing how, via skills, mindset and beliefs) knowledge (Goossens and Murata, 2019). According to the findings by Badger et al. (2012) and Evans et al. (2011), specific areas were suggested to mostly affect people's culture. For example, emphasis was laid on areas such as language, communication, religion and dietary needs. They argued that communication is a key issue in engaging with minority ethnic parents, especially where language difficulties exist. In addition, they found that religion is one of the important defining characteristics for some ethnic minorities and its dimension should be recognised more explicitly. In terms of dietary needs, they argued that lack of access to traditional ethnic foods might hinder the process of adaptation in the care home. These authors

carried out their study with either the manager or the care staff, and responses within these areas were that plans were in place to remedy each occurring problem. For example, in terms of language issues, they provided interpreters, and for those residents who had communication problems, families were asked to write cards with words or whole phrases in the resident's local language as well as English to tackle difficulties. However, the resident's voice was lost, and the results derived solely from the opinions of staff members. In this study, findings revealed that residents' voices are needed to help them navigate the care they want. It was also found that resident voices could be heard through effective communication skills. As earlier indicated at the beginning of the chapter, residents declined to lend their voice to staff regarding their needs, but the staff overcame this through the use of effective communication skills. Firstly, they considered ways of approaching which could give room for cultural needs to be heard. This was seen to work well for the staff in care home 3, as they expressed that their Nigerian resident was appreciative of it. Secondly, they utilised ideas shared by similar ethnic staff about food to engage the residents. For example, when a resident refused the foods that were offered, ideas were shared to use the cooking skills of similar ethnic staff to meet residents' expectations. As earlier mentioned, effective communication is less about talking and more about listening. In other words, it is the presentation of views by the sender in a way best understood by the receiver. This study found that constructing knowledge about cultural sensitivities through the staff and residents highlighted a discrepancy between what the resident wanted and staff were able to understand and provide. This explains the need to give voice to the older person to continue to navigate the care they seek.

In the resident findings, it was revealed that largely across the four participating care homes, there were a range of various ethnic and cultural backgrounds, and various lifestyles, experiences, and interests that exist among Nigerian resident population. There were varying reactions to the way they viewed life in the care home as well the care provided. However, one of the critical issues identified was that some of these residents who took part in the study were reticent in expressing their views to staff. Some participants suggested that staff know their needs, hence there is no need to tell them. This could lead to situations where an individual's needs might not be identified and addressed. These situations led to discomfort for the individual. However, findings in chapter six (page 169-175, section 6.3.2.) revealed that some staff who understood these needs sought ways to provide them, while others who were unaware struggled with providing for these needs. As seen in chapter 5, the social realities of these

Nigerians are not equal, even though they occupy the same physical or virtual space. The findings in this study drew attention to the need for a more skillful approach to culturally-sensitive communication to support residents to negotiate the lifestyle they want.

7.4. Practicing cultural awareness within the synergistic (3rd) and participatory (4th) stage

In this study, all care homes were primarily practicing cultural awareness under the third and fourth stage of cultural awareness. In all care homes, staff talked about receiving residents from different cultural backgrounds, however only participants in care homes 2, 3 and 4 recognised and altered practices to respond to the differences in the cultural needs of their residents. Care homes 2, 3, and 4 staff teams acknowledged that the differences in cultural needs can be valuable, and were experimenting with different strategies and approaches to address the cultural needs of the Nigerian residents. However, care home 1 was the only site whose approach was to identify these needs without further attention. As a result, all residents were treated the same, regardless of their ethnicity. In sites found in the participatory third stage, people from different cultures came together to derive a culture with a shared context of meanings. This results in having a common goal and shared interest in meeting the cultural needs of the residents. This is also achievable in the context of care as findings derived from this study revealed various ways to go about it. For example, the findings in this study revealed that shared ways of thinking, which include shared values and beliefs about resident culture among the staff team, can enhance team working, performance, and service improvement for the residents.

The second idea revealed in this study is that the care home may need to have a sense of community between all involved. This is having the feeling that members matter to one another and to the group, and a shared faith that members' needs will be met through commitment to be together. This study found that some residents felt left out and, as a result, kept their needs to themselves. It then suggests that having a sense of community could connect staff with the resident effectively, both in giving and obtaining valuable information. Another idea that worked well is staff upskilling other staff. There is no doubt from the findings that some staff were going the extra mile to meet the demands of the residents' needs. The findings in this study revealed that some staff did not have answers to the unveiling of resident needs, and staff

needed clarity about the goals of care for individual residents and the skills and opportunities to assess whether these goals are achieved. What worked for some of the care homes was team working which helped staff manage that aspect of their work. The demand of the participatory stage is having 'our way' (this includes that of the residents and the staff) in the delivery and method of care. This stage is said to occur following a series of other stages. For instance, the first stage portrays that their way is the only way to do things, so it tends to neglect cultural differences. The second stage posits that the individual has knowledge of cultural differences and ways of doing things but still considers theirs as the best one. Then, the synergistic stage indicates that the individual is aware of differences and choose the best approach according to the circumstances, and this could be their way or that of the other person. Finally, the participatory stage is when there are shared understandings between the individual and the organisation in such a way to create shared meaning (our way). It is argued that at this stage the individual does not have all the answers but is ready to undergo dialogue to generate new rules and meanings. In this stage, constant solutions to problems are possibly generated through new rules and meanings.

This was evident in care homes 2, 3 and 4 where staff constantly met to discuss their diverse residents' needs. This is when ideas are shared and harvested to meet the best interest of the resident. For example, staff in care home 3 shared and idea to seek guidance from families, particularly in order to teach them the residents' favourite meals. Meanwhile, staff in care home 2 cooked residents' favourite dishes and brought them in from home, with the manager offering extra money for the provision of culturally-appropriate food. Mrs Nneka, the resident participant in this care home (2), expressed positive differences in the way that she experienced the provision of culturally-appropriate care in this home in comparison to the previous care home where she had lived. She expressed satisfaction with the approach to the choice of food she was offered. Care homes 2, 3 and 4 practiced using a shared idea of offering part-time hours to their ethnic staff to make residents' ethnic food.

The implication of having knowledge and understanding of what defines culture is the first step in becoming more culturally sensitive. In this study, staff demonstrating cultural awareness ensured that they met the requirements for the synergistic and participatory stage. A fundamental strategy used by staff was culturally-sensitive communication . Staff did this

because they understood that culturally-sensitive communication creates a mutual understanding and respect of each other's values, beliefs, preferences and culture. They argued that use of this type of communication with Nigerian residents demonstrated their desire to learn about the individual's cultural needs. The term cultural desire was coined by Campinha-Bacote (1999) as part of her model of cultural competence. The constructs of this model include cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire. It is the desire to practice in a culturally-competent manner that motivates a health care professional to seek the knowledge, skills and encounters of cultural competency. Staff participants in care homes 2, 3 and 4 demonstrated their desire and willingness to know more about older Nigerians. This was through various means, such as ongoing assessment, staff upskilling other staff, etc. This type of learning is a lifelong process that has been referred to as "cultural humility" (Tervalon & Murray-Garcia, 1998). Cultural humility is being other-oriented rather than self-focused, and having a sense that one's own knowledge is limited as to "what truly is another's culture" (Hook et al. 2013).

7.4.1. Demonstrating cultural desire

As stated earlier, cultural desire is motivation to "want to" engage in the process of becoming culturally aware, culturally knowledgeable, and culturally skilful, and seeking cultural encounters (Campinha-Bacote, 1999). In this study staff in care homes 2, 3 and 4 showed motivation and desire to meet residents' cultural needs. Though the approach to this need varied across the four care homes, they were demonstrating their desire to achieve cultural care through

- ✓ Working cooperatively/staff upskilling staff
- ✓ Recruitment of diverse workforce
- ✓ The initiation of social interaction according to the resident culture (greeting)
- ✓ Seeing food beyond nutritive value

7.4.2. Working cooperatively/ staff upskilling staff

In this study, the findings revealed that some care home staff struggled with meeting the cultural needs of their Nigerian residents. As a result, one approach to address this issue was

through care staff upskilling their colleagues. This approach was based on the assumption that Nigerian care staff could share their knowledge about their culture and understanding of the Nigerian residents' cultural requirements because they had a shared cultural background. This sharing of understandings of Nigerian culture was intended to enable other staff to develop understanding of the cultural needs of Nigerian residents. According to Kamrul, Malin and Ramsden (2014), culturally-appropriate needs are those needs that are centred on the individual requiring it. These needs encompass specific meaning, symbols, and expressions of the individual culture. Meeting these specific symbols is a challenging part for those unaware of the existing culture, as found in this study especially, in areas such as food (taste and choice). In one care home, the manager (page 143 section 5.7.2) adopted a strategy of recruiting a diverse ethnic workforce because they recognise the differences in skill, ways of thinking and working, and levels of knowledge and experience. Also, other managers attempted to skill-up the workforce by offering extra hours for a skilled domestic staff to cook for their Nigerian resident.

7.4.3. Recruitment of diverse workforce

The recruitment of a diverse workforce is in agreement with the commission for social care inspection (CSCI). CSCI regulates, as well as enforces, the national minimum standard and has published its race equality diversity strategy (NHS, 2014; Care Quality Commission, 2016). The aim is for employers to grant equal opportunity for people from BAME backgrounds. According to this regulation, race equality is important because the findings reveal that it creates a motivated, inclusive and valued workforce and helps deliver high-quality patient care and patient satisfaction. For example, ideals from practice from the Care Quality Commission (2016) indicated that this worked for some care homes in meeting their diverse resident's needs. An illustration of the benefit of this practice from the Care Quality Commission (2016) indicated that a care home manager expressed that a certain Asian lady in their care was proud of the effort staff made towards meeting her need. This was in regards to meals, as it was arranged that the local Asian day centre brings food for the residents, including to celebrate festive periods. As part of attracting more Asian residents, the care home recruited a few Punjabi-speaking staff, and managed the rota to ensure that staff with this linguistic skill were on duty every day. They found that this was a successful strategy as their existing residents were astonished and settled well in the home. This approach was also evident in this study,

whereby the manager of care home 3 aimed to recruit staff of the same ethnicity as residents. However, the Nigerian resident population in this home was small and the manager questioned how recruitment of staff for such a small proportion of the resident population could be achieved. The same manager highlighted other approaches which they used to address the same food choices, such as family members bringing food from home as well as teaching staff how to make it. According to her, these approaches were to ensure that the resident's needs are met whilst in their care.

7.4.4. The initiation of social interaction according to the resident culture (greeting)

Though this was practiced in care 3, this knowledge was seen to be beneficial for understanding that culturally-appropriate greetings open doors to obtaining culturally-relevant information from residents. The care staff in care home 3 practiced this approach with their older Nigerian residents because they had a Nigerian member of care staff and staff from other African regions within their team. They understood that communication is something we do all the time, in different ways and different contexts (Morreale, Spitzberg and Barge, 2007; Battle, 2012b; Likupe, Baxter and Jogi, 2018). The findings in chapter 6 (page 186 section 6.5.3) revealed that Nigerian staff understood that their Nigerian residents would love to be approached in a certain way compared to the way they were previously addressed. They understood that greetings are considered an essential part of Nigerian cultural practice. For example, some of these staff in this care home expressed the importance and meaning of greeting to them. These care staff expressed that greetings make a good first impression and are seen as a sign of respect. The care staff understood what this simple act meant, and started by initiating it without waiting for the older person to speak, which is regarded as a mark of respect in Nigeria.

The care staff understood that the content of the greeting must start with a prefix, which is usually the titles; for example, it could be nurse, mama, papa, Engineer, Mrs. and Dr. It is also useful to mention that those with more than one title are expected to parade them; this is done to show that a person is important (Falola, 2001). The care staff expressed that in everyday interaction, especially with their Nigerian resident in the morning or when they first meet, they begin by addressing a Nigerian with their title followed by a long list of inquiries about the person's family, health, and life in general. This mode of communication is known as phatic

communication (Mortensen, 2011). This is considered as establishing sociability or sharing feelings. For Nigerians, this is an important preamble before progressing to the main aim of conversation. It is known as chat or small talk. The objective of this, according to the care staff, is to establish a rapport rather than gaining in-depth information about the family. In essence, the content of the information is not essential but instead preference is given to establishing a social relationship (Burnard, 2013). The social relationship in itself can be beneficial to forming a therapeutic relationship, which refers to the close and consistent association that exists between at least two individuals. (Weisz, 1998). This builds trust and respect, which are needed for ongoing care.

However, the findings in chapter 6 (see page 186 section 6.5.3.) also reveal that this was only practiced in care home 3. From the other care homes, older Nigerians would prefer to be addressed in a certain way compared to the way they were addressed. Some of the resident participants were unimpressed when addressed by their first names but would not discuss this with the care staff. In the West, especially in the USA and Northern Europe, people communicate more in informal ways, which are known as a flattened hierarchy (Bernard and Gill, 2014). It is also common to use first names instead of titles, but this may not be appreciated by other people, as demonstrated in this study. Most of the residents frowned at the way staff approached them. Some did not like being approached using their first names, and others were unhappy how the staff prompted them for food without addressing them properly. In the wider literature, greetings are a form of universal sociolinguistic act used in recognition when meeting someone (Abdulraheem and Aliyu, 2018). Greeting is as old as mankind and, as seen in this study, the older Nigerian participants valued the way others greeted them (Chao, 1956; Daba, 1987; Goody, 1972; Oumarou, 1992; Salzmann, 1993).

The distinctiveness of greetings is determined by the cultures of the people practicing (Abdulraheem and Aliyu, 2018). People that are more culturally conscious attribute more significant meaning to how greetings are sent out (Abdulraheem and Aliyu, 2018). In Nigeria, greetings contain both the linguistic and paralinguistic, which is seen as a way of strengthening love and brotherliness, and promoting unity and peace of mind (Abdulraheem and Aliyu, 2018). This is to say that it is not only seen as a mere social interaction (phatic communication) but is also an avenue used to convey meaningful information, as seen from this study. In Nigeria

there are three major ethnic groups, the Hausa, Yoruba and the Igbo, and within these ethnic groups the pattern of greeting differs. In Hausa culture, regardless of gender, people squat while greeting their parents. Meanwhile, the Igbos bow, whereas in Yoruba, the girl kneels down while a boy prostrates himself on the floor (Schleicher, 1997).

This mode of greeting within this ethnic group is inculcated in the child as part of the culture and, even with Western education, if this part of culture is not practiced, the person is classed as only knowledgeable and not educated (Schleicher, 1997). This is because part of being educated is to know your culture, which is inculcated right from childhood (Daramola, 1967). Parents or older people teach their children culturally appropriate greetings because the culture demands it, and also because of the importance attached (Schleicher, 1997; Nwoye, 1993). For Hausa, Yoruba and Igbo, greetings are classed as a mark of respect and value for one another, and therefore it is frowned upon if not received from the younger person (Schleicher, 1997; Nwoye, 1993). In this study, the older Nigerian participants were reluctant to tell the staff how they would want to be approached because greetings are something taught in early childhood. They wanted to be approached with the use of mama or papa before their names, which the care staff did not know. Use of these honorifics are very common cultural practices in Nigerian when approaching an older person. If the older person has more than one title, the younger person is expected to parade them; this is done to show that a person is important (Falola, 2001). The idea of the younger person initiating the greetings reveals superiority, implying that the older you get the more respect you are given (Nwoye, 1993). Meanwhile, the manner of approach has been highlighted as an important aspect of care, and it has also been strongly emphasised that effective communication in practice includes asking people how they wished to be addresses (SCIE., 2014). The scenario of asking what they want to be called might never be achieved, as seen in this study. This is because it is uncommon for some people to address older people, other than their parents, with mama or papa (Hendricks, 2019). In turn it might be difficult for an older Nigerian person to ask to be called mama or papa because they believe it is culturally related and the younger person should have learnt this from their parents. There were instances where care staff did undertake this practice, and they attributed this to their knowledge about what is culturally acceptable for the Nigerian residents in their care. This also highlights the importance of care home staff understanding cultural norms and addressing these within their practice. This study has established that this mode of communication gives room to build familiarity and trust with their Nigerian residents. The meaning of communication used

by the care staff in this study is not attributed to the act of communication but is instead situated in a cultural context (Schirato and Yell, 2000).

7.4.5. Seeing food beyond nutritional value and assumption

The findings indicated that staff were committed to understanding the ethnic food preferences of residents. They started by engaging in much more dynamic communication with the residents, empowering them to speak out about their cultural needs. A dynamic communicator needs more than words to get action (Schiefhelbein, 2017). Dynamic communication lives beyond words and provides residual impacts (Schiefelbein, 2017). The findings in this study from care home 2 revealed that through familiarity and trust gained from practicing greetings as illustrated above, more informal chat went on to reveal some of their needs. This was particularly in relation to food. Such discussions resulted further effort from staff to prepare and bring food for the residents from their homes. Once the management saw this was working, they used the insight to offer part-time hours to Nigerian staff to make the same food in the care home. Once the food was made, it was stored and served when needed. Though this act was only observed in care home 2, the resident who received this care highlighted it as a particularly positive aspect of her care. Other care home staff, such as the care home 3 team, worked closely with families. They monitored the frequency of a particular ethnic food a resident consumed, asked the family to teach them this dish and went ahead to make the same food. Care home 4 staff implemented similar ideas from a new employee who is a Nigeria,. This resulted in ethnic food being made available to their Nigerian residents.

However, there are contradictory views that the disruption and changes in food habits after a migration may cause dietary acculturation (Holmboe-Ottesen and Wandel, 2012). This view was shared by the deputy manager in care home 3, who believed the residents had acculturated based on food and, as a result, could be grouped and cared for with other residents. Acculturation is a process of adaptation where the individual adjusts to the culture of the destination country (Osei-Kwasi *et al.*, 2020). However, this is not always the case in all aspects of culture, as seen from the findings in this study. A symbolic function of food is cultural identity and what one eats holds significant meaning. Acculturation occurs when one ethnicity moves to another area with different cultural norms and begins to adapt to their cultural norms. Kittler, Sucher and Nelms (2011) indicate that food is the most unlikely of things people change through acculturation, unlike dressing and language. They state that people are forced to

acculturate on food only if there are lack of native ingredients (Kershen, 2017; Hadley, Patil and Nahayo, 2010; Mellin-Olsen and Wandel, 2005). The findings here (see chapter 6 page 175) indicate that food is regarded highly and is symbolic of cultural identity (Kershen, 2017). These cultural attributes are instilled in early life as part of social upbringing, are inbuilt and automatically shape food habits (Kershen, 2017). This is why Kittler, Sucher and Nelms (2011) indicated that, as a result of this process, food remained a part of culture that is unlikely to go through acculturation. In a stable category, the model indicated that people choose and adjust to the most suitable food, but maintain their staple diet for a long time. This model implies that staple foods are people's cultural identity and cannot be changed through the process of acculturation, as compared to complementary food. Whilst in accessory food, change in this category occurs quickly because they are not core to the individual's culture. In this study, the residents (Mrs Joan and Mr Peter) revealed that they are used to the local foods because of a lack of choice, and expressed that they miss their favourite Nigerian cuisine which isn't offered in the care home. This explains why assumptions about acculturation, as seen from the deputy manager in another care home, could be problematic. However other staff from care homes 2, 3 and 4 made effort to provide food through various strategies based on resident preferences and choice. Also, the NMC code of conduct has advised that practice should recognise diversity and individual choices and avoid making assumptions. The NMC code added that staff are expected to listen to people to understand and respond to their preferences. In this study, though some residents were reticent in discussing their preferences, staff were seeking to understand why certain needs were posing a problem. For example, in care home 4, the manager sought to understand why Mrs Amaka left her food untouched and found that taste and preferences were the problem. The same manager explored with other staff and decided to offer extra hours to Nigerian domestic staff to make food.

Therefore, seeing beyond food's nutritional value in this study is to appreciate why it is regarded as cultural identity. Food tells more about who we are and where we come from. As a result, this affects the choices people make and how much we regard them (Oyebade and Falola, 2003). This implies that the way people regard food is dependent on the value and meaning attached to it. Every culture has a symbolic attachment or meaning they construct from their food which could be emotional, or a communication of love, disapproval or discrimination (Bronner, 2015; Oktay and Sadıkoğlu, 2018). Also, certain foods denote welcome in Nigerian, for example in Igbo land the breaking of the kola nut is a sign of

welcome, and contains a ritual element of remembering iconic older adults, both living and dead, as part of a blessing (Imber-Black and Roberts, 1998). Rice is one of the classic and popular Nigeria foods prepared in different ways, and popularly used during occasions (Oktay and Sadıkoğlu, 2018). This cuisine is distinct based on its unique ingredients, unlike other similar cuisines prepared in Europe (Bronner, 2015; Oktay and Sadıkoğlu, 2018). This denotes the significance of culturally-appropriate food to the Nigerian residents. Also, food, just like other identities, tells more about how we see other people, which in turn shapes how we associate with them.

Therefore, change in culturally-appropriate food can also be classed as change in one's cultural practices (Aboh, 2018; SCIE, 2014). If food denotes people's identity, the absence of this can mean the individual is deprived of their cultural identity, which could lead to poor adaptation in their current environment. The importance of meeting this aspect of need has also been highlighted in the National Minimum Standards and The Care Homes Regulations (2001), Standard 12.1-3 (meals and mealtimes), which posits that residents receive a varied and nutritional diet, offering choices at mealtimes and providing an alternative when choices are refused. However, in this guidance there is some omission of culturally-appropriate food. Provision of food is important for human survival, but the provision of culturally-appropriate food that is not highlighted in this guidance is crucial in meeting that aspect of need, as seen from the findings in chapter 6 (page 171 section 6.4.3). This is particularly important when considering taste, which is highlighted in this study as a crucial factor. For example, Mrs. Nneka expressed that the care staff were brilliant in meeting both the taste and choice of Nigerian food. Mrs. Nneka started enjoying Nigerian food from the friendly Nigerian staff who cooked her favourite dishes in their home and brought them over for her to enjoy. Things became even more interesting once the management got involved and provision of these dishes were extended. This had a positive impact, as earlier mentioned, where Mrs. Nneka said the care home is distinct in the way they cared for her as compared to her previous placement and, as a result, she will hold nothing against them. This showed how culturally appropriate food makes an impact on older Nigerians adapting to and living well in a care home environment.

In contrast Mrs. Amaka, who resides in care home 4, highlighted issues with the taste of the food. The Nigerian food was made due to concerned management but the taste was not quite

right. The whole effort shown by the manager was to meet this aspect of her need, and while this was appreciated by Mrs Amaka she did not like the food itself. The findings in this study highlight the effect of culturally-appropriate food on settling into care home life. Food has been highlighted in the literature as one of the challenges of transitioning into care home life for the residents and their families (Hutchinson *et al.*, 2011; Brownie, Horstmanshof and Garbutt, 2014). Adaptation in this area of cultural need becomes more challenging if the resident is cognitively intact, as they try to work out the meaning of the evolving nature of their current life (Custers *et al.*, 2012; Roberts and Bowers, 2015).

7.4.6. Working with families

In this study, data given by staff provided evidence that there were no clear guidelines on how care should be rendered to older Nigerians. The staff in care home 3 were seeking guidance and enquiring with residents' families to meet residents' culturally-appropriate food preferences and choices. According to Hughes et al (2019), working with families, friends and carers is an important part of delivering person-centred care. Families are often a vital part of the life of someone who needs care and support. The point illustrated by this study was that staff assumed that they were the best channel to obtain needed knowledge with little involvement from the receiver (resident). As a result, although working with families in this study may have addressed the need that has been identified, this may not reflect the actual demand by the resident or achieve the outcome they desire. As seen from the findings, the staff who made ethnic food for Mrs. Amaka and Mr Peter were applauded for trying, but there were issues relating to the taste, as pointed out by theses residents. Perhaps a shift in knowledge seeking from care staff and family to residents may make a massive difference in understanding the residents' preferred need. This does not mean that older people's families are empty vessels; they may have good ideas to bring, which might be instrumental for caring staff in looking after residents. Nevertheless, this was demonstrated by care staff to remedy the problems associated with culturally-appropriate food, thus showing desire to know more as demonstrated in cultural desire above.

7.5. Demonstrating cultural humility

Cultural humility is a lifelong commitment to self-evaluation and critique, and staying open to new information (Johnstone, 2019). Wrestling with the tendency to view one's own beliefs, values and worldview as superior, it represents a willingness to hear "you don't get it" (remaining teachable no matter how much you already know) (Yeager and Bauer-Wu, (2013), Hook *et al.* 2013). The findings in chapter 5 (care home 2,3 and 4) revealed that care staff from three out of four participating care homes were eager to make a change despite the frustrations they encountered. They wanted to continue to make changes despite the challenges. The cultural humility model posits that it is ok not knowing your stance, suggesting the importance of embracing failure, and continuing to ask and not assume (Wilchins, 2004). To provide strategies to get unstuck, they utilized several culturally-appropriate approaches such as:

- ✓ Role extension
- ✓ Celebration of significance

7.5.1. Role extension

Role extension implies supplementary skills and responsibilities that extend beyond statutory responsibilities and competencies (Hardy and Snaith, 2006.). Role extension is not a new concept, as it has been in existence over the last 30 years (Daly and Carnwell, 2003). In hospital settings nurses have been performing tasks traditionally associated with the 'medical' profession, such as acting as a surgical assistant, and providing intravenous cannulation and suturing (Hardy and Snaith, 2006). Such examples comply with the conventional interpretation of role extension as development into an area previously regarded as the domain of another healthcare profession (Daly and Carnwell, 2003). However, in the care home sector, the job description of care staff includes both physical and emotional support for the resident. Such a work contribution can have a huge impact on someone's quality of life, particularly by being supportive to residents and their families as well as providing care daily to suit the residents' needs.

Care staff in this study accepted to extend their roles to ensure residents received the care they wanted. They extended their role and responsibilities even when the task is not interchangeable

with their current role (MacNaughton, Chreim & Bourgeault, 2013). The care staff were willing and happy to extend their roles, in order to make residents happy and help tap into what was previously unfulfilled potential. It remains unclear at what point such role extension becomes accepted as normal or common practice within the adopting profession (Daly and Carnwell, 2003.). However, care staff found that lack of skills in making Nigerian cuisine from their chef meant that the need to diversify was necessary. This was through a shared and accepted idea by the staff team to take up the role of cooking for their Nigerian residents Also, the initial assessment, according to the care staff, was not consistent with ongoing need and, as a result, they had to harvest ideas from every space to provide the need for their diverse residents. This echoes with the concept of cultural humility, as staff had to acknowledge and accept their own limitations in order to find solutions for their residents.

7.5.6. Celebration of significance

Ethnically diverse staff also shared a powerful insight about celebrating individual ethnicity (making them feel among, or belonged), aside from other regular care home activities. This included celebrating each resident's Independence Day, and Mother's and Father's Day. This was evident in care homes 2 and 3. They were confident that these celebrations were part of cultural activities. During these occasions, the residents' traditional favourite songs were obtained from their families were compiled and played through the day to keep residents entertained. As seen from the findings, marking these occasions with the residents' favourite traditional music was a powerful skill shared by care staff. The impact of the music was particularly significant as residents expressed their joy and satisfaction. It is said that old times come crowding back at old age (Cassano, 2012). Using music as a therapy to increase health and wellbeing in older people has been used elsewhere in practice (Istvandity, 2017). However, the idea of residents' traditional favourite music was a powerful, particularly when all residents' preference were compiled and played.

7.6. Cultural awareness is a complex process in long-term care

7.6.1. Cultural awareness

Cultural awareness of the requirements of Nigerian residents is a complex process and difficult for staff working in care home services. Cultural awareness is the self-examination and in-depth exploration of one's own cultural and professional background. This process involves the recognition of one's biases, prejudices, and assumptions about individuals who are different. Practicing cultural awareness, according to Halter, Pollard and Jakubec (2018), starts with being aware of the differences in people's cultural backgrounds, as this enables the individual or organisation to avoid misinterpretation, help to understand, and communicate effectively with the diverse groups. Becoming aware of the differences in people's culture is complex. The staff struggled to obtain cultural knowledge from their Nigerian residents because they refrained from sharing their needs with staff, assuming that they knew their needs through the initial assessment prior to moving into the care home. However, staff argued that the initial assessments are insufficient to understand nuanced cultural needs. For example, in terms of food, staff emphasised that providing culturally-appropriate food has to meet the taste and choice of residents, and this was difficult to achieve due to the lack of these skills in their chef. Some staff argued that they tried to become culturally aware through ongoing assessment of residents' needs and preferences, as this would highlight any discrepancy or change from the initial assessment and aid additional understand through increased engagement and effort. The care staff pointed out that they have learned a lot through their years of experience, particularly that residents' needs do change, and some of the needs change within days of arriving in their care. At this stage, the resident is put into a situation of struggling to reaffirm or make a new choice. This situation, according to the managers in care homes 2, 3 and 4, made it challenging to understand their current need. However, suggestions from the Social Care Institute for Excellence (SCIE) indicate that it is useful to find out as much as possible about the culture and religious beliefs of the older person you are assessing before care is provided (Social Care Institute for Excellence (SCIE), 2006). However, this is only applicable if one is already aware of what facts to look out for. In this study, the residents were uneasy with how they were approached and expressed how this ruined other aspects of their daily lives. It was clear that culturally-appropriate greetings were not part of the assessment, so it is not achievable with their current assessment process.

This study found that staff awareness of ways of approaching played a significant role in getting to know the resident's cultural needs as well establishing effective communication. This implied that culturally-appropriate greetings should be a key element of politics on appropriate cultural assessments. Learning about individual cultures and their way of approach can be overwhelming. However, widely used models for teaching and assessing communication skills highlight the importance of greeting patients appropriately, but there is little evidence regarding what constitutes an appropriate greeting. This is why this research is important to understand what constitutes appropriate greetings to Nigerians. Research from Makoul (2007) suggests that handshakes could be a good start, but cautioned to remain sensitive to nonverbal cues that might indicate whether patients are open to this behaviour. They added that, given the diversity of opinion regarding the use of names, coupled with national patient safety recommendations concerning patient identification, people initially use patients' first and last names and introduce themselves using their own first and last names. Overall, research is needed to understand people's culturally-appropriate greetings as use of first names as suggested in Makoul's (2007) findings could pose a problem for older Nigerians. Also this research is particularly more beneficial in improving these residents quality of life and sense of wellbeing especially which is in the danger of been neglected particularly in this pandemic situation. It is therefore suggested from the findings in this study that care home staff are provided with education to develop their awareness, as well as their skills, in interacting appropriately with residents.

Cultural awareness is a first step to cultural sensitivity and competence (Lum, 2010). However, this study found the content of what staff knew, alongside their willingness and attitude, determined what they practiced and at what stage of cultural awareness they practiced at. For example, in care home 2, care staff spoke about gaining more understanding of residents' cultural food choices through informal communication (chat), and then they cooked the food at home for the residents because they had the necessary skills to do so. Then the manager, through a shared understanding by the staff team, offered flexible hours for the food to be prepared in the care home. This showed the level of their knowledge of the residents' food choices and preferences, as well as willingness the ability to effect the necessary change as portrayed by the manager. As already discussed above there are 4 stages of cultural awareness, and the four participating care homes who fell under the third and fourth stage demonstrated strategies and approaches to becoming culturally aware. This included drive (desire), which

involves their urge to satisfy the residents' preferred needs via ongoing assessment. They displayed their knowledge, strategy, and action through cooking the food themselves because they have the skills. These skills, as already discussed above, are built on cultural humility. According to the findings in chapter 5 (page 148, section 5.8.2 and page 121 section 5.6.2)) in this study, cultural humility was the only thing that enabled them to push forward. They stayed teachable, extending their roles, sharing ideas and managing the workforce to meet the demands of the cultural needs. Though they faced challenges they were focused on a resident-centred approach to cultural care. However, the impact of blurring their roles, sharing ideas and managing the workforce on the residents varied. Some residents applauded care staff for making the effort, especially on food as already highlighted by Mrs Nneka. She expressed satisfaction with staff meeting both choice, preference and taste. Other residents, specifically in care home 3 (Mr Peter), were happy that staff came up with the idea of Nigerian food but indicated that the taste was the only issue. In care home 4, Mrs Amaka was also grateful with the effort made by the manager to provide her favourite food, but highlighted that the taste was, again, an issue. In response to Mrs Amaka's concern, the care home manager offered part-time work in the kitchen to their domestic Nigerian staff who was skilled in cooking. Most importantly, the interesting part of these strategies are that they are embedded in cultural humility. This is the understanding that this aspect of care is a life-long learning process and remaining teachable is the key to lasting effects, as illustrated by the manager in care home 4. This now explains what it truly meant to be culturally sensitive. It is the ability to appropriately respond to people's cultural needs through knowledge and understanding of their culture, remaining humble and being open to learning throughout life. Jowsey, (2019) and Jongen, McCalman and Bainbridge (2018) argue that cultural awareness and sensitivity lead to cultural competence that adds to the provision of culturally-appropriate practices in care settings. For culturally-competent care to exist every care provider must have a set of attitudes, behaviours, and policies that allow them to work effectively in cross-cultural situations (Curtis et al., 2019). In the participating care homes, some of the staff worked towards cultural competence by trying to recruit and retain professionals with similar minority backgrounds to enable more understanding of the residents' culture while in their care. Some included families in most decisions regarding the care of the residents as a way of meeting their cultural needs. The will and action displayed by these managers and care staff demonstrated aspects of cultural competence. These cultural competence skills can be beneficial in healthcare because they help one to offer the best services to every resident, leading to high satisfaction with care.

Culturally competent caregivers are essential to providing top-quality services to their patients, which in turn translates into better health care. Cultural competence is about our will and action to build understanding between people and be respectful and open to different cultural perspectives, aiming to strengthen social security and working towards equality in opportunity (Battle, 2012a). There are key features of cultural competence, such as awareness of our cultural worldview, our attitude towards cultural differences, knowledge of different cultural practices and worldviews, and cross-cultural skills (Griffin, Phillips and Gully, 2016). These fundamental elements are essential to help eliminate inequality in an organisation (Jowsey, 2019; Jongen, McCalman and Bainbridge, 2018).

The first element of awareness has been described above where care staff were seeking guidance from their work colleagues and resident's family. The second is the attitude where care staff were displaying their cultural skills, such as cooking and bringing food from their homes, and marking important occasions to keep the residents happy and active, all of which is vital in promoting more positive health outcomes and satisfaction (Jowsey, 2019; Jongen, McCalman and Bainbridge, 2018). According to Cross et al. (1989), cultural competence is an ongoing process, which requires a regular review of organisational policies, practices, and attitudes. In this study, care staff required support to understand the needs and preferences of Nigerian residents and those from other ethnic backgrounds. They explored various ways to achieve this, such as those with in-depth understanding of Nigerian culture enhancing their colleagues' knowledge and understanding and adopting practices such as role burring, sharing ideas and the managing workforce. To become culturally competent, the providers must understand that it is an evolving process which is similar to developing other skills. To summarise, it is an awareness beginning with desire and humility in order to start the process of acquiring knowledge and understanding of another people's culture. Then, once knowledge and understanding is achieved, the individual can move to the next stage of cultural sensitivity which is practicing what you have understood. However, humility is a lifelong skill that strengthens one at every stage of practicing culturally sensitive. This is done by accepting all challenges and failures as a learning process.

7.7. Summary

Life in the care home can be challenging, especially in an environment where one's cultural needs are unknown or not understood. The discussion in this chapter has provided a distinctive insight into the daily life experiences of older Nigerians and the practices and approached used by care staff to meet their culturally-appropriate need. It offered a unique contribution to knowledge by demonstrating cultural sensitivity and willingness to address cultural requirements. Residents expressed their unique cultural identity in various ways. This adds to current evidence about cultural sensitivity in practice. It highlights that culturally-sensitive practice defers in context, and desire and humility are the skills needed to begin the process of knowing and understanding cultural awareness. These current insights further reveal that practice of cultural sensitivity in the care home would require the care homes to understand that residents are the owner of their culture, and provision of culturally-appropriate care requires hearing their voice through more awareness about ways of approach as a key determinant to engaging in a culturally-sensitive communication. Development of more staff-to-resident feedback mechanism. Instead of relying on family and social workers, could be key in facilitating this. It is important to understand that learning cultural differences can be difficult, hence collaboration is needed to improve organisational knowledge and interventions. These points make an original contribution to knowledge and provide insight into what it means to be culturally-aware and sensitive to the needs and preferences of Nigerian residents and those of other cultures. Currently, health care delivery is facing challenges in meeting the increasingly cultural needs of its population, as highlighted in chapter 2. In addressing their needs, an understanding of the population being served needs to be in place. Research is crucial to attain this as it offers the insight needed to care for them. This study offers insight about older Nigerians, which could be beneficial for understanding the needs of other BAME residents. It may be worthy to mention that no two cultures are the same, and what works for one lifestyle may not be applied to the other. The findings in this study are still a starting point to understanding the cultural needs of Nigerian residents and BME at large. Above all, these findings continued to reflect the gap in meeting the cultural needs of older black minorities in the care home.

Chapter 8

8.1. Conclusion

8.2. Introduction

The study set out to explore the cultural sensitivity of care home services to the needs of older Nigerian immigrants, living in a care home. Also, it set out to understand how daily life is experienced by older Nigerians living in a care home. Equally, it aimed to understand how care home staff respond to the needs of older Nigerian residents and their families. It also aimed to examine practices and approaches within care home services to address the individual needs of residents and their families, and how those practices and approaches support the provision of culturally-sensitive care. The findings from chapter 6 (page 161-163 section 6.3.2) revealed that life in general was experienced differently, and responses from these resident's about how they perceived care home life varied. Some residents showed positive signs of adapting to their new environment while others struggled. The compelling factors to this were mostly based on personal circumstances. However, what was uniform was culturally-appropriate food needs. Most Nigerian residents wanted to enjoy the cuisine they were used to before they moved into the care home. Responses from care staff to these residents' needs reflected their level of cultural awareness. It showed that the services the staff provided were based on their attitude, willingness and knowledge to effect change. Those staff who were willing to accept cultural differences applied the knowledge they had about the resident's culture and this saw a positive impact on their residents while those with little or no knowledge endeavoured in various ways. Some practices by these care staff showed staff commitment to meeting the cultural needs of their residents. What was significant from these findings in both the resident and staff populations was culturally-sensitive communication. This was related to manner of approach according to residents' culture. Residents were reticent about telling the staff how they wished to be approached yet were unhappy when this is not done properly. Some of the residents expressed that this was inappropriate and believed that staff were aware but had not paid attention to it. Some staff, however, were unaware of this need and as a result did not pay close attention to it. Some care staff who were well aware of this need expressed using it as a channel to give respect, as well as create a trusting and mutual relationship between them and the resident. These staff expressed that they also take advantage of the trust created to informally enquire about the Nigerian residents' cultural needs. Culturally-sensitive communication as found in this study is a gateway to knowing and understanding cultural needs. The study found

that approaches and greetings appropriate according to the resident culture portrayed a sign of respect and eagerness to learn more about their cultural needs. Staff who practiced this expressed that it made their Nigerian residents happy. Practicing this requires knowledge and skills related to the culture of the recipient of care. However, as already mentioned at the start of this chapter, not all staff possess this skill. This is a significant contribution to knowledge as such approaches create a healthy relationship between staff and residents, as well foster successful cultural needs assessments. Assessment is an important aspect of developing a plan to deliver the best patient care. It gives comprehensive data about residents' needs, yet this is a skill that is lacking as seen from this study.

This final chapter reflects on the significance and impact of the narratives derived from the residents and staff about care home life. The chapter commences with the study's original contribution to knowledge. This is followed by a review of ways the older Nigerians expect to live their lives in a care home setting. The chapter then concludes by detailing the implication of the knowledge gained and its impact on theory development and practice.

8.3. Contribution to knowledge

This original research provides insight into the cultural needs of older Nigerians living in care homes and the approaches that staff implement to provide culturally-appropriate care. In general, the voice of older Nigerian residents has been almost unheard in research, specifically in relation to their day-to-day living in the care home. For this reason, the research was designed with the precise aim to speak directly to the older person and construct an understanding of care home life through their views. Although these stories may seem like a straightforward account of what one might expect in care home life, they particularly represent a touching effort made by residents to continue to live the last phase of their lives.

One of the key contributions to knowledge is how staff gave insight to a nuanced understanding of cultural awareness and sensitive practice in the care home. It detailed what culturally sensitive practice under the synergistic and participatory stage looked like in the care home settings, and how care staff attained to these stages. Recapping from what was already highlighted under these stages in chapter 7(see page 192), staff employed some strategies and approaches under the synergistic stage of cultural awareness, such as developing positive attitudes towards cultural differences by trying to recruit and retain professionals with similar minority backgrounds to enable more understanding of the resident culture. This was

specifically to deliver a diverse and inclusive environment, as this allows for greater innovation and higher employee engagement. This worked well for staff in care homes 2, 3 and 4 because the staff expressed that it was beneficial to gaining knowledge of different cultural practices and world views through similar ethnic staff shared ideas. Some of the ideas were that these ethnic staff highlighted the need for recognition of important dates as a way to inculcate cultural activities in the care home.

Another key contribution derived from recruiting from a diverse workforce was regarding culturally-appropriate food and how care staff approached this need. It found that these residents were particularly concerned about culturally-appropriate food. They wanted to be able to enjoy their favourite Nigeria cuisines while in the care home. Their ethnic care staff who understood this need paid close attention to the details of what they wanted. They found that taste and choice was crucial, albeit within their dietary needs. The ethnic staff shared compelling insights about the practicality of this intervention. Firstly, they started with cooking the resident's favourite food at home, which further attracted the manager's attention to making this work in the care home. Secondly, they opted for overtime in the kitchen to cook Nigerian cuisine and stored these dishes away in the freezer and served it when needed. Thirdly, they undertook a further assessment to check the consistency of choices.

Another key contribution under synergistic stage of cultural awareness was how some of the staff gave insight on the importance of culturally-sensitive communication as a gateway to enhance effective communication, negotiation and assessment of resident's needs. Developing skills for communication and interaction through initiation of greetings according to the resident's cultures was found to be an important skill. This discussion, or negotiation, aimed at reaching an agreement which is a key element of nursing practice. Effective communication is the ability to convey information to another successfully and efficiently. For example, this included ways of approaching which showed that further positive conversation with the resident was dependent on how care staff approached them. The Nigerian care staff who understood this took advantage by displaying their cultural understanding, and then followed the route to establish a gradual relationship which took the cultural implication of words and language into account. Outcomes associated with the use of culturally-sensitive communication include increased resident satisfaction, and better engagement in their care.

Under the participatory stage, some staff used their skills in the synergistic stage to demonstrate their understanding and acceptance of cultural differences. This was done through interaction with diverse groups of staff to gain nuanced understanding of residents' cultural requirements, trying to gain deeper understanding of the dynamics of difference and institutionalizing cultural knowledge by adding residents' food choices to the menu. This stage posits that the individual can work with people of different cultures to create a culture of shared meanings. They can also work with others to create new rules to meet the demands of any situation that arises.

Also, this study found through review of the national minimum standard for residential care homes that culturally-appropriate food is yet to be included. Currently, according to Criteria 12.1, care staff are to ensure that residents are provided with a diverse and nutritious diet, which meets their individual and recorded dietary needs and preferences. The findings in this study showed that residents considered this as an essential cultural need. Therefore, if the philosophy of the minimum care standards supports that residents' views are taken into account in all matters affecting them, this core cultural need should be included in the minimum standard to hold care homes accountable for their care.

8.3.1. Value was paramount to the residents

The move into the care home can be a challenging decision that an older person makes (Lord et al., 2016; Cook, Thompson and Reed, 2015). These are individuals from different cultural backgrounds who have retained and maintained their culture before this life transition. When they move into the care home, they come with these cultural values and beliefs, and the evidence from this study indicates that most individuals expect that the care team will have knowledge and understanding of their cultural needs and requirements, and also have the skill to address those needs. In this study, the findings showed that these residents expect that their core cultural needs will be met. The most significant was greeting, which they highlighted as a mark of respect. These become more intense as they attempt to settle and make meaning of the sophisticated daily life which further shapes the way they communicate their needs and preferences.

As they live and interact with fellow residents and care staff, these cultural needs become more evident to them. If these needs are not adequately met, they affect further choices they make, including the way they relate with staff and their fellow residents, their engagement with activities, and other facets of care home living. The way people react to a particular situation

or problem is dependent on their culture (Lim, 2016) and cultural norms influence emotions and how individuals respond in various situations. Lim (2016) found that some emotions have been seen to be culturally related. In this study, it was found that the way staff approached the residents determined the information that was discussed with them. If residents are not appropriately greeted, it prompted some level of undisclosed negative feelings. In Nigerian culture the value of a greeting cannot be overemphasised. For example, an inappropriate greeting could hinder a woman from getting married (see page 145. Section 5.7.2.). This implies that the right approach leads to a successful assessment or discussion. Successful assessment in turn is a starting point in meeting cultural needs. This explains the power of culture and the act of communication as a means to obtain knowledge.

8.3.2. Practicing culturally-sensitive care and challenges

Rendering culturally-sensitive care can be challenging to those with little or no awareness of the existing culture (Shepherd *et al.*, 2019). Care home workers are expected to abide by the regulations from governing bodies (CQC, 2019). For example, the regulatory authorities of nurses and midwives stated that the appreciation of culture is a key area in providing care services (NMC, 2018). The organisation encourages staff to acknowledge diversity and avoid making assumptions during care delivery and ensure that as much of the resident's care as possible is evidence-based. This promotes the use of varying verbal and non-verbal communication, and consideration of cultural sensitivities to achieve positive care outcome. These expectations from the governing bodies point to the findings of this study, which highlights the use of varying cultural assessment to determine approaches and strategies to provide culturally-sensitive care.

However, to know is to act and findings from this study found that care staff were eager to learn and increasingly sourcing information to care for their ethnic residents. These sources of information were from the family, social workers, care staff and in limited cases from the residents themselves. The topics for information being enquired ranged from food to activities. They understood that uniform care did not apply to people from different cultural backgrounds, nor should it be applied to anyone. The goal is personalised care. They displayed varying cultural skills based on their level of awareness, such as performing appropriate greetings and providing culturally-acceptable food (chapter 7 page 193 section 7.4.4). In chapter 6, the care staff identified that getting to know their diverse residents was more challenging than the initial assessment because residents have evolving needs. To effectively care for Nigerian residents,

some staff participants discussed how they searched for ideas to understand and address residents' needs. Nigerian residents want to be valued, respected and empowered to communicate their preferences and care needs. This should be directly with the individual residents, rather than proxy decision makers such as family or social workers who may hold different understandings of the older residents' preferences and needs. These individuals could impart further knowledge to care home staff and this will inform the assessment and care plan.

8.6. Implications for practice

There has been growing concern and demand according to the literature of practicing-culturally appropriate care (Schill and Caxaj, 2019; Burnard and Gill, 2014), particularly given the already existing difficulty faced by older people on their transition to moving into care and what quality of life will mean to them while they are there. In particular, there are many difficulties, as seen from the data analysis in the previous chapter, on how to provide care that meets the cultural needs of the Nigerian residents, especially those that are culturally appropriate. In that data analysis, there were issues related to knowledge underpinning practice. As a result, most of the care homes relied on ideas and insights from staff or family to guide them. There was less exploration of cultural care and living requirements with residents. However, this might be seen as a move to acquire skills and knowledge about this group to enable them to learn and understand them better, thereby becoming better in looking after them. This move by the care home team portrayed cultural awareness, standing back and strategizing approaches, thoughts, and decisions to ensure positive outcomes in cross-cultural interactions. There is need in current practice to develop knowledge of the older person and subsequently care in this knowledge (Cook, 2008).

Involving and empowering the older person in decision making, as well as developing a practice that allows an older person to thrive in later life, has implications for practice. As a result, two significant contributions are discussed here. The first is the act of communication as an asset to knowing and obtaining crucial knowledge, and the second is involvement of the recipient of care as the central starting point to achieving culturally-appropriate needs.

8.6.1. Cultural ways of communication as a way to obtain knowledge

Findings in this study reveal that residents were not convinced to relay further information about their needs once the reality of care home life comes into play and interferes with their cultural values. Some felt that their voices were not heard, while others felt there was no need

to voice their needs due to the staff's inability to offer culturally-sensitive care. This posed a massive challenge to the care staff looking after them; as a result, staff attempted to identify and respond to these needs in various ways. They do this according to the extent of their understanding of culture, rather than seeking ways to identify the issues from the resident themselves. This is to say that culture and communication are interrelated. People could be easily misunderstood in the process of communication because of the differences in language use, beliefs and culture (Novinger, 2008). Communication covers all activities that convey meaning and stemmed from what their culture has taught them (Novinger, 2008). People speak extensively through their behaviour as a result of their cultural background or what the culture has instilled in them (Novinger, 2008). Culture enables one to know when to speak or keep quiet or maintain eye contact (Elegbe1 and Nwachukwu2, 2017). This study has established that culture has a significant influence on the way people communicate based on greetings, silence, and expressing themselves. It is essential, therefore, that these factors are considered when dealing with people from other cultural backgrounds.

This has implications for practice if care homes aspire to develop practice that is person-centred and culturally sensitive to the older person who wants to continue to make contributions to their lives. These findings point to key areas of practice. First, residents are the bearer of their culture and value, and thus seeking understanding about them should be based on a broader understanding and acceptance of their knowledge.

8.6.2. Develop culturally-sensitive care within care homes

Findings from this study suggest that limited knowledge of individual culture led to various challenges faced by care staff in the care home while trying to provide culturally-sensitive care. In chapter 2, literature indicated the need to provide culturally-sensitive care but none has detailed what this really means and includes. These findings indicated that culturally-insensitive practice was one of the key factors for BME people not using care homes. In this study, the care staff were also struggling to understand what culturally-sensitive care looked like. However, some literature has identified the benefit of an older person's perspective (Cook, 2008). This indicates that this perspective could bridge the gap between staff perceptions and that of the residents in issues regarding their care. This resonates with the description above on

how residents felt they were not valued and their voices were lost. Assessing resident's views and acting on them should be a priority. Care staff are required to learn about the individual culture of the resident to enable them to understand their needs, and this should be the focus of the care homes if practices are to aim at being culturally sensitive. Residents know which aspects of their culture staff should be sensitive to and accessing this information is one way to develop culturally-sensitive care. These findings have implications for practice in all areas of care home placement and living, particularly if care homes are to provide culturally-sensitive care for all concerned.

8.7. Implications for theory development

The knowledge about care home life and culturally-sensitive approaches derived from this study questions various theoretical views about culturally-sensitive practice in long-term establishments. This study can make possible contributions to both nurse education as well as practice development in multiple ways, specifically by adding to the current bodies of literature as well as contributing to professional and academic discussions about culturally-sensitive practice in care homes.

8.7.1. Residents want their voice to be heard

The findings in this study highlight the necessity to listen to Nigerian residents and the importance of valuing their beliefs and views. Their life while living in the care home is dependent on the daily, fashioned routines of that home. Often carers are carried away with the overfamiliarity they have established with the older person and may ignore an important aspect of their lives. The resident participants here indicated that they expected care staff to understand the way they wanted to be approached. Most importantly, the findings in chapter 5 indicated that most of what the residents wanted was different from what some of the staff knew or understood. This highlights the importance of direct negotiation between the receiver and the giver of care. Negotiation is a discussion aimed at reaching an agreement and is a particularly important skill used in nursing practice. Essentially also, this highlights the importance of understanding ways to establish effective communication, which has been highlighted previously as way of approach. Effective communication occurs when the presentation of views by the sender is best understood by the receiver.

Also, the re-assessment is usually done when the resident settles into the care home, and will only be productive if the carers or the assessors have the skills (understanding way of approach) to establish effective communication, as mentioned above. The knowledge of these skills are important attributes within culturally-sensitive care. Way of approach is not specifically relevant to Nigerians; studies have found that first impression matters in all cases, as indicated in chapter 7 (see page 195). To make a good first impression is one thing; to understand how the first impression fits the receiver is another. This study has found that to initiate culturally appropriate conversations lies in the way people approached them. Once this is incorrect, it can make the receiver unhappy and the giver unaware of this problem. Also, seeking further information from families may seem like one useful approach to find out the needs of the resident, but this may not work in some instances (McCormack, 1998; Graneheim, Norberg, & Jansson, 2001). For example, in this study, in some care homes what the resident wanted was different from what the staff provided, even though the residents assumed that the staff have the knowledge they require. This made it complex for staff to provide them with the care they yearned to receive.

Much of what has been learned about the perspectives of Nigerian residents might also apply to residents from other ethnic backgrounds. The findings clearly indicate that there is substantial variation across care settings regarding cultural sensitivity and the way cultural needs are responded to by care home teams. In some aspects of life, such as provision of culturally-acceptable food, more attention is given by staff, whereas other aspects of care home life, such as greetings and negotiation of daily activities, receive less attention. Thus, this is an area of care home practice that requires further attention to develop care home practices and related workforce development.

8.7.2. Care home staff needs to be more culturally equipped

Caring for diverse ethnic residents can be challenging for carers, as it requires continually thinking of ways to get things right, as seen from this study. Delivering culturally-appropriate care requires some cultural skill acquisition which could be challenging to acquire. In this study, the staff had no core information about Nigerians and, as a result, they showed the desire to learn the means to solve culturally-related issues. In chapter 7 (see page 191 section 7.4.2),

cultural desire, which refers to the motivation and the genuine desire for cultural understanding as opposed to the obligation of encountering cultural diversity, was discussed. Cultural desire can be manifested through openness to cultural diversity and a willingness to learn from others. To achieve cultural awareness, care home teams are expected to acknowledge that everyone is different based on their cultural compositions, and to achieve positive healthcare delivery they are required to understand the differences that exist between these cultures. The findings in this study suggest that a key cultural skill, such as culturally-appropriate communication, is needed to understand and perform the cultural assessment in order to gain the residents' cultural knowledge. This agrees with Campinha-Bacote's (2002) argument that nurses must develop knowledge and cultural skills to conduct a cultural assessment of each client. However, development of a cultural communication skill is dependent on the cultural awareness of the person being assessed. The findings point to this key skill opening the door to other nursing transcultural cultural assessments such as that of Giger and Davidhizar's *Transcultural Assessment Model* (2002), Leininger's *Cultural Care Diversity and Universality Theory* (2002), Purnell's *Model for Cultural Competence* (2013), or Spector's *Model of Cultural Diversity in Health and Illness* (2009). Though Giger and Davidhizar's *Transcultural Assessment Model* (2002) explores communication as one of the six cultural phenomena, it is still believed to be culturally unique among persons that become the object of cultural assessment. These variables are: (1) communication, (2) space, (3) social organization, (4) time, (5) environmental control, and (6) biological variations (Giger & Davidhizar, 2002, p. 185). However, the practicality of this remains an issue. This study found that knowledge about what is specific about culturally-sensitive communication was more important than the mere meaning of communication. **Cultural knowledge** refers to knowledge about cultural groups and how their cultural beliefs and norms may impact on perceptions and experiences of health. More research and training is crucial if care delivery is to be culturally sensitive and this has implications across the discipline. The assessment or re-assessment will not be practical if homes are not culturally aware and sensitive.

8.7.3. Staff need more support and skills

In chapter 5 (page 149, section 5.8.2), the manager of care home 4 highlighted cost as one difficulty in meeting Nigerian residents' needs. Although according to this manager this will

not impact on the cultural care provided to the residents, other care home staff have also expressed the extra miles they had to go to meet the cultural needs. One of these approaches was blurring of their role boundaries and investing extra money to meet these needs, both of which are profoundly valuable. Other challenges associated with these are that long-term living exposes both residents and staff to a more challenging health demand (residents) as well as more complex healthcare needs. Staff argued in chapter 5 (see page 130, section 5.7.2) that residents; needs are more eminent and challenging in long-term services such as care home, and they are usually faced with difficulty meeting these needs. These care staff showed the skills of dedication and hard work in using any diversified way in meeting resident's needs, but this calls for concern over the reduction of resources as a result of government cutbacks and underfunding. These reductions have potential to reduce the effort that these staff are making if they are no resources to attain to it. This then questions the growing need to provide culturally-competent care in all healthcare delivery systems. Findings from Ham *et al.,* (2012) indicated that funding has not kept pace with the demand of quality healthcare systems being advocated. Therefore, if the government continues to underfund these services this may create more complex problems in provision and delivery of culturally-competent care, as care staff highlighted, and to the detriment of the vulnerable population being served.

8.8. Strengths of the study

Also, as already highlighted in chapter 3, the constructivist methodology used in this study was designed and refined throughout the period of data collection. This implies that the constructivist approach is more flexible and its design is emergent as long as its use is maintained. The emergent nature of the constructivist approach in this study was a strength and best fit as care home routines and management have been proven to be unpredictable. This was a proven fact in this study as focus group interviews planned prior to data collection were declined by some care home managers due to time issues. However, because constructivist perspectives indicate that data could be gathered from a variety of sources and in different ways, data gathering could both occur by asking a respondent questions but also be encouraging them to engage with the researcher in a less structured way so that their hidden assumptions and constructions begin to surface. As a result, I undertook one-to-one interview using a semi-structured approach, thus allowing for a discussion with the interviewee rather than a

straightforward question-and-answer format. This created and facilitated the co-construction of knowledge, which agrees with the constructive methodology used.

Another significant strength is my ethnicity as a Nigerian researching older Nigerian residents. As already stated in chapter six, staff ethnicity helped them to understand the resident's needs, which was achieved through closer relationship and communication because they understood every nuanced behaviour of the resident. In this study, this was a significant strength because the resident participants and I are all Nigerians with a similar cultural background, which boosts residents' confidence in sharing their views and experiences without fear of race interview effect. The race interview effect has been defined as when people have to make adjustments to what they say and how they behave when questioned by people from a different racial or ethnic background (Gunaratnam, 2003). It has also been known that research participants are less willing to participate in interviews about their opinion on racial-related topics with someone from different ethnic or racial groups (Gunaratnam, 2006). Also, this study explored the cultural sensitivity of care homes to the needs and requirements of older Nigerian residents, and participants were expected to discuss their immigration history, factors that led to their move, and their daily life experiences in the care home. Comments around how they are treated, as well as how they expected to be addressed, were all expected, which at some point may be racially related. Therefore, it was unavoidable that the race of the researcher would have an impact on the ability to obtain the real opinions and viewpoints of these participants.

In addition to ethnicity, gender, age, and my previous experience may have influenced the study. According to Bhopal (2018), how researchers position themselves (insider or outsider) has the potential to affect the research relationships or enhance the effectiveness of the research process. Gender, identity and experiences can give rise to a shared understanding as well as empathy between the researcher and the participant, giving room for building rapport and encouraging them to speak freely about their personal experiences (Bhopal, 2018).

In this study, however, my age and experiences may not entirely fit in as an insider as I do not share similar age and experiences with that of the participants. The majority of the older Nigerian participants are within the age range of 70 and above, and they have worked in different sectors while in the UK, as already described in chapter 5 (see each residents profile). The similarities, however, exist in terms of country of origin, beliefs and culture, and as a result

they felt I was able to understand their expectations, which were deep-rooted in Nigerian culture which we share. Also, my previous experiences as a nurse in Nigeria, as well as a carer working in a care home, was an added advantage because it enabled me to hold inside knowledge of this care setting as well as understand not only the cultural part of their experiences but the nuanced meaning attached to it.

Another significant strength in this study was understanding culturally-sensitive care through resident and staff view. In this study, findings revealed that residents' voices are needed to help them navigate the care they want. It also indicated that care staff struggled to understand the needs of their residents because some of them did not disclose it. However, constructing the knowledge about cultural sensitivities through the staff and resident views revealed that what the resident wanted was different from what staff understood and were able to provide. This study found that it is extremely important to listen to both sides to gain nuanced and in-depth understanding. This makes a significant methodological contribution to knowledge on the understanding and sensitive practice of long-term care.

The findings of this research could serve as an understanding and additional knowledge for care homes struggling to care for Nigerians under their care. However, this is only possible if staff perceive that they are struggling to provide this type of care, particularly if cultural sensitivity and related awareness of issues is low. As already seen from some of the literature, there is an urgent need for nurses and other care workers to develop culturally-sensitive care if they are to meet the needs of the diverse population they serve. This study creates insight into cultural awareness and sensitivity and these are key determinants to cultural competence. Cultural competence is the ability to provide care to patients with various values, beliefs, and behaviours, while tailoring healthcare delivery to meet patients' social, cultural, and linguistic needs. In essence, it is the ability to interact effectively with people of different cultures and address health inequalities (Sahler et al., 2017). The commitment to equality in health care provision according to the nursing and midwifery council code of professional conduct, as described in chapter one, is ingrained within the core values of healthcare professionals, stating that nurses must treat every patient as an individual, respect their dignity and not discriminate irrespective of age, ethnicity or cultural background (Wheeler, 2013).

8.9. Limitations

In recent times, there is a growing need for evidence-based practice in the care home industry, and mounting pressure on researchers to provide tangible research on the effectiveness of new findings or interventions. One of the crucial factors in this study was recruiting an adequate sample size to answer the research question. Difficulty in the recruitment of older people to research is widely acknowledged, and research within the care home sector has remained a significant concern. In this study, there were several issues faced while researching older Nigerians in the care home, and these issues were related to design factors, which included adequate sample size and method of data collection. In recruiting a sufficient sample size, it is understood that estimating amount required is one of the most critical aspects of the recruitment process to show the importance of the findings.

Also, qualitative research experts have argued that there is no straightforward answer to the question of how many people is appropriate, but that it is dependent on epistemological, methodological and practical issues (Edwards and Holland, 2013). However, it is recommended that qualitative sample sizes should be large enough to allow the unfolding of a 'new and richly textured understanding' of the phenomenon under study, but small enough for 'deep, case-oriented analysis' (Vasileiou et al., 2018). The small sample size which was used in this study was due to pragmatic considerations, which are seen as the most frequently invoked arguments appearing from some qualitative researchers. This was mainly related to time constraints and the difficulty of accessing the older Nigerian populations living in the care home. This difficulty was one of the significant factors that led to using a small sample size in this study.

Accessing difficult to reach populations for research can be problematic, suggesting that an innovative approach, such as partnering with a community organisation or charity, could help recruit the sample (Liamputtong, 2010). This study explored this route before data collection by accessing a local non-governmental organisation working for the welfare of older Nigerians in care homes. The organisation, however, was reluctant to provide further information about which care home housed this population when their services were needed, thereby requiring a more rigorous route. Up to 653 care homes (329 nursing homes and 324 residential care homes)

were identified and contacted across the three participating cities, and in the space of a month and a half, only one care home agreed to participate, which resulted in asking participants to recommend others. On reflection, it was noticed that one of the issues encountered during the recruitment of participants that might have contributed to them refusing to participate was sending the information sheet to the potential participating care home weeks before the actual data collection. Though the information sheet was meant to provide brief and precise information on the essential elements of the study, it was discovered that, once they went through the information sheet, the gatekeepers had a concern about the rigorous process of data collection, and that influenced the care homes refusing access to potential participants.

Also, purposive sampling was used in this study to ensure that residents who met the inclusion and exclusion criteria were selected, and this was done by the manager as the gatekeeper. It could be argued that managers might have selected some residents who would reflect the positive aspects of the care home. However, this was not the experienced in this study, as managers were clear about the availability of Nigerians and took me around the care home to meet the rest of the residents, so the potential for selection bias was ruled out in this study.

Essentially, also, the participants are all Nigerians and, as a result, the findings cannot be generalised to those from other ethnic backgrounds. Also, the four participating care homes had very few older Nigerian minorities and, as such, the findings cannot be expected to reflect the experiences of all Nigerians in other UK care settings in general. However, this research area is needed due to the predicted increase of ethnic minorities in care homes. Another limitation that resulted in adjustment as a result of pragmatic reasons was the data collection method. This study set out to use narrative interviews with the residents and focus group interviews with care staff and the managers. On arrival, this was not achieved because of the busy schedule of the care home, resulting in the use of on-to-one semi-structured interviews, with one care home consenting to focus group interviews. Finally, the time-consuming nature of the length audio recordings took a lot of time during data analysis; this ranged from transcription to coding and presentation.

8.9. Recommendations for future research

There is evidence from the appraised literatures in chapter 2 that care home research originating from the UK is limited, specifically within the private establishments. This is concerning as core areas of need within this sector are under-researched. In specific, experiences of older black ethnic minorities remained an under-explored area that needs exploration. Though this study has explored culturally-sensitive practice, more research will be needed on how this affects residents, families and staff. The challenges of recruiting from the care home sector are widely acknowledged in the literature, and this could influence the quality of care rendered. In this study, the search for participants was harder than writing the entire thesis itself. This is because the population being researched is small and where these residents live is almost unknown. In the recent times, the nursing and midwifery council have advocated that nurses should base their care on the best available evidence. This implies that research within this sector is needed, particularly with the anticipated increase in this resident population. Further research might explore if guidelines or policies could be helpful in making information about the ethnicity or diversity of residents available for easy identification and further research of these population.

Also this study found that care home managers utilised a range of alternative strategies to meet the need of black ethnic minorities. Specifically, the use of shared ideas from ethnically diverse staff was employed. Other research around black ethnic minorities in care homes could explore how training of other staff who are not black could enhance the provision of culturally-appropriate care using the same strategies, particularly ethnically diverse staff, used in this study.

From the findings in this study, further questions could be asked about how other care homes without diverse staff ethnicity, who are yet to receive people from other ethnic minority, will look after and support them to live a life they aspire to live. Also, there is a growing need for care homes to be culturally competent and culturally sensitive, and from the findings in this study assessment formed a significant starting point of their culturally-appropriate care delivery. However, the assessor may not be from the same ethnic background as the resident and may not be familiar with the lifestyle and cultural needs of the older person. Further

research can be done on how to assess individuals from different ethnic minorities, detailing their core cultural needs.

The research done around cultural sensitivity in the care home is still at an early stage of development and therefore requires further elaboration. This study is however beneficial to understanding the needs of older Nigerians living in a care home and offers an insight into the existence of diverse needs for people from other ethnic minorities.

8.10. Reflexibility/brief personal viewpoint

My experience throughout this research is that the move to a care home was not always by choice for these older Nigerians. As a result, these individuals may be classed as vulnerable, given that some of consequences for moving were health-related issues. However, this vulnerability may silence their voice in asking for the care that they need. Making their voices heard was an important move to remedying some of the undisclosed needs. However, the experiences through gaining access to them to take part in research poses difficulty for future research within these populations. However, the arguments from the gatekeepers are that they are more vulnerable to research and need to be protected.

As a result, careful consideration of the methods adopted in the study was done to ensure that participation is voluntary and achievable. This required careful thought, time, and preparation to ensure that individuals are provided with the opportunity to participate and express their views. This started with being respectful, understanding, sensitive and responsive to individual Nigerian participants. For instance, the font style for their consent considered their sight as an older person, and as a result a 14-font size was used to write the consent form. Each resident was respectfully addressed to avoid immediately putting them off. This is informed by my background cultural knowledge. It was also anticipated that participants might have different communication abilities/difficulties, so it was necessary to provide an alternative way of communication (Pidgin English) which was familiar to the participants in order to help them to express their views clearly and coherently with little additional support. Mrs Nneka for example was speaking Pidgin English at some point during the interview and, as a result, this

was easy to respond to without interrupting the flow of the interview. Being patient and flexible with the participants was required at every stage of the study. For example, time was giving to articulate dates which they had to remember. Other residents were able to communicate fluently in English throughout the interview. The use of multiple interviews were to Create a framework for dialogue to evolve between the researcher and the participants (see chapter 4, p.), and in this study this was viewed as a co-construction of knowledge between the researcher and the researched. Also, the use of multiple interviews, provided a way of developing the interpretation as the interview progressed, thus ensuring that the interpretation presented in chapters 5 - 8 represented the reality of living in a care home as an older Nigerian. Throughout the interview, I learnt the importance of commencing with a history about their immigration into the UK. This continued to echo the challenges of life as a migrant, as well as an older person now living in the care home. During this narration I captured graphic stories of their life that enabled me to see beyond the older person now living in a care home. During the interview, they were curious to learn more about my personal life by asking if I was married with children and if my mother lived in the UK. At first, I thought this was a difficult story to tell, not knowing the impact it may have on some of the residents, such as Mrs Joy who never married and lost her son. I sensed that a more mutual sharing of some these stories might strengthen the relationship and trust needed for this interview. Throughout the interview some participants required encouragement to tell stories of their life in the care home, as they frequently stated there was nothing else to say. Efforts to reassure and encourage some of them to speak were difficult. At this point, the value of building up a relationship with the participants became important. This was aimed to move beyond brief superficial descriptions of the happenings in their daily life in order to tell of the experiences that had often been kept private.

Through the journey of this research process, I have become more informed and sensitized to the issues experienced by older Nigerians living in care homes. As I stated in chapter one, my experiences as a nurse in a care home and a Nigerian led to the research of this topic. This has widened my horizon of what care home life looks like for older Nigerians and also proved that there is no evidence to prove if separate services are more preferable, as I originally thought. I have come to realise through this study what it actually means to be culturally sensitive in practice and how care home staff are constantly looking for ways to achieve this height. Though I have not cared for older Nigerians in UK care homes, I have observed that most of the older people decline most of the food or activities based on their own reasons and, as a carer at the

time, we were told not to push it if a resident refuses any of this. In this study, it was found that inappropriate culturally-sensitive communication was particularly a problem. This has now made me to wonder if this could be the case for other ethnic minorities or older residents. Also, one interesting point is that residents are having to hide other needs because of the current care they receive. In this study, these residents were very cautious and continued to discourage any effort to inform the care team about their concern. This must be a devastating situation for them, something that will not cost anything to fix and the care staff are happy to embrace. I now understand even better that this type of situation could arise in a care home and know how to remedy the situation. It was interesting to see that care homes are gradually moving away from an institutional approach to a more homelike environment where care staff come with their own clothes as well as cook in the kitchen for the resident. This changes the frightful preconception of care homes to a homelike environment, where the resident could talk about their choices and, where possible, have these met. As this thesis comes to a conclusion, these experiences expressed by the participants about care home life add to the body of literature and develops more understanding of culturally-sensitive practice

8.11. Conclusion

This study set out to explore the cultural sensitivities of the care home to older Nigerians in the UK. It has detailed evidence to strengthen the understanding of cultural sensitivities in the care home among older Nigerians, including their daily lives and coping strategies. The method used was innovative as it offered the residents and staff a chance to elicit their stories. These stories pulled together understandings around care home life, as well as approaches that care home teams implement to address identified cultural needs and preferences. These stories varied, as some were enjoyable and some were unpleasant, as expected, due to the effect of cultural expectations. A lot has been learned about the specific needs of Nigerian residents and the challenges the staff faced as a result of trying to meet the demand.

Also, this study has offered an original contribution to knowledge by identifying the practicality of culturally-sensitive practice and offered a more nuanced understanding of cultural sensitivity in the care home setting. This was through various strategies and approaches, such as the role diverse ethnic staff played in understanding the needs of older

Nigerians. The findings reveal that the initial assessment done before moving into the care home was not always sufficient, and subsequent attempts to gain more understanding of further needs required additional understanding and the development of closer relationships and effective communication with residents by care staff, especially those from the same ethnic background. However, there was difficulty surrounding the recruitment of ethnically diverse staffing, although once this was achieved significant benefits were uncovered. As a result, such diverse staffing can be seen as facilitating the provision of culturally-appropriate care of older Nigerians.

The study has also highlighted the importance of integrating family as a support network in providing care, indicating the impact of culturally sensitive-communication as a way to obtain cultural knowledge. Unlike the findings from the reviewed literature in chapter 2, this study gave a combined detailed description of resident and staff data, as well as the analyses. The use of this two-way method of analysis, though common within thematic analysis, is an additional layer provided for an in-depth understanding of the nature of their lived experience (hermeneutic phenomenology). The constructivist approach used in this study was particularly relevant due to my desire to view cultural sensitivity in different care home context, and its subjective epistemology allowed the knower to jointly construct and create understanding with the researcher.

9. Appendices

9.1. Information sheet for resident participants

Northumbria University, Coach Lane Campus. Benton, Newcastle upon Tyne .NE7 7XA. 01912326002.

Information Sheet/ Consent.

Exploring the cultural sensitivities of UK Care home Services to the older Nigerian residents

Information Sheet for Resident Participants

You are invited to participate in the above research study conducted by Ifeoma Maria-goretti Amuji a Ph.D. student at Northumbria University Newcastle Upon Tyne. Please before you decide to participate, it is extremely important to understand why the study is being done and what it will involve. Find below the information related to this study, read it carefully, and feel free to ask me or discuss with others any unclear issues related to this study or if you required more information that might help you decide whether or not you would like to take part.

What is the study about?

The aim of this research is to explore and understand the experiences, choices and aspirations of older Nigerian people through their move to a care home, and how daily life is experienced by older Nigerians living in a care home. The study also seeks to understand how care home staff, respond to the needs of older Nigerian residents and their families.

Why I have been asked to take part in the research?

You have been identified as an Older Nigerian living in a care home. You are in a valuable position to help me understand how sensitive the care home is to your needs and how this affects your wellbeing.

What is involved and what am I being asked to do?

If you agree to be involved, you will be asked to indicate that you consent to participate in the study. You are being asked to take part in an individual interview. In this discussion you will be asked about your daily life experiences in the care home. This will involve discussion of food, etiquette and other experiences that you might have to share. If you agree to take part in the interview it will last approximately one hour. The interviews will be held within the care home. The interview will be recorded. This is to help the researcher to correctly remember what you say.

What happens if I do not want to participate?

Participation is completely voluntary. It is entirely up to you to decide if you would like to take part.

What would happen if I agree and then change my mind?

You are under no obligation to take part and if you do decide to take part, you are free to withdraw at any time if you change your mind without giving a reason. Not taking part or withdrawing at any stage of the project will not affect the care that you receive in the care home in any way.

Will my participation in the research be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. The recording of the interview will be transcribed and all names or other aspects which may identify the people involved will be removed and replaced with a code. Only the researcher will have access to a key to the codes. In this way all transcripts will be made anonymous and your participation in the study will be kept confidential. If things you have said are quoted in presentations, publications or reports, care will be taken so that you cannot be easily identified.

What are the possible advantages of taking part?

By taking part in the interview you will be contributing to an understanding of the sensitivities of UK care homes to Nigerian people. This may inform how care home services may adapt to provide relationship-centred services that are sensitive to the older person's culture and care expectations.

What are the possible disadvantages of taking part?

It is stressed that it is thought most unlikely that participants or researchers could be harmed as a result of participating in this study. However, experience in this field has shown that discussion can sometimes reveal sensitive information and very occasionally information that calls for further action to be taken.

The following procedures will be in place:

- Participants are free to terminate their involvement in the interview at any time and, if necessary, ask for the interview material to be destroyed.
- The interviewer is an experienced professional working within care sector, she is also skilled at responding appropriately to difficult issues.
- With your consent any arising issues can be explored with the care home staff.

What will happen to the information that is gathered?

The interview data will be transcribed and analysed by the researcher. Any direct quotations or comments that are used in the final report or any subsequent publications or presentations will be anonymised. Names and details of participants will not appear in any printed document. The tapes will be stored securely in an external hard disk which will be encrypted and password protected and a locked bag during transport. As soon as data collection is completed the data will be transferred and stored on Northumbria University computers. Following transcription audio recordings will be permanently erased. When the study has been concluded, the data obtained will be held for up to ten years, and then destroyed. All the paper records will be shredded. The record stored on the University shared drives will be erased in compliance with university procedures. Information stored on audio recording device will be permanently

deleted. Records showing that all these records has been deleted, when and how it was done will be well documented.

What will happen to the results of the study and how will the research report be disseminated?

The results of this study will be published in academic journals. Findings may also be reported in presentations given at professional scientific meetings and conferences. Details of publications or presentations and copies of reports will be obtainable from the researcher. If requested on the consent form, a summary of the research findings will be sent to you and the full report can be requested after the final report has been produced.

Who has reviewed this study?

Before this study could begin, permissions were obtained Northumbria University. The Faculty of Health and Life Sciences Research Ethics Committee, Department of Nursing, Midwifery and Care at Northumbria University have reviewed the study in order to safeguard your interests, and have granted approval to conduct the study.

Who do I contact if I want to ask more questions about the study?

You are free to contact the Principal supervisor Professor Glenda Cook with the details below:

If you are willing to participate we would like you to complete the reply slip. We will then contact you with details of the arrangements for the interview.

Professor Glenda Cook

Professor of Nursing

Faculty of Health & Life Sciences

Coach Lane Campus West

Northumbria University

Newcastle upon Tyne NE7 7XA glenda.cook@northumbria.ac.uk

Tel: 0191 215 6117

9.1.2. Information Sheet for care staff and manager participants

Northumbria University, Coach Lane Campus. Benton, Newcastle upon Tyne .NE7 7XA. 01912326002.

Information Sheet/ Consent.

Exploring the cultural sensitivities of UK Care home Services to the older Nigerian residents

Information Sheet for care staff and manager participants

You are invited to participate in the above research study conducted by Ifeoma Maria-Goretti Amuji, a Ph.D. student at Northumbria University Newcastle Upon Tyne. Please before you decide to participate, it is extremely important to understand why the study is being done and what it will involve. Find below the information related to this study, read it carefully, and feel free to ask me or discuss with others any unclear issues related to this study or if you required more information that might help you decide whether or not you would like to take part.

What is the study about?

The aim of this research is to explore and understand the experiences, choices and aspirations of older Nigerian people through their move to a care home, and how daily life is experienced by older Nigerians living in a care home. The study also seeks to understand how care home staff, respond to the needs of older Nigerian residents and their families. Practices and approaches within care home services to address the individual needs of residents and their families; and how those practices and approaches enhance the provision of culturally sensitive care will also be explored.

Why I have been asked to take part in the research?

You have been identified as a care home manager or staff member who is caring for an older Nigerian, and is in a valuable position to help me understand how sensitive, individualised care is provided for this individual.

What is involved and what am I being asked to do?

If you agree to be involved, you will be asked to indicate that you consent to participate in the study. You are being asked to take part in a focus group interview. Other members of this discussion have also been involved in the care of Nigerian residents in your care home. In this discussion you will be asked about daily life in the care home and how practices in the home address the specific needs of residents. If you agree to take part in the interview it will last no longer than one hour and 30 minutes. The interviews will be held within care home. The interview will be recorded. This is to help the researcher to correctly remember what is said throughout the group discussion.

What happens if I do not want to participate?

Participation is completely voluntary. It is entirely up to you to decide if you would like to take part.

What would happen if I agree and then change my mind?

You are under no obligation to take part and if you do decide to take part, you are free to withdraw up to the point that the interview has been transcribed and anonymised, without giving a reason. Not taking part or withdrawing will not affect your employment in the carehome.

Will my participation in the research be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. What is said during the group interview will be bound by rules of confidentiality at the beginning of the interview. The recording of the interview will be transcribed and all names or other aspects which may identify the people involved will be removed and replaced with a code. Only the researcher will have access to a key to the codes.

In this way all transcripts will be made anonymous and your participation in the study will be kept confidential.

What are the possible advantages of taking part?

By taking part in the interview you will be contributing to an understanding of the sensitivities of UK care homes to Nigeria immigrants. This may inform how care home services may adapt to provide relationship-centred services that are sensitive to the older person's culture and care expectations.

What are the possible disadvantages of taking part?

It is stressed that it is thought most unlikely that participants or researchers could be harmed as a result of participating in this study. However, experience in this field has shown that discussion can sometimes reveal sensitive information and very occasionally information that calls for further action to be taken.

The following procedures will be in place:

- Participants are free to terminate their involvement in the interview at any time and, if necessary, ask for the interview material to be destroyed.
- The interviewer is an experienced professional working within care sector, she is also skilled at responding appropriately to difficult issues.
- With your consent, issues discussed during the focus group interview will be explored with the care home manager.

What will happen to the information that is gathered?

The interview data will be transcribed and analysed by the researcher. Any direct quotations or comments that are used in the final report or any subsequent publications or presentations will be anonymised. Names and details of participants will not appear in any printed document.The tapes will be stored securely in an external hard disk which will be encrypted and password protected and a locked bag during transport. As soon as data collection is completed the data will be transferred and stored on Northumbria University computers.

Following transcription audio recordings will be permanently erased. When the study has been concluded, the data obtained will be held for up to ten years, and then destroyed. All the paper records will be shredded. The record stored on the University shared drives will be erased in compliance with university procedures. Information stored on audio recording device will be permanently deleted. Records showing that all these records has been deleted, when and how it was done will be well documented.

What will happen to the results of the study and how will the research report be disseminated?

The results of this study will be published in academic journals. Findings may also be reported in presentations given at professional scientific meetings and conferences. Details of publications or presentations and copies of reports will be obtainable from the researcher. If requested on the consent form, a summary of the research findings will be sent to you and the full report can be requested after the final report has been produced.

Who has reviewed this study?

Before this study could begin, permissions were obtained Northumbria University. The Faculty of Health and Life Sciences Research Ethics Committee, Department of Nursing, Midwifery and Care at Northumbria University have reviewed the study in order to safeguard your interests, and have granted approval to conduct the study.

Who do I contact if I want to ask more questions about the study?

You are free to contact the Principal supervisor Professor Glenda Cook with the details below: If you are willing to participate we would like you to complete the reply slip. We will then contact you with details of the arrangements for the interview.

Professor Glenda Cook

Professor of Nursing

Faculty of Health & Life Sciences

Coach Lane Campus West

Northumbria University

Newcastle upon Tyne NE7 7XA glenda.cook@northumbria.ac.uk

Tel: 0191 215 6117

9.1.3. Interview Consent For The Resident Version 1

INTERVIEW CONSENT FOR THE RESIDENT Version 1

Research Title: Exploring the cultural sensitivities of UK Care home Services to the older Nigerian residents.

Researcher: IFEOMA MARIA-GORETTI AMUJI	Yes (please tick)	No (please tick)
I have read and understand the Information Sheet dated 22.12.16 (Version 1) and have had the opportunity to ask questions which have been answered to my satisfaction.		
I understand that I do not have to take part. If I do take part I may withdraw at any time, without giving a reason. This will not affect my relationship with the care home service providers.		
I agree to participate in an individual interview. I understand that this will be recorded. I give permission to the researcher to have access to this information for analysis.		
I understand that I will be asked to take part in an individual interview about sensitivities of UK care home services to the needs of older Nigerian residents.		
I understand that the information I have given in this study may be used in the future as part of further work on this subject.		
I understand that interview transcripts and results from the study will be anonymised and that my name and details will not appear in any printed documents**.**		
I agree to take part in this study		
I would like to receive a summary of the results of the study		

I understand that data collected during the study may be looked at by individuals from authorities regulating research conduct (e.g. University ethics auditors). I give permission for these individuals to have access to the data.		

_____ _____ _____

Name of Participant Date Signature

_____ _____ _____

Name of Researcher Date Signature

9.1.4. Interview Consent for The Care Staff And The Manager Version 1

INTERVIEW CONSENT FOR THE CARE STAFF AND THE MANAGER
Version 1

Research Title: Exploring the cultural sensitivities of UK Care home Services to the older

Nigerian residents

Researcher: IFEOMA MARIA-GORETTI AMUJI	Yes (please tick)	No (please tick)
I have read and understand the Information Sheet dated 22.12.16 (Version 1) and have had the opportunity to ask questions which have been answered to my satisfaction.		
I understand that I do not have to take part. If I do take part I may withdraw at any time, without giving a reason. This will not affect my employment in the care home.		
I agree to participate in an individual interview. I understand that this will be recorded. I give permission to the researcher to have access to this information for analysis.		
I understand that I will be asked to take part in an individual interview about sensitivities of UK care home services to the needs of older Nigerian residents.		
I understand that the information I have given in this study may be used in the future as part of further work on this subject.		
I understand that interview transcripts and results from the study will be anonymised and that my name and details will not appear in any printed documents**.**		
I agree to take part in this study		
I would like to receive a summary of the results of the study		

I understand that data collected during the study may be looked at by individuals from authorities regulating research conduct (e.g. University ethics auditors). I give permission for these individuals to have access to the data.		

_____ _____ _____

Name of Participant Date Signature

_____ _____ _____

Name of Researcher Date Signature

9.2. Interview guide for residents

Areas to be explored during the interview

Exploring the cultural sensitivities of UK Care home Services to the older Nigerian residents

Care home residents

1. Check informed consent

    - Friendly greeting
    - Friendly chat.
    - Listen and express interest in what the participants tells me with more of a friendly conversation.

2. Could we begin with a chat about you
    - How old are you?
    - Where are you from originally?
    - Do you have family around here?
3. About your journey into the care home
    - Please can you tell me about making a choice to move into a care home?
    - Whose decisions was it? Yours or your family?
    - If it was yours, what influenced your decision?

4. How is daily life in the care home?
    - Please describe your daily life in the care home?
    - How are your preferences and needs met?
    - Are there areas of life in the care home you find challenging based on your belief or culture?
    - Do you get regular visits from family or friends?
        - o If yes what is their experience of the care home?
5. Can we have a chat about the meals?
    - Could you tell me more about the meals in this care home and your particular preferences…..
    - Do you have problems eating other cuisines other than the food you are used to?

6. Let's have a chat about etiquette.

We all understand that in the UK handshake is the common form of greeting. When you meet people for the first time, it is normal to shake hands. With greetings such as 'How do you do?' said at the same time with the hand shake which is not usually prolonged.

- As an older Nigerian living in care home, what experiences have you encountered around etiquette such as hand shakes?
- How does it affect you?

7. Can we have a chat about activities in the care home?
    - How do you cope with activities available in the care home?
    - What is your involvement?
    - Please could you tell me more about how these activities are conducted?
8. Approaches within care home environment
    - Are there any aspects of life in the care home that you would like to discuss further?
    - How do these affect your daily life in the care home?
    - What are the main challenges with sensitive issues?
    - Can you tell me about the areas you would like changed?
    - What were your expectations prior to coming into the care home?

9. Is there anything else you would like to add regarding daily life in the care home and your preferences and your needs?

9.2.1. Topic guide for care staff and managers

Exploring the cultural sensitivities of UK Care home Services to the older Nigerian residents
Care staff and manager

1. Check informed consent

- Friendly greeting
- Friendly chat

2. Can we have a chat about caring for older immigrants who are resident in your care home and also focus on those who are Nigerians

- What approaches do you use to identify specific personal and cultural needs?
- How do you ensure those needs are met in all aspects of daily life in the care home?
- Do older Nigerians have specific needs and cultural preferences o Examples
    - o Share experiences of tailoring services and practices to the needs of older Nigerians
- What is your experience of caring for older Nigerian residents?
- Are any specific adjustment you make to provide the care they require? How does this differ from the care you provide for other residents?

3. About the meals

- Tell me about the planning of meals in the care home and how this accommodates the needs of residents?
    - Do Nigerian residents have specific requirements?
    - Do you make adjustments for these residents? o How did you decide what adjustments to make?
    - What factors do you take into account?
    - Were these adjustments effective in addressing specific needs/preferences?
    - What are the lessons learned from this experience that you would like to share?

4. About etiquette.

We all understand that in the UK handshake is the common form of greeting. When you meet people for the first time, it is normal to shake hands. With greetings such as 'How do you do?' said at the same time with the hand shake which is not usually prolonged.

- With older Nigerians in your care what experiences have you encountered in relation to these issues?
- How have you identified what is the appropriate way to interact with Nigerian residents?
- How did you change the way you or the service provided in the care home to accommodate the needs of these residents?

- What could you do in the future?

5. About activities in the care home
    - What activities are available in this care home, would you give me an example?
    - How do Nigerian residents engage with these activities?
    - Have you adjusted activities to address the preferences and interests of Nigerian residents? How?
    - Please could describe the strategies you used to identify what Nigerian residents want to do? And were these strategies successful?

6. Is there anything else you would like to add regarding our discussion today?
7. Thank you for your time.

9.2.3. An invitation to take part in a study (letter of approach)

Northumbria University, Coach Lane Campus. Benton, Newcastle upon Tyne .NE7 7XA.
01912326002.

Ifeoma maria-Goretti Amujj

Northumbria University

Coach Lane Campus Benton,

NE7 7XA .Newcastle upon Tyne

Dear…,

An invitation to take part in a study (letter of approach)

I am Mrs. Ifeoma Maria-goretti Amuji, a registered staff nurse and a registered midwife in Nigeria. I am a PhD student at Northumbria University and I am very much interested in the health and needs of older people. I am undertaking a study on the Sensitivities, of Care Home Services to the needs and preferences of Older African (Nigeria) residents. There is not much known about the cultural sensitives of people living in the care home. I am inviting you to take part in my research study. Your participation will be a valuable addition to my research and findings could lead to a greater public understanding of need to be 'culturally competent' in all care sectors. If you are willing to participate please suggest a day and time that suits you and I'll do my best to be available. However, if there is any reason why you will not be willing to participate, you are not obliged to give reasons or contact anybody, also if you have any concerns regarding this information or the study please feel free to drop a few lines with the above address.

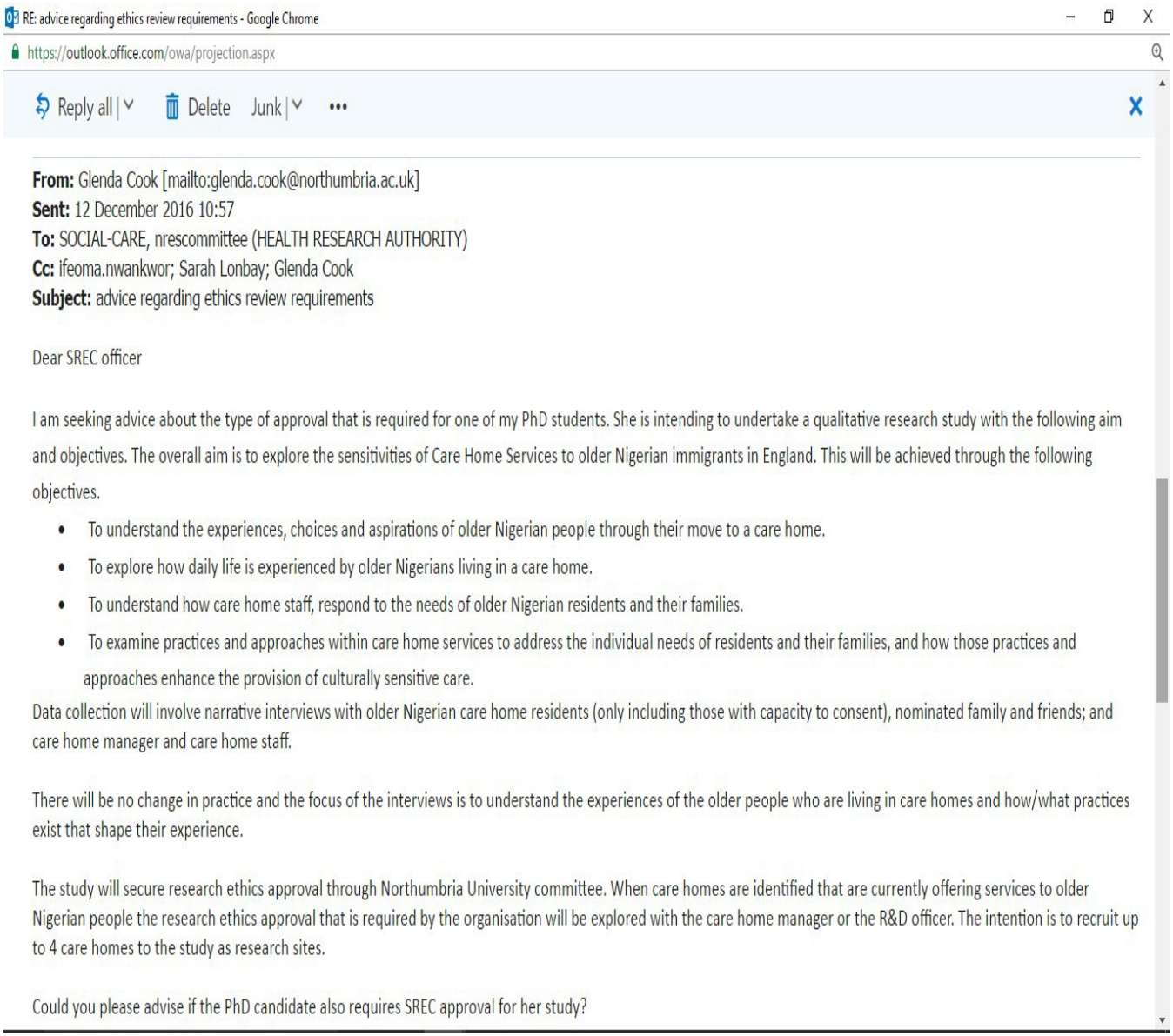
Thank you for your cooperation in anticipation.

Ifeoma maria-Goretti Amuji

(Interviewer)

9.2.4. Confirmation from REC on non-NHS research involvement

Confirmation from REC on non-NHS research involvement.(email and online confirmation


RE: advice regarding ethics review requirements - Google Chrome

https://outlook.office.com/owa/projection.aspx

Reply all | Delete Junk | •••

From: Glenda Cook [mailto:glenda.cook@northumbria.ac.uk]
Sent: 12 December 2016 10:57
To: SOCIAL-CARE, nrescommittee (HEALTH RESEARCH AUTHORITY)
Cc: ifeoma.nwankwor; Sarah Lonbay; Glenda Cook
Subject: advice regarding ethics review requirements

Dear SREC officer

I am seeking advice about the type of approval that is required for one of my PhD students. She is intending to undertake a qualitative research study with the following aim and objectives. The overall aim is to explore the sensitivities of Care Home Services to older Nigerian immigrants in England. This will be achieved through the following objectives.

- To understand the experiences, choices and aspirations of older Nigerian people through their move to a care home.
- To explore how daily life is experienced by older Nigerians living in a care home.
- To understand how care home staff, respond to the needs of older Nigerian residents and their families.
- To examine practices and approaches within care home services to address the individual needs of residents and their families, and how those practices and approaches enhance the provision of culturally sensitive care.

Data collection will involve narrative interviews with older Nigerian care home residents (only including those with capacity to consent), nominated family and friends; and care home manager and care home staff.

There will be no change in practice and the focus of the interviews is to understand the experiences of the older people who are living in care homes and how/what practices exist that shape their experience.

The study will secure research ethics approval through Northumbria University committee. When care homes are identified that are currently offering services to older Nigerian people the research ethics approval that is required by the organisation will be explored with the care home manager or the R&D officer. The intention is to recruit up to 4 care homes to the study as research sites.

Could you please advise if the PhD candidate also requires SREC approval for her study?

RE: advice regarding ethics review requirements - Google Chrome

https://outlook.office.com/owa/projection.aspx

Reply all | Delete Junk | ...

Could you please advise if the PhD candidate also requires SREC approval for her study?

Regards
Glenda

Prof. Dr. Glenda Cook
Professor Nursing,
School of Health, Community and Education Studies,
Northumbria University,
Newcastle upon Tyne
NE7 7XA
0191 2156117

Professor of Nursing: northumbria University
Adjunct Professor of Nursing: Griffith University (Australia)

Winner of Nurse Education Provider of the Year: Post Registration 2012 and 2013

****

RE: advice regarding ethics review requirements

SN

SOCIAL-CARE, nrescommittee (HEALTH RESEARCH AUTHORITY) <nrescommittee.social-care@nhs.net>

Reply all

Wed 14/12/2016, 10:54

Glenda Cook; ifeoma.nwankwor; Sarah Lonbay

Inbox

Remit of Social Care RE... 105 KB

does-my-project-requir... 183 KB

Updated GAfREC 24 Feb... 161 KB

Show all 3 attachments (448 KB) Download all Save all to OneDrive - Northumbria University - Production Azure AD

Action Items

Dear Glenda

Thank you for your query. I am attaching the remit of the Social Care REC, an algorithm and the Governance Arrangements for RECs so that you can check if this application falls within the remit of the Social Care REC.

As you will see from our remit and the other documents, social care research does not require review by the Social Care REC if it is reviewed by another committee operating in accordance with the ESRC's Framework for Research Ethics, unless sections 1 or 9 (of the attached document) apply or the research involves NHS patients or service users as research participants. A review is required if there is a legal requirement for REC review e.g. under the Mental Capacity Act. Student research within the field of social care should ordinarily be reviewed by a University REC (UREC). If a UREC review is not available to a student, they can contact the REC Manager for advice.

As this project will not include adults lacking capacity to consent, or the NHS, review by the University of Northumbria REC should be sufficient.

Best wishes

Barbara

s://outlook.office.com/owa/projection.aspx 1/

Barbara Cuddon | REC Manager
Health Research Authority
Skipton House, 80 London Road, London SE1 6LH
E: nrescommittee.social-care@nhs.net | T: 0207 972 2568
HRA: 020 797 22545 | [http://www.hra.nhs.uk%20]www.hra.nhs.uk

MRC Medical Research Council

NHS Health Research Authority

Do I need NHS REC approval?

To print your result with title and IRAS Project ID please enter your details below:

Title of your research:

Exploring the Sensitivities of Care Home Services to the Older Nigerian Minority; a Challenge to Health and Wellbeing of the Healthcare System in the United Kingdom

IRAS Project ID (if available):

Your answers to the following questions indicate that **you do not need NHS REC approval for sites in England.** However, **you may need other approvals.**

You have answered ***'YES'*** to: Is your study research?

You answered ***'NO'*** to all of these questions:

Question Set 1

- Is your study a clinical trial of an investigational medicinal product?
- Is your study one or more of the following: A non-CE marked medical device, or a device which has been modified or is being used outside of its CE mark intended purpose, and the study is conducted by or with the support of the manufacturer or another commercial company (including university spin-out company) to provide data for CE marking purposes?
- Does your study involve exposure to any ionising radiation?
- Does your study involve the processing of disclosable protected information on the Register of the Human Fertilisation and Embryology Authority by researchers, without consent?
- Is your study a clinical trial involving the participation of practising midwives?

Question Set 2

- Will your study involve research participants identified from, or because of their past or present use of services (adult and children's healthcare within the NHS and adult social care), for which the UK health departments are responsible (including services provided under contract with the private or voluntary sectors), including participants recruited through these services as healthy controls?
- Will your research involve collection of tissue or information from any users of these services (adult and children's healthcare within the NHS and adult social care)? This may include users who have died within the last 100 years.
- Will your research involve the use of previously collected tissue or information from which the research team could identify individual past or present users of these services (adult and children's healthcare within the NHS and adult social care), either directly from that tissue or information, or from its combination with other tissue or information likely to come into their possession?
- Will your research involve research participants identified because of their status as relatives or carers of past or present users of these services (adult and children's healthcare within the NHS and adult social care)?

Question Set 3

- Will your research involve the storage of relevant material from the living or deceased on premises in the UK, but not Scotland, without an appropriate licence from the Human Tissue Authority (HTA)? This includes storage of imported material.
- Will your research involve storage or use of relevant material from the living, collected on or after 1st September 2006, and the research is not within the terms of consent from the donors, and the research does not come under another NHS REC approval?
- Will your research involve the analysis of DNA from bodily material, collected on or after 1st September 2006, and this analysis is not within the terms of consent for research from the donor?

Question Set 4

- Will your research involve at any stage intrusive procedures with adults who lack capacity to consent for themselves, including participants retained in study following the loss of capacity?
- Is your research health-related and involving prisoners?
- Does your research involve xenotransplantation?
- Is your research a social care project funded by the Department of Health?

If your research extends beyond **England** find out if you need NHS REC approval by selecting the *'OTHER UK COUNTRIES'* button below.

OTHER UK COUNTRIES

If, after visiting all relevant UK countries, this decision tool suggests that you do not require NHS REC approval follow this link for final confirmation and further information.

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Northumbria University NEWCASTLE

FORM TO AMEND AN APPROVED ETHICS PROJECT

Principal Investigator	**IFEOMA MARIA-GORETTI AMUJI**
Project Title	**EXPLORING THE CULTURAL SENSITIVITIES OF UK CARE HOME SERVICES TO THE OLDER NIGERIAN RESIDENTS**
Project Code (where applicable)	
Date of original ethical approval	**16/5/2017**
Date of amendment request	**21/02/2019**

Description of Amendment:

Amendment is requested to expand data collection *(*please see page 7 of previous ethics application)

Amendment is requested in relation to data collection (see page 7 of the previous ethics application). In the previous ethics approved form, the study proposal included data collection from three groups (residents, staff, friends and families of residents). However, during recruitment process, family and friends were invited to take part in the study however they declined. Only older residents and staff were recruited and they took part in a semi-structured face to face interview. During the analysis of this data it became evident that there were gaps in the resident's stories of their immigration history and their move to a care home. This knowledge would enhance understanding of the residents experiences of care home life. Amendment therefore is needed for additional data collection with this group of participants. I have maintained contact with the participating

care home staff and this led to telephone discussion with the older residents and during this conversations the participants were aware that the conversations they provided were going to be used for research purposes and they gave their consent prior to that conversation. However, as some time has elapsed, I will revisit the participants who originally consented to my recording their phone discussion to ensure that I still have their consent and if is necessary for further data collection either additional face-to-face or telephone interview to be carried out – whichever is more acceptable to the participants.

As a result of this change in data collection, various stages were developed which are discussed below:

Consent

Verbal consent will be revisited prior to the interview to ensure that participants are happy to take part in the study at their own will without undue pressure. Following successful consent, the researcher will re-introduce herself to the participants to ensure that they know who they are speaking to. Also, a brief overview of the aim of the study will be reiterated to ensure the participants are aware of what is about to be discussed. Participants will be assured of confidentiality and what the study will be used for including the estimated length of the interview. They will be informed that the face-toface/telephone interview will be taped for data recording accuracy purposes and that their comments will be held confidential. By guaranteeing confidentiality which is central to ethical research practice, it is anticipated that participants will be free to relay their information without any fear where possible that their data may be traced back to them in any form.

Time and date

Time and date of the interview will be communicated in advance and agreed only when it is most convenient for the participants. This is to ensure more relaxed and stress-free

situations in communicating with the participants which is expected to yield rich data from participants. The time will be finalized by the participants before the start of the interview.

Reasons for Amendment/Change:

Following transcription and analysis of the previous data, it became obvious that there were unforeseen topics/areas of care home life which needed further clarification. As a result of this, follow-up was needed to ensure clarity which was not part of the previous plan detailed in the initial ethics application. I have been in discussion with the care home managers to inform them of my study and also spoke with the residents. Time and distance are crucial factors to consider at this stage of my doctoral program if further data collection is required, hence for both the participants and myself, this data might be collected via a telephone interview

Anticipated Implications:

Anticipated risks (addressed in page 15 of previous ethics form)

Though every research has its associated risk, this research has minimal risk for both participants and the researcher. For the researched, the study focuses on their experiences and views about care home life and they will have the opportunity to express their views about daily life. Through this process sensitive information might be discussed and be distressing to the participants. Measures used in the previous ethics application will be applied where necessary. By analyzing conversations with residents and collecting further data there will be a more in-depth understanding of the older person's experiences. This will enhance the authenticity of the insights and understandings gained through this study.

TO BE COMPLETED BY THE ETHICS COORDINATOR

Acceptance (Circle as appropriate)	 Signature: Name: Cathy Bailey
Date:4th March 2019	

Follow-up action passed to:
Reason for Rejection:

9.9. **Form to amend an approved ethics project**

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