

THE SOCIAL LIVES OF OLDER MEN LIVING IN CARE HOMES AND THE
IMPLICATIONS FOR THEIR WELLBEING

by

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LLB and MSc in Sociology
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A Thesis submitted in fulfilment of
the requirements for the degree of
Doctor of Philosophy

University of East Anglia
School of Health Sciences

November 2017

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ABSTRACT

Older men's social networks tend to be smaller with less frequent contact than those of older women. In care homes, the majority of residents and staff members are female: Of the population living in care homes for older people in England and Wales three quarters are female as are 90% of staff. It is not known how this might affect the social lives of those, particularly men, living in care homes. This study explored the following research questions: *1. How do male residents socialise in a care home for older people? 2. How do residents shape their social relations in terms of gender? 3. How does the predominance of women in care home environments impact on male residents' social experiences and their sense of wellbeing?* An ethnographic approach was used comprising participant observation and informal interviews in three care homes. Communal areas of the care homes such as the lounge tended to be gendered spaces as female residents extensively used these areas to socialise through 'shared intimacy'. Men spent long periods of time in their bedrooms where they had greater control, autonomy and privacy and experienced moments of solitude while using the communal areas instrumentally to attend activities. Meal times were essential for male residents' social lives. Men used the dining spaces as platforms to socialise with their peers and experience the social life in the care home community. Residents' table assignments were key to forging and maintaining closer social ties with peers. The table assignment consisted of two stages: a. *allocation* (in which care staff exerted control over the communal areas by determining residents' seats in the dining room); b. *appropriation* (residents' exerted agency by routinely occupying the same space in the dining room). Care homes for older people tended to create spaces and activities which were orientated towards female residents and therefore may socially isolate male residents. However, men's ability to determine their social routines by alternating periods of time in both public and private spaces appeared to be important for their care and therefore, to their wellbeing.

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ACKNOWLEDGEMENTS

With thanks to my supervisors Professors Francine Cheater and Antony Arthur.

I am extremely grateful to all the people in the care homes who took part in this study.

I would like to dedicate this work to my partner who supported me in every step of this journey.

To all my family and friends in Brazil and in the United Kingdom.

1. INTRODUCTION

My experience working as a support worker for people with learning disabilities gave me an initial insight into the social lives of vulnerable individuals. I perceived them to be isolated within the care home and mostly segregated from the rest of the community. My interests in researching the social lives of older men living in care homes stemmed from my initial visits to a nursing home for older people in which I could observe how some male residents seemed less connected or even isolated from the rest of the group. Additionally, while visiting this particular nursing home I noticed how difficult it was to approach and engage with the male residents compared to their female counterpart residents. These initial impressions led me to consider how the ideals of masculinity contrasted with the health decline and needs for personal and health care for male residents.

The research presented in this thesis aimed to examine how men living in care homes for older people socially interact within the care setting, particularly the relationships amongst residents. To this end, this study explored, through gendered lens, how residents performed their day-to-day social routines. This included the examination of gender differences in using the spaces in the care homes, the ways in which men and women tended to socialise, and the possible effects on male residents' wellbeing. The ethnography presented in this thesis scrutinised how social processes were used by residents to produce and reproduce their social realities and routines, with a focus on the actions and interactions and use of language. Power relations were also explored in terms of residents' control over their actions and their decisions in the context of care provided by the staff at an organisational level.

The dominant conception of masculinity as conceived in western societies is bound up with the ideas of competitiveness and power (Prentice & Carranza, 2002) and a tendency to adopt risky behaviours amongst men from more deprived social backgrounds (Messerschmidt, 1993; Sixsmith & Boneham, 2003). Studies

on social capital and social networks have demonstrated that older men living independently in the community usually have weaker social capital and smaller social networks compared to older women (Cornwell et al. 2008; Gray, 2008; McLaughlin et al. 2010). Moreover, older men have less contact with members of their social network and made less use of the resources and support of their social capital (Sixsmith et al., 2003). In addition, older men were less likely to get involved with their local community and social groups (Cornwell et al., 2008; Gray, 2008). Men were found to be more exposed to emotional and health crises (Sixsmith et al., 2003), while social isolation is particularly common amongst men who live alone or suffer from mental health problems (Iliffe et al., 2007).

The demand for care home accommodation is set to rise in the coming years (Kingston et al., 2017) due to the ageing demographic of the UK (ONS, 2013, 2014b, 2015). Men's presence in care homes for older people has increased substantially in 10 years between 2001 and 2011, by approximately 10,000 individuals, an increase of 15% (ONS, 2013). Yet, in comparison to women, men's presence in care homes in England and Wales at age 65+ was still only 26.4%. Amongst individuals aged 85 years or above, men's presence further drops to 17% of the population living in communal establishments (ONS, 2013). Nevertheless, the gender gap in the population living in care homes has narrowed over time. In 2001 there were 3.3 women for each man aged 65 years and over living in a care home. In 2011 this ratio was 2.8 women for each man (ONS, 2014a). Hence, the increasing presence of men in care homes for older people may change how residents are currently provided for. This research aimed to explore and compare the possible differences in how male and female residents tended to socialise and whether any differences might have an impact on men's wellbeing. Such knowledge would form an important contribution to the academic literature in the field and to support care practices and policy to better serve the men living in these types of care organisations.

Women's greater presence in care homes is also reflected in its workforce. The workforce in care homes for older people in England and Wales is largely made up

of women. For example, the staff who provide direct care for the residents in care homes – care workers, senior care workers and registered nurses are made up of 151,729 (88.7%) females workers and 19,084 (11.2%) male workers (NMDS-SC, 2017). Similarly, the managerial positions in those organisations are more likely to be occupied by women 10,408 (86.2%) compared to men 1,660 (13.7%) (NMDS-SC, 2017). The greater presence of women in care homes may affect the way that male residents socialise with potential consequences for their wellbeing.

Very little is known about the gendered social aspects of older people living in care homes and how men tend to socialise and structure their routines in these types of settings. Andrew, (2005) reported that male residents were less likely to engage in group activities provided by the care home and they also exhibited lower levels of trust compared to female residents. Moss & Moss (2007) argued that men do not seek to form closer relationships in care homes and this might be related to the diverse social background of the residents and the different levels of cognitive capacity of their peers. Men also placed great importance on their former occupational experience which seemed to shape their self-identity (Moss & Moss, 2007). However, social relations with other men seemed to be relevant for men in advanced stages of dementia (Bartlett, 2007). Thus, men living in care homes may find it challenging and struggle to socially adapt in these settings, not only because they are numerically outnumbered, but because of the loss of control over their social lives due to their health impairments.

It has been argued that older men's experiences in general have been ignored by academia in social sciences and sociology causing a 'blind spot' in the academic literature (Fleming, 1999). This has been described as the 'invisible men' in knowledge (Fennell & Davidson, 2003). This somewhat explains why the social aspects of men living in care homes has been neglected in research and is to date poorly understood.

This research aimed to address a gap in knowledge concerning the social aspects of men living in care homes for older people. The focus of this study was on how

men tended to interact with other residents and organise their social routines. This included an exploration of the use of different spaces within the care home and how they engaged in social activities in these settings. The research also investigated gender aspects of how residents tended to socialise, making a comparison between how male and female residents tended to use the spaces in the care homes, how they took part in diverse types of activities and how they interacted with each other. A further aim was to understand how the social relations in care homes may have affected the wellbeing of male residents, especially the issue of men being numerically outnumbered.

It is hoped that the knowledge generated by this study will provide relevant insights into how older men tend to socialise in care homes and how gendered relations shape social interactions in these types of settings. Thus, the present study provides insights to inform care practices and strategies with the objective to better socially support older men living in care and open new avenues for future research into care homes for older people.

This thesis is organised into nine chapters. The next chapter presents the literature review regarding gendered aspects of the older population living in the community and in care homes for older people. It goes on to present key studies on the health effects of social capital and social networks regarding older men living in the community and masculine identity and values. The literature review then provides a critical review of the few published studies which address social interactions in care homes. The final part of the literature review provides an examination of the studies regarding social aspects of men living in care homes for older people.

The third chapter in this thesis provides a detailed account of the methods employed in this research. This chapter sets out the ontological and epistemological stances underpinning this qualitative research. It provides the justification for the ethnographic approach and specifies the methods used to generate data, including reflexivity. Ethical issues and strategies to select care

homes and engage in the fieldwork are presented here. Reflexive accounts are provided from each of the care home settings where the fieldwork was undertaken. The chapter ends by explaining the analyses to generate the study findings.

The fourth chapter present the key aspects of each of the three settings in which this research took place. The fifth, sixth and seventh chapters present the findings of the research which are respectively: *The lounge – men’s absence in a gendered space*; *The social construction of male residents’ bedrooms*; and *The centrality of mealtimes for men’s social lives*. The eighth chapter provides a discussion of the findings in relation to the current knowledge on the social aspects of residents living in care homes for older people. The last chapter summarises the main contributions of the study, explores its strengths and limitations and finally, provides suggestions for policy and practice and directions for future research.

2. LITERATURE REVIEW

2.1. Introduction

This chapter critically reviews the key literature regarding men living in care homes with and without nursing care for older people (referred to from this point as 'care homes'). It starts by describing the size and demographic features of care homes in the United Kingdom (UK). The social capital and social isolation of older men living in the community is then discussed. Studies where gender is a specific focus of life in care homes are then explored in greater depth. Lastly, the aims of the research and research questions are presented. The content of this literature review was generated by searching the following databases: Google Scholar, Academic Search Complete, CINAHL Complete, MEDLINE and PsycARTICLES, E-Journals and ASSIA. The Office for National Statistics (ONS) was consulted separately for publications on population demographics in the UK.

2.2. Ageing population trends and gender

In 2008, people aged 65 years and above represented 17% (84.6 million) of the total population of the 27 countries in the European Union plus Norway and Switzerland (Giannakouris, 2008). This is projected to increase to 30% (151.5 million) by 2060. Similarly, the number of people aged 80 years and older is expected to rise from 21.8 million to 61.4 million by 2060 (Giannakouris, 2008).

The current number of people aged 65 years and above in the UK is 11.9 million, representing 18.1% of the total population. This number is set to increase to 17.7 million by 2040 representing 24.3% of the total population of the UK (ONS, 2017b). The number of people aged 85 years and above will increase from 1.6 million to 3.1 million over the same period (ONS, 2017b). Gender is a significant factor for determining morbidity and life expectancy. The life expectancy between 2010 and 2012 in UK was 78.8 years for men and 82.6 years for women (ONS,

2016). In the UK, women's life expectancy has not increased as much as men's life expectancy over the last few decades, however women's overall health and physical mobility has improved considerably compared to men's (ONS, 2014a). Men experience more physical disabilities later in life than women (ONS, 2014a) and older men still have higher mortality than women despite their increase in life expectancy in recent years (ONS, 2014a). A systematic review of studies from 13 countries consistently reported lower morbidity but higher mortality for men and suggested that men's tendency towards risk-taking behaviours and reluctance to seek medical care might explain the variation (Oksuzyan, Juel, Vaupel, & Christensen, 2008).

The combination of an increasingly aged population and the associated morbidity of this age group means that the number of people living in care homes and nursing homes is expected to peak in 2033 (Cracknell, 2010). More recent projections indicated that 71,000 additional places in care homes for older people will be required by 2025 in the UK (Kingston et al., 2017).

2.3. Care home population

There are around 11.8 million people aged 65 years and over living in the UK of which 13.5% (1.6 million) are aged 85 or older. There are approximately 421,000 people over 65 years of age living in 6,023 residential homes and 4,699 nursing homes in the UK (ONS, 2017a).

In England and Wales, the population aged over 65 is nine million and approximately 291,000 (3.2%) of these people live in in care homes (ONS, 2014). Commercial and not for profit care home organisations are their main source of care. The 2011 Census reported 103,000 people living in care homes and 69,000 in nursing homes were aged 85 or older (ONS, 2013).

The population residing in care homes are diverse in terms of their health needs, although there is a high prevalence of dementia, which is the main reason for moving into care homes (Prince, et. al., 2014). It is estimated that 57.9% of the

population in care homes have some degree of dementia, and the figure for nursing homes is higher still at 75% in the UK (Prince, et. al., 2014)

2.4. Gender ratios in care homes for older people

Based on the 2011 Census for England and Wales, 26.4% of care home residents were male for the population aged 65 and older. However, this proportion has increased substantially over the previous 10 years. The male population living in care homes increased by approximately 10,000 individuals (15%) between 2001 and 2011, whilst the number of women declined by around 9,000 individuals, a decline of 4.2%. At age 85 years and over, men comprise only 17% of the total population living in communal establishments (ONS, 2013). The overall population living in care homes remained fairly stable over this decade with an increase of only 0.3% (ONS, 2014). Hence, the gender gap has narrowed slightly. In 2001 there were 3.3 women for each man aged 65 years and older living in care homes. In 2011 this ratio was 2.8 women for each man (ONS, 2014a). Overall, men in care homes tend to be younger than women. 56.3% of male residents were aged between 65 and 84 years, compared to 35.3% of women in 2011 (ONS, 2014a). This suggests a stronger presence of men living in care homes in the future.

A study comparing two waves of the England and Wales Census 1991 and 2001 found that men's risk of admission into care homes is lower than for women even after adjusting for health conditions and age at both time points (Grundy & Jitlal, 2007). Men's likelihood of being admitted into care homes differs in other countries. For example, a study based on a large survey in Finland showed that there is an equal risk for older men and women that live alone to be admitted into a care home. However, the risk was lower for married men than their wives (Nihtilä & Pekka, 2008). Mccann, et. al., (2012) investigated why it is that married men had a lower risk of moving to a care home than their wives based on the Northern Ireland Longitudinal Study. The study sample was based on 20,830 couples at aged 65 and older who were admitted to care homes over a six-year period. After controlling for age, women were found to be 40% more likely than

men to be admitted into a care home. The conclusion of the study reported that women were more likely to move to care homes because they tend to receive less social support from their male partners who are older and more frail (McCann et al., 2012).

Bhrolcháin (2005) concluded that married men were on average two to three years older than their spouses by analysing the England and Wales Census waves between 1901 to 2001. However, the same study found out that in the last decades this age gap has narrowed to one year. Men living longer may be able to provide better support for their female spouses which may delay women's admission into care homes (McCann et al., 2012). Thus, men's presence in care homes is likely to continue to increase in the coming years.

As with the resident population of care homes, the workforce of care homes is predominantly female. For example, in England the workforce that provides direct care for the residents (care workers, senior care workers and registered nurses) are made up of 151,729 (88.7%) females workers and 19,084 (11.2%) male workers (NMDS-SC, 2017). Similarly, the managerial positions in those organisations are predominantly occupied by women 10,408 (86.2%) compared to men 1,660 (13.7%) (NMDS-SC, 2017). No published studies have been found that investigated whether the overwhelming predominance of female care workers affects the social aspects of male residents' lives or wellbeing. However, it is conceivable that the over representation of women in the workforce has at least an indirect influence on male residents' lives. This has been alluded to through recommendations to develop social activities that are gender-neutral (Beach & Bamford, 2014) rather than activities that the female staff and residents feel more comfortable with or through the development of activities created specifically to support men (Gleibs et al., 2011).

Thus, life for men living in care homes may be adversely affected, not only due to the gradual loss of independence over their social life, but also because they live in an environment where they are potentially numerically marginalised.

2.5. Types of social capital and health associations

While the concept of social capital has been developed by several theorists in the nineteen-sixties (Portes, 1998), the most influential definition for social capital in epidemiology was more recently introduced by Putnam (Putnam 1993) on the impact of civic engagement on economic and political life in Italy and US. Social capital was defined in those works as social networks (including the ties at community level) which foster social norms (more specifically trust and reciprocity between individuals or group of individuals) and enabling to 'facilitate co-ordination and cooperation for mutual benefit' (Putnam, 2000).

Higher levels of social capital has been found to be positively associated with better health outcomes, though there are a smaller number of studies that have found no association due to the wide range of definitions and measurements used to assess social capital (Harpham et al., 2002). In some specific cases, the opposite association has been found, where having higher levels of social capital is negatively associated with health; for example, children with higher social capital from black communities in deprived areas in the United States (US) were found to be more likely to suffer from depression than children with low social capital scores (Caughy, O'Campo, & Muntaner, 2003).

Self-rated health, as well as externally measured health outcomes have been found to be positively associated with higher levels of social support and trust (Hurtado, Kawachi, & Sudarsky, 2011; Iwase et al., 2012; Poortinga, 2006), while higher levels of community integration enables better access to health care via reinforcing individuals' social capital (Hendryx, Ahern, Lovrich, & McCurdy, 2002). However, Uphoff (et al. 2013) argues that these associations exist but require further evidence to fully understand their mechanisms.

Alongside social class, income and ethnicity, gender is an important characteristic in shaping the social capital of individuals, which in turn is associated with health outcomes (Field 2008; Putnam 2000; Wilkinson 2009). The ageing process modifies the shape of social capital and social networks for both genders. Social

capital in this particular instance was useful in understanding the gender differences and how men were more prone to social isolation as they appeared to have weaker social capital than women (Wrzus, Hänel, Wagner, & Neyer, 2013).

More recently, a new classification for the concept of social capital was created to unpack the micro, meso and macro social layers and facilitate its analysis (Field, 2008). Bridging and bonding classification became well-known in Putnam's depiction of erosion and re-appearance of civic engagement in American society throughout the twentieth century (Halpern, 2005). Bonding and bridging social capital were described as:

'Some forms of social capital are, by choice or necessity, inward looking and tend to reinforce exclusive identities and homogenous groups. Examples of bonding social capital include ethnic fraternal organisations, church-based women's reading groups, and fashionable country clubs. Other networks are outwards looking and encompass people across diverse social cleavages. Examples of bridging social capital include the civil rights movement, many youth service groups, and ecumenical religious organisations. ... Bonding social capital provides a kind of sociological superglue whereas bridging social capital sociological WD-40' (Putnam, 2000 : 22-3).

According to Morrow (1999) men and women have different levels of bonding and bridging social capital. Women seem to be more resourceful with bonding capital because they are more competent in dealing with affection and emotion while historically women dominated the private sphere (Morrow, 1999). It had been suggested that bonding capital is a more stable social resource because, unlike bridging capital, bonding capital is less vulnerable to economic crises (Russel, 1999 in Field, 2003). However, there are indications that showed that bonding capital has negative effects in the sense that it is a type of social capital which favours pernicious factors in the group and can be oppressive to its members. As bonding capital is inward looking, it is composed of homophile social links in the sense that the individuals come from similar social backgrounds (McPherson, 2001) and often

live in the same geographical area (Hogg, 2006). The negative effects of the bonding capital have been observed in previous studies. Mitchell et al. (2002) concluded that higher levels of bonding social capital had a positive association with mental distress while bridging capital had minor inverse effect on individuals' distress levels. The research was based on a survey of 222 households limited to families with low incomes living in a deprived area in the inner-city of Birmingham, US (Mitchell et al. , 2002).

Although some theorists have criticised the bonding/bridging distinction as a simple and 'binary' choice for a highly complex social phenomenon (Patulny et al. 2007 : 36), this classification is useful in understanding the need for and use of different types of social capital during someone's life course. Pahl at al., (1997) speculates that bonding capital might have a greater importance during childhood and older age because it provides stable and closer ties in times when individuals need it the most. Bridging social capital might have greater significance to overcome the challenges in the adult life like securing a job or advancing a professional career. Thus, having the ability to access and gain different kinds of social capital throughout life is essential for someone's wellbeing (Warde, 1999).

2.6. Older men's social capital and social isolation

The body of research which has investigated gender differences in terms of social capital and social networks of older people is limited to a few studies. The main studies and their findings are listed in the following table:

Study	Country	Population / Sample size	Methods	Key Findings
Sixsmith (2003)	UK	Community based 18 male individuals in the UK (age 56 to 84 years old)	Qualitative research In-depth interviews and focus groups	<ul style="list-style-type: none"> - Health problems were considered private matters hence it should be avoided in social situations; - Participants failed to ask help from health services and close networks in stress and illness crises; - Traditional male behaviour such as drinking alcohol can worsen stress and health crises.
Dolan (2007)	UK	Community based 22 participants living in two contrasting social economical areas – a relatively advantaged area and a relatively deprived area	Qualitative research In-depth interviews	<ul style="list-style-type: none"> - In the affluent areas, social capital was created and maintained by bonding ties within homogenous neighbourhoods. - For men living in deprived areas, unemployment is seen as a threat to self-identity because they no longer see themselves as working class men; - In the deprived area, respect, integration and solidarity was associated with traditional features of social working-class masculinities such as dominance, toughness and willingness to use violence to resolve differences;
Cornwell(et al. 2008)	US	Community based N=3,005 aged 57 to 85	Cross-sectional quantitative research Structured interviews from the National Social Life, Health and Aging Project (NSHAP) dataset	<ul style="list-style-type: none"> - Men were less involved with the community, attending religious services less frequently and do less volunteer work; - Women tend to feel closer to their social network than men.
Gray (2008)	UK	Community based Sample size - N=1,924 present in both waves aged 60+	Longitudinal quantitative research British Household Panel Survey data – 2 waves: years 1991 and 2003	<ul style="list-style-type: none"> - Partner status in both waves was associated with weaker social support score, for those without a partner, but men presented a lower score in this group; - Women were more present in religious associations and volunteer work;

				<ul style="list-style-type: none"> - Neighbourhood support was greater amongst women, although manual workers had a lower score than non-manual workers; - Overall, men presented smaller social networks than women.
McLaughlin (et al. 2010)	Australia	Community based N=5741, men n=3152 and women n=2589 aged 72-79	Cross-sectional quantitative research	<ul style="list-style-type: none"> - Being separated, divorced or single was likely to reduce men's social network, while widowhood increased the size for men and women; - The authors argue that the tendency to have fewer relationships and rely more on their wives may leave men vulnerable when intimate relationships are disrupted. Hence, the consequences of divorce are greater for men than for women; - Overall, women reported significantly larger networks than men.

Table 1. Studies of older men's social capital and social network

There are indications that older men living in the community tend to have smaller social networks and lower social support compared to older women (Cornwell et al., 2008; Gray, 2008; McLaughlin et al., 2010) in the few studies which have analysed older men's social capital (including social support and social networks). In addition, older men are less likely to get involved with volunteer work and religious groups (Cornwell et al., 2008; Gray, 2008). Using two waves (1991 and 2003) of the British Household Panel Survey, Gray (2008) explored the social capital of older people arguing that men had lower degrees of attachment and support related to their neighbourhood compared with women and the lowest levels were amongst manual workers.

In a US national survey, older men were found to have less contact with their closer social network than women (which was measured by participants choosing their five closest contacts and rating them using a five-point Likert Scale) alongside other controls such as having higher education, being white American and being retired (Cornwell et al., 2008). This finding has been further explored in qualitative studies in the UK. For instance, older men were reluctant to seek help from their closer social network because they found it harder to talk about their own feelings as this could endanger their identity embedded in values associated with masculinity (Dolan, 2007). Social constructions of masculinity in Western societies portray men as being powerful and competitive (Prentice & Carranza, 2002). In particular, men living in impoverished areas are likely to present themselves as the 'tough guy' by adopting violent and/or risky behaviours (Messerschmidt, 1993). For instance, older men living in deprived areas are prone to adopt health risks such as heavy drinking as this is part of their sense of manhood (Sixsmith et al. 2003). Dolan (2007) however, highlighted the danger of generalising the behaviours of minority groups to larger sections of the population.

Masculinity norms and values have a key role in shaping men's relationships with their social capital and social support resources (Dolan, 2007; Sixsmith et al. 2003). It has been suggested that the values and norms from working class masculinities prevent men from forging supportive and health enhancing associations with

members of their communities (Dolan, 2007). Furthermore, Sixsmith et al. (2003) argued that older men in deprived areas were reluctant to reach out for help from their social network because they considered health problems very personal matters. On the other hand, older men perceived health community spaces as feminised environments.

In fact, men's perception was that women were more socially connected and made better use of the health resources allocated in their local communities (Dolan, 2007). In many circumstances, older men's social capital and social support from the family and community were ineffective as they failed to seek help from these resources. Thus, older men are more exposed to health crises rooted in social isolation, stress and the use of alcohol (Sixsmith et al., 2003). Another contributor to onset of health or emotional crises is related to job loss which can threaten a sense of masculinity among men (Dolan, 2007).

Nilsen, et al. (2017) argued that engaging in leisure activities was important for successful aging but there are differences between women and men. The study compared mortality rates and levels of leisure activity amongst people aged between 76 and 101 living in different living arrangements in the community in Sweden. Activities with social characteristics such as taking part in social organisations or having relatives' visits were statistically significantly associated with lower mortality for men living alone. Women of the same age had reduced mortality if they completed crosswords as a leisure activity (Nilsen, et al., 2017). Previous research showed contradictory results, indicating that older men usually had lower mortality if they took part in solitary activities while older women benefited from taking part in leisure activities with social attributes (Lennartsson et al., 2001). These studies however were unable to examine and explain why such associations between mortality rates and leisure activities varied with gender. Neither can they demonstrate how activities, with social or solitary characteristics, can increase older men's life expectancy.

Indeed, social isolation and loneliness is more likely to be experienced amongst older men than older women with serious health risks (Shapiro & Yarborough-Hayes, 2008) while social isolation is particularly common amongst men in old age who live alone or suffer from mental health problems (Iliffe et al., 2007). Overall, social isolation in older age has also been related to poor diet, higher blood pressure and higher mortality, and increased chance of suffering from mental illnesses such as depression and dementia (Cacioppo, Hawkley, Norman, & Berntson, 2011; Luanaigh & Lawlor, 2008). In fact the impact of health risks caused by social isolation is equivalent to that of cigarette smoking (Iliffe et al., 2007). Older men perceived themselves marginalised due to material deprivation and health decline which in return can aggravate their emotional and health status (Dolan, 2007).

2.7. The long-standing impact on family networks and friends

Older men and women who live in their home have been shown to have higher levels of social support than people living in care homes (Andrew, 2005). It is not clear whether the reason for this reduction of social connections is related to moving into care homes or whether older peoples' social capital had already declined because of health deterioration by the time they moved into the care home (Freedman, Berkman, Rapp, & Ostfeld, 1994; Rockwood, Stolee, & McDowell, 1996).

Furthermore, the trend towards the decline of social networks of family and friends is predicted to continue after older people have moved into a care home (Gaugler, 2005; Parmenter, Cruickshank, & Hussain, 2012; Port et al., 2001). It has been found that after people move into a care home, there was a reduction of almost 50% of phone calls and visits from residents' family members even after controlling for the distance to the care home (Port et al., 2001). Family members' and friends' visits had a further substantial reduction after living in the care home for four years or more (Parmenter et al., 2012). However, the degree of reduction of social contact from family and friends has been found to be unequal; with size

of social network, socio-economic factors, ethnicity and gender as explanatory factors (Bear, 1990; Parmenter et al., 2012).

This finding suggests that reciprocity plays a key role in sustaining social connections. Residents who received financial assistance from the state in the US were likely to have a more persistent social network because the residents' networks were more involved in providing material support and for the resident (Bear, 1990). According to Bear (1990), this was because the family member had to be more involved in the care and looking after the resident's interests and wellbeing. There are suggestions that being active and reciprocal in their network whilst mentally and physically fit provides long standing social networks because their friends and relatives would feel obliged to be in touch and give assistance when they become frail (Parmenter et al., 2012).

Another important factor for visits and face-to-face contact is the geographical distance between residents' external network (family members and friends) to the location of the care home (Bear, 1990; Parmenter et al., 2012; Port et al., 2001). Residents tended to move into care homes located closer to where their family members lived. This often reduced the number of visits from resident's friends because of the transport barriers (Bear, 1990). In contrast, residents in care homes located in the same area where they were born and lived most of their lives had a higher frequency of visits by relatives and friends (Parmenter et al., 2012). The decline of the support of family and friends after moving into the care home highlight the importance of developing new social ties within the care home group.

2.8. Social interactions amongst residents

A number of quantitative studies using observational methods have concluded that care homes are settings deprived of social interactions in which the majority of residents spent most of their time without any type of interaction (Sackley, Levin, Cardoso, & Hoppitt, 2006). Indeed, there is evidence that residents spend most of their time in social and emotional isolation (McKee, Harrison, & Lee, 1999).

Nevertheless, residents do socially interact with each other from time to time and qualitative research has identified that these interactions were reciprocal and caring (Powers, 1991; Reed & Roskell Payton, 1997). There is growing evidence that social interactions have a positive effect on residents' quality of life (2006; Bradshaw, Playford, & Riazi, 2012; Cooney, Murphy, & O'Shea, 2009) and their wellbeing (Bergland & Kirkevold, 2006). For example, Bergland & Kirkevold (2006) concluded that residents who forged positive relationships with their peers and took part in meaningful activities were more likely to have a 'thriving life' in the care home and had greater wellbeing (Bergland et al., 2006 : 601). However, a quantitative based study in three care homes found no associations between residents' (n=64) wellbeing and self-rated friendships levels nor with levels of social activities (McKee et al., 1999). The essential features in social interactions between residents are discussed below.

2.8.1. Talking

Qualitative studies have demonstrated that the most common 'activity' for residents was talking (Andersson, Pettersson, & Sidenvall, 2007) and the most common topic for conversations was about their impressions of living in the care setting (Gutheil, 1991). Social occasions might influence the subject of conversations amongst the residents. For example, Philpin, Merrell, Warring, Gregory, & Hobby (2011) explored the mealtimes in two care home settings using different qualitative methods (interviews, focus groups and observations) and reported that the main subject of conversation during the meals was mostly limited to food. Barnes, et. al., (2013) reported similar behaviour. Talking at the mealtimes included exchanged greetings and pleasantries that were observed as a way to 'make conversations' (Curle et al., 2010).

2.8.2. Humour

Humour has been observed as common interaction by residents in varied ways with different purposes. Using an ethnographic approach in two different care homes, Hubbard, Tester, & Downs (2003) observed that humour was employed by the

residents to deal with their own frailty. The study observed that humour was used in negotiating meanings and to dissipate concerns about health and the possibility of death. Also, humour was manifested through practical jokes and teasing by referring to sexuality. Practical jokes included non-verbal interactions that implied the sharing of meanings amongst the residents (Hubbard, Tester, et al., 2003). However, humour was also used to express aggressiveness between residents through the use of jokes and teasing which implied 'sarcasm, jeering, or making fun of a resident that was perceived as hurtful' (Pillemer et al., 2011 : 28).

2.8.3. *Aggressiveness*

In a focus group study with 103 participants (96 care staff and 7 residents) based in the US, screaming and yelling were noted as the most common form of resident-to-resident aggression (Rosen et al., 2008). Aggressiveness was also manifested through discrimination towards their peer residents who presented different behaviours such as wandering at night time or who had cognitive impairments. Residents in this instance labelled their peers with such behaviours with names such as 'idiots', 'stupid', and 'funny types'. This labelling was used by the residents to distance themselves from their peers who did not display conforming behaviours (Hubbard, et. al., 2003 : 110).

2.8.4. *Sexuality*

It has been argued that care homes environment may reduce the possibilities for residents to express their sexuality (Zeiss AM & Kasl-Godley J, 2001). Sexuality and the expression of affection has been framed in two different ways according to the cultural context of the care. First through *open affection* (holding hands, kissing) in which residents acted as romantic couples or sexuality was expressed. In this situation, couples were labelled by the residents and care staff as 'boyfriend' and 'girlfriend'. Second, through flirtation in which residents used social interactions, both verbal and non-verbal communication that had sexual connotations (Hubbard, Tester, et al., 2003).

A qualitative study in a nursing home in Tel-Aviv using semi-structured interviews concluded that the majority of residents who took part in the study (16 women and 15 men) were in favour of openly discussing issues related to sexuality with health professionals (Aizenberg, Weizman, & Barak, 2002). Although this finding may not be transferable to the UK and requires further investigation, it challenges the traditional view of the population of care homes as asexual (Elias & Ryan, 2011). Elias & Ryan, (2011) concluded in a systematic literature review that there is consistent lack of rigorous research regarding sexuality in care homes.

2.8.5. *Spaces*

Hubbard, et al., (2003) argued that the communal areas of the care home were socially divided with certain areas for people with cognitive impairments and other areas used by residents able to engage in conversations. This research however did not explore what those spaces were and how this social division of space occurred. Several studies of mealtimes reported that the material conditions of the dining rooms influenced residents' interactions with others during the mealtimes (Barnes et al., 2013; Harnett & Jonson, 2016; Philpin et al., 2011; Wikby K, 2004). Moreover, care homes which encouraged socialisation and the sharing of common spaces had higher levels of respondents reporting to have 'good friends' while care homes which did not provide social activities and left the residents to their privacy were less likely to report having good friends (McKee et al., 1999).

In terms of residents' social interactions, Hubbard, Tester, et al. (2003) provides a theoretical explanation as to how residents socialise with each other. The study argued that care homes are institutional care settings in which care staff and residents continuously produce a cultural and structural framework with shared meanings. Residents interacted with their peers according to this framework by projecting the 'self', 'labelling' and taking the 'role'. Projecting the 'self' consisted of interpreting the meanings of and interacting with others through jokes, being affectionate, being aggressive, flirting, etc. Residents reinforced their sense of self by labelling other residents who showed unconventional behaviours, i.e. naming

someone as 'stupid'. Taking the role were actions that had shared meanings such as holding hands and stroking. This study has some limitations though. There is no exploration regarding gender differences in social interactions or how sharing meanings had different connotations for men and women. Hubbard et al. (2003) ignored an essential element of residents' identity; their gender. Another limitation in Hubbard et al. (2003) is the absence of any recommendations for care practice to improve the wellbeing or quality of life for people living in care homes.

Similar studies on the topic were equally gender blind or did not represent older men's perspective as they were underrepresented in the studies. Moreover, as women are in a majority in care homes, participants on related studies were more likely to be female. Hence, the results might represent social interactions and situations related to women-to-women or women-to-men. Therefore, men overall might be overlooked in the present literature.

2.9. Social aspects of men living in care homes

Only a few studies have explored gender issues of the social lives of people living and working in care homes for older people. Such research based on older men living in care homes is limited to four studies as table 2 shows.

Study	Country	Population / Sample size	Methods	Key Findings
Andrew (2005)	UK	Community and care home based (n=1,677) and care home residents (n=2,493) at age 60+	Cross-sectional quantitative research – secondary analysis of the Health Survey for England (HSE) 2000	<ul style="list-style-type: none"> - Male residents were associated with a lack of social support; - Male residents were less likely to engage in group activities; - Older respondents and women reported higher levels of trust.
Bartlett (2007)	UK	Care home for people with dementia 1 male resident – case study	Qualitative Research Ethnographic approach (interviews and observations) Using phenomenological analysis.	<ul style="list-style-type: none"> - Social exclusion experienced by the case study resident extended to the economic, spatial and emotional sense; - The participant aligned himself with other men in the home and masculine behaviours.
Gleibs et al., (2011)	UK	Care Home Based – 6 settings 26 residents (14 female, 12 male; age: M = 86.06, SD = 7.94, range 70 to 90 years) 21 men (age 60 to 99 years)	Quantitative Research (intervention) Measurements: five-point Likert scales were used to evaluate: <i>Identity</i> (measured using scales of social identification with others and personal identity; <i>cognitive ability</i> and <i>well-being</i>)	<ul style="list-style-type: none"> - The results showed a clear gender effect by taking part in the meeting club. Women maintained the same levels of well-being and identification through the intervention. -men experienced a significant reduction in depression and anxiety, and an increased sense of social identification with others. -Building new social relations through group memberships in the form of gender clubs can counteract the decline of wellbeing, particularly among men.
(Moss & Moss, 2007)	US	Nursing Homes – 5 settings 21 men (age 60 to 99)	Qualitative research - In-depth interviews	<ul style="list-style-type: none"> - Men's identity was centred on their past work experiences; - The sense of couplehood amongst married men defined how they saw themselves amongst the residents. - Men tend to regulate their relationships with other residents

Table 2. Studies related to social aspects of men living care homes for older people

Analysis of the Health Survey for England (2000) found that older men living in care homes had lower levels of trust than women and were less likely to take part in group activities within care homes (Andrew, 2005). This might suggest that older men living in care homes are more likely to be at risk of social isolation than women. Using qualitative research, Moss & Moss, (2007) sustained that most of the men tried to distance themselves from the group in a care home by deliberately not seeking, or by avoiding, close relationships with other residents. Men's tendency to distance themselves from their peers is because they struggled to socialise with people from different backgrounds and people with cognitive impairments (Moss & Moss, 2007 : 50). Men distancing themselves from the group might explain their risk of isolation within the care home social group.

Masculine identity was also an important component in how men tend to socialise in care homes. Qualitative studies on masculine identity had theorised that men maintain their sense of identity from their working life and professional experiences (Bradley, 2013; Thompson, 1994). In the same manner, studies involving older men living in care homes found that their past work life was an important topic of conversation amongst male residents (Savishinsky, 1991 in Davidson, 2004) who often have fresh memories about their work experiences even after many years of retirement (Kaufman, 2000). However, the inability to work anymore and the constant reminiscence of this subject has been found to cause despair amongst some men (Moss & Moss, 2007).

Pleck (1975) argued that men's sense of identity was not orientated towards socialising by talking and speaking about their feelings. On the contrary, men are inclined towards 'doing' things by sharing activities, experiences and interests as a way to socialise. Hence the decline of physical and mental capacity for men living in care homes and the perception of living in an institutional setting was particularly challenging for men's socialisation and wellbeing.

An intervention called the Gentlemen's and Ladies' Club involving social activities for residents in care homes (Gleibs et al., 2011; Gleibs, et. al., 2014; Gleibs, et. al.,

2010) has highlighted the importance of the gendered activities for men's social lives and the positive impact on their wellbeing. Published in different papers, this research employed mixed-methods to measure and explore an intervention with 26 participants (12 men and 14 women) living in six care homes for older people in the South West of England. The intervention consisted of regular meetings for the residents organised by gender groups every fortnight to undertake different activities (watching movies, visiting museums, having meals). These activities led to a reduction in anxiety and depression and an increase in life satisfaction amongst male participants of the club. Interestingly, women who took part in this experiment did not improve their wellbeing. For male residents who were in the transition of moving into a care home, the Gentleman's Club worked as a mechanism to enable a sense of control over their choice, relieving the feeling of being psychologically and physically 'stuck' in the new environment (Gleibs et al., 2014).

Similarly to the Gentlemen's Club in care homes, there are other examples of gendered interventions which increase social interactions for men living in the community in the UK and other countries and these had impacted positively on the wellbeing of their participants. These interventions have been successful in mitigating social isolation and improving wellbeing as the participants were able to create and maintain social ties with their male peers. These interventions employed DIY activities such as gardening and carpentry as a vehicle for men to socialise (Batt-Rawden & Tellnes, 2005; Golding, Foley, Brown, & Harvey, 2009; Milligan, Payne, Bingley, & Cockshott, 2015). The Gentlemen's Club intervention suggested that the participants increased their sense of identity (Gleibs et al., 2010 in Gleibs et al., 2011 : 462). Men's sense of minority has been noted in another study in which residents mentioned the constraints to socialise with other men due to the lower numbers of male residents and the fact that for a good portion of these residents socialisation was challenging due to cognitive impairment (Moss & Moss, 2007).

Although Gleibs et al., (2011) provided relevant findings on how to improve men's wellbeing in care homes, it had limitations. The study was unable to establish causation between the variables, i.e. social identification and depression. Furthermore, as the content of the results relied on quantitative results (with qualitative data mentioned in other papers), there is no explanation regarding why or how men benefit from socialising in gender groups. The study does not examine the importance of activities for men's socialisation within the club. Although the Gentlemen's Club produced interesting results, it is a type of event which can be costly and difficult to implement depending on the geographical area where the care home is located. Perhaps investigating everyday practices within the care home could improve men's wellbeing in addition to such interventions. Finally, the mentioned study excluded people in advanced stages of dementia.

Evidence produced from a single study based in one male resident (one case study) living in a large care home for older people showed that men with dementia benefited and enjoyed meeting other male individuals, residents and carers, and having the opportunity to align himself with masculine behaviours (Bartlett, 2007).

Another important aspect that defined men's identity in care homes was having a wife. Based in the US, Moss & Moss (2007) investigated the lives of 21 older men in two nursing homes in end of life care through interviews.. Moss & Moss (2007) argued that the married men in the study had a different association with the rest of the residents in the care home and this was due to their wives' presence. The study concluded that the marriage ties for men were essential for men's identity in the care home and often reduced their association with peer residents. However, married men whose wife lived in the community helped them to be more connected to the outside world. When the wives lived in the same setting, there was a tendency for the couples to segregate themselves from the social life of the care home (Moss & Moss, 2007).

As shown above, there are only a few studies which are dedicated to the social lives of older men living in care homes. The results of those studies are based on a

limited amount of data. Most of the studies were based on interviews and quantitative measures which explored residents' own perspectives of how life is for men in care homes. The methods employed by those studies were likely to exclude people in advanced stages of dementia. In this respect, only Bartlett (2007) provided an insight in to how men with advanced stages of dementia tend to socialise.

For some time social science and sociology has tended to focus on the social world of older women due to the fact they are in the majority compared to older men living in the community (Hearn, 1995). The consequent gerontological feminisation of the literature created a 'blind spot' in the literature regarding older men's social experiences (Fleming, 1999 : 4; Fleming, 1999; Fennell et.al., 2003) coined as 'the invisible men' in ageing studies. This highlights the comparatively little research related to older men, including the social context of their lives. Hence it is not surprising that there is limited knowledge about the social aspects of men living in care homes for older people. The research presented in this thesis aimed to investigate residents' gender differences in socialising within the context of care homes, how male residents tend to interact and organise their social lives within the care home social constraints, and how this might affect their wellbeing.

2.10. Summary

The literature review presented in this research highlights that older men have lower social capital and smaller social networks than women which can lead to them experiencing social isolation. The literature review highlighted that knowledge regarding gender differences in care homes for older people is limited. It presented what is known so far about the social aspects of men living in care homes and stressed that the social aspects around older men living in care homes has been mostly neglected in social and health research. The present research in this thesis aimed to address these gaps in the literature regarding men and their social lives in care homes for older people. In the next chapter, the methods

undertaken in this research are specified in order to fully answer the research questions.

3. METHODS

3.1. Introduction

This chapter presents the methods selected for conducting the study. It starts by outlining the research paradigms and my choice of qualitative methods. I then explain my decision in adopting ethnography as my overarching approach and define the theoretical underpinnings of my research enquiry which includes constructionism and reflexivity. It describes the planning and procedures for sampling care homes and participants and how I gained access to the settings.

Ethical issues are discussed for doing research in health contexts of care homes for older people and the inclusion of vulnerable adults in the research. The fieldwork is then explored through reflexive accounts of my impact in the settings and the process of data generation. The chapter ends by describing the analytical process employed.

3.2. Research aims and questions

This research in the present study aimed to explore and understand the social processes that unfold in care homes in which residents socialise from gender perspectives. The focus of the study is to understand how male individuals socialise and integrate in care home communities and the potential effects on their wellbeing overall. The study examined how men and women used the different spaces according to social activities or opportunities and highlighted the gender differences in the care home in structuring their social routines during the day. The research questions aim to address the gap in knowledge about the lives of older men living in care homes and to produce insights which can inform care practices for this population and improve their wellbeing. This research sought to address the following research questions:

- 1. How do male residents socialise in a care home for older people?*

2. How do residents shape their social relations in terms of gender?

3. How does the predominance of women in care home environments impact on male residents' social experiences and their sense of wellbeing?

3.3. Research paradigms

During the design phase of my research I was concerned with applying methods which were sensitive to the cultural aspects of men and women living in care homes for older people. More specifically, I was interested in exploring and understanding how male residents socially fit in these environments and whether there were gender differences in socialising and adopting different life styles amongst the residents. To this end, the methods selected for collecting data aimed to produce a detailed examination of social events and the use of spaces in the care homes to understand the social structures that men and women used to create a sense of normality in their social lives. The design of this research was informed by the disciplines of sociology and ethnography.

Social research entails two main methodological approaches: quantitative and qualitative. Quantitative research is based on measuring concepts such as attitudes by using statistical models to quantify the social phenomenon (Carter, 2000). Quantitative research is guided by reductionist, determinist and deductive principles and is based on positivist epistemology which seeks to produce laws of cause and effect (Parahoo, 2014). This research approach also assumes that the nature of the social entities (ontological proprieties of the social phenomenon) are external to the social actors (Bryman, 2012). However, given the nature of the research questions guiding this study it was decided that a quantitative approach would not be appropriate.

In contrast to the quantitative approach, qualitative research approaches enable the researcher 'to access the processes by focusing on the context of people's everyday lives where such decisions are made and enacted upon it' (Barbour, 2014). Qualitative approaches are described as an umbrella of research

approaches which can investigate the meanings of the social actors through their behaviours, perceptions, intentions, motivations and beliefs (Parahoo, 2014).

The ontological assumptions about the social world requires the researcher to make conscious choices and to not assume there is only one reality (Mason, 2002). Since this research was concerned with the social and cultural contexts of care homes for older people, it entailed understanding people's actions and the meaning they attached to these actions when going about their daily lives. Such evidence is not available 'out there' (Mason, 2002). My understanding of the social phenomenon in this study followed the idea that social actors continually assemble social meanings through their actions and behaviours within the cultural boundaries of the group. This epistemological stance is constructionist and is based on actions and interactions of individuals and their discourse (Holstein & Gubrium, 2008). Knowledge gained through the constructionist perspective also refers to the idea that meanings and knowledge are constructed through the interactions between the participant and the researcher (Parahoo, 2014). Having settled on the epistemological and ontological approaches, the main characteristics of the ethnography and the model applied in this research are now explained.

3.4. Ethnography

According to Brewer (2000 : 10), ethnography consists of '...the study of people in naturally occurring settings of fields by means of methods which capture their social meanings and ordinary activities, involving the researcher participating directly in the setting, if not also the activities, in order to collect data in a systematic manner but without meaning being imposed on them externally'. Perhaps, the most distinct trait in ethnography is that it provides a first-hand experience of the social world for the researcher (Atkinson & Coffey, 2001), unlike other methods based on what some have referred to as the 'grab it and run' approaches (Gobo, 2008) in which the data is generated within a framework defined prior to the data collection.

My choice for using an ethnographic approach was determined by the research questions that sought to understand what social processes enabled the male residents to socialise with the care home community. I adopted gender as a theoretical framework to examine how closer relationships are established between male and female residents. Ethnography also enabled me to explore to a certain extent the impact of social interactions on the wellbeing of male residents.

Other research approaches such as phenomenology were considered for this research. However, such an approach is focused exclusively on individuals' interpretation of their experiences and how they express them (Parahoo, 2014). An ethnographic approach however allowed me to explore and generate knowledge regarding the cultural aspects of social groups within care homes and examine the social process that structure residents' lives. However, this type of qualitative approach does not exclude the individuals' interpretations as in the case of phenomenology, but these interpretations were complementary to the main analyses and results. Importantly, the choice of an ethnographic approach allowed for the inclusion of people with cognitive impairments who represent the majority of the population living in care homes for older people.

Hence, by adopting an ethnographic approach I was able to acquire an insider standpoint or *emic perspective* (Fetterman, 1998 : 20) of how people socialised day-to-day while I continually analysed the social interactions of the group members in order to achieve *etic perspective* (Fetterman, 1998 : 22).

This study did not adopt the naturalist ethnography model which is concerned with elucidating the insider's accounts of those being researched. Rather, this research employed a constructionist approach which aims to investigate the social phenomenon by looking at 'how do people do things?' rather than 'how do people see things?'. The constructionist ethnography model (Silverman, 2011 : 150) is orientated towards exploring how the processes are assembled by the actors in the setting, which is different from the aims of the naturalist model which is concerned with asking what the meanings are for the participants in the field. Constructionism

aims to understand ‘how social realities are produced, assembled and maintained’ (Holstein & Gubrium, 2008 : 375). Table 3 compares the constructionist model employed in this research to the naturalistic ethnography adapted from Silverman (2001 : 152)

Constructionist ethnography
- focus on everyday procedures and routines (rather than asking ‘what is going on?’)
- exploring how ‘reality’ is assembled (rather than getting inside social reality)
- examining narrative constructions (rather than understanding meanings)

Table 3. Constructionist ethnography model compared with the naturalistic model

The constructionist approach also aims to explore participants’ perceptions and meanings when this is relevant to understand how they construct their everyday lives.

3.5. Reflexivity

Reflexivity refers to the attitude of thinking about the social process in the field that affects the data, including the ethnographer’s own impact on the participants in the field (Brewer, 2000; Silverman, 2011). It demands a critical attitude from the ethnographer and acts as a bridge that links the interpretation of the data to the ethnographic text (Brewer, 2000).

Reflexivity can be categorised into two main branches: descriptive and analytical reflexivity (Stanley, 1996). Descriptive reflexivity relates to the impinging factors which shaped the data such as the location of the setting, the power relations between the ethnographer and the participants, his/her role in the setting, and the sensitivity of the topic studied. Analytical reflexivity refers to the examination of ontological and epistemological properties of the research results and demands an intellectual examination on the changes of the processes of interpretation (Stanley, 1996).

The examination of the different elements of the reflexivity provides an insight into the conditions of the research and the internal articulation of its claims. Reflexivity therefore, allows the reader to assess the credibility of the research findings (Brewer, 2000). Thus, reflexivity in this research has a significant role for the trustworthiness of the research findings.

3.6. Participant Observations

I employed participant observation as one of the methods for the data collection in this study. 'Participant observation' is defined as a method that allows the researcher to observe and experience the phenomenon by immersing himself in the setting to generate first hand data (Hammersley et. al., 1995; Mason, 2002). It involved '... gathering by means of participation in the daily life of informants in their natural setting: watching, observing and talking to them in order to discover their interpretations, social meanings and activities' (Brewer, 2000 : 59).

I chose participant observation because I was interested in the ways the social phenomena occurred in the context of the setting through experiencing and engaging with the participants in the research. Non-participant observation was discarded as an option because it would not have allowed me to interact and infer people's understanding in constructing their social world. Participant observation in this research aimed to focus on residents' daily activities, routines, social encounters and conversations. It was intended that the social encounters included social interactions between residents and also between residents, visitors and care staff. Observations were to be used to generate ethnographic data about residents' behaviour and their verbal and body language as well. These observations would also include my reflexive impressions of the settings and participants, and their interactions with me. Moreover, participant observations also aimed to include people with limited cognitive capacity. It was anticipated that great care was required to ensure these conversations were conducted in a respectful and sensitive manner to everyone involved in the research which comprised the

assessment the appropriate opportunity and space to engage the residents, care staff and visitors in the care homes.

Following preliminary visits to one care home, the plan was for the observations to be mainly performed in the communal areas of the settings – in the spaces which were accessed by all residents, care staff and visitors. These spaces were the lounge, the dining room, the entrance hall and corridors of the care home setting. Regular events such as the mealtimes, group activities and sitting times designed to promote residents' social interaction in those communal areas were also included during the observational periods. Therefore, observations were designed to be focused on generating data on the residents' social interactions and the use of different spaces.

Participant observation requires the researcher to actively engage with the actors in the setting (Hammersley & Atkinson, 1995; Mason, 2002). Having a clear role enabled me to have a 'function' in the care homes which would help me to immerse myself in the setting (O'Reilly, 2005). As I did not have any professional training in working with older people living in care homes, I chose to adopt the role of a 'volunteer' while undertaking the fieldwork. In this way, the role enabled me to interact with all individuals in the settings while I helped residents with simple tasks in the communal areas of the care home. The volunteer role was not to include any tasks which required formal training. For example, the tasks would consist of talking to the residents when they wanted, reaching objects for the residents, helping the staff with any task which was unrelated with residents' care, serving food and drinks, and helping with recreational activities by supporting residents in performing the tasks.

The volunteer role was designed to blend or immerse myself in the setting while creating rapport with participants. The researcher's role in ethnographic research varies from 'complete participant' to 'non-participant' (Spradley, 1980). I planned my role in the setting as 'moderate participant' (see table 4) as I intended to be fairly interactive in the setting although being a volunteer did not have an essential

function in the setting compared to the role of a care worker which would lead to a 'complete' or 'active participant' role.

- | |
|---|
| <ul style="list-style-type: none"> • Complete participant • Active participant • Moderate participant • Passive participant • Non-participant (as observer with no interaction, often with a concealed role) |
|---|

Table 4. Classification of roles in participant observations (Spradley, 1980)

I chose not to adopt the role of a 'non-participant' since my research was conducted overtly throughout the fieldwork and I interacted with people in the settings.

3.7. Informal interviews

In addition to the participant observation, 'informal interviews' (Fetterman, 1998 : 37) were selected as a method to investigate how men in the care home, particularly male residents, interacted with others in the settings. The informal interviews were designed to consist of unstructured and casual conversations with interviewees regarding the underlying elements of the research agenda (Fetterman, 1998). Interviews were designed to collect data by exploring the social lives of men living in care homes. Male residents' life stories and their reminiscing accounts were included as a topic in the interviews as this information was expected to provide further depth and nuance to understanding how men socialise in the care home and with their network of external support – family members and friends. This method would allow me to engage in conversations with the participants in which I could explore different aspects of their social lives by asking 'how' questions about their social habits and routines. For example, during the interviews I would prioritise the social processes and routines during the mealtimes by asking how the male residents chose their seats at the tables in the dining room.

Thus, the observations, conversations and interviews aimed to investigate the social process of how people constructed their everyday lives.

3.8. Selecting the settings

During the research design phase I accessed a care home for older people to assist in preparing the methods of data collection. Gaining access to that care home allowed me to gain familiarity with residential care for older people as I had no previous experience working in this type of setting. This helped me to design the strategy for selecting sites and planning the sampling of observation hours and selection of male residents as case studies. Moreover, I anticipated that that this care home would take part in the data collection after I gained ethical approval from the relevant research authority. However, by the time I received ethical clearance for data collection, this setting was no longer interested in taking part in the research as the managerial team had changed.

Residential homes vary greatly for the type of care provided to residents - from those providing qualified nursing care to the care homes that look after people due to age-related disability to the care homes that specialise in the care of people with dementia. The rationale for including more than one setting in this research was to understand broad social elements of the people living in care homes regardless of the care provided by the different care homes. Including more than the one care home in the research was intended to enhance the transferability of the research findings. Another important reason for performing a multi-site ethnography was to increase the numbers of male residents in the research as their presence in each care home was limited.

The sampling strategy for the selection of settings was based on the type of care provided with the aim of sampling care homes with different care environments through purposive sampling (Mason, 2002). The three care homes included as study sites were as follow:

- *Beech Home* – a care home that cared for people with advanced dementia, therefore the residents were under a high level of supervision including restricted access to bedrooms during the daytime;
- *Cedar Home* - a care home with nursing care assistance in which most residents had physical impairments and often experienced mobility restrictions although the home also cared for people with cognitive impairment;
- *Oak Home* - a care home in which most of the residents required lower levels of care, and were therefore able to live more independently and have more control over their social lives and structure of their daily routines.

Table 5. Characteristics of the care homes recruited for the study

To select and contact potential care homes for the study I used a catalogue published by the local authority in the South of England which listed all 56 organisations providing care for older people in one local authority in which I could feasibly travel to. I excluded all care homes which were smaller than ten beds and provided specialised care for certain conditions such as alcoholism, drug addiction and learning disabilities. Using the criteria for inclusion, 29 care and nursing homes were considered for the study.

I approached 12 organisations in person to recruit the target number of three care homes. The care homes were recruited between Jun 2015 and March 2016. The recruited sites fitted the sampling criteria as planned in the research design.

3.9. The initial research design and subsequent changes in the fieldwork

The initial research design was based on a number of ‘case studies’. Each case study was to comprise a male resident and their social network inside the care home (close care staff and peer residents) and outside the care home (family members and external friends). The intention was to use the case studies to generate an in-depth understanding of how male participants perceived, interacted and sought support from their network. The case studies would form the units of the study and each case would be analysed by their intrinsic qualities with a focus on their

‘particularities and ordinariness’ of each case study rather than making generalisations that went beyond each case (Stake, 1994).

Figure 1 specifies the types of data collection (participant observations and interviews) in the different spaces in the care homes and the different participants who were involved in the data collection.

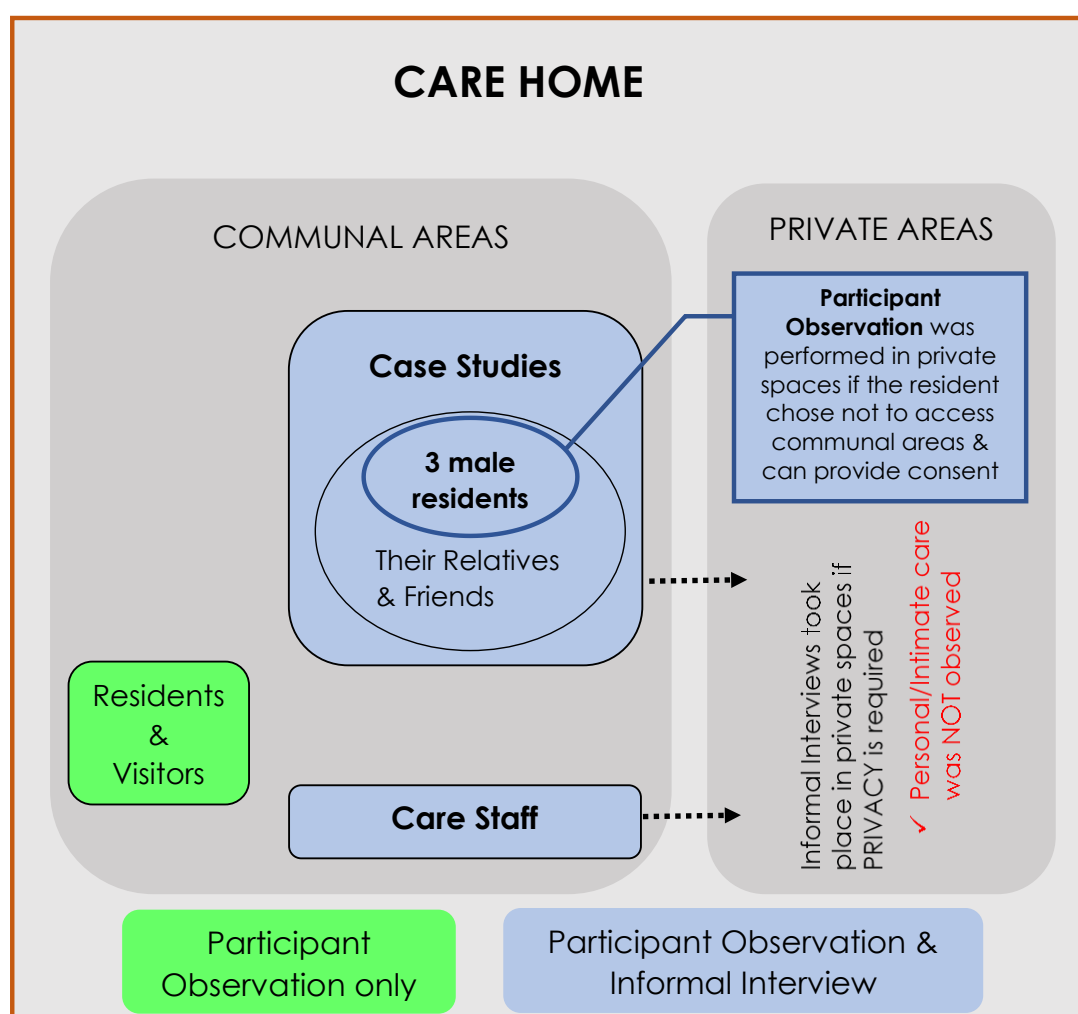


Figure 1. Illustration of the study design where participant observations and informal interviews took place

However, in the early stages of the data collection I found several impediments to developing the research based on case studies. While collecting the data I noticed that the male residents were mostly absent from the communal areas while the women’s presence was greater. This reduced the chances I had to observe and

interact with male residents in the communal areas of the care homes in Oak and Cedar Homes. Moreover, I found it challenging to establish rapport with the male residents and found that in comparison with the female residents that they were less likely to engage with me as volunteer. These difficulties are further reflected upon in the reflexive accounts section later in this chapter.

In some cases, the male residents agreed and signed the written consent form to take part in the research, but they avoided further contact with me during the data collection and declined to undertake the interviews. Only two male residents fully engaged with the research whereas my original target was nine individuals. As most of the male residents did not seem keen to engage in the research, I considered it unethical to approach their visitors knowing that the residents themselves seemed uninterested as this could have created potential distress for the participant. For the male residents who were actively engaged in the research, there were some practical issues that I did not foresee when initially planning the data collection. The family members and external friends visited the residents sporadically and often unannounced or at short notice. Thus, I had no opportunity or little time to organise and attend the visit for the observation. During the whole fieldwork in the three settings, I managed to observe only one visit.

Facing the difficulties in collecting data regarding the case studies, I made some important alterations in the sampling and design of the research. While male residents avoided the communal areas of the care home, some of the females spent long periods of time in those spaces. Thus, I changed the case studies from male residents and their social network as units of the research and adopted the different spaces of the care homes, communal areas and male bedrooms as the units of the study presented in this thesis. Male residents who were initially sampled as case studies became 'key informants' and they remained fundamental for the research enquiry although no longer served as units for the study. This allowed me to produce transferable explanations about the residents' gender differences for the use of the communal areas in the settings and how men utilised their bedrooms and structured their social lives within the care home group,

especially with other residents. These changes had important consequences for the analysis and the ethnography and they are further explained later in the analysis section in this chapter.

The rationale for the sampling of observation periods was to cover the different routines in the care home from 0900 hours to 2000 hours, across weekdays and weekends. As I observed during the initial preparatory work the residents spent most of their daytime in the communal areas, engaging in different routines during the day which varied throughout the week. The routines comprised activities such as mealtimes (breakfast, lunch and dinner in the dining room), recreational-times (comprising social activities involving music, craftwork, games, quizzes) and sitting-times (socialising with other residents, having beverages, reading or simply resting while in the TV lounge). The data collection schedule was initially organised into three-hour observation slots.

The period of data collection and number of participant observations are described in the table below:

Care Homes	Data collection periods	Observational hours	Interviews
Beech Home	10/08/15 to 25/10/15	89	3
Oak Home	09/11/15 to 04/02/16	91	9
Cedar Home	06/04/16 to 22/07/16	86	5
TOTAL	10 months	266	17

Table 6. Dates and durations of observations and interviews

3.10. Recording the data

The data recorded during the participant observations consisted of making jottings in a pocket handbook. The jottings consisted of short notes about the events and conversations I made in the field as shown in appendix A. These notes about key conversations and events served as a reminder when writing the detailed fieldnotes (Emerson, Fretz, & Shaw, 2011). The jottings were written in areas away

from the participants, to avoid any disruption, uneasiness, or upset (Hammersley et. al., 1995). Although on some occasions I made the notes in front of residents after seeking their permission as an indication that I took his or her opinion seriously. The residents on these occasions usually dictated the content of his or her narrative which I interpreted as a sign of the residents' engagement in the research (Hubbard, Tester, et al., 2003). I did not adopt such a strategy with the care staff as I noticed certain uneasiness on the few occasions that they saw me taking notes in the setting.

The fieldnotes were written as soon as I left the setting in order to reduce the likelihood of failure to accurately recall the data (O'Reilly, 2005). Appendix B provides an example of the fieldnotes produced during the data collection. The fieldnotes consisted of chronological accounts of the events, participants, conversations and the descriptions of the objects in the settings which I found relevant to the research. The fieldnotes were organised by the date, time and space in which the observation took place. My fieldwork notes comprised reflexive accounts about my impact on the fieldwork, how I interacted with the participants, how they reacted with my presence, their expectations and disappointments (O'Reilly, 2005). The fieldnotes included drawing maps that represented residents' geographical positions in the communal areas of the care home and myself. The progress of the fieldwork, changes to the research design and analytical thoughts were recorded in a journal written separately from the fieldnotes.

3.11. Reflexive accounts

Reflexivity was an essential instrument in evaluating how I interacted with participants and impacted on the fieldwork. According to Gobo (2008), fieldwork in ethnography refers to the time in which the researcher is immersed in the field during the data collection process. Thus, the researcher's immersion into the field is an open-ended, reflexive and iterative process in generating the data (Spradley, 2016). The fieldwork is a term used here to indicate the whole process of data collection that comprised the observations and interviews.

During the fieldwork, I constantly monitored how my presence might be affecting residents' wellbeing and the work of the care staff to evaluate if my presence was causing problems. In this regard, I was particularly aware of intruding on residents' privacy and whether my interaction or presence caused any burden to those in the setting. This required negotiating sensitively and sensibly with the participants and assessing if my presence was appropriate to the welfare of the residents.

My personal characteristics and background impacted and shaped the fieldwork to some extent. I am a male Brazilian who speaks with an accent as English is my second language. I was in my early forties when I undertook the fieldwork for this research. During the fieldwork, I was conscious about and reflected on how my social background shaped the way people reacted and engaged with me. Not sharing the same cultural references (I had lived in the UK only for the past eight years) was sometimes a barrier to interacting with residents. For example, I found it difficult when participating and helping residents in events such as quiz games as the questions usually involved cultural topics related to the UK with which I was unfamiliar. The participants, and especially the residents, were curious about the way I spoke and invariably they commented or even enquired about my background. However, rather than avoiding or suppressing such topics of conversation, I used this as the way to create rapport and engage with people in the settings.

Sharing my personal information with the people in the three care homes facilitated building rapport, and in return, they sometimes shared information about their lives. Talking about myself and 'Brazil' was particularly useful when approaching the male residents. However, in most of the cases I struggled to engage and create rapport with men living in the settings as the conversations with those individuals did not flow as easily compared to the female residents. When conversing with the men I found it necessary to find some element of common ground to speak with them about, hence talking about Brazil or my life in the UK helped me to build rapport with the men living in care home.

Other subjects of conversations gravitated towards this research as some male residents became highly engaged in the study. Another topic of conversation was sport, despite my own lack of knowledge of this area. This was in contrast to how I engaged with the female residents. The female residents, in contrast to the male residents were more likely to initiate conversations and ask me questions. The conversations and questions were most of the times personal to me – *are you married? Do you have kids? Do you have a dog? Your ears are quite small!* This type of intimacy is part of the analysis and findings, but it had a great influence on how the participant observations unfolded differently with women and men living in the care homes. Moreover, my gender defined how the fieldwork evolved, especially when interacting with male residents. My role as a volunteer varied in each care setting, largely due to the different health impairments and needs of the residents in each home. Also, the level of support that each care manager provided greatly affected my role in the different settings. The care managers, as gatekeepers, were important in helping me to access and develop relationships with the staff, residents and visitors. Reflexive accounts related to each care setting are presented in sections 4.2.5 (Beech Home), 4.3.4. (Oak Home) and 4.4.4. (Cedar Homer) of the next chapter.

3.12. Conducting the interviews

Interviews were conducted to understand how male residents constructed their routines and socialised with others in the settings while undertaking different activities. The topics guiding the interviews were selected from the participant observations. Additionally, the interviews were also used to explore in-depth the lives of the key informants (male residents). I encouraged the resident to direct the interviews if the resident wanted to speak about a specific subject such as to reminisce about their lives.

There were some difficulties encountered in performing the ethnographic interviews. Some of the interviewees had speech impairments and frequently I struggled to understand some of what they were saying. On these occasions, I

asked the interviewees to repeat words or sentences but often I could not recognise what they were trying to tell me. Hence, I avoided interrupting them further because these interruptions seemed to irritate or frustrate the residents and interrupted the natural flow of the conversation. However, that strategy meant that I continued the interview without catching certain segments of the conversation or the ideas that they wanted to convey. During the reading and listening of the interview transcripts I found a number of missed opportunities that I could have explored further or where I could have re-oriented the interview.

The use of the voice recorder in interviews tended to inhibit the interviewees' from talking. I often noticed a stark difference as soon as I switched on the device and the flow of conversation changed as the resident sometimes constrained his answers. To overcome this problem, I tried as much as possible to engage in casual conversations while I informed the resident about the device and gained his consent to record the interview. My strategy was to divert their attention from the recording device while setting it up by engaging with conversations which I believed were relevant to them.

The use of the recording device also had a major effect on residents with poor health. One of the male interviewees had frail physical health caused by Parkinson's disease. He spoke with difficulty in a low voice with long pauses. The interviewee agreed to record the interviews but in the first minutes of the interview I noticed that the interviewee struggled to speak and became breathless. I then terminated the interview and switched off the recorder. Within a few minutes the resident recomposed himself and he confessed to me that the recorder disturbed him. As the resident was an important key informant for the research I wanted to record the interview rather than producing notes, so I could generate richer data. Thus, I devised a strategy to record the interview without impacting on the residents' wellbeing. I explained to the resident that I would make notes in the interviews, however, I would record the interview as a 'backup'. The resident agreed with my suggestion. During the interview, I held a notebook and pen close to me to show that I was making notes throughout the interview while I

placed the recorder some distance from us. I regularly said to the interviewee to 'hold on' or 'just a minute' while I was taking notes. I did this, not out of necessity for my note taking, but purposely to make sure that there were lots of pauses and breaks so that the resident would not become tired or out of breath. These brief pauses allowed the resident to continue the interview without feeling he was taking too much time to speak. While I was taking notes, the interviewee would sometime try to repeat the words said earlier, showing his rapport with me and the desire to contribute to the study.

I reflected on the ethical implications of my strategy with that specific interviewee. Although there is an element of deception in my practice I believe I was not causing any sort of harm to the interviewee, nor was I restricting his rights. Indeed, on all occasions that I applied that strategy I gained informed consent to record the interviews. In my view that strategy allowed the resident to engage more in the research as he seemed keen to lead and take part in it and I was able to generate more complete and accurate data which proved to be helpful in producing the findings of the research.

The wellbeing of the residents was an important consideration in conducting the interviews. For example, I did not disclose my 'etic' views (the researcher perspective) to verify whether my preliminary interpretations in the fieldwork about men's social lives were sound (Brewer, 2000). For example, in my preliminary conclusions I found that men were more isolated compared to women. In my view, sharing this interpretation could potentially harm the participant, hence I did not share my interpretations and avoided taking any risks. Nevertheless, the interviews impacted on residents' perceptions of their social lives. In one of the interviews I explored with the interviewee how his closer social group socialised at the meals. He described the meetings in a rather vivid way which contrasted with my observations on those occasions. During the observation on the day after that interview I noticed that the interviewee made an extra effort to speak with his group which was usually silent most of the time. I believe that my question was

related to the interviewee's behaviour change as he became aware that his social life might not reflect what he had reported to me the day before.

3.13. Leaving the fieldwork

As the research plan specified, I ended the fieldwork in all three settings by saying good-bye to all of the residents I had met. I gave each resident in the care home a 'thank you' card with their name in it. For residents with advanced stages of dementia I had to help the resident to open the envelope and read or explain the content of the card. Although it was not my intention, some of the residents became very emotional with this gesture and the fact that they would not see me anymore. Nevertheless, my hope was that such a gesture would minimise the negative impacts of me leaving the setting. At the same time, I said good-bye to the care staff who were working during my final visit. I gave a box of chocolates and a card to each staff team in each of the three care homes

3.14. The analysis process

3.14.1. Data organisation

While writing the fieldnotes I reflected on the circumstances that unfolded in the field. These reflections were recorded in a diary. While in the field I tried to examine the social patterns of people while undertaking different activities according to the spaces in which they occurred. These first reflections allowed me to approach the research critically and helped me to explore the issues through in-depth interviews and ethnography. The fieldnotes were stored and manipulated electronically using NVivo 11 qualitative software. Eighty-five fieldnotes entries were written in total.

Many ethnographers support the idea that the analysis is a process that starts with the fieldwork. Brewer (2000) and (Bogden & Biklen, 1982) suggest that the analysis in ethnography occurs in two phases: the analysis in the fieldwork and the analysis after the data collection when general codes, categories and arguments are

developed. An initial analysis in this sense was undertaken during the fieldwork in order to guide the data collection and build the primary units of the analysis. The data collection in fieldwork were part of the initial analysis as I had to select what I considered relevant as data for the ethnography. However, initially I lacked adequate focus in selecting the relevant observations as data in the fieldwork. This led me to record too much information from the fieldwork which was redundant and time consuming. In the subsequent stages of the fieldwork I developed greater focus in observing and recording fieldnotes with accuracy and precision without the inclusion of unnecessary details. The interviews were digitally recorded in audio format and transcribed into text for the analysis with the fieldnotes.

3.14.2. Coding the data

The analysis began by coding the data. This process is not only useful to organise the data for the next stages of the analysis but also to become familiar with the whole dataset (Boeije, 2010). The codes were used to identify the patterns in the data (Braun & Clarke, 2006). I adopted the following principles when building the coding framework in the following order (Emerson et al., 2011):

- i. the coding identified patterns related to the processes (events, activities, relationships) which took place in different spaces (the dining room, lounge, bedroom) observed in the fieldwork.
- ii. a focus on the individuals' practical concerns and how they habitually acted out their daily lives.
- iii. a focus on the individuals' views and understandings of these events and processes.

The first wave of coding was based on 'open codes' (Bryman, 2012; Denscombe, 2010; Emerson et al., 2011; Sarantakos, 2013) formed around practical situations involving routines, actions, talking, etc. Table 7 shown how I created open codes in the data. The table uses fieldnotes from the dining room in Cedar Home during the mealtimes:

OPEN CODES	FIELDNOTES
<i>Interactions at the female table</i>	Saying hello to the residents at table B – I asked Sandra <i>how are you, okay?</i> and Sandra replied to me: <i>I am not sure</i> and then Mary said: <i>and I agree with that!</i> looking at me with a mischievous smiling. I smiled back to Mary and then asked Mary how she was this morning and Mary said with wit <i>not any better than any other morning!</i>
<i>Silence at the men's table</i>	I said hello to the guys at table A (the men's table) and Paul replied <i>yeah, fine</i> and the Terry replied some monosyllabic answer. Then I tried to initiate a conversation but soon fell into silence. I felt uncomfortable with that situation and soon moved to another table of residents (table B)
<i>Description of the lunch meal</i> <i>Interaction – working (staff)</i>	The lunch today was running on time (12:15) and the 6 carers were gathering in front of the kitchen hatch waiting for the meals to be prepared one by one, while the kitchen staff and the carers engaged in humorous conversations and most of residents were in silence. The carers seemed relaxed while waiting (or patiently waiting for the meals to be ready). The conversations amongst the carers alternated between work to personal life. One of them was explaining her experience in the town centre in previous days which prompted laughter amongst the other staff and the cook. The staff told a story: <i>I got lost in the town yesterday, can you believe it? I don't know how I managed!</i> and laughed. I believe the story should be a funny tale because the town centre is relative small, but it could have other reasons. Terry seemed to pay attention to the conversation and the subsequent conversation and teasing from the other staff.
<i>Interaction - talking (staff)</i> <i>Silence at the men's table</i>	

Table 7. Open codes derived from the data

In a second stage of the coding process, I grouped the open codes into units which comprised elements from one specific phenomenon. The grouping of the initial codes was based on data related to routines undertook in different spaces of the care homes (events such as mealtimes, recreational-times and sitting-times), and the social interactions, verbal and non-verbal from residents, care staff, visitor and myself. Importantly, the coding was also organised by the gender of the residents to address the key points in the research questions of this study. For example, I produced a code 'men's table relation' which grouped other sub-codes such as:

silence; conversations; sport talking and humour. The codes were organised by units named as 'nodes' (different spaces) and 'child nodes' (the activities undertaken in each space). Each type of activity was clustered into the child nodes. Figure 2 shows the partial tree of the nodes and child nodes on NVivo 11 software:

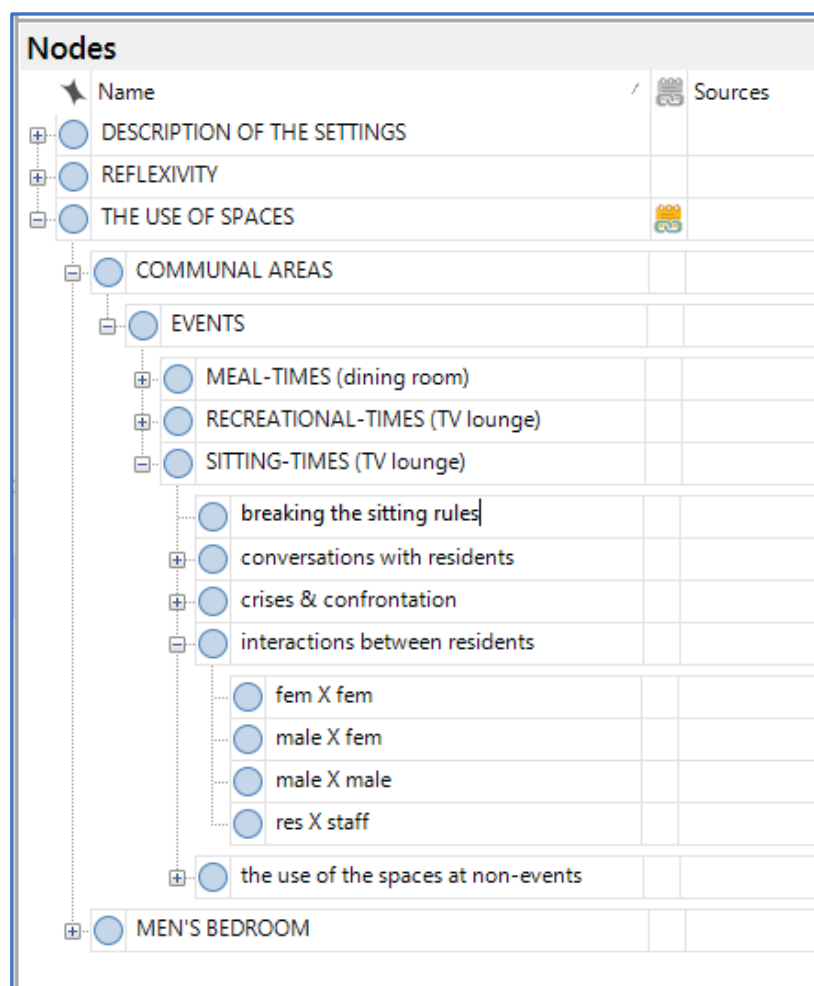


Figure 2. List of codes displayed on NVivo 11

Appendix C in this thesis includes some examples of how the data was grouped under the nodes developed in this stage of the analysis.

3.14.3. Developing themes and writing up

In this phase I turned my focus to exploring possible patterns within and between the units of the broader coding system. The patterns were further analysed in order to develop them into themes. The preliminary themes were organised in a thematic

table as shown in appendix D. Several flow charts were created during this phase to visualise and test possible ideas as a strategy to develop the analysis. Appendix E provides an example of these charts. At this stage, I identified the themes which I believed generated relevant answers to the research questions (Coffey & Atkinson, 1996). The initial stages of the data interpretation were solely inductive, however, as the interpretations and development of the concepts and theories progressed, I used a deductive reasoning by applying theories to broaden and reinforce the research claims. This type of reasoning has been termed as an abductive research strategy (Blaikie, 2000) which is a reasoning that moves between theory and data in a dialectical process (Mason, 2002).

My analysis used some of Goffman's concepts and ideas to interpret the findings presented in this work. The first of Goffman's concepts used in my analysis referred to the idea of 'impression management' which supports the idea that people use different strategies and practices to portray an adequate image to others depending on the audience and situation. Invariably, we as social beings '... divide ourselves up in all sorts of different selves with reference to our acquaintances.' (Mead, 1962 : 142). In my work, for example, I interpreted male residents' presentation of their selves in terms of what they wanted to project to their closer social group, usually all men, in contrast to their more distant contacts, usually female residents. The idea of 'self' in the context of impression management is essential to understand how I generated my analysis. The concept of the 'self' in my findings is not related to the individual's internal thought processes and the image of themselves. Similar to Goffman's conceptualisation, the self in this thesis is related in how someone presented him or herself to the others, the particular 'demeanour' of someone in conducting him or herself and the 'deference' that his or her demeanour evoked on others (Appelrouth & Edles, 2011 : 200). Analysing the demeanour of the gender patterns led to an exploration of two different main avenues for how men and women living in care homes socialised: amongst female residents, I looked at how closer relationships were negotiated, a phenomenon that I named *shared intimacy* which meant that the female residents engaged in conversations about varied topics including talking

about their feelings and personal matters. Amongst male residents, I looked at how the male residents adopted traditional masculine behaviours by avoiding closeness between themselves, thus adopting *impersonal conversations* and or by adopting *shared activities* as the strategy to socialise.

The analysis contained in this thesis also employed some elements of Goffman's Dramaturgical Theory (Goffman, 1990). More specifically I looked at how resident's interactions were like theatrical performances as residents behaved differently accordingly to the *social situations* and *regions* (Appelrouth, et al., 2011 : 202). The term regions (which I referred to as 'spaces' in this thesis) is related to the distinct types of territories that I concluded existed in care homes. There were two different spaces in the care home. The communal areas such as the lounge and dining rooms which I argued in the findings chapters had a more public nature. In the communal spaces residents had less control over those environments while they had an 'audience' (Goffman, 1990 : 110) to interact with and observe them. The audience was composed of the individuals who access these spaces: residents, carers and visitors and as such, it required the individuals to put on a 'performance' 'front stage' (Appelrouth et al., 2011 : 216). The individuals' bedroom regions formed more reclusive and private spaces as the residents had greater control over the bedroom and because there was an absence of an audience for most of the time. The analysis showed that the bedroom scenery enabled the male residents to experience back stage moments in their bedrooms during which they could relax and be themselves (Goffman, 1990 : 104). The use of Goffman's work in this study highlights the importance of ordinary day-to-day actions which are often taken for granted and assumed to have no relevance (Crow, 2005). Indeed, the analysis in this study is occupied with actions and interactions of the participants to reveal how men and women living in care homes tend to socialise and how this impacts on men's wellbeing.

The ethnographic data and analyses in the findings chapters were structured by first providing an introductory paragraph for each main section. This introductory paragraph aimed to give an overview to orientate the reader. Thereafter, the data

were presented with the analytical commentary. The findings chapters were written in the first person to highlight my input in the fieldwork and reflect how this might have shaped the results. I tried as much as possible to fully and fairly represent the participants' voices during the fieldwork. Cases which did not conform with the theories and concepts articulated in these research findings were presented and highlighted as negative cases.

All fieldwork excerpts mentioned in the finding chapters were identified by the type of space (bedroom, lounge and dining room), the name of the care home and the part of the day (morning, afternoon and evening) or activity in which it was observed. The interviews are identified by the pseudonym of the resident, care staff and visitor and the care home. Male and female residents were assigned fictitious names according to their gender. Male and female care workers and visitors were designated names indicated with: (S) for care staff and (V) for visitor.

3.15. Ethical considerations

This research adopted an ethos which was centred on the following principles:

- i. Conducting the whole research overtly as much as was possible;
- ii. Respecting participants' decisions during the data collection (residents, care staff and visitors);
- iii. Avoiding intrusion into residents' privacy;
- iv. Gaining informed consent of participants;
- v. Protecting the interests of vulnerable residents;
- vi. Protecting residents' wellbeing by avoiding unnecessary burden; and
- vii. Not disturbing the working routines and care provided the care staff.

Several strategies and procedures were used to ensure that those principles were respected during the fieldwork. Prior to the data collection in each care home,

there was a period of familiarisation which occurred two or three weeks before the fieldwork took place in the setting. This period of time was used to inform all individuals in the setting of the research and to provide enough time for everyone to decide whether they wanted to take part in the research or not. I used this period of time to meet and become familiar with the potential participants during sporadic visits aimed at organising the research and informing all parties of what would take place. The figures in appendix F shows all the steps that I undertook to gain informed consent from the care home organisation and all participants involved in the research. Different documents were produced to inform the people who lived, worked and visited the care homes. A poster explaining the research was put up in the main entrance of the care home for easy visualisation for everyone to become aware of the study, and leaflets were distributed in the key areas of the care home for easy consultation for anyone interested in the study (documents attached to appendix G).

Participant information sheets containing relevant information about the research were provided to the people who considered taking part. Distinct participant information sheets and consents forms were produced for each type of participant – male residents (key informants); care staff, care home managers (giving permission to access the setting for observations) and visitors. All the documents produced were to inform the participants of the research and obtain their consent and were written in plain English using lay terms (documents attached in appendix H).

A senior member of the care staff assessed residents' mental capacity which aided decisions about who might be willing to take part in the research. A 'consultee' was nominated by the care home manager for residents deemed not to have sufficient mental capacity to decide to take part, as required by the Mental Capacity Act 2005. The selected or available 'consultee' decided whether residents without cognitive capacity should take part in the research based on the residents' best interests. Participant information sheets are included in appendix H of this thesis.

I sought written consent to collect data as a participant in the research from male residents, residents deemed without mental capacity through their consultee, care staff and visitors. Consent forms are included in appendix I. Nevertheless, before I initiated participant observations in the care home I sought verbal consent of everyone found in the room where I was collecting data, this included female residents and participants who had provided written consent. In addition, a great portion of the residents considered able to decide for themselves had fluctuating cognitive capacity during the day. This meant that I reminded the participating residents about my role as a researcher and asked their permission to collect data on each occasion. I discontinued the data collection when I realised that the resident seemed unresponsive to my interactions or somewhat disorientated. In this sense, I did not rely exclusively on residents' verbal consent but also reading their body language, searching for any sign of agitation and stress.

During fieldwork I wore a badge, which stated my full name, the word 'researcher' and the name of 'University of East Anglia' and its logo. The badge identified me in the care home, especially for residents in advanced stages of dementia as most were still able to read. As the fieldwork progressed I noticed that some residents retained more information about my identity and about the study. On a number of occasions, residents demonstrated some irritation when I asked about consent, discussed my role as a researcher and the purpose of the study as they were already aware of the research and could recollect it. Therefore, I adopted certain strategies such as showing and waving my notebook to the resident when I approached the individuals and before collecting any data. In response residents reacted to my gesture by shaking their head affirmatively. Being more succinct about acquiring residents' continuing informed consent aimed to avoid burden on the participants.

My presence in the setting and interactions with residents was continuously assessed and reflected upon in order to detect whether I was being overly intrusive even in the communal areas of the care homes as these spaces constituted extensions of their home. The observations made in the male residents' bedrooms

were particularly sensitive in regard to the potential intrusion and burden for the resident. The data collection in these spaces were mostly restricted and incidental to conducting interviews. I did not feel it ethical to access the residents in their bedroom specifically to observe them. I felt that this would be too invasive to their privacy and put an unjustified burden on someone in poor health. The burden on the care staff also was considered when having conversations and interviews. I tried to minimise my impact on their work routines as this had the potential to interfere with residents' care. I only engaged in conversations with the staff when I felt it was the appropriate time and space to do so. The interviews were conducted with open ended questions asking how the care staff perceived residents' social lives and how they interacted with male and female residents. I avoided being too inquisitive in the interviews but rather engaged with the care staff in a conversational discussion.

The study sought and obtained a favourable opinion by the National Social Care Research Ethics Committee – National Research Authority (NHS) – Reference number: 15/IEC08/0039 (letter attached in appendix J).

3.16. Summary

This chapter presents the methods adopted to address the study research questions. This research used the ethnographic approach with a constructionist stance which focussed the research endeavour of how people assembled and made sense of their everyday lives. It employed participant observations and interviews in three different care homes that provided different types of care for residents.

Reflexivity was employed to assess my impact on the settings and how I produced the data in each setting. Due to the difficulties in gaining access and producing data based on cases studies of male residents and their entire social network, there were changes to the initial design of the research to focus on how men socialise within the care home social group, especially in relation to their peer residents and the gender differences amongst the residents.

My impact and role varied in the fieldwork for each care home. This also shaped the preliminary analyses during the fieldwork. The analyses used a coding framework which helped to systematically organise the data. The findings in this research are presented in the following three chapters.

4. THE SETTINGS

4.1. Introduction

In this section I provide some general information and my personal impressions of the settings in which the fieldwork took place. The descriptions contained here not only mention the material conditions of the spaces but also includes an account of how I perceived these spaces when they were used in their daily routines by residents, staff and visitors. All three care homes were located in and around a large town in the South of England, within 10 miles distance from where I was located. From my observations, all residents living in the three settings were British born apart from one individual while a large proportion of the work force in Beech Home and Cedar Home were from overseas. Table 8 shows key information on the three settings for comparison.

	BEECH HOME (Residential Care Home)	OAK HOME (Residential Care Home)	CEDAR HOME (Nursing Home)
Type of care	Care for people with advanced stages of dementia	Care for older people in general	Care for older people with complex needs (i.e. cancer, stroke)
Price range pw	£550.00 – £800.00	£900.00 – £1500.00	£820.00 - £920.00
Type of building	6 floor building adapted as a care home	4 floor manor house adapted as a care home	2 floor building, built for purpose
Number of wings	1	1	2 - <i>larger wing</i> - 33 residents & <i>smaller wing</i> – 22 residents (excluded) from the research
Number of residents	26	21	56
Number of male residents	8	9	11
Mean residents' age	87	90.5	86.7
Number of staff (carers and nurses)	19	21	29
Number of male staff	3	3	1

Table 8. Comparative information of three settings

4.2. Beech Home

Beech Home was a residential home which belongs to a business group including two other care homes; all three care homes in the group specialised in dementia care. The care home is located in a dense urban area in a building dated to the late nineteenth century on the sea promenade. As with most of the buildings in the area, the care home is located close to the street with tall buildings on either side. The communal areas of the home (front room and dining room) are located on the ground floor of the building which is below the street level; thus, from outside, the

pedestrians can see the rooms while people from inside the building have a restricted view.

I found the staff workload heavy compared to the other two care homes in my sample. The care staff did not seem to have enough time to socialise with the residents although the residents' physical and health care needs appeared to be met.

4.2.1. The main entrance and corridors

The entrance of the care home consisted of a single door on the side of the building which was secured at all times. The door leads to a narrow corridor in which there is a small table displaying a fire logbook for visitors. Above the table there is a TV screen that displays pictures and describes events and occasions involving the residents and the staff. On the same wall, there are all sorts of information about the care home, signs and awards.

The corridor extended to the right, as illustrated in figure 3, to several areas of the care home – 'front room', lift, office, toilet, stairs, etc. I felt the corridor confusing to navigate and oppressive as it was narrow, allowing only one wheelchair to circulate at a time, and had low ceilings. Besides, the corridors had no windows and it was illuminated with bright white lights which gave the ambience of an office rather than a home feeling. On many occasions I found the entrance lights switched off (especially at the weekends and early mornings or late evenings) which made the space dark and difficult to walk in. Very often, I felt the care home to be very warm and humid with a hint of unpleasant odour (especially in wintery cold days).

On the way to the lounge, there was a side board cabinet with a few old objects on the top, i.e. a typewriter. Above the cabinet, there were several large pictures on the corridor walls of the residents and the care staff on excursions and visits. The corridor was painted a light-yellow colour that looked tired, scratched and dirty in some sections.

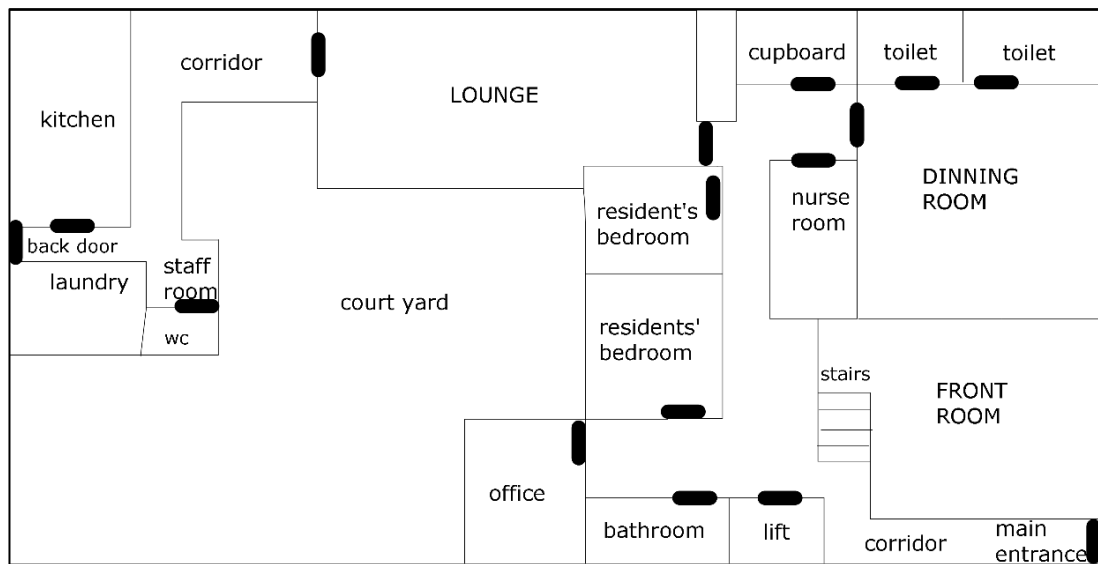


Figure 3. Beech Home ground floor plan

4.2.2. The dining room

The dining room was furnished with four round tables for the residents and an inbuilt 'bar' that was used for storing glasses and crockery. On the surface of the bar was stored a few domestic gadgets for the meal (juice container, a toaster, et cetera).

When the room was not used to serve the meals, the tables are pushed against the walls to enlarge the area for the people to circulate in the room. The room was often used by the staff for formal and informal meetings and for their paper work. Some of the residents tended to spend some time in this room during the day.

Each mealtime: breakfast; lunch (called 'dinner') and dinner (called 'tea time') would follow a different dynamic. The breakfast happened at a slower pace and over a longer time (from 9:00 to 11:00) serving no more than five residents at the same time, but I noticed that the most physically impaired would have their breakfast later in the morning. The residents sat in random seats during these occasions and were brought to the dining room after their bath and visit to the toilet. A team of carers assisted the residents to come to the dining room, while the breakfast was normally served by the porter and another carer. The porter

prepared the residents' breakfast at the 'bar area' which was then served and/or fed to residents by the staff. There were frequent conversations between the staff as they circulated in the room, including through the use of a walky-talky and conversations between the staff and residents while they were assisted and served their breakfast.

The lunch time had a different dynamic though. From 11:45 the most impaired residents were moved to the dining room and they occupied the most peripheral seats in the room (between the tables and the walls) followed by the rest of the residents. Very often the residents had to wait to visit the two toilets located in the dining room before and after the meal. This slowed down the residents' ability to move in and out of the dining room, forcing the people to queue in the corridor that accessed the dining room. Some of the residents had set regular seats while others sat in the spaces available as the carers managed and helped to accommodate the residents. The dining room space became crowded and difficult to move in once all residents were accommodated at the tables.

At around 12:15 all the meals were brought on a trolley from the kitchen, which was located at the rear of the building. The meals were served immediately and the care staff worked hectically while serving meals and assisting the residents. The lunch was normally served by two carers who would constantly walk between the bar and trolley to the centre of the room to access all residents. Once all residents were served the room became quieter as the residents ate their meals while the carers observed the residents finish their meals and walked between the tables or stood next to the bar. The carers would encourage or assist the resident to eat meals, i.e. cutting the food, reaching drinks or anything that they might want. As the residents finished their meals, the staff collected the residents' plates and served the dessert course and left the room as soon as most of the residents had finished their meals and drinks.

Before leaving the dining room, some residents visited the two toilets annexed to the dining room. Normally two or three residents had to queue for the toilet, hence

the staff asked for the residents to remain in their seats or to take a seat closer to the toilet until there was a vacant toilet. On a few occasions in the fieldwork I could smell a bad odour coming from the toilets as the residents used them, impregnating the air in the dining room and corridor. Figure 4 represents the layout of the room.

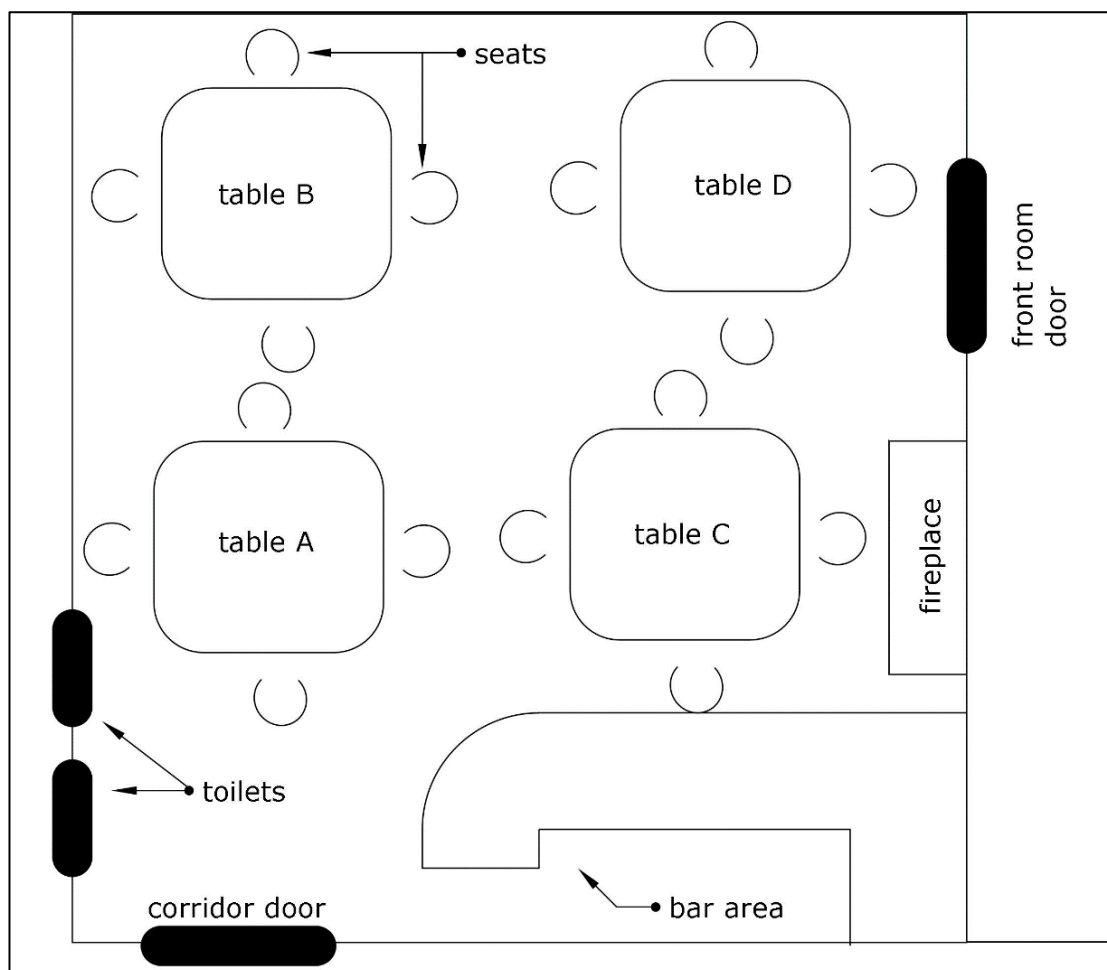


Figure 4. Beech Home dining room

The dinner time followed the same pattern as the lunch time, however, the food came on trays and each meal was assembled by one staff working inside the bar, while two further care staff assisted and served residents with a more hectic pace.

Although the room had a low ceiling, it didn't come across as claustrophobic as it was well illuminated with warmer spotlights and had windows that gave the view to the street.

4.2.3. The front lounge

The front room had two bamboo seats and rounded tables. The room was redecorated during the fieldwork. The room which had no 'theme' before the refurbishment and called by the staff as the 'front room' became the 'garden room' as the manager and senior staff casually referred to it as in conversation with me. The redecorated room had one of the walls decorated with life size image of a garden, giving the illusion or effect that a garden extended from that wall. A plastic fountain in the form of a girl was placed next to the panel with running water. There was a small section of a wooden mesh attached to the wall behind the water fountain and flashing blue lights were hung on the mesh.

The room had multiple uses. The room was used daily for recreational activities (games and craftwork). The front room also accommodated some of the most impaired residents, providing a quieter space for them to spend the day.

The room was also used to serve the lunch and dinner meals to the most physically and mentally impaired residents - six individuals. The residents in both rooms were served at the same time, although the residents who could not feed themselves had to wait until everyone was served first.

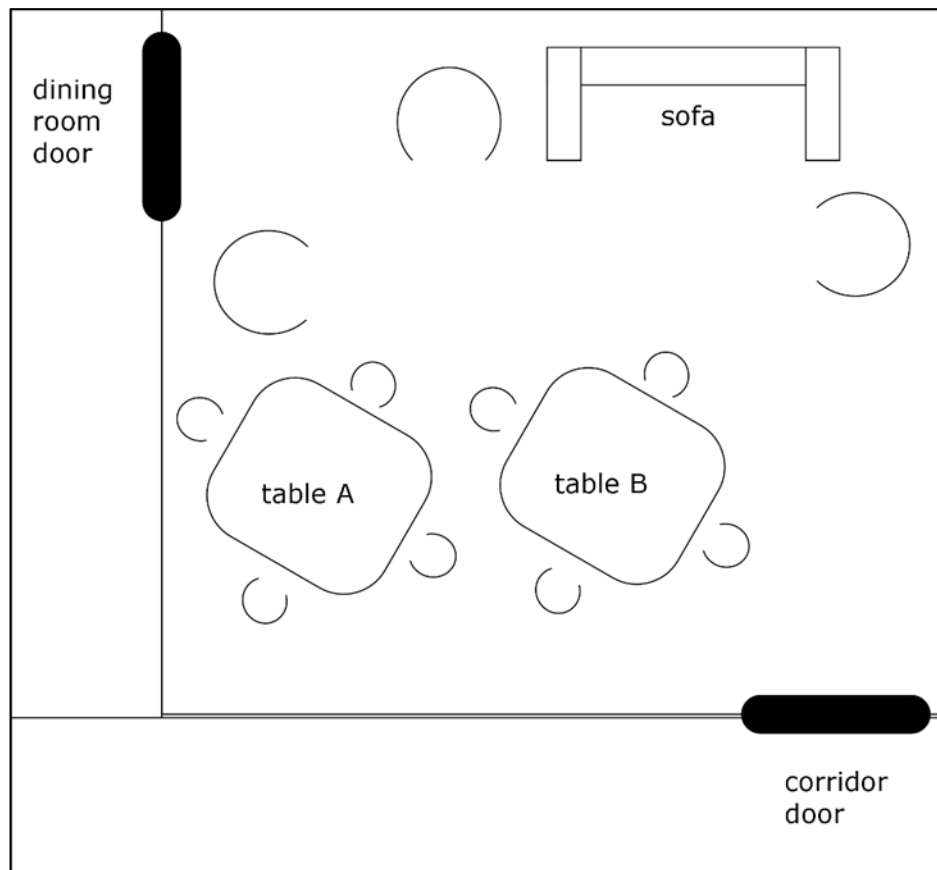


Figure 5. Front room in Beech Home

4.2.4. *The lounge*

The lounge was a narrow and long room with armchairs placed in rows next to the walls with a small coffee table between them. All armchairs were occupied when most of the residents moved into the lounge, having no space for staff or visitors to sit. The passage for people to circulate was narrower on one side of the room where there were five armchairs placed in a semi-circle, allowing one person at a time to walk between the other side of the room and the rest of the care home. The care staff tended to gather between the nursing room and this side of the room as shown in figure 6.

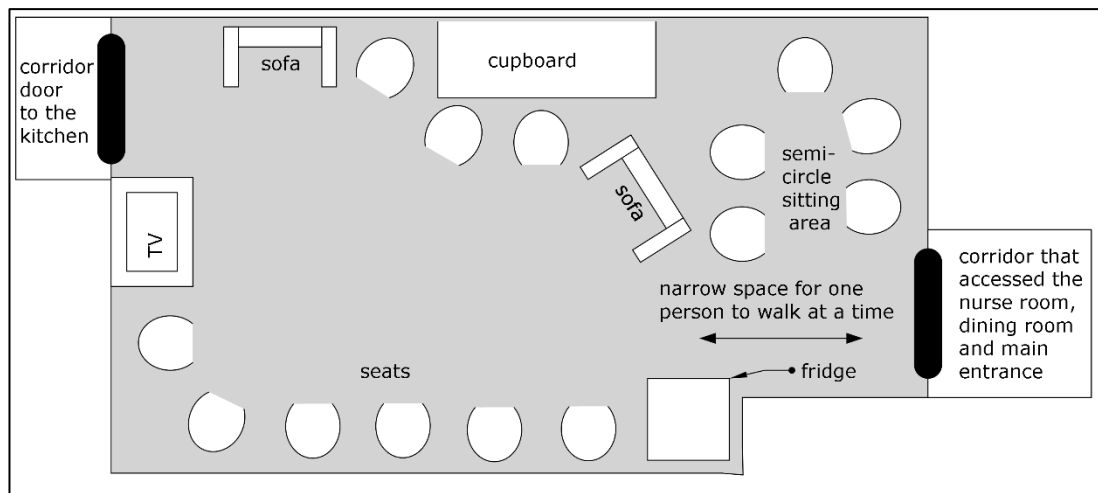


Figure 6. Lounge in Beech Home

A TV set and audio equipment were placed at the other end of the TV room and it was normally switched on at a loud volume. Most of the residents have fixed seats in the lounge or sat at the same area of the room. Most of the residents spent their day in the communal areas from 09:00 to 21:00 as they could not access the other floors of the care home without staff support, for example, the large majority of the residents were mentally and or physically unable to climb the stairs or operate the lift. Two male residents though had access to their bedrooms as they were deemed capable enough to stay without supervision in their bedrooms.

The daily routine in Beech Home was often hectic. The environment was usually noisy as the TV or audio equipment were constantly on and very often loud. Some of the residents had the tendency to keep wandering in the setting and there were occasions when they were vocal and loud. The staff were most of the time rushing to look after the residents or performing other sorts of activity, although there were times in the fieldwork that allowed them to congregate in the communal areas and socialise with the residents.

4.2.5. Reflexive accounts

There were some obstacles in engaging as a volunteer and as a researcher in Beech Home. My role as a volunteer was, overall, a useful mechanism to engage with the residents as the care staff were usually negotiating a heavy workload. The manager

of Beech Home acted as a gatekeeper and introduced me to all the residents. This was useful for me to 'break the ice' and build rapport, although some residents required me to introduce myself several times before they recognised me. However, in contrast, the manager did not introduce me to most of the care staff team. As such, I introduced myself to care staff and some individuals reacted with understandable suspicion or caution to my presence. Researcher and gatekeeper links are very often reported as being problematic to building rapport with participants (Hammersley & Atkinson, 1995).

Overall, it was easier to develop rapport with the younger and junior care staff and they were the most likely to engage with me and the research. The older and more senior staff tended to avoid me or completely ignore me. This might have been related to the way in which I presented myself and performed the participant observations. I tended to present myself in an informal, friendly and relaxed way when dealing with everyone during the fieldwork. I believe my relaxed attitude facilitated building rapport with most of the participants although some care staff may have misunderstood this as a lack of professionalism or seriousness in the research.

The crowded spaces of the communal areas in Beech Home made the process of conducting observations problematic at times. Very often there were no seats available in the lounge and this made it difficult to speak with the residents. On many occasions, there were no spaces to sit or stand during the mealtimes. When this occurred, I had to observe the mealtimes from the corridor leading to the dining room which prevented me from hearing some conversations and interactions during these events.

As a novice ethnographer, I found it hard to deal with the long periods of silence amongst the residents. There was a distinct lack of interaction between residents in Beech Home as most of the people living there had advanced cognitive and physical impairments. In my initial observations, I caught myself initiating the conversations with the residents and care staff more often than I believed I should

have. Working as an ethnographer proved to be a challenging task as I felt as though I was intruding on the people working and living in the three settings and there were uncomfortable situations regarding seemingly trivial things when I was solely observing the group: where to stay in the room? what to do with my hands? how to react? By concentrating and sometimes overplaying my role as a volunteer I eased my anxieties by keeping myself occupied with functions that naturally fitted within the social group.

In reference to Spradley's (1980) classification, my role gravitated between 'active participant' (in the initial phase of the fieldwork) to 'moderate' or 'passive participant'. The adjustments taken during the fieldwork were an integral part of my role as a researcher and required me to take on-the-spot decisions (Mason, 2002) in the three care homes.

4.3. Oak Home

The care home is part of a family business which owns another care home specialising in the care for people with dementia. The building is located in a secluded and private woodland. The care home building consisted of a manor house originally built in the eighteenth century with high ceilings and Georgian windows and doors. Previously, the building was used as a maternity hospital and in 2012 the building was restored and adapted to accommodate a care home for older people.

The care staff were all white British born. The workload of the staff in Oak Home seemed smaller than in Beech home and they seemed to have more time to socialise and provide care for the residents. On many occasions I observed the care staff congregating in the lounge of the care home as there was no staff room in Oak Home. The staff gatherings were always conducted in a friendly atmosphere. Compared with Beech home, some of the carers in Oak Home seemed to have a higher level of education, i.e. Cornelia(S) was a white British, well-spoken person who used to work as a nanny in the US before working in Oak Home. Generally

speaking, the care staff were more engaged with, and keener to take part in, the research study.

4.3.1. The main entrance and hall

The entrance door was a large and heavy and normally kept unlocked, providing the residents and visitors with free access. The entrance door opened into a glazed room that looked like a porch and had a large sofa and table in it which was used as a waiting area or reception. The porch led onto a spacious hall that gave access to the kitchen, to the lounge, quiet room, office and residents' bedrooms as represented in figure 7. The hall was an open area with high ceilings. In the hall there was carved wooden stairs giving access to the bedrooms upstairs. The hall had a large crystal chandelier in its centre and large windows in a Georgian style that let in the daylight and illuminated the room, although the lights were also kept on during the day.

The room was painted in pastel colours and was decorated with carpet and fine furniture and objects, i.e. a grandfather clock and three armchairs. The hall was a quiet place though there was a fairly constant circulation of visitors and staff. A few residents had the habit of spending some of their time in this area.

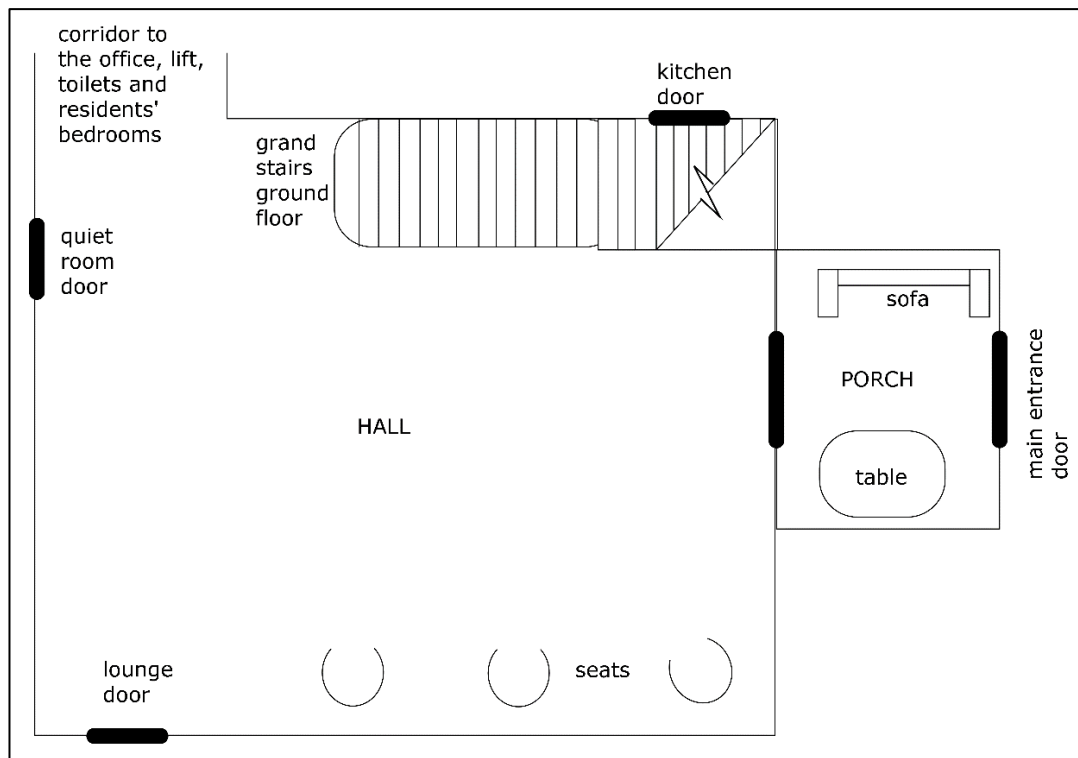


Figure 7. Hall in Oak Home

4.3.2. *The lounge*

The lounge was a large room which accommodated the TV seating area and one of the dining areas as well. Around two thirds of the room was furnished with armchairs that faced a TV set in one of the corners of the room. There were a few regular residents that stayed in the room during the afternoon and part of the evening. The TV was normally kept switched off unless there was someone watching it. The space was decorated with three smaller chandeliers making it well illuminated. The room had a fireplace in its centre and large windows on three sides of the room with views over the surrounding garden of the property, flooding the space with daylight. The room was regularly used for larger gatherings and meetings such as church choir, parties, dancing presentations and singing entertainment that usually happened every two or three weeks.

The dining area was located on other side of the room with four tables as represented in figure 8.

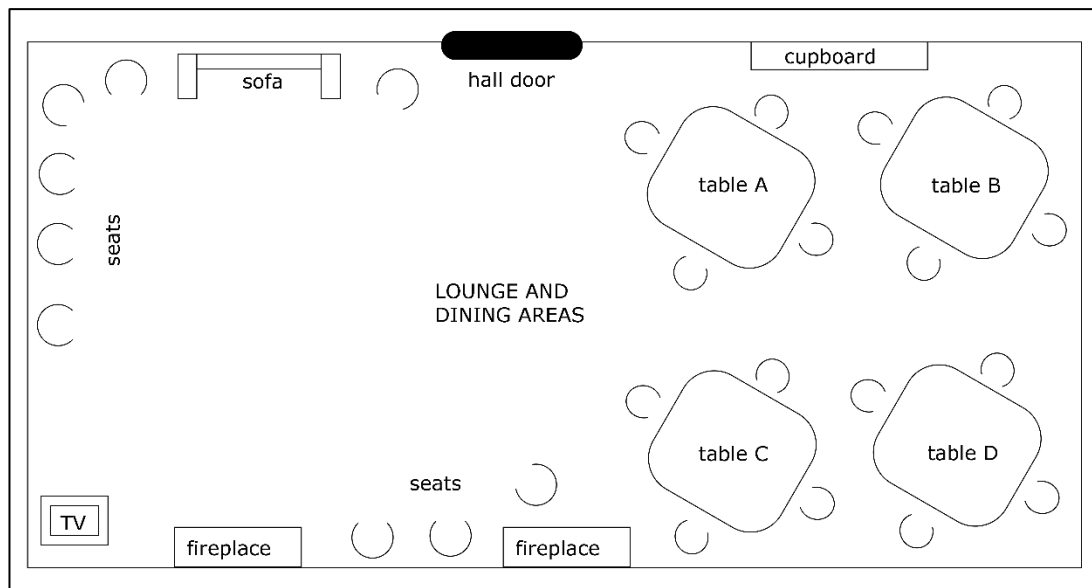


Figure 8. The lounge area in Oak Home

This area of the room was fitted with wooden floorboards while the rest of the setting had beige carpets. Social activities such as playing games or craftwork were held in this area once or twice a week. The majority of residents had their meals in this area. Breakfast was normally served in the residents' bedrooms while the lunch and dinner were served in this room or in the quiet room unless the resident chose otherwise. The residents arrived 15 or 20 minutes earlier than the meal time, normally escorted or assisted by the care staff. The room became quiet as the lunch progressed and the TV was usually switched off. The staff moved away from the room as they had to prepare the service of the next course or just waited until the residents had finished their meals. Once the lunch was finished, the residents seemed keen to leave the room and the staff supported and helped the residents to return to their bedrooms. However, three or four female residents spent most of the afternoons in this room.

The dinner followed the same routine, but it happened over a shorter time (it was served as two courses) and not all the residents attended the dinner.

4.3.3. *The quiet lounge*

The quiet lounge was located next to the lounge and was accessed through the hall. Opposite to a table there was a Georgian style high patio door that gave a view out to the gardens and illuminated the space with daylight. In one of the walls there was a fireplace and opposite, a large and heavy looking sofa that occupied the whole length of the wall. There were another three armchairs placed in the room as well which are represented in figure 9 below. A permanent group of six female residents had their lunch in the quiet room and they made constant conversation while waiting for the meals while the more residents seemed to take charge of organising the tables and looking after the less able residents. The communal areas in Oak Home were well maintained and normally calm throughout the day. The staff appeared to have a slower pace of work than Beech Home and had enough time to spend with the residents while providing support.

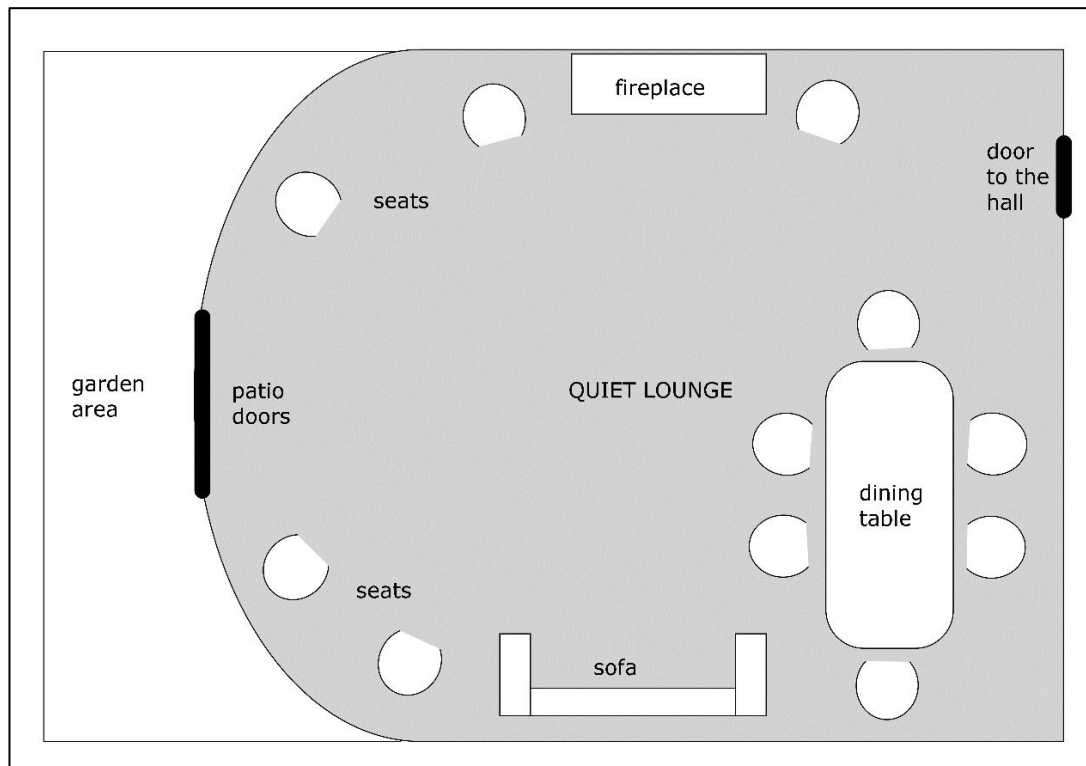


Figure 9. The quiet lounge in Oak Home

In general, the care home had a homely feel as the care home building didn't have a business layout with reception as such and long corridors. The communal areas in Oak Home did not show signs or posters about the care home business or public interest information unlike the other two settings. The only signs in the communal areas were the green fire signs on the top of the doors for evacuation. The communal areas of the care home were quiet spaces except when the care home hosted events or group activities.

4.3.4. Reflexive accounts

I recruited Oak Home by contacting the manager. The manager was supportive and enthusiastic about the research and she provided all the assistance that I required to complete the data collection. She introduced me to most of the care staff which facilitated their inclusion into the research from the beginning. She also introduced me to residents and visitors. Her constant presence in the communal areas was helpful in supporting me during the fieldwork hours. The staff grasped better the idea of my research and this in return encouraged their participation and engagement.

In contrast with Beech Home, the residents were supported to stay in their bedrooms if they wished. The communal areas in Oak Home were vacant during most of the day. Thus, I adjusted the observations by using events as the units for the participant observations - attending the mealtimes (twice a day) or recreational times (once a day, four days in the week plus special occasions) rather than the originally planned hours during the day between (9:00 to 20:00). This allowed me to optimise my time spent in the field and avoided performing observations when there was no one or very little activity in the communal areas.

My role as a volunteer was valuable to engage with the routines in the care home and create rapport with the care staff. I volunteered to perform the tasks as a volunteer in more subtle ways (helping the residents with simple tasks, serving food, etc) compared to the way that I had acted in Beech Home. As the fieldwork progressed, the manager and other care staff asked for help when someone was

missing in the work team. This perhaps reflected the trust that care staff had in me during the fieldwork.

I encountered some obstacles to observing the social events (mealtimes and recreational-times) in Oak Home. The care staff were absent during the mealtimes and I observed the group from the television sitting area which was distant from the dining tables. I found it intrusive to observe the residents in these situations despite their consenting to this. The distance from the seating area and the tables also prevented me from fully watching and hearing the group conversing. Thus, with the care staff and residents' permission I dined with the residents at different tables (seven occurrences in total) when there was a vacant seat. This allowed me to observe residents more closely while softening my impact as an observer during these events. The residents seemed glad for me to dine with them and I did not perceive any opposition from the residents or care staff on these occasions.

Overall, my role in fieldwork in Oak Home fluctuated between 'moderate participant' and 'passive participant' according to Spradley's (1980) classification.

4.4. Cedar Home

A business group own Cedar Home and another two care homes specialised in dementia care. Cedar Home has two nursing wings. The *smaller wing* looked after 22 residents and most of the residents there were bedbound and very few residents, all women, accessed the communal areas. The residents living in the larger wing did not access the smaller wing and vice versa. Therefore, I did not conduct the fieldwork in the smaller wing.

Cedar Home was located in a two storey building situated next to a busy road, although most of the building was hidden from the road by trees and wooden fences. The main entrance of the building imitated a Tudor style, however the rest of the building resembles a modern and plain construction.

The care staff were mostly white British but the presence of overseas workers was strong. The staff workload did not seem heavy as in Beech Home but the care staff

tended to provide the care in the bedrooms and were less present in the communal areas. The care staff in Cedar Home had diverse background but most were white British who had worked in this care home for many years.

4.4.1. The reception and corridors

The entrance door was secured 24 hours. A receptionist controlled the entrance door during the working hours and other member of staff provided access to visitors and residents in their absence. The reception room was a long and slightly narrow room which gave access to different wings of the Cedar Home. There were two desks in the reception – one for the use of the receptionist and another where the visitors sign in and out of the fire book log and another desk for the receptionist's work. Several ornaments furnished the room such as a lamp and mantel clock (both placed on the first desk) and paintings on the wall with landscape motives. The reception was poorly illuminated despite having the lights switched on all the time. On the wall next to the receptionist's seat space there was a board displaying signs and announcements for visitors and residents about the care home activities, health information and legal guidance. Behind the receptionist's seat, there were two matching old-style armchairs facing each other which looked battered and worn with use. Overall, the decoration and aspect of the reception room looked outdated and slightly shabby. One of the doors in the reception room led to the 'reminiscence room' which is furnished with several antique objects such as an old sewing machine and a gramophone. The room was underused by the residents and very often it was used as a storage for medication or wheelchairs.

The reception room led into two corridors, on the right leading to the *larger wing*. In the corridor of the larger wing was located a 'nurse office' which was fitted with a large window that overlooked that section of the corridor. That section of the corridor lead to the manager's office, lift, fire stairs, toilets and residents' bedrooms allocated on the ground floor of the larger wing, see figure 10 below. Although the corridor had a simple layout, the distance between the reception, lift,

dining room and lounge was quite long to walk. The corridors were wide though, allowing two wheelchairs to transit side by side.

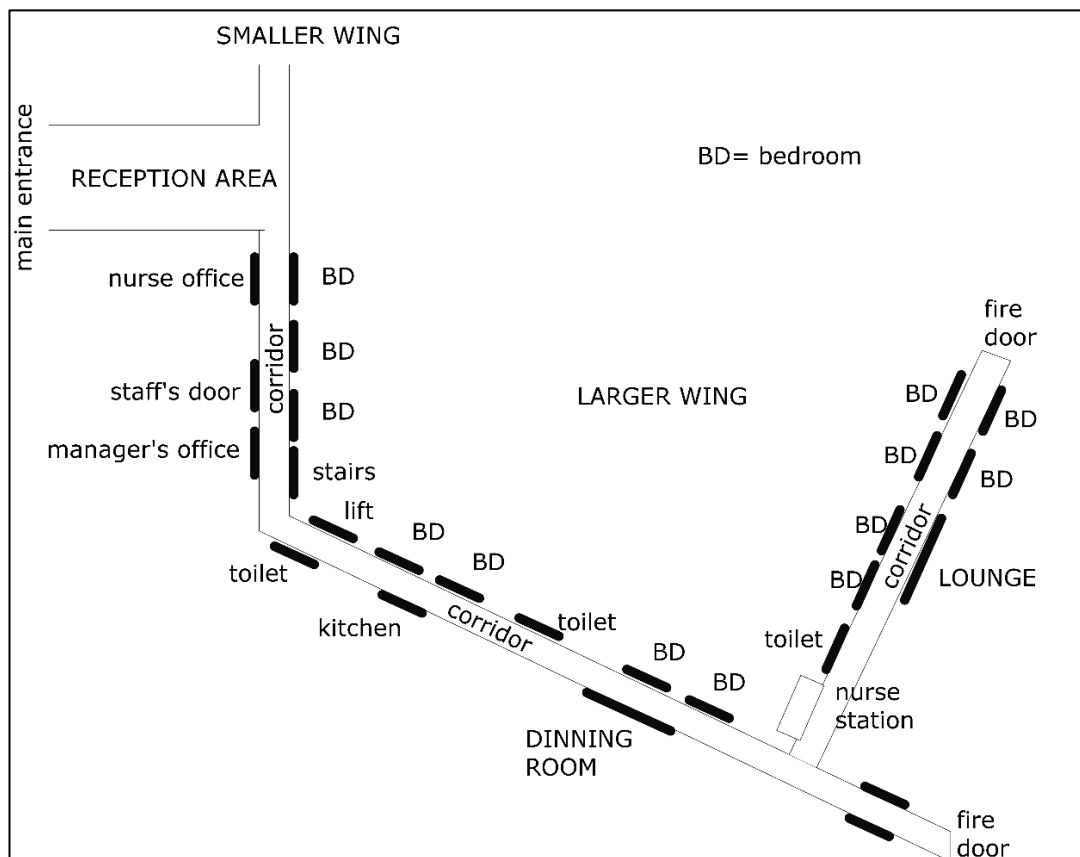


Figure 10. Reception and corridor area of the larger wing in Cedar Home

The reception and corridors were fitted with a hardwearing, thin, dark red carpet dotted with dark yellow spots. The corridors were fitted with suspended ceilings usually seen in commercial buildings (with aluminum frames and white polystyrene tiles). The corridors were kept free of obstacles though you could find lifting equipment parked in some sections of the corridor. The corridors were illuminated with artificial light as they run inside the building, hence the lights were on all the time. All walls in the nursing home were painted in light cream coloured paint from the reception, corridors, dining room, lounge and also residents' bedrooms.

4.4.2. *Dining room*

The dining room was accessed by a double fire door which was normally kept open. The dining room was a spacious room furnished with five tables for the residents to dine at. The room was decorated with two large cabinets, one side board and a display cabinet with glasses and crystal. The cabinets seemed to have a decorative purpose as most of kitchen utensils, cutlery, and plates were stored in the kitchen. A large window area and patio doors gave a view to a wall of bricks in a semi-circle shape which formed a small courtyard. Heavy floral curtains were fitted to the windows. There was a large kitchen hatch that was used by care staff and kitchen staff during the mealtimes. The hatch was large enough to provide a partial view of who was in the dining room from the kitchen, which looked like an industrial kitchen (a large metal extractor and large fridges or freezers) and staff working in the kitchen.

During the fieldwork, the room had no use between the meals. The atmosphere of the dining room changed somehow at the lunch time -12:30 to 13:15, as the room became noisier and busier with staff and residents. From 12:15 onwards the residents started to arrive one by one as most of them were assisted by the care staff. After all the residents were accommodated at their places, the staff tended to stand up waiting around the kitchen hatch (normally four to six individuals). Depending who was working, there were lively conversations between the care staff and the kitchen staff with laughs, humorous exchanges and sometimes theatrical gestures. The room became noisier and livelier with all sorts of noise as the wait for the meal advanced with conversations, crockery noise, the radio sound from the kitchen and the constant loud buzz from the alarm located on the corridor next to the dining room door that went off for long periods of time. When the meal was served the room became quieter as residents were eating. This silence was broken as the residents finished their meals and gradually left the dining room.

As the meals were served one by one, the room became quieter as the carers left the room to serve the residents who were in their bedrooms. The room became

impregnated with the food smells at this point. Usually two care staff stayed in the dining room to assist the residents to eat their lunch. They would feed the residents who could not feed themselves, while supporting the others who might need any other kind of help. Only a few residents (two or three) had their breakfast and dining room.

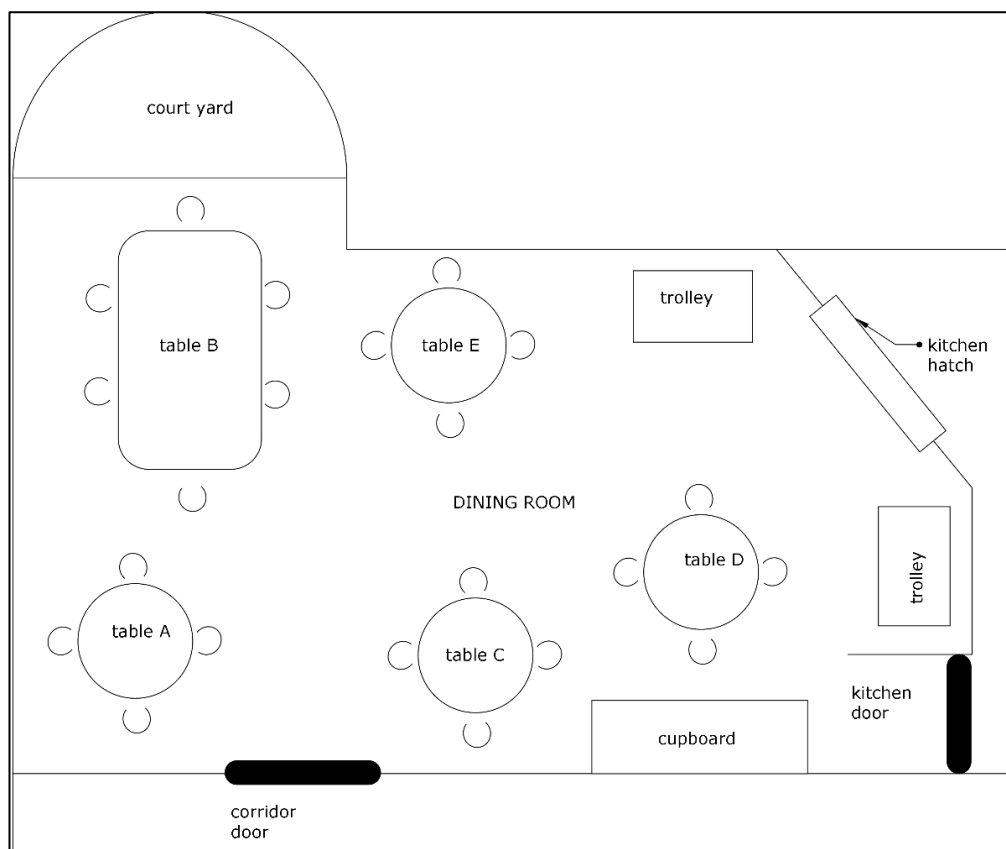


Figure 11. Dining room in Cedar Home

4.4.3. Lounge

The lounge was a large room, triangular in shape with a large window area that provided a view to the enclosed garden at the back of the property. The room was furnished with two sofas near to the entrance. There were ten armchairs allocated around the window area for the residents' use although these seats were rarely fully occupied. There were other sets of sofas placed in other parts of the room and normally used by the visitors. In the middle of the room there were two tables and chairs at which residents used to do craftwork, play games and read.

A large television was placed in the corner of the room which was normally switched on during the whole day. There were two columns placed near to the centre of the room, which combined with the furniture, partially obstructed the view across the room. There were four display cabinets and desks placed against the wall for decorative purpose only. On the left side of the room, there was a pile of board games stored under and around one of the desks. In the same area a bucket and a few boxes of bird food also lay around making the space look cluttered and isolated from the rest of the room.

On the left side of the room there were two trays placed outdoors near to the windows. Bird food was deposited in the trays for the birds and squirrels to feed during the day. In general, the communal areas of the care home did not resemble someone's 'home' but the soft furnishing in the communal areas (carpet, ornaments and furniture) softened the nature of the setting, albeit the sanitisers fitted in strategic places might contradict this perception.

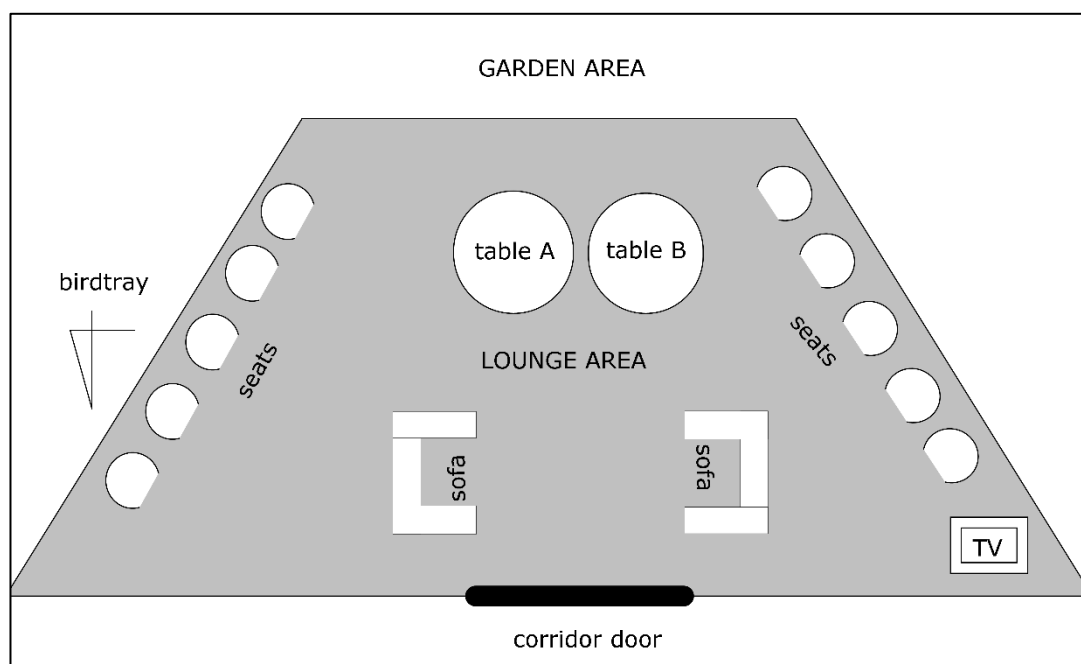


Figure 12. Dining room in Cedar Home

4.4.4. Reflexive accounts

I experienced a different dynamic in the fieldwork that took place at Cedar Home. The care staff, visitors and residents were not as engaged and I received the highest number of refusals to take part in the research, particularly from care staff. The large size of the nursing home might have contributed to this. Also, the head manager who secured my access to the setting as a gatekeeper was usually absent from the communal areas, hence I did not have her support when recruiting and interacting with the care staff. Similarly, as happened in Beech Home, the gatekeeper did not introduce me to the care staff team, hence I introduced myself and this might have negatively affected how the care staff perceived me. The nursing home was the largest of the three study sites and employed the highest number of carers and nurses. This also made it more difficult for me to recruit participants and establish rapport, although there was a group of carers on specific working shifts who became more involved in the research as the fieldwork progressed.

During the mealtimes the dining room appeared overcrowded by the number of carers working or waiting in this room. Nevertheless, the crowdedness of the room facilitated my presence during the observations in the mealtimes as I became just another person standing up in the room (or that was my perception). In the fieldwork in the other communal areas of the home I managed to participate more and get involved with the residents by performing my work as volunteer. The care staff did not spend much of their time in the communal areas, hence I was more useful to residents in these areas. My role in the Cedar Home fieldwork consisted of being a 'passive participant' for the majority of the time in the fieldwork (Spradley, 1980).

4.5. Summary

The descriptions presented in this chapter provides an overview of the material conditions, routines and practices which the residents experienced. These descriptions illustrate the context for the observations, conversations and

interviews generated in the fieldwork in each care home. The following three chapters presents the findings.

5. THE LOUNGE – MEN’S ABSENCE IN A GENDERED SPACE

5.1. Introduction

This chapter reports the findings related to gender differences in how men and women living in care homes used and interacted in the lounge spaces and what the effects were on their wellbeing. The lounges in the three care homes were spaces to which all residents had free access. These spaces had different functions: they had televisions and were socialising spaces (residents, care staff and visitors), they also served as working spaces for the care staff and a space in which residents were cared for. The lounges had similar uses in the three care homes although in Beech Home the lounge was more intensively used as care space as the majority of residents did not access their bedrooms during the daytime because they were in advanced stages of dementia. The lounges also hosted different social occasions and activities during the daytime such as group activities. Group activities involved residents undertaking different types of activities which were coordinated by a member of the care home staff. These activities involved craftwork (sewing and flower arranging), singing sessions, games and quizzes. The care staff encouraged and facilitated residents’ integration into the group during the activities. Sitting-times refers to different activities that the resident could undertake such as talking, reading, drinking tea, watching the TV (which was rare), looking at the garden, dozing or just waiting.

The findings in this chapter are divided into four sections: section 5.2. provides an overview of how female residents in Cedar and Oak homes socialised in the lounges during sitting-times and created feminised spaces; section 5.3. analyses how men with poor cognitive abilities socialised in the communal areas of the care homes; section 5.4. presents the findings about men in the lounge during sitting-times and section 5.5. explores how men usually engaged in group activities.

5.2. Creating feminised spaces by enacting 'shared intimacy'

This section reports the findings in relation to women's social interactions in the three care homes. Residents used the lounge spaces to pass parts of their mornings and afternoons informally as sitting-times (as defined above). In care homes which supported residents to remain in their bedrooms during the day if they so choose, as was the case in Oak and Cedar Homes, some of the female residents made habitual use of these communal spaces during the sitting-times. In contrast, men were largely absent from the lounge spaces. Female residents who spent time in the lounge (although rarely for the purpose of watching the television) in Oak and Cedar care homes took steps to organise and control the seating arrangements in these spaces by maintaining fixed seats that were exclusive to those individuals. The residents' geographical positions in the room enabled them to maintain social ties with their favourite companions.

Female residents used 'shared intimacy' as a device to socialise and spend the day during the sitting-times. 'Shared intimacy' consisted of social interactions which involved closeness by using verbal communication (sharing feelings, comforting each other and expressing their opinions about themselves and others freely) and non-verbal communications, such as touching and eye-contact. *Social watching* was also activity engaged in by residents during the sitting-times and consisted of observing the people in the lounge such as residents, care staff and visitors when present. Women with advanced stages of dementia presented *dyad relationships* through shared intimacy and noticeably by physical touching as explained later in this section.

The sitting-times in the lounges in all three homes were divided into two periods; mornings and afternoons. However, this division of time was most noticeable in Beech and Cedar Homes where the residents required closer care supervision or physical support in their daily routines. In Oak Home only two residents required closer attention and support to walk and they spent most of their time in the lounge while the rest of the residents stayed in their bedrooms. Thus, the

routinisation and division of sitting-time periods seemed to affect residents who required greater care and assistance.

During the morning period, which was shorter (usually one to two hours) the residents moved to the lounges after they undertook some tasks in preparation for their day (for example bathing, dressing and having breakfast) with care staff help. After lunchtime, the second period of using the lounges consisted of spending long periods of time during which residents felt little happened (between five to eight hours depending on the care home). Female residents commonly remarked on the slow pace of time and/or lack of activity:

We just sit here and wait, there is nothing to do for the whole day! We have a coach! They could take us to London for the day! [fieldnotes, Oak Home, afternoon]

And

I am off to the lounge – I am going to see what it is not happening!

Laughs - Mary referring to the lounge when she was leaving the dining table after lunch – [fieldnotes, lounge, Cedar Home, afternoon]

And

Lucy – There is nothing coming in this week

Wendy – We had tea [the tea was served by the care staff minutes before this conversation]

Lucy - I mean entertainment.

Wendy – Yeah [brief pause] Amanda(S) will be back only on Monday [it was Friday when residents had this conversation] - [Fieldnotes, Cedar Home, lounge]

These remarks by female residents showed that some of them perceived the lounges as monotonous or tedious spaces during certain periods during the day. Nevertheless, the female residents still opted to access and use those areas rather than stay in their private bedroom during the daytime.

Residents tended to sit at the same seat during the sitting-times in the lounge in all care homes. The seating arrangements during sitting-times were important components in shaping social interactions amongst the residents during the daytime. Each resident took steps to re-occupy her individual seat in the lounge, reproducing these arrangements by: walking straight to their usual seats and sitting on them; there were no verbal exchanges or disputes between residents about where to sit in the lounge. However, when residents required assistance by care staff to take a seat in the lounge, for example as a result of poor mobility and/or cognitive impairment, there was no negotiation as to where residents sat. The care staff acted with a tacit assumption that the resident would sit in a particular seat in the lounge. Residents reproduced the seating arrangements because it allowed them to maintain continuity in their daily routines as they secured their 'own' space in the lounge. Also, the seating arrangement allowed the resident to foresee who she (or he in the case of one male resident in Beech Home) would spend their time with during the sitting-times. Conversely, not being able to sit in their usual space or seat was a cause for disruption, discontinuity and discontent for the residents:

Daisy was sat in a different place for this evening. She was sat next to Jessica in a two-seat sofa in which nobody usually sat. When I approached her she seemed stressed by looking around and trying to get the attention of a care staff; she said to me: *I have been deprived from my chair that I have had for years! Why?* I shook my head and replied: *I don't know*. Daisy seemed unsettled for most of the afternoon. [Fieldnotes, Beech Home, lounge]

Nevertheless, a few residents were less inclined to sit in one seat all of the time and if they carried out such perceived 'transgressions' as occupying a different seat, other residents usually treated their actions as contentious as the following fieldnote excerpt from Beech Home demonstrates:

Susan was sat on Eve's seat, next to Grace. Eve was Grace's favourite companion and they spent the sitting-times sat next to each other.

Grace was agitated and seemed angry with Susan's presence. Grace kept shouting swear words and looking towards Susan. While I was speaking with Susan on that occasion she said to me and said *there were not nice men here and not nice women either! [pause] there are some old fogey that don't sit where they sleep, and I don't sit where they think I should - I don't hear a word from them!* [Fieldnotes, Beech Home, lounge]

Residents like Susan were less attached to a particular seat in the lounge because they did not have any close connection with another resident. Susan's case meant that not having a fixed seat in the lounge was an indication that she was viewed as a social outsider from the group of residents. However, a few female residents with diverse social ties amongst the residents, such as Mary in Oak Home, deliberately kept different seats to reach different individuals in the lounge.

During sitting-times residents could do a range of different activities and 'social watching' seemed the most common way to past the time. Social watching consisted of watching people in the lounge doing different activities. When I asked Wendy in Cedar Home why she spent long periods of time in the lounge (usually 09:00 to 17:00) she replied: *'I don't know [pause] I like to see who is about'*. I argue that the motivation for Wendy and most of the women in frequenting the lounges during the sitting-times was to seek and enjoy the companionship of their peers. At the same time, the sitting-times enabled social watching and this could translate into practical care or help for residents as the next excerpt illustrates where Wendy supports the care of a fellow resident:

Sandra got up from her wheelchair and started to walk unsteadily. Wendy, Lucy and Monica stopped talking and observed the resident. I got up from my seat and reached for Sandra to help her to avoid a fall. In the meantime, Wendy pressed the alarm that she carried with herself for calling for the care staff [Fieldnotes, Cedar Home, lounge].

Social watching was an activity which served as a form of entertainment for the residents when spending long period of sitting-times in the lounges of the care homes. However, the activity of social watching led residents to exercise and enforce a degree of surveillance on other residents themselves. The surveillance exercised through social watching by the residents required a constant presentation of the self as in Goffman's concept of 'front-stage' (Goffman, 1990). Thus, the lounge formed a micro public arena within the care home where it demanded the self-presentation of its occupants. Furthermore, the constant surveillance which demanded self-presentation in the sitting-times in the lounges of Oak and Cedar Home may have influenced male residents' decisions to avoid these areas.

In my observations, I noticed that the female residents frequently engaged in conversations and interactions throughout the sitting-time. These interactions were freely employed by the residents to express their opinions about others in the care home. In these exchanges, women found emotional support by sharing feelings with their companions as the excerpts below illustrates:

Lucy came to the lounge supported by Clara(S). She looked frail and seemed upset. Lucy sat next to Wendy and exchanged greetings with us [Wendy and I]. After the staff left room, the residents then had this conversation:

Lucy – *I am feeling so down, I am not well.*

Wendy – *Um!*

[long pause]

Lucy - *I miss my big kitchen – go home! But I have to stay here until I get better.*

Wendy – *You will again, you are getting stronger!* [Fieldnotes, Cedar Home, lounge]

This excerpt suggested that women living in care homes often exchanged intimate conversations and shared feelings. Numerous studies have identified intimacy as

an instrument for women to forge same-sex friendships in Western Culture across different age groups (Aukett, Ritchie, & Mill, 1988; Camarena, Sarigiani, & Peterson, 1990; Cronin, 2015; Reisman, 1995; Rubin, 1985). However, the term intimacy has been coined with different definitions in friendship studies (Roy, Benenson, & Lilly, 2000). In my analysis, I define 'shared intimacy' as disclosing personal information which included sharing information about feelings, as Lucy did with Wendy in the excerpt above. I also use it to refer to conversations amongst the female residents in which they freely expressed their personal opinions about others and themselves regarding varied and personal subjects. The following excerpt illustrates how the women living in Cedar Home took an interest in others and freely expressed their opinions:

Monica arrived in the room while Wendy and Lucy were already there. Monica greeted Wendy and sat in the chair between the two residents. Lucy was sleeping with her head thrown backwards with her mouth opened. She didn't wake up with Monica's arrival. Monica observed Lucy sleeping and said to Wendy:

Monica - *she seems so tired* [turning to Wendy and making eye contact]

Wendy - *she wears that cardigan all the time!* [while looking to Lucy]

Monica - *oh! she always wears that green cardigan. I am sure they could get other clothes for her.*

Wendy - *she doesn't care...* [Fieldnotes, Cedar Home, lounge]

Discussing someone's clothing as a conversation topic showed the residents were aware of Lucy's dressing habits. It also showed that Monica and Wendy felt free to vent their personal opinions about their closer companion's (Lucy's) dressing habits. The women living in Beech Home could still be seen to interact despite having more limited cognitive impairment. During the fieldwork, I regularly observed some of the female residents interacting with one another while this was rare amongst male residents. These interactions involved holding hands, praising

each other, listening and comforting one another as the following fieldwork excerpt illustrates:

When I arrived in the lounge I observed Eve and Grace sat next to each other holding hands. Although their armchairs were placed in parallel, Eve and Grace positioned themselves facing each other. Grace kept saying *'it was a lovely Christmas! Dad and I, Dad said: Grace! We are going abroad! We are not spending Christmas here and we flew in a plane...'* Grace kept repeating this story over and over for almost one hour while Eve kept smiling and reassuring Grace by saying: *'Oh yes my dear!'* and *'Oh, I know, it was lovely time, it really was!'* [Fieldnotes, Beech Home, lounge]

I observed that some of the women living in that care setting formed 'dyadic relationships' (temporary or permanent relationships between two female residents who spent time together and provided social and emotional support to each other). The care home manager in an interview explained how some of the women engaged in different types of ongoing relationships based on their individual biographic characteristics and their different levels of dementia. One such relationship was between Eve and Sarah which shared features of a mother-daughter relationship.

Then Eve came along, and Eve is a mothering type and Sarah then seemed to go more towards Eve for the mothering. And the two used to walk around the house so Eve would say 'now come on dear, come on', and that's to Sarah, 'now dear, come this way' and really that was Eve's purpose. [Interview, Beech Home, manager]

While another dyad female relationship seemed to conform to that of a 'friendship' as the manager explained:

I think it has declined a bit but they will say 'my friend', so Christina and Iris, they went through a little spell perhaps where they weren't

sitting close by but they seem to have gone back. Because Doreen in the morning she'll say 'is Christina up then?' When we're trying to get her to have a shower, 'is Christina up then?' 'Yes, she's sat, she's waiting for you, she's having her breakfast' and they will greet each other, so that's a little friendship. [Interview, Beech Home, manager]

According to the manager, these relationships were not static, but they changed over time as their health and cognitive ability deteriorated and as new residents were admitted to the care home. The dyad relationships were also interpreted as friendships by the care staff. In the following transcript, the manager explains the relationship between two female residents:

Sarah's health went down a step or two and where she was constantly walking around saying 'what the bloody hell's going on?', only she'd have Eve in the background saying 'come on dear, come on dear', Sarah didn't wander as much. She [Sarah] sat more and you could see in Eve a difference because her role was taken away as the carer of an individual. So that was very interesting, and Eve then became a little bit more upset because 'what do I, how do I figure in this?' The dynamics seem to have settled after that ... [Interview, Beech Home, manager]

The dyad relationships between the women bonded the individuals very closely; they were often seen together during the sitting-times and usually engaged in physical contact such as holding hands. These relationships between female residents seemed to provide a source of valuable social and emotional support. These kinds of associations were less common amongst men as I discuss in the next section. The group of female residents in Cedar Home who spent most time in communal areas during sitting-times had similar social and professional backgrounds. Monica and Lucy were housewives when younger while Wendy was a housewife when she had children and was a dinner lady later in life. Their social background and domestic lives may have encouraged intimacy and closeness by

being part of a group rather than prioritising their individuality. In contrast, women from more affluent backgrounds and/or professional occupations seemed less likely to spend their time together during the sitting-times with the group of female residents (Lucy, Monica, Wendy). For example, Gladys in Cedar Home represented a negative case when it came to interact by employing *shared intimacy* and socialising with the group of residents in that setting (Lucy, Monica, Wendy and Mary). Gladys was a former school teacher, who used to read the newspaper every morning in the lounge. Although Gladys' morning routine in the lounge prompted some interactions with the female group of residents, i.e. short and formal greetings with the group, she did not socialise with the rest of the female residents. Gladys seemed to engage in less personal conversations and conversations with more practical purposes. For example, Gladys spoke regularly with a visitor (Helen's daughter, who visited her mother every other day). Their conversations gravitated around travelling abroad, good restaurants nearby to eat and Gladys' engagement in organising day trips out for the residents which she spoke about with enthusiasm with the visitor and the care workers. Nevertheless, Gladys and her visitor also spoke about personal matters as well, for example the visitor used to share her concerns about her mother's health (Helen) with Gladys.

Marks (1998) suggested that mothers from working backgrounds in the 1930s generation used 'inclusive intimacy' as a tool to create closer social ties as a group to overcome the difficulties from working conditions in factories and the hardship of looking after their families. Inclusive intimacy served as a vehicle that enabled individuals to retrieve emotional and social support from the group. The strong social bonds enabled the women to perceive themselves as part of a collective group rather than dissociate individuals (Marks, 1998). Thus, the use of intimacy employed by the female residents varied according to their social background and this may affect how female residents tended to use the communal areas of the care homes.

5.3. Men's relationships in Beech Home and the impact of dementia

While the female residents often formed close relationships with each other in Beech Home, the male residents did not. The men who were in advanced stages of dementia were also more isolated compared to their female counterparts with the same impairments. The findings reported in this section on men interacting in the lounge (during the sitting-times) were mostly drawn from Beech Home observations and biographical data relating to Abraham and Christopher. These individuals' life story accounts, considered in relation to their health, provides insights into how far they were able to integrate within the social world of the care home.

There were 16 female and four male residents who stayed in the communal areas in Beech Home during the day. Three of the male residents (Christopher, James and Antony) were mobile and walked without any assistance while Abraham was a wheelchair user and had a fixed seat in the lounge. Christopher, James and Antony spent most of their time during the day walking in the communal areas (lounge, corridor, dining room and front room). They did not have fixed seats in the lounge but sat at available seats when accessing this space. Unlike the female residents, these male individuals were not observed displaying dyad type relationships with other residents, although there was one exception.

Christopher could verbalise but was unable to answer simple questions nor could he engage in sustained conversations. I learned from the care staff and from a Bernard (V) (a male friend of Christopher from childhood who regularly visited him twice a week) that Christopher had been a sporty person and an amateur boxer when younger and he had worked in the docks for his entire working life. When meeting people, Christopher often made punch gestures in the air as if he was doing boxing movements. He then said phrases such as *we like to play!* and smiled. He enjoyed meeting me as on many occasions he took the initiative to approach me as he was walking and initiated conversations while smiling. These occasions were restricted to greetings exchanges and sometimes a few comments. The

greetings involved handshakes initiated by Christopher. We shook hands with a sport handshakes style as it involved more than one movement. Christopher repeatedly made comments involving physical appearance or being physically fit:

Christopher walked to my direction when I was in the corridor and greeted me with two firm handshakes, he then said *keep well!* He then continued to walk towards the dining room. [Fieldnotes, Beech Home, corridor]

And:

I was sat next to Christopher observing the room. Today he seemed upset or distressed and continually spoke disconnected words for the time I was there. At one point, he turned to me and asked my age. He replied to my answer with surprise: *Oh! You are in good shape! forty-one.* I asked Christopher's age and he answered: *I don't know, I think 36....* [Fieldnotes, Beech Home, lounge]

And:

Christopher approached me and we exchanged handshakes. He then squeezed my up arm and said: *you are fit!* Which I then replied, *So you are too!* He then smiled and laughed shortly in content replying to me: *yeah, I am!* [Fieldnotes, Beech Home, front room]

Christopher's life story and background was evident when expressing his frustration about his current physical state:

I found Christopher pacing in the lounge, he seemed upset and confused. I approached him and asked if he was okay. Christopher shouted to me *I want to be fit!* looking around the room in distress. He left the room afterwards. [Fieldnotes, Beech Home, dining room]

Christopher's life history had clear connections to explicitly masculine environments: he was a bachelor who worked in the dockyards and dedicated his

spare time to the gym where he boxed as an amateur. Perhaps Christopher's desire 'to be fit' as expressed in the previous excerpts were also related to the type of environment in which he used to work and socialise. One of the care staff recognised the influence the past experiences and professional background in shaping the behaviour of residents in advanced stages of dementia as the interview transcript shows:

...it's interesting, when you start having dementia, it's always going to be wrapped up around your personality, and the work you have done in your life, that's going to influence your behaviour with dementia

[Interview, Beech Home, Alma(S)]

The care home was a stark contrast to the environments with which Christopher might be familiar with: it was a predominantly female environment in which most of the residents and care staff were women. Moreover, over the fieldwork period, Christopher did not interact with any of the men living in the care home although he was happy to interact with me. Perhaps this is because my physical appearance may have helped Christopher to remember his former physical appearance, life style and environment that he used to be familiar with. Thus, male residents with severe cognitive impairments may struggle to interact with their male peers as they were unable to articulate conversations or interactions which comply with men's usual social framework of sharing activities and common interests. In fact, in my observations I noticed that they isolated themselves from the group of residents. The continual walking and having no fixed seats in the lounge may have contributed to the social isolation of Christopher, James and Antony in Beech home. Similarly, Abraham was isolated from his male peers but for different reasons. His isolation was rooted in his lack of mobility as he was completely dependent on the care staff to move and also by the limited number of men living in the care home (as the other male residents seemed to avoid socialising in general). While I spent time in Abraham's company, he continually reminisced about his working life. These episodes usually occurred in the mornings or the beginning of the afternoon when he retained better cognitive awareness. He was keen to tell me about his job in

London as a chemist in a factory. Abraham always mentioned the fun time he had in *'playing cards with the lads'* and described those moment as *good fun!*

As Abraham spent his daytime in the communal areas in the company of female residents only, he had a closer relationship with a male member of the care staff, Max(S), with whom he could relate. In one of his reminiscences, Abraham incorporated Max(S), a male senior nurse, as part of his life story before moving into the care home:

'I can't hardly walk because I had a motorcycle accident. I stayed in hospital for God knows how long! [pause] I've been in hospital ever since.' I told him that he was not in a hospital and he replied to me *'I know I am not in hospital!'* Abraham then explained to me that he came to *'this place'* because he was known to Max(S) *'because he lived near to my landlady.'* Abraham's story was not confirmed by Max(S).

[Fieldwork, Beech Home, lounge]

On another occasion, I asked Abraham who the person was that he most enjoyed speaking to. Abraham thought for a moment, looked around and saw sm2 walking into the room and pointed to the male carer and said: *'I like to talk to him!'* seeming to place a great value on the social ties with male carers. Thus, the presence of male care staff (carers and nurses) held specific importance for the men living in care homes, especially for male residents with advanced stages of dementia. This seemed to be further supported by the positive interactions which Christopher had with me during the fieldwork. The presence of male care staff can make the care home environment less feminised while male care staff were able to establish social interactions which overcome residents' cognitive and physical impairments.

In contrast with other male residents restricted to the communal areas in Beech Home, Abraham presented a dyadic relationship with another resident. Abraham was not physically mobile and spent most sitting-time in the lounge in the company of three other regular female companions, Alice, Rose and Daisy. Abraham and Alice had a romantic relationship as he expressed to me:

Abraham was silent when Alice suddenly woke up in a jump and said: *'where is Abraham?'* (Alice was short sighted). I replied to Alice *'Abraham is here'* and then she quietly laughed and smiled and accommodate herself to a more comfortable position. Then Abraham told me: *'she's stolen my heart...'* while looking towards Alice with watery eyes. [Fieldnotes, Beech Home, lounge]

Most of the care staff in Beech Home were aware of and encouraged Abraham and Alice's relationship as the following excerpt shows:

Max(S) was coming around to administer the medication to one of the residents sat in the same areas with Abraham and Daisy. Daisy was sat next to Abraham and was holding his arm as she wanted to speak to him, but he did not seem interested to speak to and ignored Daisy. Max(S) observed both and said to Abraham: *'don't let Alice see this!'* with a smile and Abraham became red faced and replied to the staff: *'you will not tell her!?''* and the staff laughed and said: *I won't but don't let her to see it* (Alice was dozing while this conversation happened). Max (S) then commented: *You little flirter!* Abraham smiled at Max(S)'s comment. [Fieldnotes, Beech Home, lounge]

The seating arrangements in the lounge and in the dining room during the meals were essential to maintain the relationship between Abraham and Alice. Abraham's seat was a special and larger armchair which was positioned in the same spot throughout the fieldwork. Equally, the two female residents (Alice and Rose) sat regularly in the same armchairs and depended on the staff to be moved into the lounge. I was not able to explore the care staff's views about who and how the decision was made about the residents' seats in this instance.

In my interpretation, the residents like Abraham, Alice and Rose had no choice to sit elsewhere in the lounge during the sitting-times but were confined to the same seat and area in the lounge because of their physical impairments and that they had dementia. Abraham's relationship was a rare case amongst men in advanced

stages of dementia and I did not observe these types of relationship between two male residents. Abraham and Alice's relationship was based on a romantic/couple relationship differently from the other types analysed here (friendship and mother-daughter types). What is important to recognise is that all types of dyadic relationships involved different levels of 'shared intimacy'. Hence dyadic relationships may be unusual between men or at least heterosexual men as they would avoid shared intimacy and at the same time, their cognitive impairments may prevent them from socialising through normal male channels by sharing interests and activities.

5.4. A space to avoid - men's instrumental use of the lounge

During the fieldwork in Oak and Cedar Homes I noticed a distinct pattern in how men used the lounges compared to women. While some of the female residents used the lounges as part of their own personal spaces in which they socialised with other female residents, care staff and visitors, male residents did not.

Men's absence (with a few exceptions) from the lounge spaces during the sitting-times was largely related to the gendered aspects of these spaces due to the women's overwhelming presence combined with other factors such as men's individual backgrounds and their ways of socialising as explained in the following sections. What Terry did when he was in the lounge to attend a group activity provides an example as to how men took part in these events and how they interacted with other individuals in the room:

The activity was scheduled at 10:30 on a timetable placed on the entrance door of the lounge. Around 10:15 Terry walked into the room and greeted us (Wendy and I) with a short salutation and said *Hi!*, then continued to walk towards the tables in the centre of the room. There were no chairs at the tables so I took a chair for Terry and placed it at one of the tables. When I was carrying the chair, he said to me: *there!* [pointing to the space] *I want to see the birds*. I placed the chair as he had asked me. Terry sat at the table and started to read a magazine

that he brought with him but often he looked up to observe the people in the room – carers who came to assist the residents, a visitor who arrived minutes later. Terry exchanged greetings with these individuals, but he didn't engage in conversations with anybody else until the beginning of the activity. As the group activity got closer to starting, the female residents moved to the table but they sat at another table away from where Terry was sat. [Fieldnotes, Cedar Home, lounge].

Terry's choice of sitting at the table in the centre of the lounge and away from the other residents in the room (all sat in the armchairs around the room) suggested he was less interested in meeting or talking with the female residents already located in the room. Moreover, Terry kept himself occupied by reading a magazine while waiting for the activity to start. The activity of reading can be interpreted as a device to avoid boredom and to conform with a role in the room but also could be seen as a strategy to avoid the need to socialise with the female residents. The term 'conform' in this context means finding a role to justify his presence in the room to the rest of the group while waiting for the activity to start. Terry's intermittent reading combined with glances around the room at the other residents and what was going on might suggest that Terry engaged in social watching while waiting in the room.

In an interview, Terry expressed the view that the lounge had no appeal for him and therefore, he accessed that space for the sole purpose of attending activities of his choosing rather than considering it an opportunity to socialise with others or spending his day in this area:

I go there if there's anything on, I always. There's not a lot on there to see, yeah. There was going to be a sing-along on Tuesday, but they cancelled it. So it's next Tuesday, yeah. [Interview, Cedar Home, Terry]

The lounge in Terry's view was clearly a space used to engage in activities of his preference but not considered as a social space where he could spend time in the

company of other residents. In the same interview, I asked whether he would consider sitting at the table with the female residents in the dining room (as he usually sat with other male residents) and socialise with them. Terry gave me the following answer:

Researcher - Would you consider to sit in another place [in another dining table]?

Terry - *Not really, no, not that I can talk to. Paul was there and that was it. There was none of them* (Paul and Mark who Terry shared the table) *in there. I wouldn't want to sit with the ladies* [laughs].

Researcher - No?

Terry - *No.*

Researcher - Can I ask why?

Terry - *Well I don't know them enough and, you know, you can't talk to a lady about certain subjects, can you?* [Interview, Cedar Home, Terry]

Although my question referred to socialising in the dining room, Terry's answer provided an indication as to his perceptions and how he acted when sharing the communal spaces with other female residents which extended to the use of the lounge. Terry's military background (he fought in the Second World War with a long career in the armed forces) suggested that he was more comfortable in male environments where he felt at ease to socialise by talking 'about certain subjects' than with the female residents who stayed in the lounge in Cedar Home.

Most significantly, Terry's answer indicated the strong bond and comradeship with another male resident in the care home, Paul. Terry who was aged 92 and Paul who was aged 89 were of the same generation and shared similar life experiences. Both male residents had careers in the armed forces and had fought in the Second World War. However, Paul never accessed the lounge while I was in the fieldwork. The only place and time they met was in the dining room at lunch time.

Importantly, as Terry was the first person to sit at one of the tables for the upcoming activity (there were two circular tables in the centre of the room), the

other female residents had the choice and therefore some degree of control to regulate their geographical distance from Terry. In fact, all the women sat at the other table away from Terry. This suggested that female residents (or at least some of them) tried to avoid sharing a closer space with Terry preventing any sort of socialisation with him.

Another man from a military background but living in Oak Home also completely avoided the communal areas in his care home. Abel perceived the lounge in Oak Home as a space dominated by the female residents. Abel's interview provides an insight as to how he perceived the lounge in Oak home and explained why he didn't access that space:

No, no – it is full of bloody women! If I go down there, there is a lot of old ladies, 'You want a game of cards?' Like that, 'No!', 'Are you going to have a game of cards?' 'I don't want to!', so I don't go down there now. These women they, you know, they think you must do it and I think 'No, I don't have to!' [Interview, Oak Home, Abel]

Abel perceived the lounge as a space in which his privacy was 'invaded' with continued requests by the female residents. As Abel was an ex-navy serviceman who had fought in the Second World War and spent most of his life sailing on missions, his need for privacy might have conflicted with the intimacy that the female residents sought when interacting with others in the care home.

Western societies before 1950s were culturally orientated on stereotypes of masculinity and femininity which reflected on the structural division of labour and organisations based on gender (Oakley, 1972). This might be especially the case for men in the armed forces in Great Britain who fought in the Second World War who were immersed in environments that were almost exclusively male. Furthermore, male residents in general may have found it difficult frequenting spaces which were preponderantly occupied by female residents. Not having the company of another male resident to spend their time with during sitting-times deterred them from using the lounge spaces. For example, Matthew was a school teacher and spent

most of his time in the hallway rather than the lounge area in Oak Home. The hall of Oak home was the busiest area in the care home as it was linked to the main entrance, the kitchen, lounge, the office, the quiet lounge and the corridor to the residents' bedrooms. Matthew used to exchange greetings and have conversations with the visitors and staff of the care home from the seats placed in the spacious hall as he explained in the following interview:

Researcher - Okay, I notice that most of the people sit in the lounge but you sit in the hall, I wonder why is that?

Matthew - *I sit in the adjunct of the lounge, I normally don't sit in the lounge for long.*

Researcher - Okay and could you tell me why is that?

Matthew - *Because, why do I not sit in the lounge very often? Boring I suppose, I find more chance of seeing people come down the stairs or through the door or something which would interest me more.*

Researcher - So, you don't spend time in the lounge? Why is that?

Matthew - *I don't, well occasionally but not often, some people irritate me so I, particularly the women who go on a bit you know.*

Researcher - Do they?

Matthew - *Well they get on your nerves don't they! So I prefer silence to some of them.*

Researcher - Do you want to talk about?

Matthew - *... I think I have a commanding teacher's voice, and that irritates some people, and she made a comment about this and I was, oh, take it or leave it...*

Researcher - Does she stay in the lounge

Matthew - *Yeah she more or less stays in the, and she goes through the door, if you go straight across, she's normally sitting in one of those easy chairs there... (Matthew's description referred to Barbara)*
[Interview, Oak Home, Matthew]

Matthew's explanation suggested he avoided the lounge because he considered it

monotonous although this seemed related to the residents who frequented it; all women with advanced stages of dementia. Only female residents occupied the lounge area during the sitting-times and they were described by Matthew as the '*women who go on a bit you know*'. Matthew's answer referred to a certain type of women which he seemed to struggle to be around and interact with and these were the female residents who had advanced dementia such as a Barbara. Barbara could not engage in meaningful conversations or answer simple questions most of the time. In fact, on many occasions, Barbara could display anger towards the care staff and other residents. However, in the fieldwork I noticed that male residents struggled to share the space and interact with people with cognitive impairments while female residents were more patient and showed empathy towards these residents as I discuss in section 5.2. of this chapter. As explained, these types of interactions required the use of 'shared intimacy' from the residents, which Matthew and perhaps most of the male residents were unable to engage with. However, on one unique occasion, I did observe the men spending time in the lounge while waiting for a group activity. On this occasion, the men did not seek individual isolation but sat closely to each other while accessing the lounge in Oak Home. The excerpt involving Peter and Matthew illustrates how men tended to interact in such circumstances:

A Christmas carol service was arranged for this afternoon and Peter, instead of going back to his bedroom after lunch, stayed in the lounge in his wheelchair. I was sat at the sofa facing Peter when Matthew came in to the room escorted by Ada(S). Ada(S) followed Matthew closely as he walked slowly with a Zimmer frame and she made a hand gesture towards the chairs indicating to Matthew to take a seat near to where Peter was sat. Matthew walked looking down at the floor while crossing the room. He walked a few steps into the room and looked up to Ada(S) saying: '*where?!*' Ada(S) replied '*you can sit over here*' making a hand gesture and placed herself next to the chosen armchair, two seats away from Peter. Matthew didn't sit in the seat chosen by Ada(S) but instead he sat next to Peter.

This was the 1st time that I saw Peter and Matthew spending time together that was not at the dining table. Matthew and Peter stayed in silence throughout the time I was in the lounge and they didn't make eye contact for the rest of my observation [Fieldnotes, Oak Home, lounge].

The excerpt demonstrated that despite Ada(S)'s guidance, Matthew chose to sit somewhere else which was next to Peter, a person whom Matthew considered to be '*someone he liked to talk to*' and as a '*very interesting person and as a friend.*' The absence or lack of social interaction between both residents might be explained by the absence of any activity while waiting for the Christmas carol service to commence. This is explained in Webster (1995) which theorised men's friendship, by separateness, side by side interactions and lack of self-disclosure. The situation illustrated that Matthew actively exercised his agency in choosing to spend time with his closer companion who was the only male resident in the room before Matthew's arrival. This indicates that male residents' do seem to seek the companion of other men (they often forged closer social ties as argued in the mealtimes, chapter 7) while spending time in the communal areas, including the lounge. Thus, men might struggle to frequent spaces where they were the only male in the room and might benefit or find support in sharing the lounge in company of other men. Nevertheless, in Oak Home there was one male resident who, contrary to the other male residents, accessed and used the lounge routinely and sometimes interacted with the people found there (female residents, visitors and care staff). Joseph had dementia and liked to watch the news in the afternoon and evenings and read the newspaper in the mornings. He held a fixed seat when staying in the lounge. The following excerpt illustrates how he used the lounge in Oak Home:

I was talking to Philippa and Joan in the dining area in the lounge. They were interested to talk to me about my work in the Oak Home and asked me several questions: *where did you find this job?; was it advertised somewhere?; who pays you? Is it the government?* In the meantime,

Valery was in room dosing and Joseph was reading a copy of the Guardian newspaper. Both were sat in the sitting area of the lounge. I heard a few times Joseph saying *shush!* and the whipping sound of the paper. When I looked to Joseph, I saw him with his head hidden in the newspaper. Philippa and Joan seemed oblivious to Joseph's protests (as they probably could not hear him – both had hearing loss). Joan and Philippa continued to speak to me: *oh, you must be very clever...* As we kept talking (with Joan and Philippa talking loudly), I heard Joseph shouting: *shut up!* As I noticed Joseph increasingly become impatient by shaking his head and getting agitated, I made an excuse to Joan and Philippa and left the room. [Fieldnotes, lounge, Oak Home, afternoon].

Joseph had a military background, ending his professional career in the armed forces. Joseph represented a 'negative case' in this ethnography as the male resident routinely used the lounge while I was in the fieldwork and socialised in a space which was predominantly a female environment.

Joseph's attitude in frequenting the lounge might reflect a more comfortable and relaxed attitude in socialising with the female residents found in the lounge in Oak Home. However, in contrast to Matthew or Terry Joseph had dementia and had minimal short term memory (he did not recognise me throughout the fieldwork despite me repeatedly introducing myself and he had no mobility issues). He readily socialised with the female residents in the lounge in Oak Home during sitting-times.

Moreover, the excerpt showed that Joseph's habitual use of the lounge space empowered him in using and controlling the lounge space. This is shown by Joseph's protests and reprimands when Joan, Philippa and I were talking. This sense of empowerment over the lounge space showed that Joseph perceived the lounge as his own and a familiar space, unlike the other men living in the Oak and Cedar Homes. The findings in this research indicated that men tended to use this type of space as instrumental to undertaking group activities with rare exceptions.

Men's instrumental use of the lounge is likely to be rooted in the overwhelming female presence in those spaces and absence of other male residents in those situations. Hence, men found the lounges somewhat monotonous places and didn't perceive the lounges in the care homes as social spaces. Men's instrumental use of the lounge meant that they restricted their time spent in those spaces compared with women, which meant that they were less exposed to social interactions with all the people who accessed these spaces; care staff, visitors and residents themselves.

Men from a military background seemed to find it particularly difficult to socialise with the female residents. However, male residents from other professional and social backgrounds also struggled with socialising with female residents, especially if these women were in the advanced stages of dementia. The findings revealed that men sought other men's company on the rare occasions they accessed the lounge, suggesting they value and appreciate spending time in the company of other men; usually their closer companions.

5.5. Men engaging in the group activities

The group activities were events organised by the care home and managed by a member of staff. The term *group activities* covers various types of activities which were performed in group by the residents such as sewing, playing board games, colouring books, doing craftwork. The group activities also included religious services, dancing and singing presentations by amateurs or professionals. Singing and dancing presentations were very popular amongst male and female residents alike. Singing and dancing presentations were group activities in which residents became recipients of the activities rather than having an active participation in the group. Although these types of group activities created social situations which prompted residents to interact, such as exchanging greetings, making conversations they did not promote or encourage extensive periods and social situations where residents could socialise amongst themselves. All of the group activities could be seen as more likely to be woman-oriented or 'gender-neutral'

activities, but none of the care homes provided more male-specific activities for male residents. The following excerpt illustrates how Terry took part in a group activity (flower arranging) with a group of four female residents and a visitor known by all present during the activity in Cedar Home:

While Terry was in silence occupied with his arrangements, the group of women engaged in numerous conversations. Most of the conversations were initiated and nurtured by the staff (Amanda(S), a staff member specialised in providing activities) and a frequent visitor known by all in the room (Emma(V) – Helen’s daughter):

Emma(V) – *is your boy any better?*

Amanda(S) – *he is now but he went to hospital last week*

Wendy – *Oh! poor boy!* [Wendy and Gladys stopped to listen the staff]

Emma(V) – *Poor boy really, I hope he get well soon*

Amanda(S) – *he is getting better, but the doctors still don’t know the cause...*

As the activity progressed, Terry and Amanda(S) occasionally spoke with the staff when he needed her opinion or help reaching any material to complete the arrangement. Terry was the first in the group to finish the arrangement and left the room shortly after, carrying the arrangement that he made himself. The group stayed longer in the room talking even after everyone had finished their arrangements. The group disassembled around twenty minutes later, when the care staff came to the room to support the residents to move to the dining room for the mealtime [Fieldnotes, Cedar Home, lounge]

The excerpt illustrates that the group activity undertaken by Terry did not have the effect of providing a mechanism for him to integrate with the group of female residents. Being the only male resident in the group might have contributed to his isolation, as the conversation between all women in the room (residents, care staff and visitor) gravitated around personal and intimate matters perhaps more comfortably discussed by the women in the group.

The staff was key to encouraging the only man present to socialise in the group, while most of female residents seemed willing to socialise amongst themselves apparently without additional staff support. In the excerpt, Amanda(S) helped to break Terry's isolation from the rest of the group, although the conversation, as far I could observe, was focused on the activity. The conversation between them included asking for materials, exchanging opinions about the combination of flowers. Despite Terry now having a part in the activity, he seemed somehow isolated from the group which interacted through continuous conversations that in many circumstances involved intimacy, while Terry was mostly focused on the activity rather than in talking to other individuals. Nevertheless, Terry engaged in social watching of the group of participants as the group activity progressed.

The seating arrangement of residents, staff and visitor provided a further illustration of ways in which Terry became disconnected from the group of female residents. Figure 13 shows the positions of the participants:

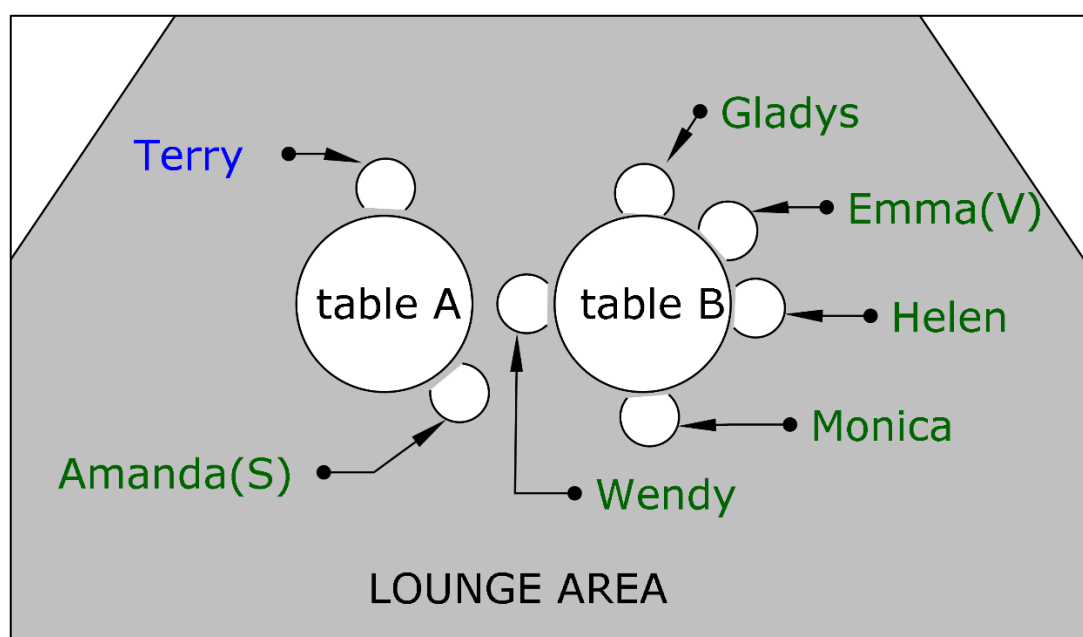


Figure 13. Individuals' positions during the group activity in Cedar Home

While the visitor and the four female residents all sat at the table B, Terry sat at table A as illustrated in figure 13. The staff conducting the activity, Amanda(S) stood next to Terry's table supporting him. The data regarding the group activity

reveals that the activity in which Terry took part was clearly orientated towards women (making home craftwork with flowers). Terry's preference in taking part in the social activity reveals his individual preference which did not reflect the tastes of other men living in Cedar Home (Paul and Mark), hence he was the only male resident in this activity. Thus, this might explain his isolation from the group of female residents. This isolation was further exacerbated as the female residents used shared intimacy as the means to socialise which Terry did not engage with.

Terry's experience in the social activity showed that he was cut off from group of female residents. Hence, male residents from a military background might benefit from taking part in a group activity only for men. All three care homes offered group activities which were orientated towards female residents, hence it would be clearly possible to implement group activities which are socially perceived as masculine activities that promote men's social gathering in care homes for older people. These activities could include tasks such as carpentry, gardening, darts and social gathering that involved 'pub-type' environments. A successful example of this is provided in Gleibs et al. (2011). However, the small number of male residents in the care homes may be an obstacle for the implementation of group activities only for men.

5.6. Summary

The lounges were spaces that were used to provide care and social support for the men and women living in care homes for older people. The lounge in each care home comprised a unique environment and was shaped by the health needs and the social background of the residents.

In all care homes, the female residents tended to reproduce the seating arrangements by keeping individual seats in the lounge. The seating arrangements were important devices to maintain social ties with their closer companions. The women in these spaces tended to socialise through intimacy practices which entailed talking about personal matters related to themselves and others, showing empathy, attention in listening to others, having eye-to-eye contact, touching.

Alongside intimacy practices, social watching was also an important activity for those women to spend long periods of the day in those environments.

The findings showed that female residents formed same-sex dyadic relationships which seemed to provide reliable emotional support for those individuals especially for the women who suffered from advanced stages of dementia. These dyadic same-sex relationships used intimacy practices and entailed different dynamics depending on the health impairment of the female individuals, i.e. mother-daughter relationships or friendships. Most of the men with advanced stages of dementia tended to isolate themselves and they avoided social contact with other residents. Men may struggle to establish same-sex dyadic relationships as they did not tend to socialise through shared intimacy. Most of the men in advanced stages of dementia did not have specific seats in the lounge nor close companions. However, one man developed a dyadic association with a female resident through a romantic relationship which suggested that shared intimacy was used as the means for a romantic relationship.

The findings also indicated that older men with severe cognitive impairments may benefit from socialising and receiving care from male care staff (nurses and carers). In this context, male care staff served to enhance and better represent a masculine presence and role in the care homes. This is because the presence of male carers may remind and connect male residents' to more masculine environments with which they were previously familiar and therefore, improve male residents' wellbeing.

The majority of men living in care homes who were supported to and able to safely stay in their bedrooms during daytime used the lounges instrumentally to attend group activities only but not as social spaces to spend time and meet other residents and visitors. The findings indicated that men perceived the lounge areas as monotonous spaces. This might be related to men's instrumental use of the lounge but not as spaces where they could socialise. When men accessed these spaces, they tended to isolate themselves by undertaking individual activities and

keeping a social distance from others in the room (all female residents). The reasons for men's avoidance of the lounges were mainly rooted on gendered aspects of the lounge. Men who lived and worked in more homogenic gender environments, such as the men from the armed forces, may struggle to share spaces and socialise in a female environment such as a care home. Male residents from other professional and social backgrounds might also struggle in making frequent use of the lounges, especially if these feminised spaces are used to care and accommodate residents who were in advanced stages of dementia. However, male residents sought their favourite male companions on the rare occasions when there was more than one male resident in the room.

Men regularly attended group activities involving presentations (singing, dancing and plays). However, men rarely took part in group activities based on craftwork or games tasks. When men took part in those types of activities, they were isolated, or they purposefully isolated themselves from the group of female residents. Nevertheless, these situations prompted some sort of social interaction such as exchanging greetings and social watching. The care staff in these situations were vital for men's socialisation. The lack of men's participation in social activities may be due to the feminine or gender-neutral activities. Thus, men may benefit in taking part in activities that tend to be socially seen as masculine, i.e. such as gardening, carpentry, drinking, watching sports and playing darts.

6. THE BEDROOM – MEN’S PRIVACY AND CONTROL OVER THEIR SPACE

6.1. Introduction

This chapter presents the findings on how male residents spend their time and interact with others in their private spaces i.e. their bedrooms in the care homes. The ethnography presented here is based on the key resident informants who preferred to stay in their bedrooms during most of the daytime – Peter, Matthew and Luke at Oak Home and Terry and Mark at Cedar Home.

The findings presented here are predominantly based on men’s perspectives of the social and physical properties of their private bedrooms. Additionally, I used my reflections and own experiences in visiting and interacting with the residents in their bedrooms as data to analyse the social aspects of these spaces. The analyses draw comparisons from similar situations in the communal areas to contrast how residents experienced those spaces differently in their daily routines.

6.2. The space for retaining privacy and exercising control

The bedroom areas were spaces where the male residents acted in private. Privacy was obtained by being able to exercise some power over their bedrooms. Residents exerted power by having command over the bedroom in relation to other people; namely visitors and care staff. In contrast to the bedroom, the communal areas in the care homes were public areas for all actors in the care home; residents, care staff and visitors, whereas the privacy of the bedroom enabled the residents to relax and enjoy solitude.

The communal areas of care homes were spaces that the care staff team used as social areas to accommodate visitors and to provide care to the residents during the daytime. Care staff used those spaces as working areas. For example, the care staff undertook tasks in the communal areas such as: giving residents their medication, observing residents’ safety and health, filling out residents’ care forms

and doing other administrative work. Visitors accessed and used the communal areas to meet their relatives in the care home and sometimes to socialise with others. Residents also used those spaces as social areas while engaging in different activities as described in chapters 4 in this thesis. Thus, all the actors constructed those spaces by enacting and reproducing social norms that gave a public character to the communal areas of the care homes.

The public aspect of the lounge is hinted at by Wendy's slip of the tongue in the following excerpt when the female residents were leaving the space in the late afternoon:

It was past 5pm and Monica, Lucy and Wendy started to talk about the tea (dinner time). Monica asked Wendy where she would have her meal. Wendy replied *I stay here*. Then Wendy asked Monica:

Are you going to the café? [pause]

Are you going to the restaurant? *Um...* [pause while she shook her head impatiently]

I mean, what is the word? [pause] *The dining room!*

The residents then continued the conversation. [Fieldnotes, Cedar room, dining room]

When speaking to Lucy, Wendy mentioned the words *café* and *restaurant* to refer to the dining room area in the care home. The words *café* and *restaurant* are related to public spaces or at least spaces which are not related to home. Cafés and restaurants are public spaces conjuring up the idea of being with strangers with whom you may or may not interact. The language used by Wendy suggested that she may perceive the communal areas like the dining room in the care home as public spaces and in which one should act accordingly and project the 'front of stage' performances (Goffman, 1990).

The public aspect of the communal areas in care homes were denoted through other customs and etiquettes. For example, residents, care staff and visitors

followed a dress code by wearing day-time clothing and avoiding nightwear or exposing parts of their body. In contrast, as I observed on one occasion, the dress code in the male residents' bedroom could be very relaxed. The following excerpt shows how male residents used the bedroom areas as a personal space in which the dress code was less relevant:

I knocked on Mark's bedroom door which was open. The sunlight was coming through an external door that gives a view of the internal gardens in the care home. I could see Mark's silhouette enjoying the sun as he had his wheelchair halfway out onto the small balcony attached to his bedroom. Mark, who had his back towards the door, replied to me – *'Oh! Hi!'* [he seemed to have been dozing before I knocked on the door] *Who is that?'* I identified myself and Mark invited me into his bedroom. When I entered into the room I noticed that Mark was topless and sunbathing. I apologised for the interruption and left the room [Fieldnotes, Cedar Home, Mark's bedroom].

Mark's choice in sunbathing topless is an example of how the resident himself retained and managed his own privacy in the care home while residents' body exposure might not be an acceptable behaviour in the communal areas. Thus, for Mark, staying in the bedroom enabled him to experience a space in which he enjoyed more privacy by choosing and doing activities which did not comply with the etiquette and other expectations in the communal areas.

The enclosing aspect of the bedroom space contributed to the private nature of the room and residents used this to exercise their right to privacy. Furthermore, as much as I could observe, most of the care staff in Oak and Cedar Homes recognised male residents' right to privacy:

I was interviewing Peter in his bedroom in the morning with the door closed. By the end of the interview there was a knock on the door and I heard someone

saying, 'hello Peter'. The door opened and Calvin (S) showed himself in. Calvin(S) seemed embarrassed about the interruption and said:

Oh, I didn't know you were having a visitor! Sorry to interrupt you!
Shall I come back in – ah! Let's say 5 minutes? [it was near to the lunch time] Peter nodded affirmatively to Calvin(S)'s suggestion. Calvin(S) replied to Peter *all right, see you later* and left the room. Once the staff member had closed the door we resumed the interview. [Fieldnotes, Oak Home , Peter's bedroom].

I interpreted the care staff knocking on the door and announcing himself as acts which acknowledge the resident's right to privacy in his bedroom. Calvin(S)'s expression of embarrassment and his apology for interrupting the interview were further indications that he had contravened some convention. Therefore, the privacy of the bedroom is given by the physical arrangement of the bedroom itself but also by the social convention of the care staff's recognition to residents' right to their privacy. Thus, as I observed in this fieldwork, the privacy of residents' bedrooms was simultaneously and repeatedly constructed and reaffirmed through the interaction between the care staff and residents.

However, residents' experiences of privacy were not absolute, as the care staff routinely inspected spaces to check the residents' safety and wellbeing. While visiting various male residents in their bedrooms I observed the care staff regularly checking their bedrooms. Their visits or checks varied in frequency depending on what care the residents required. For example, Mark who had restricted mobility and coordination was visited by a carer approximately every 20 to 30 minutes. The visits to Mark's room were made for many reasons such as to bring a letter addressed to him, to talk about his medication and his doctor's appointments, to ask about his choices for the food on the menu for the next day, to say hello at the start of their shifts, or simply to ask if everything was okay. Residents with fewer impairments may have more privacy as staff may judge them to be more capable of seeking assistance themselves when they need it. Peter for example, had an

alarm next to his chair in case he needed any help. Hence, privacy depended largely on residents' general health and their capacity to exercise physical control over the bedroom. The care routines and cultural ethos of the care home might have contributed considerably to shaping the extent to which residents' privacy could be exercised in their bedrooms. However, the influence of care home ethos on men's level of privacy in their bedrooms was not evident from the fieldwork in the settings sampled.

Throughout the observations in residents' bedrooms I repeatedly noticed that the male residents exercised certain control over their bedrooms in relation to people who access the bedroom space. This is shown in the excerpt below:

Ada(S) escorted me to Peter's bedroom. She knocked on Peter's door (it was open) and announced herself and me: *It is me Peter* [she stepped into the bedroom to speak with Peter who was sat in his armchair], *the nice man wants to talk to you*. I did not hear his reply, then Ada(S) got very close to Peter to ask if I could be around to observe him while she was caring for him. Peter looked at me with a serious face and replied *ah!* and nodded affirmatively. In the meantime, Albert(S) came into the room to get a piece of equipment out of Peter's bedroom. I stepped out of the room so that Albert(S) could manoeuvre the equipment out of the room more easily. After Albert(S) left the room I stood by Peter's bedroom door observing Ada(S) draining Peter's urinary catheter. Peter observed me at the door and said: *come in! I don't bite* and laughed. I stepped into his bedroom [Fieldnotes, Oak Home, Peter's bedroom]

Residents' control over the bedroom also extended to other people in the space. This is exemplified by Peter saying to me: *'come in! I don't bite'*. Peter's commanding words showed that he felt in control of his bedroom and I, as a guest, obeyed his command. Residents recognised control shaped the attitudes of care staff and visitors about residents' right to privacy in their bedroom. The following

excerpt shows a similar pattern in how a male resident controlled his bedroom while I visited him:

I heard Matthew's reply when I knocked on his bedroom's door. I opened the door and saw Matthew sat at his armchair watching the television. He seemed surprised and happy to see me [I spoke with Matthew previously in the hall of the care home]. He said to me from his seat '*come in please!*' and told me to take a seat, on the other side of the room. I asked whether we could talk about the research and whether Matthew would like to take part in it. When he had completed the form, he held up the papers to give back to me and said *Coronation is starting soon*. Matthew then took all the forms and information sheet and said: '*I don't like to keep paperwork, you can take back*' and waved the papers with an impatient gesture. I took the papers from Matthew's hand and said bye. Before I left the room, Matthew put the television volume on again and asked me '*could you leave the door open?*' I did as he asked me and left his bedroom.

[Fieldnotes, Oak Home, Matthew's bedroom]

This excerpt illustrates the power relations between Matthew and me over the bedroom space. The excerpt showed that Matthew and I adopted different roles during my visit and this was largely related to Matthew's entitlement over his bedroom space. Matthew exercised his control over the bedroom in different manners: when he admitted my presence into the room as his guest as he invited me by saying '*come in please!*', by telling me *to take a seat*, by asking '*could you leave the door open?*' Most importantly, to some extent Matthew dictated the social interactions in our meeting. He tacitly determined the end of the meeting by saying '*Coronation is starting soon*'. My role while I accessed and interacted in Matthew's bedroom was as a guest and as such I acknowledged and followed his requests.

However, the examples provided in this section involving Matthew reflected the power relations between the male residents and me over their bedroom space and this might be intrinsically different from the relations between the residents and the care staff. Residents' power over their own bedroom to exercise privacy is therefore not unrestricted but negotiable and sometimes reduced when it comes to receiving care and maintaining their own safety. Nevertheless, the men's bedrooms were the spaces where they exercised greater control and retained certain privacy compared to the communal areas in the care homes.

Moreover, residents' greater control over their bedroom and their privacy allowed them to have a more intimate and restful environment where they were not being continually placed under care staff scrutiny or where they could avoid unwanted interactions with other residents. As I observed in my visits, some male residents like Mark (Cedar Home) and Abel (Oak Home) enjoyed the quietness and solitude of their bedroom as they slept and rested most of the time. The bedroom spaces for the residents allowed the resident to act 'back-stage' in terms of presentations of the self, identified in Goffman's dramaturgical social theory (Goffman, 1990) which will be further described in the discussion chapter of this thesis. Residents in their bedroom could act without constant self-awareness of being watched by others but instead could experience solitude in a relaxed ambience.

6.3. Creating a personalised environment and enabling autonomy

Male residents exercised autonomy in their bedrooms by choosing how to organise their daily routines. Their autonomy was sustained by the material conditions of their rooms which could reflect their own life story and personal tastes. It seemed that residents organised their bedrooms with the support of the care staff to overcome their physical impairments but also to reflect their biographical life and aesthetic tastes. Through the organisation of the bedroom, residents exercised control and therefore experienced certain autonomy during their daily routines without the need for assistance. For example, Abel's bedroom had been prepared

to cope with his health limitations but then clearly displayed features which reflected his biography and hobbies:

Abel's armchair faced a large window which viewed the care home's open garden. He spent most of his daytime sat in this armchair. Underneath the window there was a small table full of different plants. Outside of the building, in front of his window there was a wooden bird tray which Abel proudly explained to me his nephew had built for him. Next to his bedroom there were several frames hung on the wall displaying military medals. In my first visit Abel was keen to tell me about his military experiences and the medals that he earned from fighting in the war. In all my visits I noticed that Abel always kept his bedroom quiet [Fieldnotes, Oak Home, Abel's bedroom].

Abel invariably reminisced about his life. He was keen to show the medals gained in the armed forces during the Second World War. On those occasions, he explained the value and the circumstances of each medal. Also, later in life he became a trained gardener working for the local council. When I asked how he spent his time he replied to me:

Researcher - What sort of things you do during the day?

Abel – *I like to write poetry [pause], ah, feed the birds* [he nodded towards the window where there was a bird tray outdoors]

Researcher - oh yeah, that is a nice a thing to have!

Abel – *yeah, I do a little bit of gardening* [Abel then pointed to the small table placed underneath the window full of flowers and plants planted in individual pots] *where I grow things*. [Interview, Oak Home, Abel]

I noticed that Abel also had a less active routine, spending long periods of time sleeping and resting in his bedroom. Abel's bedroom allowed him to look after his plants, watch the birds and look at the garden while the room remained quiet without interruptions from others, be they residents or staff. The bedroom space

enabled Abel to structure his routines and pursue his hobbies that reflected his personal preferences and life story. Similarly, Peter's bedroom was organised in such a way that allowed him to perform certain actions and overcome his physical impairments, as the following excerpt about his bedroom shows:

Peter's bedroom was a bright space during the day. There was an armchair which reclined electrically. The armchair control was hung on the side of the chair close to Peter. Next to the armchair there was a small table. On the table, there was a pile of magazines, newspapers and a small radio. All the stuff on the table was within a reachable distance for Peter's use, despite his frail physical condition. On the other side of the room, there was a large television screen placed on the top of a chest of drawers which he controlled remotely. The television remote control was kept by Peter. Peter also had an alarm button placed next to his armchair which called the care staff if he needed anything. However, Peter's bedroom decoration was plain without pictures or any personal objects [Fieldnotes, Oak Home, Peter's bedroom].

It seemed that Peter had organised his bedroom with the assistance of the care staff in such a way that allowed him to undertake his favourite activities despite his frail physical condition. Peter was in the advanced stages of Parkinson's disease and was wheelchair-bound. The bedroom for Peter formed a space which supported him to spend his time as he wished, as he explained in a conversation:

Researcher - I noticed that you attend the meals downstairs but you don't spend much time between the meals there but I guess in your bedroom.

Peter - *yeah! I like to watch sport on the TV and radio.*

Research - is there any other reason for not coming downstairs more often?

Peter: *well [pause] I am very selective. I like to choose what I want to see and do. I like sports on live.* [Fieldnotes, Oak home, lounge]

Peter was keen to spend his time undertaking his favourite activities, listening to the radio and watching sport on the television. Peter arranged his bedroom to provide him with the support and autonomy necessary to undertake his favourite hobbies. Peter's answer also suggested that the communal areas could not support him to undertake those activities. That meant that spending time in the lounge for example, could require him to compromise or to be less '*selective*' about what he '*wanted to see and do*'. Thus, the male residents' preference for staying in their bedroom might be related to their sense of autonomy in choosing their own routine based on their personal choices.

The physical limitations experienced by the male residents created barriers to retaining their autonomy as Peter explained:

I plan my day to do what I want [and after a pause to breath he said]. *I know where I want to go, the problem is how to get there.* [Fieldnote, Oak Home, lounge]

Peter experienced considerable barriers to managing his daily life. Hence, his bedroom was the space in which he could conduct his routines without the need for support due to his physical impairments. Men's autonomy over their bedroom space was commonly used to undertake their favourite activities as Luke explained to me in the transcript below:

Researcher - So Luke(B), could you describe to me how you spend your day here normally? What do you do usually?

Luke - *Not a lot, if the weather's nice I'm usually out the garden. This time of the year I go out a couple of times for a smoke and basically watch the television. I enjoy television.*

Researcher - Alright, so you spend most of your time here? [referring to the bedroom]

Luke - *Yeah.*

Researcher - Yeah, then the rest of the time you watch TV or do you do something else?

Luke - *I watch the television or listen to the radio, unfortunately I can't read, my glasses are no good, my eyes are dodgy* [Interview, Oak Home, Luke].

In Luke's case, the bedroom provided the environment that allowed him to overcome the disability of being partially sighted. In a conversation, he explained to me that he watched old black and white movies in his bedroom in the dark. The contrast of the colours allowed him to understand the images on the television screen. Luke's bedroom provided the specific conditions that limited the effects of his impairments.

For Peter, as for most of the male residents, the television was an important piece of equipment for passing their time. Exercising control over the television was key for him in adjusting the bedroom environment to his needs and wishes:

Researcher - I wonder if the TV sound does not interfere when people are visiting you in your bedroom?

Peter - *If you notice I always switch it off when you come in because it interferes too much with my relations.* [Interview, Oak Home, Peter]

Peter's answer showed his awareness that the sound of the television could disrupt his conversations with other people as he had considerable problems with speaking due to Parkinson's disease. Peter's use of the remote control enabled him to avoid any difficulties when talking to visitors and care staff. Peter's use of his bedroom enabled him to control the environment according to his choices and facilitated his communication with visitors and the care staff. Watching television and listening to the radio were important activities for the male residents to occupy themselves while in their daily routines. Although the task of watching the television and listening to the radio could be seen as relatively passive, it is necessary to recognise that the choice and execution of their favourite activities such as watching and listening to sport were achieved by the residents themselves without requiring

somebody else's assistance. Thus, the bedrooms for the male residents were important spaces for providing a higher degree of autonomy, even if they were experiencing considerable physical impairments. In contrast, the televisions in the communal areas were usually not controlled by the residents but set up by the care staff. The following excerpt shows how residents reacted to the use of the television in the lounge in Cedar Home:

I was sat close to Wendy and Lucy in the middle of the afternoon. Wendy was reading a magazine while Lucy was dozing. The television placed on the other side of the room was set on loud volume. Helen was in the room as well sat close to the television. Helen was verbalising loudly as usual. Lucy at some point woke up, looked around with an unhappy expression and said to Wendy:

Lucy: *Why do we have to put up with that noise for the whole afternoon?*

Wendy: *What?*

Lucy: *The television! It is on all the time! Nobody watches!*

Wendy: *It is for Helen but she is not watching* [saying this as she looked towards Helen on the other side of the room].

As I heard Lucy's complaint I offered to switch the television off and Wendy replied to me: *would you really?* The two residents seemed glad about my suggestion. When I turned off the device and sat back in my seat Wendy said: *That was very kind! Thank you!* [Fieldnotes, Cedar Home, lounge]

Wendy and Lucy had mobility impairments (they walked with a Zimmer frame), hence there were physical barriers for them to control the television. However, throughout the fieldwork in Cedar Home I did not observe any of the residents in the lounge asking to change the television settings. This might be related to the lack of entitlement that those residents felt they had over the communal areas in Cedar Home.

On many occasions in Cedar Home the television was put on before any resident moved into the lounge and continued that way for the rest of my observational period. On other occasions, I observed the care staff setting up the television in the lounge without consulting the residents who were in the room. These occasions happened when the care staff assisted the very disabled residents who had dementia and could not express their wish. Nevertheless, the sound of the television affected all residents who were in the lounge as the excerpt above illustrated. There were some negative cases in which the residents exerted control over the electronic devices and over the space in communal areas. For example, Philippa, Theresa and Joseph felt in charge using and controlling the lounge in Oak Home, including the electronic equipment.

It seemed that male residents did not perceive the communal areas of the care homes suitable spaces in which they could engage in activities such as watching the television. The bedrooms were perceived as more appropriate spaces in which they were able to keep themselves occupied, as Terry in Cedar explained:

Researcher - I notice that you spend quite a lot of time here in your bedroom. Why is that?

Terry - *Well I usually watch the programmes or do crosswords, you know. I like to be active all the time whenever I can.* [Interview, Cedar Home, Terry]

Terry's answer suggested that to be active or to have the sense of being active seemed to be an important component for men to orientate to their daily routines, and the bedroom was the only place where he could undertake his preferred activities. Men's accounts suggested that they were keen to structure their daily routines by undertaking their activities of choice. Men's private bedrooms were the spaces in which they could create their own space which reflected their biography and personal tastes. In this particular sense, the organisation of the bedroom allowed the men to have a higher degree of autonomy as they were able to choose their favourite activities or to be inactive. Exercising control over the

electronic devices such as the television were an important part of enabling them to regulate the own environment.

In the next section of this chapter I will present findings on how the bedroom space supported the feeling of 'homeliness' for men in the care home and why they may have actively sought solitude.

6.4. The space to seek solitude and create the feeling of homeliness

While undertaking the fieldwork in Oak and Cedar Home, I noticed that most of the male residents stayed in their bedrooms most of the day. In these spaces men appeared to seek solitude and to actively isolate themselves from the types of social life offered in the communal areas of those care homes. However, men's habits of deliberately seeking to detach themselves from the social life of the care home did not seem to lead to feelings of loneliness for most of those individuals; rather they sought and enjoyed solitude. Men's tendency to seek solitude might be related to their biography rather than being associated with older age or failing to socially integrate within the care home. The bedroom spaces allowed the men to experience solitude and a certain degree of autonomy which appeared to foster the feeling of homeliness. Luke's answer illustrated how he perceived being in his bedroom.

Researcher - what are the reasons for you to not spend more time in the lounge but here? (in the bedroom)

Luke - *I enjoy being by myself, I'm a loner, but I've got friends down there but I like my own company. I'm so used to it after 30 years living by myself before I came here, I tell you, people say, 'He must be lonely', actually no, I'm not.* [Interview, Oak home, Luke]

When asking the carers about Luke, the manager referred to him as a '*loner*' and by Constance(S) as an '*outsider*'. The interview transcript shows that Luke was aware of people's perception about his tendency to prefer his own company. In Luke's case, being isolated from others was his own preference perhaps contrary

to the care staff's views about his life. Luke sought isolation in his bedroom and did not seem to relate this to being lonely or troubled.

Constance(S) explained as she was the staff responsible for residents' social activities (organising day outs, parties, group presentations and activities in general) how Luke struggled to interact with others in social gatherings:

... Luke doesn't like spending, if he has too much hassle, like with somebody, he doesn't like to tolerate it too long, he'd rather stay in his room and watch a black and white movie than come downstairs if he knows he's going to get a lot of hassle from anybody. [Interview, Oak Home, Constance(S)].

Another member of staff in the care home, Dora(S), knew Luke from his previous life outside the care home. Dora(S)'s husband used to work in the same company where Luke used to work as a deliverer. Dora(S) explained her husband's impressions about Luke's life before moving into the care home in the following transcript:

Yeah, he [Dora(S)'s husband] knows that he [Luke] was married but he doesn't know that much about him and you wonder what happened to him actually and he was surprised that he was here, you know, yeah, because he always thought he would be in a home on his own I suppose, you know, he didn't think that he mixed very well, that's all... [interview, Oak Home, Dora(S)].

Dora(S)'s accounts provided a glimpse of Luke's life when he was younger and confirms Luke's own picture of himself. Luke who was from a working-class background seemed inclined to seek solitude and isolation from others in the care home as the data suggests here, thus, the bedroom was the space in the care home in which he could maintain his solitude and privacy as he wished. Hence, the bedroom provided a space in which men were able to experience solitude by retaining privacy and exercising autonomy in choosing how to spend their time as

shown in the earlier sections of this chapter. Similarly, in the fieldwork, I noticed that Mark spent long hours resting and relaxing in his bedroom, but this behaviour did not seem to affect his wellbeing negatively, as explained in the following interview excerpt:

Yeah. With certain people, you know. I mean I can be quite happy and content, but I can be quite happy and content on my own in the little room. I know it seems funny to a lot of people but it's, I think one of the reasons is because I've been here so long now that although it's only one room, it's my little home. And that's how I treat it and I'm not snubbing the other people at all, you know... [Interview, Cedar Home, Mark]

Marks remarks about the bedroom: *'it's only one room, it's my little home'* expressed his feelings of homeliness to the bedroom space as his own space and own home. Mark's answer also expressed that there were boundaries he perceived which formed thresholds between the care home space and the space he considered his own home. That means that he did not perceive the other areas of the care home, such as the lounge and dining room, as part of his 'home'. Men's feeling of homeliness for their bedroom was enabled through their control of these spaces which allowed them to experience moments of solitude and privacy. All these qualities are likely to instigate the feeling of homeliness which are essential to enhance the wellbeing of men living in care homes.

6.5. Summary:

This chapter examined the physical and social properties of the bedroom spaces to provide an understanding of how and why men in care homes spend great parts of their daily routines in such spaces. The enclosed space of the bedroom enabled residents to retain privacy and exert a degree of autonomy. Privacy was also retained and enforced by the resident through his control over the space in relation to visitors and care staff.

Men living in care homes placed great importance on being active throughout their daily routines. The organisation of the bedrooms around residents' health needs and impairments allowed residents to take autonomous choices in engaging with their favourite activities. The material conditions of the bedroom, such as the use of electronic devices and operating them remotely, were significant in achieving residents' autonomy in regulating the ambience without the support or permission of the care staff. These personal spaces reflected residents' life stories and aesthetic tastes.

In addition, the bedrooms were spaces which allowed residents to retain certain privacy and experience moments of solitude. All these characteristics enabled men to experience the feeling of homeliness in the care homes. Men's isolation in their bedrooms may not necessarily lead to loneliness, but rather, enhance their wellbeing.

7. MEAL TIMES AND THEIR CENTRALITY FOR MEN'S SOCIAL LIVES

7.1. Introduction

This chapter presents the findings on the social aspects of mealtimes, the use of the dining spaces for men living in care homes and the role this plays in shaping daily routines and social lives. The chapter starts by analysing how residents understood or perceived the function of mealtimes as social events in their daily routines in broad terms. The subsequent section presents the findings on how residents assigned themselves to the dining table spaces and how care staff took part and influenced residents' table assignment. The chapter then explores the importance and main social features of the mealtimes for male residents. In the final section, the main characteristics of how men tended to communicate during the mealtimes are presented.

7.2. The value of eating together

Eating together during meal times was an activity that had value for the residents beyond the consumption of food. Eating together were occasions with a social importance for residents' lives. These occasions promoted the residents' inclusion into the wider group and immersed them within the care home's social life. The social functions of these meal events are examined and discussed in this section, not only in terms of gender but more broadly, with the aim to provide an overview of their importance to the residents' social lives and their wellbeing.

Food and eating were recognised as being important to residents in their evaluation and perception of their lives in the care home, as Theresa told me in a conversation:

While talking with Theresa in the lounge, I asked if she likes to live in Oak Home and she replied: *this is a nice place to live. I like the food here, the food is very nice and we don't have to worry about that.* I

then asked where she usually had her meals and she replied to me:
that is my thing, I don't like to eat on my own. Some people here eat in their bedroom but I could not do that [Fieldnotes, Oak Home, Theresa]

Theresa placed particular importance on the space where she ate in the company of other residents. For Theresa, the bedroom signified isolation from other people in the care home, or at least from other residents. The dining room was a space, and mealtimes were moments, in which she was able to socialise while eating with her close companions and with the wider group of people involved in these events; care staff and visitors. Thus, Theresa saw joining in the mealtimes as opportunities where she could avoid the isolating experience of eating on her own in her bedroom.

The act of eating the food in the communal areas of the care homes therefore facilitated or even stimulated residents to engage in some sort of social interaction. As Mark explained, being in the company of others and having the opportunity to interact was equally important to eating the food:

I wanted to have somewhere to sit that I could have a bit of conversation with the people that were there, you know, I didn't want to just sit there and eat and go. [Interview, Cedar Home, Mark]

Indeed, having a space, '*somewhere to sit*' and performing the actions '*eat and go*' would be empty of any significance for Mark if the mealtimes did not enable social gathering with other residents and care staff. Thus, being able to socialise during the mealtimes was viewed as more important than consuming the food, as Daisy also expressed to me before going to the dining room on one occasion:

The care staff were helping the residents to move to the dining room and I noticed that Daisy and Susan were agitated and impatient to get out of their armchairs. Daisy asked me: *Where they are going? What is happening?* I then explained that it was time for the dinner but they had to wait until the carers moved the least mobile residents to the

dining room. My explanation did not seem to convince either of the residents as they seemed agitated, observing attentively the carers and residents moving out the room, sat in an erect position and ready to get up from their seats. After a brief pause Daisy replied to me *I am not hungry but I want to be with the people – do you know what I mean?* [Fieldnotes, Beech Home, lounge]

Although Susan and Daisy had dementia which prevented them from processing and retaining basic information about the routines in the care home, the excerpt above illustrates how anxious some residents felt if they perceived themselves excluded from the rest of the group. As Daisy expressed, feeling hungry and eating the food had no importance in that circumstance. Her main concern was to join and be part of the group and overcome the fears of being isolated. For Daisy, being excluded from the social gatherings of mealtimes in the communal areas of the care home meant to be socially ostracised from some residents.

The mealtimes in all three care homes were activities with functions that went well beyond satisfying bodily or biological needs of ingesting food and drink. The residents placed further significance on how particular mealtimes helped them to structure their daily routines as Geraldine from Oak Home explained succinctly when I asked her why she preferred her meals in the dining room:

I have breakfast in bed and come downstairs for lunch and tea [dinner]. It helps to break the day. [Fieldnotes, Oak Home, Geraldine]

I interpret Geraldine expression of '*breaking the day*' as a property of the mealtimes which allowed Geraldine to divide the day into different slots of time and perhaps made her day flow more easily and quickly. Moreover, I argue that mealtimes in care homes were especially important for the residents' social lives because these events orchestrated the whole group in the care home, the residents, the care staff, the kitchen staff, nurses and eventual visitors, to engage in one single task which was the residents eating or being fed during the meals. During my fieldwork in all three homes I noticed that the mealtimes, lunch at noon

and dinner in the evening were set up, carried out and coordinated by the care staff with the active cooperation of the male and female residents if they had the capacity to do so.

However, breakfasts followed less rigid routines as the residents chose where and when to have their breakfast according to their personal preferences. For example, in Oak and Cedar Homes the breakfasts were usually served in residents' bedrooms with a few exceptions, and the few residents who ate breakfast in the communal dining area did so at different times in the morning. Residents in Beech Home had their breakfast in the dining room, however, the residents arrived at different times in the morning as they were helped to get ready for the day. For the breakfasts in Beech Home, the residents did not follow a set seating arrangement, but they sat at the most convenient available seat. The social interactions were mainly between care staff and resident, with the care staff focussed on the task of helping the resident in eating his or her morning meal. The coordinating aspect of mealtimes was especially noticeable for the lunch and dinner times because the whole team of care staff assisted the residents, when he or she needed, to move to the dining room in preparation of mealtimes. The care staff also supported the residents by serving the food and, when necessary, supporting the resident to eat.

The mealtimes encompassed a set of additional activities that demanded social interactions such as: moving to the dining room; negotiating the support with the care staff if the residents had mobility impairments; accessing the dining room; exchanging greetings with the people found in the same room; waiting while the food was served; eating the different courses; choosing and drinking the drinks and hot beverages; and finally moving away from the dining room after the meal. All these actions or activities were mutually coordinated by the group as the care staff and residents moved from one task to the next. All these tasks engendered a sense of togetherness for all individuals as they had to socialise to complete tasks which created a sense of community. In this respect, mealtimes were irreplaceable social events for the residents in the care homes as no other activity within the home led to the coordination of all residents and most of the care staff in undertaking one

task. For example, group activities would involve one or a small team of care staff and most of the residents declined to take part in them.

7.3. The table assignment process

The processes of staff allocating residents to tables in the dining room partially shaped resident's use of the dining room space and defined residents' closer social ties with their peers. Table assignment involved two different phases: *allocation* and *appropriation*. The care staff took roles which empowered them and made them responsible for allocating residents to 'their' tables. There were different strategies to allocate the residents to the dining tables and they varied according to the managerial style and the space conditions of each care home. These strategies were based on grouping residents with similar traits such as gender; cognitive capacity; social background and compatible behaviour or personality. The appropriation phase consisted of the resident 'owning' the space at the table but also, it meant to routinely share this space with the same table mates at the mealtimes. The appropriation of a seat at the same table for the mealtimes provided continuity and enforced social ties with a close group of residents. When the care home staff could not support residents' appropriation to the table seats, as in Beech Home, this may lead to disempowerment of the residents over their routines and reduce or prevent the social connections between residents.

This section presents the findings regarding the allocation phase for assigning residents to seats and tables, followed by the appropriation phase.

7.3.1. Allocation

During the fieldwork, I noticed that the care staff were responsible and empowered to manage the dining room space during the mealtimes and the residents were subject to the staff's decisions. The allocation phase was particularly important for residents who had recently moved into the care home as it served as a 'forced' introduction to a group that shared the same dining table. Mark's explanation as

to how he was allocated a table and seat in the dining room demonstrates how he perceived the allocation stage in Cedar Home:

When you first come here and you go in the dining room it's usually the girls [referring to care staff] in the dining room who say 'oh well, we'll put you there or we'll put her there or whatever... [Interview, Cedar Home, Mark]

Mark's answer suggested that from his perspective, the care staff or 'the girls' had the 'say' as to where he would sit in the dining area when he arrived in Cedar Home. Mary, a resident living in the same care home also expressed a similar experience.

Researcher - Did you choose where to sit in the dining room? If so, how did you decide where to sit? Mary - *They decided it! I didn't! Well, it was a vacant seat, so they put me there, sort of. [Fieldnotes, Cedar Home, Mary]*

Mark's and Mary's answers provided an insight into how residents perceived their first experience in the dining area. Their accounts demonstrated they had no choice in selecting a table to sit at. Instead, the care staff exercised the control over the dining room and made the decision where to place the residents. Residents in this circumstance undertook a passive role in the process of allocation, as expressed in the following interview transcript

Researcher- Did you have any say where to sit? [in the dining room]

Peter - *They just put you there. They allocated you in that place. It is very much like going to school. Like in the school, in the class somebody new came and had change in the pattern. [Interview, Oak Home, Peter]*

These interview extracts showed that both residents perceived themselves as being disempowered by being unable to make the choice of where to sit in the dining room. Moreover, Peter's statement in comparing the dining events to being

in school suggested it can be experienced as an institutionalised and even infantilising experience for the residents. This meant that individuals were closely bound to the group as in a school class and the social experiences of the group are changeable as the group is reassembled over time. In this sense, being bonded into a group conveys some sense of external coercion like students encounter from teachers. Thus, the residents' lack of power is not restricted to being allocated where to sit in the dining room, regardless of their preference, but is widened to having no control over the changes in the group configuration of residents that shared the same dining table.

The following excerpt from Oak Home fieldnotes provides an insight into how the manager and Cornelia(S) re-allocated residents to another dining table which shaped Simon's experience of the mealtimes:

On the previous day I observed Simon having his lunch alone at one of the tables in the dining room. I decided to ask the manager whether there was any particular reason for Simon sitting on his own as everybody else was sat in groups. The manager seemed surprised with my question and checked the information with Cornelia(S) who was in the office. Cornelia(S) confirmed the information and the manager said to Cornelia(S) impatiently: *well, make sure that he sits with other residents next time*. Cornelia(S) agreed with the manager and left the office straight after her reply.

On the same day, I observed the residents arriving for their lunch in the lounge. Cornelia(S) came to the room escorting Simon by the arm. As they got into the dining area of the room, Simon tried to walk towards the same table that he sat at on the previous day.

Cornelia(S) held Simon's arm closely and said: *you sit here with the ladies!* pointing to a vacant chair between Theresa and Joan, enforcing the command by saying: *right here!* and pulling out an empty chair available at the table. Simon followed Cornelia(S) instructions with no

protest. He had his meal with Theresa and Joan on that day. A few days later, Simon was reallocated permanently to another table which he shared with a couple who had recently moved to the care home.

[Fieldnotes, Oak Home, dining room]

This observation was at odds with my initial impressions on residents' control over the communal areas in Oak Home and their apparent freedom in choosing where they sat. The interpretation of the excerpt above shows that the staff asserted complete control of the space in determining the seat for Simon. The conversation between the manager and Cornelia(S) showed that the care staff actively planned where and who the residents should sit with. Cornelia(S)'s action in directing Simon in the dining room showed how this control over the residents is enforced. I observed staff allocating residents to the dining tables in all three care homes.

I will now consider the different strategies adopted by managers and care staff in each care home to allocate the residents to the dining tables. Care staff allocated residents to the tables, however, they exercised such decisions depending on the management style of each care home and the material conditions of the space. For example, in Oak Home, the mealtimes were closely supervised by the care home manager who was concerned about providing a pleasurable dining experience for the residents. This required the manager and senior staff to consider residents' personalities and health issues compatibility to plan their seating arrangements for the mealtimes in the dining room. This strategy could provide a better dining experience for residents as the care home manager explained in an interview:

What we try to do, like we've got a lady coming in next week and she's 100 but she's got full capacity and she likes to chat. So straight away I would put her in the small lounge [for the mealtimes] because they like conversation more... We do think about where we sit them, and we've sat people before and it doesn't work, so we move them around every so often if we find that they're not getting on with those people.

[Interview, Oak Home, manager]

In her explanation, the manager in Oak Home explained her strategy about how to arrange residents in the dining room and to group them at the dining tables with the aim of encouraging social interaction while being sensitive towards the individuals' needs. The next interview transcript the manager highlighted the importance for residents to have a pleasant experience in the mealtimes:

If you've got someone that's, could be a problem person or loud, I would put them with someone that's not going to retaliate that... Because it's always a good thing if you're sat eating, you've got to enjoy your company, it's no good sat eating if you've got someone arguing between them, you have to make sure that you get a happy medium. [Interview, Oak Home, manager]

The care home manager in Oak Home aimed to provide a pleasant dining experience for the residents during the mealtimes. What the care manager did not seem aware of, or at least she did not express in her interview account, that by planning and enacting the allocation process, the team of care staff were shaping the residents' social lives in general and not only the dining experience as discussed in the appropriation phase. This was particularly the case for male residents. In contrast, the strategy for allocating new residents in Cedar Home was simpler and primarily based on the resident's gender. This might have been related to the managerial style adopted in Cedar Home in which the manager was less present in the communal areas and did not supervise the mealtimes closely. The mealtimes were not supervised by anyone in particular and the decisions to organise the mealtimes and allocate residents to the table appeared to have been taken by the care staff. Ronald's arrival during my fieldwork showed me how care staff allocated residents a seat and table in the dining room as illustrated in figure 14.

Ronald was a new resident in Cedar Home and today was the first time I observed him in the dining room. Martha(S), the larger wing head, supported Ronald to move and take a seat in the dining room before the lunch started. He sat at the table at which Helen and Fiona

normally have their meals. Martha(S) left the room after Ronald was accommodated in the room. As the room became busier in preparation for the lunch, it appeared to me that Ella(S) and Mabel(S) were discussing reallocating Ronald to another table. Ronald was moved by Mabel(S) to the table with Terry, Mark and Paul where he had his lunch. After the lunch, I approached Mabel(S) to ask her why they moved Ronald. Mabel(S) replied: *because men like to sit with men – it is the men's table*. [Fieldnotes, Cedar Home, dining room]

In this instance, the spaces in the dining room were divided into gendered areas, organised or structured by the dining tables. Thus, the staff used gender as a reason for moving and allocating Ronald to the 'men's table'. As men were the minority in the group of residents in the dining room, four male residents and nine female residents, the men were all grouped around one single table. When allocating Ronald, the staff did not consult with the group of male residents already sitting at the table – Mark, Terry and Paul. However, the term 'men's table' was known by the male residents in Cedar Home as Mark explained in the following answer:

Somebody else who comes, who comes, may come in and because it's a man they put them at our table because that's always considered the men's table. [Interview, Cedar Home, Mark]

Mark's reference to his table as the 'men's table' provides further indication that the dining room was divided by the care staff into gendered areas organised through the dining tables by the care staff. Figure 14 shows how the dining room in Cedar Home:

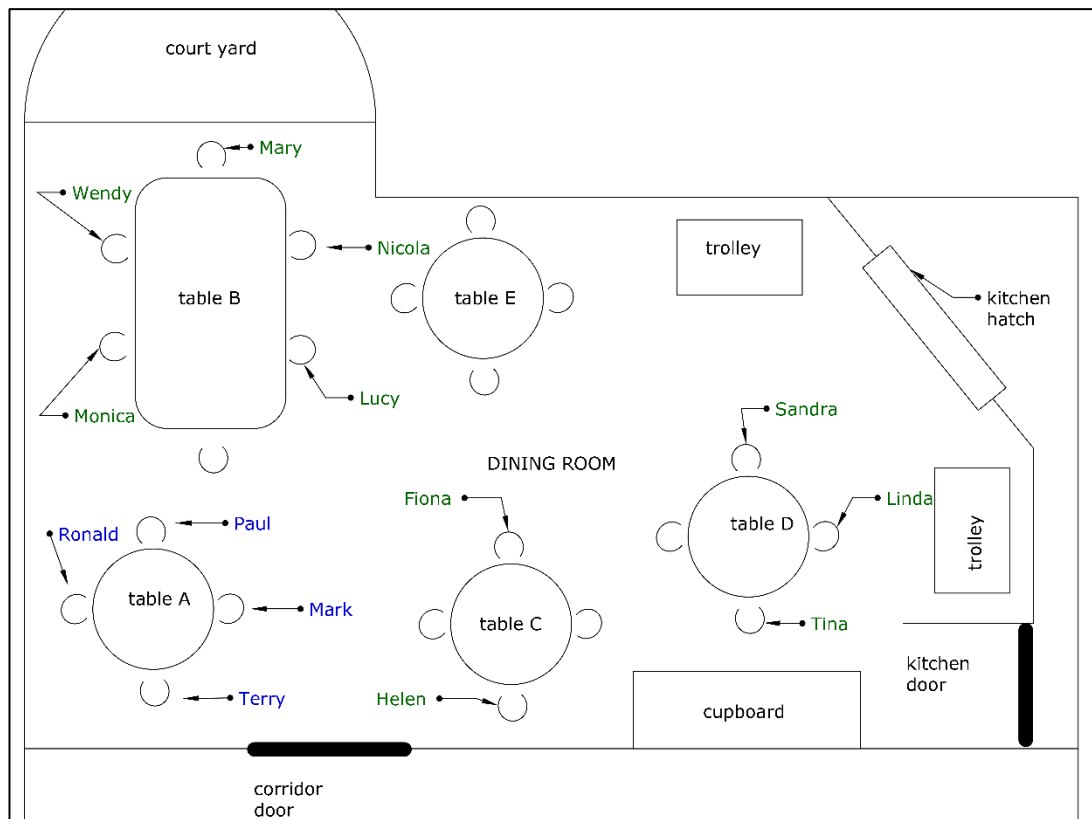


Figure 14. Residents' seating arrangement at mealtime in Cedar Home

7.3.2. Appropriation

Once the resident was allocated to the table, the resident became accustomed to sitting on the same seat, or at least to sharing the same table. In fact, the residents also exercised an indirect and parallel control over the dining space in relation to the care staff's power over the dining room. Hence, how they appropriated their table and seat manifested the residents' agency over the communal space and regulated their social experiences within the group. The care practices adopted in each care home were critical for encouraging residents' agency in supporting them to maintain their seats through *appropriation*. For example, staff always assigned the residents in Cedar Home to the same table, but sometimes allocated residents with poor physical mobility to different seats at the table. In contrast, the seating arrangements in Oak Home never varied regardless of residents' mobility impairments.

For residents who required assistance to move to the dining table, I often observed that there were no words exchanged between residents and care staff in negotiating the seat for the residents, but it was implicitly assumed by residents and care staff. I therefore concluded that the appropriation of the tables was mainly pursued by the residents although it was aided by the care staff. Residents appropriating seats meant that the space became exclusive to the resident as described by Mark as 'your place':

... But then after that, that's your place, you know, and nobody else goes, I mean if somebody sat in my chair now I think the roof would go off! (Laughter) [Interview, Cedar Home, Mark]

Furthermore, residents appropriating their seat also situated them geographically in the room and also socially in the wider group of people living and working in the care home. Residents' agency in maintaining their appropriation over the tables and seats on some occasions conflicted with the support provided by the care staff to the residents in moving to the dining areas and sitting at the tables as this excerpt reveals:

The desserts had been served by the time that Lucy arrived in the dining room. As usual, she was in a good mood and said to the people who she always shared the table with: *I was waiting for the lunch in the wrong place!* [laughter]. Edith(S) approached Lucy to help her to take a seat and serve her meal. Although there was a vacant chair at the table where Lucy routinely sat, Edith(S) tried to allocate Lucy to another table because this would facilitate residents to move out of the room as they were finishing their meals. Edith(S) then asked: Edith(S) - *Hi Lucy! Where are you having lunch? There!* [pointing to another table where no one was sitting] or *there!* (pointing to the seat at Lucy's table)
Lucy – *Here!* (holding the back of the chair placed at her table).

With certain impatience in her expression, Edith(S) repeated the same question:

Edith(S) – *where do you want to sit Lucy? Over there! Or there!*

[making hand gestures towards the two options].

Lucy - *I want to sit here?*

Edith(S) - *Yes! You can sit here!* (Edith(S) shook her head and pulled the chair for Lucy to sit). [Fieldnotes, Cedar Home, dining room]

In my understanding, when Edith(S) supported Lucy in taking a seat at the dining table, the carer aimed to not only provide support to Lucy but also, organise the space in a more efficient manner by attempting to allocate Lucy to another table. This would allow a free passage for the residents previously sitting at Lucy's table when leaving the table after they finished their lunch. Lucy demonstrated clear confidence in appropriating her table space despite the care staff's efforts to persuade her otherwise. The residents' appropriation of the space in the dining room was related to the social aspect of having habitual companions at the meals-times. Edith(S)'s suggestion of sitting somewhere else in the dining room would have resulted in Lucy becoming isolated. However, some residents retained their place even if they had no affinity with the people who they shared the table as Luke explained to me in Oak Home:

Mostly on the meals, the worst part about it actually I shouldn't say

this but Philippa is a pain in the neck. She's on our table, up and down,

up and down! Anyway, I'm not moving so I'm staying where I am!

Down there! (Luke referred to the dining room downstairs, waving his hands emphatically) *I'm quite happy!* [Interview, Oak Home, Luke]

Luke placed more importance on maintaining ownership of his seat at the dining room than avoiding someone's undesirable company. Changing the seat for Luke in this case would have undermined his agency and also, changed his geographical and social position amongst the residents in the dining room. In contrast, some of the residents in Beech Home did not appropriate the dining seats, as the

assignment system in Beech Home had a different dynamic to the other two care homes. The process to move the residents into the dining room was time consuming and required considerable coordination from the care staff. The dining room in Beech Home was not spacious enough to sit all residents during the meals and to allow the care staff to circulate around the tables in order to provide necessary care to the residents. In this sense, the dining room seemed cluttered with the furniture necessary to accommodate all residents compared to the size of the dining room. This made it impossible for care staff to support all residents to gain appropriation of individual seats in the dining area. Thus, most of the residents were allocated to different tables at every meal. The following figure is useful to understand the table assignment in Beech Home:

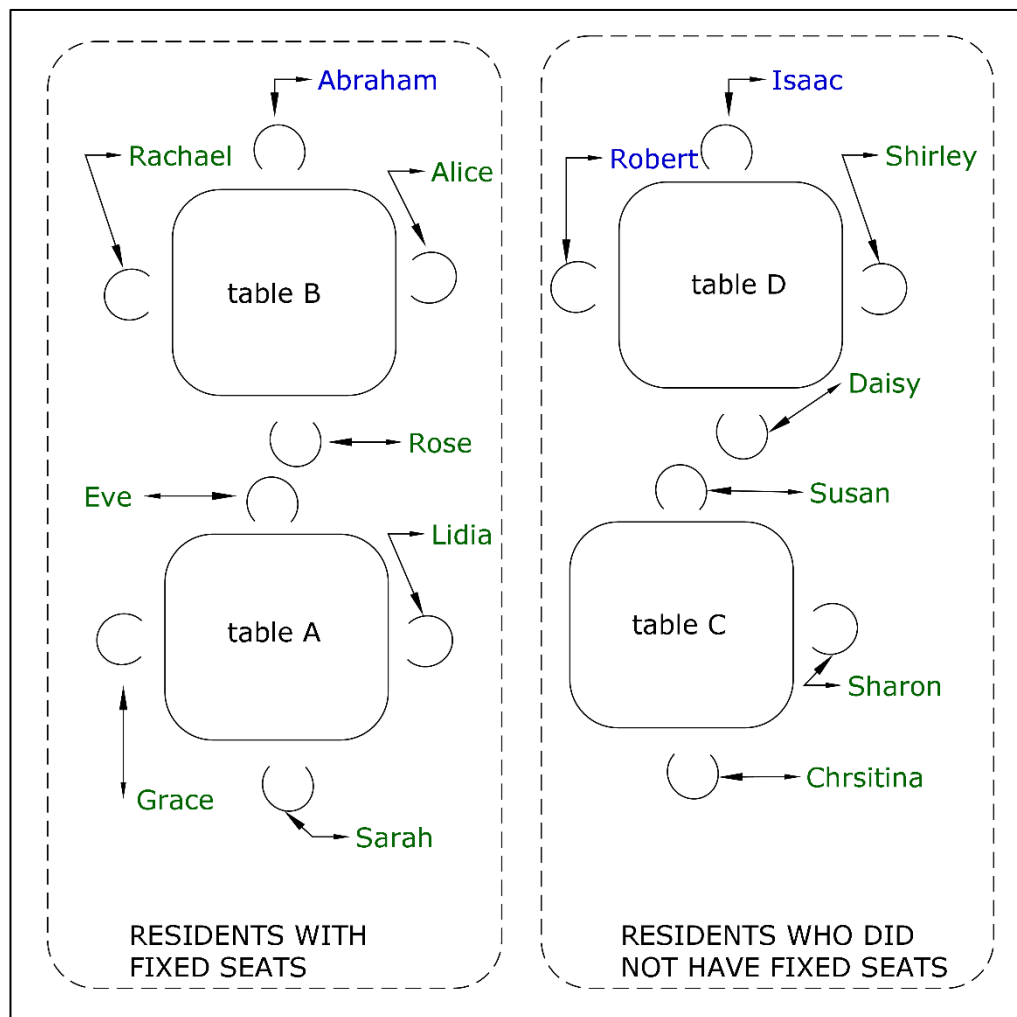


Figure 15. Residents' seating arrangements at mealtimes in Beech Home

Residents appropriated their seats at tables A and B. The group that sat at table A were all wheelchair bound, hence they were the first residents to be assisted by the care staff to move in and the last to be moved out of the room during the mealtimes. The residents at table B (excluding Lydia) were unwavering in their desire to sit at the same space each mealtime as they were closely bonded. However, residents at tables C and D were randomly reallocated to a different table every meal time and seat by the care staff. Hence, they were unable to gain the appropriation of the table and seats and this might have prevented residents from creating closer bonds with their peers by sharing the same table. The importance of sharing the table is discussed in the next section of this chapter.

Moreover, the frequent reallocation to dining seats created uncertainty and dependency for the residents who sat at tables C and D as this practice undermined residents' agency. The following excerpt illustrates how the absence of appropriation may undermine Susan's autonomy in self-regulating her everyday life:

Susan walked with difficulty towards the centre of the dining room. She moved with small steps, walking with a Zimmer frame and pushed it with great effort while looking down at the floor. When Susan got closer to Elsa(S) she stopped and looked up to the care staff and asked: *where?* Elsa(S) looked around and replied to Susan: *you sit here darling* while pulling a chair that was close Susan. Susan sat at the chair suggested by the care staff. [Fieldnotes, Beech Home, dining room]

I interpreted Susan asking 'where!?' to Elsa(S) as a form of asking permission to occupy the space and take part in the mealtime. The excerpt illustrated a situation which showed that the resident became dependent on the care staff's decisions because Susan could not exercise appropriation of the dining room space and taking part in a social event which was essential for residents' social lives. Thus, by the resident being able to exercise appropriation, this might contribute positively

to their wellbeing as they can exercise some degree of agency in using the communal areas of the care home. The appropriation of the seat in the dining space also provided certainty about the mealtimes as social events for the diners and reduced any anxieties in sharing the table with an undesirable or less known person. The table assignment in general, and more specifically the appropriation of the table seats, had a great impact on the residents' social life, especially for men living in care homes as I will discuss in the next section.

7.4. The social importance of the mealtimes for the male residents

Appropriating seating in the dining room at mealtimes enabled the men and women living in care homes to forge closer social bonds with the people with whom they shared the same table, while it ascribed the individual to a place in the whole group of residents living in the care home, the care staff and visitors. However, the findings in this section demonstrate that the mealtimes had an essential function for those who accessed the dining areas of Oak and Cedar Home during the mealtimes, which I now go on to present.

7.4.1. Mealtimes as the main social event for the men

As presented in previous chapters 5 and 6 in this thesis, the male residents preferred the solitude of their bedrooms and avoided the lounges during sitting-times or during group activities in Oak and Cedar Home. Thus, for most of the male residents who accessed the communal areas, the mealtimes provided a unique opportunity to socialise with their peers, care staff and visitors. Mark's interview account provided an insight into how he perceived the social function of the mealtimes in his daily life:

... One [Terry] has been here sort of about the same time as me. He came in a week or couple of weeks before I did. The other one, Paul, he came in about three years ago and I, I only see them at what you call lunchtime, dinner, when we have our main meal. Because breakfast is

always in your room and you can order whatever you want really.

[Interview, Cedar Home, Mark].

In his account, Mark acknowledged that the mealtimes were the only event in which he met with his closer companions; two other male residents with whom he shared the table. His explanation of these social encounters suggested the mealtimes or 'lunch time' as Mark called it, were known events with set times. Thus, the regularity of the mealtimes provided Mark with security in how he organised his social life. The intrinsic characteristics of the mealtimes in care homes, such as regularity of the events, every day, all days of the week, at the same time and the repetition of procedures such as the maintenance of the table assignment were essential for the social lives of men living in the care homes.

Moreover, male residents used the mealtimes not only to meet and socialise with closer companions but also to observe the whole social group that gathered in these social occasions. In this regard, male residents engaged in social watching while spending time with the group found in the dining room; residents, care staff and visitors. The following excerpt illustrates how Terry engaged in social watching:

As usual, there were several carers (five carers) standing close to the kitchen hatch as they waited for the residents' meals to be prepared in the kitchen. There was a relaxed atmosphere amongst the staff (carers and kitchen staff) who engaged in various subjects of conversation i.e. work related, personal life and jokes. A female care staff told of her experience in the town centre: *I've got lost in the town centre yesterday, can you believe it? I live here for 5 years!* The kitchen staff showed up at the kitchen hatch and said loudly *it is the dementia creeping up!* The comment made the staff laugh. Terry who could see the whole room from his seat observed the staff and reacted as this conversation unfolded by looking at the staff as they spoke and smiling with the staff comments. [Fieldnotes, Cedar Home, dining room].

Thus, the mealtimes were social occasions in which the residents could observe others in the room to interact and learn more about people's backgrounds, opinion, concerns, and also events that were happening in the care home. Hence, engaging in social watching was an activity which might provide stimulation for the residents and therefore may have a positive impact on their wellbeing. While most of the female residents engaged with the activity of social watching in other areas of the care home such as the lounge, male residents like Terry preferred to engage in social watching only during the mealtimes. Thus, the mealtimes were the most important events during which male residents could immerse themselves within the social group formed by each care home.

7.4.2. Mealtimes as a sharing activity

The mealtimes in care homes were important social events for all residents; men and women. However, the mealtimes were events invested with a purpose; eating the food. Mark's comments about the mealtimes indicate this:

...And Terry (a resident who Mark shares the table with) is his name. And again, we don't do anything except, well a couple of old crumples like us we can't do very much apart from stuff our faces [Laughs]. He sits opposite me, and we have a little chat and he goes off to his room and I come to my room and that's it until next day and then we put the world to rights again (Laughs) [Interview, Cedar Home, Mark]

And

...It's like we're good old friends that sit opposite one another. We don't do anything else or go anything else... [Interview, Cedar Home, Mark]

Mark's comments that his group didn't 'do anything' signifies the importance of doing something as an activity to justify their social gathering. Hence, eating the food meant to engage in an activity that justified the social gathering and spending time together. The mealtimes were social events for the residents which supported

them to focus on the certain tasks, eating the food, drinking, and waiting for the meals to be served.

7.4.3. Creating social ties by sharing the dining table

Residents' appropriation of seats in the dining room enabled them to routinely share the table with a small number of residents during meal times. The amount of space taken up by the dining table allowed the residents to have closer proximity with their peers. This closer proximity in many cases was useful for the residents to partially overcome any communication impairment. Peter's answer demonstrated how the dining table functioned as a social connector:

These are the people closest to you and you get used to them and they get used to you. [Interview, Oak Home, Peter]

Peter had Parkinson's' disease and was wheelchair bound. He depended on the care staff to in order to mobilise in the care home and had difficulties with speech. Therefore, he was able to communicate only with people within a close distance. Peter's explanation suggested that as he spent time in close proximity to the same residents at the same dining table he became socially closer and more familiar with those individuals. Similarly, when asked: do you have any friends in the care home? Luke referred to the residents with whom he shared the dining table:

Yeah two or three I know pretty well, Joseph, Eugenia. I say, I don't really have a lot to do with anybody down there (referring to the communal areas) really just that I know Joseph well and Eugenia. [Interview, Oak Home, Luke]

Luke's answer referred to the residents (Joseph and Eugenia) with whom he shared the dining table. In both answers, the male residents suggested or indicated that the people whom they shared the dining table with became socially closer to them as people they knew or who were a companion. While Luke described the people whom he shared the dining table with as the closest to him in the care home, the table could become barriers to socialising with others. This was due to two reasons:

i. in the fieldnotes I noticed that mealtimes were busy and short events (usually less than an hour), hence residents had a brief window to socialise unless they met during other social occasions; ii. the physical and sensory impairments some residents had made it difficult to interact or converse with residents at the other tables. Nevertheless, the dining tables created social ties which lasted, even after residents no longer dined together as Peter's account suggested when I asked him about people who dined in another area of Oak Home:

Researcher - Do you know any of the ladies who dine in the other room?

Peter - *Yeah. Dorothy.*

...

Researcher - Do you speak to her, I mean, how do you (pause)?

Peter - *Yeah. Dorothy and I have been here a long time, she used to sit with me until we got more people.*

Researcher - She used to sit with you?

Peter - *On my table. ... And when more people came we changed.*

Do you miss having her on your table?

Yeah. Yes, I do. ... I've got a nice pleasant relationship with Dorothy...

[Interview, Oak Home, Peter]

The habit of sharing the table with Dorothy in the past allowed Peter to develop a social connection which lasted even after they no longer dined at the same table. Thus, for Peter and most of the men living in Oak and Cedar homes, the dining tables worked as vehicle for men to socialise and build closer ties with their peers but at the same time limiting the possibility to socialise with residents sat at other tables.

7.4.4. Men's working experiences and self-identity

Sharing a similar professional background was an important feature for the male residents to socially bond with their peers through the dining table. Male residents who shared the same professional background perceived themselves to be

members of a 'group'. This was the case for men who ate together in the dining room in Cedar Home. All three male residents had a similar background as they served in the armed forces as Mark explained:

Mark - *So one is our (table), I call it the naughty table... But we're all, all three of us are ex-servicemen.*

Researcher - Okay. All from the Army?

Mark - *I was in the Royal Navy, Paul was in the Air Force and, uh, oh sorry, Terry was in the Air Force.*

Researcher - Terry was in the Air Force.

Mark - *And Paul was in the Army.*

Researcher - Okay.

Mark - *I think between us we've got nearly a hundred years of service. So it always makes for good conversation, you know.* [Interview, Cedar Home, Mark]

The expression 'the naughty table' might express masculine features of this group compared to the rest of the people dining in the room; all women. However, Mark's perception of how he saw himself as part of a group that he shared the dining table with suggested that this distinction goes beyond gendered boundaries and was related to sharing the same professional background in the armed forces. Mark placed great importance in sharing a common working and life experience with his table companion when he said '*between us we've got nearly a hundred years of service*'. Sharing a common working life in a predominantly male organisation (the armed forces) inspired a sense of comradeship in Mark for his table companions. For Mark, meeting Paul and Terry formed an opportunity for them to reminisce about their past experiences:

Researcher – What kind of conversations you have with Paul and Terry?

Mark - *All sorts really. We talk about times in the services, we talk about music because both are great music followers, um, we talk about, ooh, anything.* [Interview, Cedar Home Mark]

Mark's account, however, seemed at odds with my observations in the fieldwork as I discuss in the next section of this chapter. For Mark, he attached great significance to sharing his mealtimes with people with whom he could identify with and create a sense of belonging to the group. This identification was related to the similar professional background of the group of men who dined together.

Men's professional backgrounds appeared to be an important issue for socialising amongst those who ate together in the communal area of Oak Home as well. In this care home the residents had diverse professional backgrounds; they worked as school teachers (Matthew and Lee), a manager in the health sector (Peter), a military background (Joseph and Oliver), and engineers (Simon and Frederic). As Peter explained in the interview, this seemed to instigate the relationships with those he shared the table:

Researcher – you said before to me that you 'get on well' with Matthew. Do you consider him as a friend?

Peter – *I see (him) as a companion, not a friend.*

Researcher – is he a companion?

Peter – *yeah. We have (long pause for a drink) outside of this house normal times we... (inaudible) instead a friendship*

Researcher - Sorry, I didn't catch what you said

Peter – *Our work environments are completely different. We have nothing in common to start with it.* [Interview, Oak Home, Peter]

Peter's interview indicated that his professional background was an essential element to his identity and therefore, it defined his relationship with Matthew with certain social distance as a 'companion' or someone who he 'got on well' with but not as a friend. This social distance was based on the different professional

background and life experiences to Matthew who had worked as a school teacher for all of his working life.

Although the findings are limited to examining only two examples, Peter's and Mark's accounts suggest that men's sense of identity is inextricably tied to their former professional life. Having a common professional background seemed to define how they connected with other male residents and how they saw themselves as part of a social group.

7.5. Men's communication at mealtimes and gender differences

The mealtimes were social opportunities in which residents, men and women, engaged in different social interactions using both verbal and non-verbal communication. This section presents the findings on how male residents communicated at mealtimes in the dining room. The findings also explore the main differences in how male and female residents tended to interact.

There were noticeable differences in how male and female residents socialised in these events. Male residents during the meal times spent most of their time in silence. They tended to avoid eye contact with each other, instead looking at their surroundings and did social watching by observing the people in the room while waiting for the food to be served, especially the care staff circulating and interacting. Female residents, in contrast, engaged in conversations amongst themselves more often than the men. They also made eye contact more often than the male residents and sometimes they had physical contact with each other. The communication amongst male residents during the meal times involved conversations around food, conversations around practical help, use of the humour and impersonal conversations around shared interests.

7.5.1. Conversations involving food

Men engaged in conversations which involved exchanges about the food during the mealtimes as in the following example where Matthew and Peter conversed at the table in-between meal courses:

Matthew was the first to be served the starter dish, a small bowl of soup. Matthew then tasted the soup and Peter, sat at the same table, asked him: is the soup good? Matthew with a grave facial expression replied: *it is okay* (saying it with emphasis and slowly) '*but that is all!*' Peter replied with an *um* and nodded and the men stayed in silence for the rest of the meal. [Fieldnotes, Oak Home, dining room]

Talking about food as a topic for conversation demonstrated a certain level of closeness amongst the residents. The conversation between the two residents had several meanings and purposes while they were dining together. When Peter asked the question to Matthew, he not only showed appreciation for Matthew's opinion but also it demonstrated the togetherness of both men when they engaged in the conversation while dining together. These social exchanges may serve to strengthen their social ties. Moreover, the mealtimes represented an opportunity when residents could socialise by sharing a common activity, eating a meal. Hence the conversation about food was a justifiable conversation as was part of the activity.

7.5.2. Conversations around practical support

I observed male residents interacting at the mealtimes by supporting and seeking help for someone on the table who was having any sort of difficulties. In those infrequent and short occasions in the mealtimes allowed the men to express their sense of togetherness, sympathy and caring towards their close peers. Those occasions allowed men to find a sense of purpose in the group. The following excerpts illustrate how these situations happened:

The main courses started to be served by Ada(S) who brought each resident's plate one by one from the kitchen. She held the hot plates with a tea towel and warned each resident while she was serving his or her meal about the temperature of the plate. After Peter had his meal served, Matthew called Ada(S)'s attention while she was serving somebody else in the room. I did not what Matthew said to Ada(S).

Ada(S) then looked to Peter and said '*he (Matthew) said you asked for something*'. Ada(S) bent down to speak with Peter closely. They exchanged a few words and after a moment she turned back to Matthew and said: '*he is fine*' and left the room to get the next meal in the kitchen. [Fieldnotes, Oak Home, dining room]

Matthew's health allowed him to intervene in favour of Peter who was more frail and less able to communicate. On other occasions, the help and attention amongst the male residents had more direct and practical effects:

By that time, all residents were sat at tables and waiting for the meals. A carer who I haven't seen working before in Cedar Home served cold drinks to residents. Mark had his drink served in a normal glass. After the carer served everyone in the room she moved to do another task. Mark tried to hold and sip his drink. Mark could not hold the glass steady but rather with jerky movements that splashed the content of the glass on the table. Until that moment, Mark, Terry and Paul were in silence at the dining table. Terry observed Mark struggling with the drink and shouted loudly once or twice to the carers: *Beaker and straw for mark!* Mark was sat facing the wall with its back to the kitchen, so the staff may not have been aware that he was having problems with his drink. Paul who seemed unaware of Mark's difficulty until that point, joined the call with Terry in repeating the same phrase by shouting: *Beaker and straw for Mark!* in unison. Terry and Paul were excited when they caught the staff's attention (or that was my impression of the two residents) and Mark had his drink served in the right container [Fieldnotes, Cedar Home, dining room].

These subtle occurrences illustrated that men were eager to demonstrate that they were actively useful and able to undertake tasks. Although these opportunities were incidental and infrequent, they were part of the social interactions in the

dining room and helped those individuals to have a sense of self-purpose and togetherness which might be beneficial to their wellbeing.

7.5.3. *Conversations using humour*

The mealtimes also were social opportunities when men applied humour to interpret and make sense of their health conditions or the situations in which they lived. Humour was expressed by the male residents in many opportunities in the fieldwork. Humour was used to provoke amusement from others as Abraham did, illustrated in the field note extract below.

I was resting on the window sill next to the table where Abraham was already sat waiting for lunch while the other residents were supported to move into the dining room. Esther(S) was accompanying Alice to her usual space at the same table as Abraham. Esther(S) kept speaking while slowly accompanying Alice to the table. Alice then said in a cheerful voice: *I can't find my earrings, I don't where they are!* while touching one of her ears. Esther(S) then replied: *it is probably in your handbag* while supporting the resident to open her handbag. There was a short pause and then Abraham slowly and with a grave voice said: *I (pause) can't find mine either!* these prompted all of us to laugh including Abraham. [Fieldnotes, Beech Home, dining room]

Abraham's comment about the possibility of wearing earrings demonstrates that despite his declining cognitive capacity and physical abilities, he perceives and held his masculine identity as key to differentiate himself from the female residents. His masculine traits are contrasted with a joke which ridicules himself by raising the idea of wearing female attire. Also, being able to make people laugh with him is an ability that strengthened his self-esteem and therefore enhanced his wellbeing. Men's sense of humour also applied to ridiculing their own illnesses and frailty progression and to amuse themselves and others to lessen concerns or consternation due their health status as Frederic and Simon expressed in a group conversation while waiting for the meal.

It was lunch time and I approached the table where Simon, Frederic and Frederic's wife Nelly sat. They were cheerful to see me and we exchanged greetings. I then asked how they have been and Frederic took the lead in the conversation and said: *we are all right but I've got loads of bruises* and he pulled the sleeve up on one of his arms and showed me his left forearm which was badly swollen and bruised on the wrist. Simon then made a comment *he has been in a fight!* while smiling and winking to me in a quick gesture. Frederic reacted to Simon's comment with a joke *Oh yes! I've been in fight! A fight with the floor!* Frederic last comment caused all at the table to laugh, including myself. [Fieldnotes, Oak Home dining room]

The men dining in the communal areas also used humour to deal with tension and aggressiveness during the mealtimes as Frederic illustrated in the following excerpt:

We were waiting for the lunch meals while Theresa continually spoke about organising a bus trip to London although everybody in the room tried to avoid her. As Theresa persisted with the same conversation I heard Philippa saying: *shoosh, shoosh, shoosh! There is no need to shout!* though Theresa was completely oblivious to Philippa. The staff came to the room to serve the meals and Theresa engaged in the same conversation speaking loudly to the care staff. Philippa shouted *Quiet! Quiet! Oh! shut up!* though Theresa did not seem aware of Philippa's protests. I noticed that Frederic tried to speak to me. I turned back to look at the residents behind me and Frederic commented to me in a low voice *that is the entrainment! That is the entertainment!* while smiling. [Fieldnotes, Oak Home, dining room]

In the excerpt, Frederic used humour to disguise or deflect a situation which seemed stressful and upsetting for most of the residents. In a similar manner, Terry used humour as a device to deal with Mark's behaviour at the table:

While waiting for the lunch, Mark fell asleep in his wheelchair at the dining table. Terry then took a knife and extended with his right arm touching Mark's nose with the side of the knife blade. The touch made Mark jump in a jerk reaction. Mark then opened his eyes and looked around while Terry and Paul were laughing profusely. Mark then said with a smile: *I tell you what! I have my right eye always open!* in a stuttering and pitchy voice. Terry and Paul laughed profusely but I was not sure about Mark's reaction and whether he enjoyed the joke. The cheerful moment ended soon as the laughs wore off and the three men stayed in silence for the rest of the meal. [Fieldnotes, Cedar Home, dining room]

Terry's intervention to stop Mark falling asleep at the table aimed to manage a situation or to cover a difficulty which might have affected Terry. Using humour, Terry acted to humorously reprimand Mark. Paul's and Terry's reaction might provide further indication of their dislike for Mark's behaviour in dozing at tables.

7.5.4. *Impersonal conversations around shared interests*

On the rare opportunities when male residents spoke to each other at their tables, the male residents did not initiate or engage in conversations which involved personal matters, nor that expressed their feelings. They tended to be impersonal conversations as illustrated with Matthew in the following excerpt:

I was sat on the sofa in the lounge observing the residents waiting for the lunch to be served at the dining tables. I heard Matthew voice: *did you watch the match last night?* (it seemed that Matthew was speaking to Peter. I could not hear Peter's reply because I was away from the dining tables area and Peter had difficulties with speech). Matthew then said: *I think it was that Hamilton fella, wasn't it?* and I was not able to hear the end of the conversation [Fieldnotes, Oak Home, dining room].

In an interview, Peter explained how the conversations with his closer companions at the same table were articulated:

Researcher - Could we talk back about Matthew again? You said in the previous interview that you like his company (they share the same dining table). You also said that you don't have much in common with him so what sort of things you normally talk about?

Peter – *the one that sits at the table with me?*

Researcher – yes, or if want you talk about somebody else.

Peter - *We don't have much in common. That is why a lot people don't talk in the meal time. I would say the television is one of the things that links us all because it gives us something to talk about.* [Interview, Oak Home, Peter]

Peter explained that the reason for the lack of conversations of residents during mealtimes was based on the fact that residents did not share the same social and professional background. Peter used to be a senior manager in the health sector while Matthew was a school teacher for his whole life. The excerpt describing Matthew and Peter discussing sports shows that the television was used as a source of common interests for men's conversations. Through the television, Matthew and Peter learned about events or obtained information about the external world not related to the care home nor related to their personal lives. Instead, Peter and Matthew chose to engage in conversations which were related to their common interests, in that case sports, as a means of socialising during the mealtimes.

What seems clear is that Matthew and Peter and the rest of the male residents in the three care homes did not socialise by talking about their own feelings or shared intimacy in the same way as the female residents frequently did.

At the end of the dinner, when all female residents finished their meals, June said while looking at her hands *'look at my hands, I used to be a typist, can you believe it? It is infuriating not to be able to use*

your hands' while Dorothy, Katherine, Barbara, Abigale and Harriet listened to and observed her. June did not seem upset when she said this but rather she seemed amused. Then Dorothy replied to June *at least you are not in pain, I am not so lucky with my back*. Kathrine added to the conversation by saying about her problems with her hip. Kathrine and Dorothy continued to speak about their health problems, which included Dorothy explaining her recipe to avoid constipation. This conversation lasted for a few minutes until the care staff came into the room to help the residents to go to their bedrooms [Fieldnotes, Oak Home, quiet lounge].

And

Wendy was standing up from her seat at her table and ready to start to walk to the lounge. She then looked at Mary and said:

Wendy - *I like your curtains in your bedroom* [looking to Mary].

Mary - *This one!?* [while grabbing and holding the curtains of the patio doors in the dining room]

Wendy – *No, the curtains in your bedroom*

Mary – *Ah! They are new, my niece bought and had it fitted for me, I didn't like the old curtains.* [Fieldnotes, Cedar Home, dining room]

As the excerpts show, the female residents spoke about personal matters and expressed their individual opinions. Women's use of shared intimacy, which included discussing their personal tastes and health problems, were examples of subjects of conversation that female residents routinely and freely chose to speak about. On the other hand, men's conversations were usually based on more impersonal conversations. In this respect, perhaps the most distinctive difference in how men socialised compared to the women was the longer periods of silence that the male residents sustained during the meal times. There are a few important considerations in regard to male residents' silence that are key to understanding the gender differences in socialising. The silence was more present amongst the

men because they did not adopt the 'shared intimacy' style as a tool to socialise in the same way as the women did. This avoidance in many ways is part of the *impression management* (Appelrouth & Edles, 2011) of the individuals in preserving and fitting with masculine images of the self. Being a man living in care home entailed not only maintaining the character of a resident but performing the role of male resident, vesting the self as a masculine being which encompassed particular ways to communicate and socialise in the group. Silence, to a certain extent, was part of the overall strategy for men to socialise alongside having an activity to share and adopting certain ways of communicating. Thus, the silence sustained by the male residents during the meal times should be understood as having a social value and being an essential component in men's communication.

7.6. Summary

Residents saw the mealtimes as important social events in their lives during their daytime. The mealtimes were seen as moments to socialise with others; residents, care and staff and visitors. The mealtimes were social events that brought most of the residents to the same space for a coordinated and essential activity for the residents. The residents' assignment in the dining room had particular social significance by enabling residents, and especially the male residents, to build closer social ties with other residents in the home.

The process of assigning residents involves two stages:

1. *allocation* – in which the staff exercised their judgement and control in allocating the resident to the table in the dining room. Their judgement was based on their assessment as to which group of residents the new resident would best fit with. The criteria they used to assess this varied depending on the care practices of the care homes involved. However, they essentially focused on the residents' gender (placing men and women around different tables to each other); the mental status of the residents (especially for the female residents as they were greater in number in the dining room) and personal and social background; or simply by allocating residents to the random tables as they arrived.

2. *appropriation* – which involved the residents' acts of routinely sitting at the same table and sharing their company during the mealtimes with the same group of residents. Residents' appropriation of the dining space allowed them to 'own' the space in the communal area and build social ties over the time.

The mealtimes were the most important social event for most of the male residents as they otherwise preferred to retire to their bedrooms during the rest of the day, unlike their female counterparts. Sharing dining tables at mealtimes was the main mechanism by which male residents socialised and created and maintained social ties with their closest peers. Male residents used the mealtimes as a shared activity, eating the food, to meet and socialise with their closer peers. In this sense, the activity of eating the food provided a purpose and justification for men to socialise with their peers at the dining tables.

Men's working experience was a strong determinant for how male residents identified themselves as part of a social group with whom they shared a table. Male residents from similar professional backgrounds, such as men from the armed forces, identified themselves as a group and developed a sense of comradeship and closeness with their table-mates. Men from diverse professional backgrounds seemed to struggle to relate to other individuals with whom they shared the table and identify themselves as part of a distinct group of residents in the care home.

During the mealtimes the male residents were likely to remain silent for most the time compared to the female residents. When the men did engage in conversations this related to food, to providing practical help, to common interests and to humour. Men preferred to talk about common interests which were related to impersonal topics and avoided the use intimacy unlike women. The television was used as a source to generate conversations around common interests.

The use of humour had connotations about men's own masculinities, their health decline and about covering or dealing with unwanted (or unacceptable behaviour) in stressful situations during the mealtimes. Dementia may have greater effects on men's conversations and social lives than on women's as the former relied on

common interests and humour while the latter were more reliant on intimacy to converse which may be sustained even into the final stages of dementia.

8. DISCUSSION

8.1. Introduction

This chapter summarises how the findings in chapters 5, 6 and 7 of this thesis sit within the wider published literature and how it addresses some of the gaps in knowledge regarding gender differences and social aspects of men living in care homes for older people. This chapter is structured in four sections; the first three compare and discuss how the different spaces in care homes are used by male and female residents according to the different types of activities undertaken in these spaces. The last section discusses the findings on gender differences and male residents' tendency for socialising and organising their routines and how this may affect their wellbeing, including men in the advanced stages of dementia.

The findings presented in this thesis were aligned with what has been established through the concepts of social capital and social networks of older people in the sense that male residents appeared to have fewer social close ties in comparison to the female residents. This is extended to levels of social interactions as female residents sought the companionship of their peers more often than the male residents did. Bonding ties were more common amongst female residents who often shared the same social and professional background; they were often 'housewives' such as the group of women who accessed the lounge area in Cedar Home. A more complex picture emerged when analysing the male residents' social relations. In one sense it could be said that the men enjoyed other men's company so a component of homophile (and perhaps bonding capital) was observed. However, men's preference to have more impersonal and less frequent interactions might fit better with bridging social capital.

During the observations in the early stages of my fieldwork, I decided to move away from the original aims set for the study in regard to the use of social capital as a conceptual theoretical framework. Above all, I was interested in understanding how

the care provided to the residents and the different spaces in the care home enabled and or constricted male residents' social interactions. In this sense, the use of the social capital concept might have created barriers rather than be an enabling tool to understand how male residents socialise in care homes. Care homes comprised unique social environments in which individuals experienced many social restrictions. Although the use of social capital may afford some explanations of the social lives of men living in care homes and the impact on their wellbeing, I considered that such a concept is may be too crude to understand some major issues that profoundly shaped the social lives of men and women living in care homes for older people. In this thesis I explored some of those issues which were related to the control over spaces, residents' agency and the nature of gendered social relations. Finally, the rationale for using the concept of social capital as the foundation for the literature review in this thesis was based on two reasons: a. by exploring older men's social capital in the literature review it emphasises to the reader the importance and the of gender differences in socialising which continue to be relevant throughout older age; b. the literature review presented in this thesis highlights the lack of knowledge related to the importance of gender for residents in socialising in care homes and therefore, it substantiated the claim for further research on the subject.

8.2. Gendered spaces in care homes

The findings in this study demonstrate that some of the communal areas of the care home tended to be gendered. This occurred only when residents were healthy enough to stay in their own bedrooms as an alternative to spending their time in communal areas. Male residents in these circumstances were likely to use the lounges in care homes as instrumental spaces to attend group activities only. In contrast, some or most of the women living in the care homes used the lounges as social spaces where they could spend time during sitting-times and socialise with other residents, care staff and visitors.

In this research, the findings highlighted that female residents created their own social spaces in the lounges by acquiring and 'owning' their seats in the lounge.

The seating arrangements were essential for the routinisation of the sitting-times in the lounge and to socialise with their closer peers.

Very few studies have explored the functions and social aspects of the lounge spaces in care homes and none have examined the gender issues with regard to residents' use of these social areas. This research is innovative in exploring the gendered aspects of these lounge spaces. Gubrium's (1997) extensive ethnographic work in a nursing home in the US, described the lounges as the spaces in which the residents spent periods of time by 'sitting around' and where the time would 'just drag by' (Gubrium, 1997 : 161). The same study also described the lounge spaces and other communal areas as 'public territory' in which residents had exclusive chairs which signified a certain privacy in using these spaces (Gubrium, 1997 : 37), similar to the findings in this thesis. Interestingly, Gubrium (1997) does not provide any insight regarding the residents' gender differences in the lounge or similar communal areas. This is despite the fact that all the examples provided in the study seemed to refer to female residents only.

The findings presented in this thesis demonstrated that the lounges in care homes tended to be feminised environments. The absence of male residents in the lounge spaces is complex and goes beyond the gender issues, although the overwhelming female presence in the lounge seemed to be an issue for some male individuals, especially for men from occupations that were overwhelmingly male such as the armed forces. This study concludes that male residents' absence in the lounge spaces during sitting-times is partially related to the lack of activity in these types of spaces and the absence of group activities perceived as male or masculine activities. In addition, the lounge also may not be attractive for men living in care homes because it did not support men's preference for the greater privacy and autonomy that their own bedroom spaces afforded them, as discussed later in this chapter. The findings reported in chapter 5 is aligned with previous research. Andrew (2005) reporting that men living in care homes for older people were less likely to engage in group activities. This research provides further understanding of why this might be the case as the group activities observed in this research

tended to be designed for women or gender-neutral. This is likely to contribute to the absence or low presence of male residents in group activities as illustrated in section 5.5. Thus, when male residents took part in group activities, and they were usually the only man in the group, it did not necessary lead to interaction and integration with the group of female residents. On the contrary, male residents were likely to be socially isolated in these situations.

Men's lack of attendance and engagement in group activities were likely to have a negative impact on their overall wellbeing because they were mostly isolated in these situations. Also, by avoiding the group activities, male residents avoided a range of actions which were beneficial to their health such as physically exercising while moving between the spaces in the care home which is essential for residents to maintain fitness and autonomy (Hawkins et al., 2017).

Research findings based on communal spaces dedicated to older people living in the community support the findings of this research. Davidson, Daly, & Arber (2003) claimed that older men living in the community are reluctant to frequent day centres dedicated to retired and older people. Older men's views on the day centres indicated that they perceived them as organisations to spend time sitting around, playing bingo and chatting and therefore, these spaces were for the 'old women' or the 'too sick' or 'too old' (Davidson, Daly, & Arber, 2003 : 87). Although the research in this thesis was not primarily concerned with exploring and understanding people's perception and more specifically, male residents' perspectives of the spaces in the care home, it is possible to establish parallels regarding day centres and the lounges in care homes studied in the research presented in this thesis. These types of communal and social spaces, day centres in the community and lounges in care homes for older people, may undermine masculine identity because they are not orientated to more active life styles and because of the overwhelming female presence.

8.3. The space for men's autonomy and remaining active

The analysis in this thesis indicate that the male residents used their bedroom as the spaces in which they could experience greater autonomy by controlling the material aspects of the bedroom through electronic devices and through the bedroom arrangements. Male residents also controlled others' access to the bedroom enabling male residents to experience greater privacy and moments of solitude in the bedroom. All these features of the bedroom allowed men to experience the feeling of homeliness which is important for the individual's wellbeing. The autonomy that could be exercised in the bedrooms was essential for men to engage with their favourite activities. Being active seemed an important element for their identity and perhaps enhanced their sense of masculinity.

Community based research has previously found that people tend to invest more meanings in spaces and objects as they get older. The process of becoming attached to a place reflects the life course of individuals (Rubinstein & Parmelee, 1992). Older people's social attachment to spaces and objects provide a sense of security and belonging and therefore positively influence the wellbeing of individuals (Wiles et al., 2009).

Falk et al. (2012) argued that the sense of home for residents living in care home is based on three different strategies related to the care home environment: acquiring 'attachment to the space' which consists of the ability to decide independently how and when to interact with others (Falk et al., 2012 : 1003); 'attachment beyond institution' which consists of residents' pursuing self-determined goals which implied to live a full life (Falk et al., 2012 : 1003) and 'psychosocial process supporting attachment' which consists of sharing optimistic values and attitudes that nurtured self-worth such as looking on the bright side of life and feeling valued (Falk et al., 2012 : 1004).

Although the findings in the present research did not aim to understand the processes which enable residents to become attached to the care home and feel at home, the findings presented in chapter 5 shed light on the gender differences

in how men and women tend to acquire the sense of home through attachments to the spaces in the care homes. Indeed, while most of the women tended to access and use the communal areas more often, men seemed prone to find their own bedrooms as the ideal space in which they can experience privacy, autonomy and solitude, which was key to enhancing their wellbeing. Men's use of the bedroom seemed to be related to 'attachment to the space' according to Falk et al., (2012) dimensions for residents achieving the sense of home in care homes. However, the concept of wellbeing in this research is associated with the idea of male residents exercising agency in being able to construct and control their own environment in the care home.

8.4. The significance of meal times as social events

The findings of this research showed that eating together were important social occasions in the residents' lives. This is in accordance with previous research (Bundgaard, 2005; Kofod, 2012; Tsai & Tsai, 2008; Watkins et al., 2017; Wikby K, 2004; Wright, Hickson, & Frost., 2006), where mealtimes were found to promote activities that went well beyond the process of food intake and had great importance for residents' socialisation in care homes (Wikby, 2004; Wright et al., 2006). Indeed, the literature on care homes has identified the mealtimes as opportunities which facilitated the sense of integration as a community, the perception of normality and re-enforced individuals' identities (Philpin et al., 2011). Palacios-Ceña et al. (2012) argued that mealtimes functioned as a 'compass' for the residents to orientate themselves during the day and consequently resident individuals' routines were arranged around those events.

However, the findings in this study found that mealtimes had different social functions and effects for men compared with women. For most of the female residents, the mealtimes were social events in which they continued socialising with their close peers as they did in other communal areas of the care home, namely the lounge. For the majority of male residents however, the mealtimes were the sole and key social event in which they experienced the care home

community social life. Importantly, most of the male residents used the mealtimes as the main and only social occasion in which they could develop closer social ties with their peers. Male residents developed closer social ties by routinely sharing the same dining table. This finding regarding the social effects of mealtimes in terms of gender, and for male residents in particular, is original and adds a new perspective to the body of knowledge related to the social aspects of older people living in care homes.

8.4.1. Residents' table assignment

There was a complex mechanism for assigning residents to dining tables. Residents assignment reflected the specific care management, the material conditions of the care home space (the dining room) while it also reflected an expression of residents' agency. Residents' table assignment process occurred in two phases:

Phase 1 – *Allocation*: the phase in which staff exercised their judgement and control over the communal area in allocating residents to the table in the dining room. The criteria for the assessment varied depending on the care practices of the care homes. Three main strategies were identified: i) a strategy in which the care staff team allocated the residents according to their social backgrounds, personalities and behaviours; ii) a strategy based on allocation of residents to the tables based on their gender, with male residents being allocated to the 'men's table' (a term used in the fieldwork); iii) a strategy based on allocating the residents to vacant seats at random tables as residents arrived in the dining room every meal time.

Phase 2 – *Appropriation*: which consisted of the residents' habits to routinely sit at the same table and share the same company during the mealtimes. Residents' appropriation of the dining space allowed him or her to exercise their agency by the appropriation of the space in a communal area and to build closer social ties by sharing the same table. Previous research has found that the care staff acknowledged that the residents' seating arrangement are important for residents' social interactions and comfort (Pearson, Fitzgerald, & Nay, 2003). While residents'

table assignment was identified as being fairly rigid (Kofod, 2012) the activities around food and eating in care homes were opportunities for residents' to express their autonomy, control and agency, which reinforced and maintained their identity (Watkins et al., 2017). Thus, being able to exercise the appropriation of the dining room space was essential for residents to exert agency by having control over their routine and being able to regularly socialise with their table mates as argued in this thesis.

Before I move to the discussion of the findings in this research in relation to current knowledge regarding the social importance of the mealtimes for people living in care homes, it is important to situate the concept of agency that implies residents' actions in this thesis. The concept of agency remains a 'slippery' concept because it varies greatly according to the theoretical framework which it is built on, from sociology and politics to psychology (Hitlin & Glen, 2012 : 171). Activity or being active became central for the concept of agency in gerontological research in the nineties (Baltes et al., 1996; Rowe et al., 1997). More recently, this conceptualisation was rightly contested because it denies the possibility of individuals exercising agency with the increasing cognitive and physical decline (Rozanova, 2010; Tulle-Winton, 1999). Instead, gerontological research adopted a conceptualisation of agency from the sociological field (Morgan, 2006 and Wray, 2004). Agency from a sociological perspective denotes that individuals construct their own life trajectory by making choices and taking actions through the opportunities and limitations of history and social circumstances (Elder's et al., 2003). Thus, agency encompasses the interactions between individuals and constraints of social structures (Giddens, 1984). In relation to the concept of residents' table assignment and the stage of *allocation* presented in this research, I argue that the allocation phase of residents is comparable with the structural elements in the residents' everyday lives, as this is a constrainer on residents' choices that limits residents' actions. In this specific example, the structure derives from the care homes practices and the staff decisions when providing the care to the residents.

A more complex picture emerges when considering the *appropriation* phase as a manifestation of residents' agency. This is because the *appropriation* as conceptualised in this work does not strictly embody an action or being active but it is a rather passive performance by the resident. Gubrium & Holstein (1995) had proposed a more open concept which comprises the idea that individuals with health and cognitive impairment possess the agency to invest cultural material in their own ways. Thus, residents' appropriation involved individuals' ability to place meanings to the social routines of mealtimes and the use of the dining room by creating their own personal spaces and constructing their social routines. Perhaps a more relevant conceptualisation of agency for people living in care homes is provided by Pirhonen et al. (2018 : 34) which suggested that agency should be widened from 'doing' to include 'being'. In this sense the *appropriation* stage can be recognised as part of resident's agency because it reflects the will or wish of the individual when it comes to taking part in the mealtimes. The findings of this thesis, in many instances, validate Pirhonen's et al. (2018) in exploring residents' possibilities of exercising agency in subtle ways which do not involve direct actions through a more sensitive research method such as ethnography.

Similar studies have recognised that the surroundings and spatial dimension of the dining area influenced the social interactions of the diners (Curle & Keller, 2010; Philpin et al., 2011). In this thesis it is argued that the residents' inability to gain appropriation of the dining room might have deleterious impacts on residents' agency by negatively affecting the capacity for residents to create and maintain closer social links with other residents who shared the tables. Furthermore, the inability to exert appropriation of the space in the dining room is likely to impact male residents more as the mealtimes were often the only social occasions they tended to take part in. Overall, the absence of appropriation of the seating area during mealtimes might increase resident's sense of dependency on the care staff and impact negatively on their autonomy and identity. Previous research has argued that the assignment of residents to dining tables depends on: '(i) personal judgment; (ii) resident behaviour; and (iii) the perspectives of the residents about the composition of table groups' (Palacios-Ceña et al., 2012 : 485-6). These findings

were based exclusively on interviews and therefore were limited to residents and care staff perceptions. Palacios-Ceña et al. (2012) suggested that the care staff arranged residents to the same tables and chairs at each meal time to reduce tensions, and that residents who displayed aggression could be moved from his or her table to a place on their own. Palacios-Ceña et al. (2012) table assignment explanation perhaps over-emphasises the care staff control by failing to recognise residents' agency in the appropriation of specific seat. However, residents' agency is acknowledged in Palacios-Ceña et al. (2012 : 486) as residents were able to 'veto' disliked individuals who did not conform with the attitudes and manners shared by the people sat at the same table.

In contrast, the findings in the present study showed that the residents' table assignment was a process which involved the control of care staff in the communal areas by the initial allocation of residents at the dining tables. This included when the care staff re-allocated individuals who seemed incompatible with the group at the table to avoid disruption during the mealtimes. In addition, the findings in this thesis identify the exercise of residents' agency by regularly retaining the same seat during the mealtimes. The ethnographic approach employed in this research was key to identify the complex social processes and decisions involved in mealtimes which other types of qualitative approaches were unable to examine.

Curle & Keller (2010) reported that residents with similar characteristics (social background, language accent and common interests) tended to socially interact more at tables. Interestingly, those residents who were found dining alone at a table were moved to share the same tables with each other by the care staff. In these situations, the care staff used gender to re-allocate residents to shared tables (Curle & Keller, 2010). According to Curle & Keller (2010), the care staff tended to group residents with similar characteristics by allocating them to the same tables. Residents themselves also sought to sit at tables with people with whom they identified. This might suggest that the staff control over the dining area in the allocation phase in the present research may not be rigid as put forward in the present thesis.

The table assignment system described in this thesis constitutes original knowledge regarding the social mechanisms and the care practices related to care homes for older people. Also, the findings stated in this research regarding the table assignment might be transferable to other health settings where patients are institutionalised and depend on care staff's physical assistance.

8.5. Gender patterns in residents' social relations

The findings in this research showed that men and women living in care homes socialised amongst themselves and integrated with the care home community differently. Female residents tended to spend more time in the communal areas of the care home (noticeably the lounge area compared to male residents) in the company of their female peers. Women living in those care homes socialised with their peers through the use of shared intimacy. Shared intimacy involved verbal and non-verbal interaction (i.e. touching). Their conversations often related to personal topics and encompassed women's empathy and listening to each other. Shared intimacy provided a platform for female residents to interact with closeness. The personal attributes used in socialising among female residents enabled them to freely talk about themselves and others by expressing their personal opinions. Thus, female residents felt comfortable to spend long periods of time socialising even without any sort of structured activity or agenda to follow during sitting-times in the lounge.

This study demonstrated that women with advanced stages of dementia benefited from dyadic associations which seemed to provide them some emotional and social support. They used shared intimacy to interact with close companions which involved physical contact. Male residents with dementia seemed more isolated, although they occasionally developed dyadic relationships with female residents. Men suffering from advanced stages of dementia may benefit from the care of male workers as their presence and social support may reduce the perception of the care home as a feminised environment. However, the ethnography presented in this research showed that men who retained cognitive ability were able to build and

maintain social ties with their peers. These social ties that resembled friendships could translate into practical help, as in the situation described between two male residents in section 7.5.2., page 160, when Mathew called the staff in aid to Peter (Oak Home) or Terry and Paul asked the staff assistance for Mark (Cedar Home). Previous studies on gender differences in socialising had argued that men and women adopted different ways to socialise. Webster (1995) argued that women's self-identity is orientated towards friendships which are characterised by 'connectedness, face-to-face sociability, mutual disclosure, focus on talk' (Webster, 1995 in Davidson (2004 : 28). While men's friendships are marked by 'separateness, side by side sociability, focus on activity' (Webster, 1995 in Davidson (2004 : 28). Further evidence had been produced in behavioural research in regards to gender differences in socialising. Women have shown greater skills and competence in demonstrating empathy and affection (Eagly, 1987). In this sense women were found to be better prepared to deal with emotion than men were (Eagly, 1987; Samter, 2003) and therefore, women were more capable of socialising through showing affection and using intimacy (Holmstrom, 2009). Published qualitative studies have demonstrated how intimacy amongst women is employed to form closer and strong social bonds related to the domestic social context. Domestic friendships were created and maintained amongst women through 'inclusive intimacy' based on the shared experiences of motherhood (Cronin, 2015 and Mark, 1998). In contrast to the female residents, male residents' social encounters contained fewer social interactions, including verbal and non-verbal communication, with longer periods of silence than female residents as demonstrated in the research findings in this study.

The findings presented in this thesis also indicated that male residents engaged in impersonal conversations which avoided conversations involving self-disclosure. Men's conversations usually gravitated around men's shared interests, use of humour and practical help. Inevitably, men's socialisation involved longer periods of silence as they ran out of topics and reasons to engage in conversations and interactions. The findings showed that there was a clear distinction in the way that residents interacted between female and male groups. Women, when interacting,

employed *shared intimacy* and as a result they were able to interact more often and socialise for longer periods of times. Nevertheless, men's silence was an important element in interacting with others and should not be understood as a lack of lack of social skills but as instrumental to maintain the masculine self by impression management (Appelrouth & Edles, 2011).

Previous research has claimed that men are less inclined to self-disclosure by sharing feelings when socialising (Webster, 1995). Thus, the research presented in this thesis concluded that the men's preference for impersonal conversations may reduce or limit the opportunities for male residents to socialise. The meal times were used by male residents as an activity to socialise with their close peers. The activity of eating together provided a real function and justification for social encounters. Previous studies had identified that men are more task orientated when it comes to socialising (Webster, 1995) and they are inclined to socialise by sharing activities (Aukett, Ritchie, & Mill, 1988; Walker, 1994). Thus, male residents used the mealtimes as a type of activity in which they could meet their peers and felt easy and comfortable to spend time together as they engaged in the task of eating together.

Broughton, et al. (2016) explored the social experiences of men in the community in the US who regularly met in a coffee group. The individuals used the coffee group events as a mechanism for social interaction, connectedness and emotional support (Broughton et al., 2016). Findings based on gendered interventions, such as working in communal gardens or carpentry, established for men living in the community, their wellbeing and mental health improved (Ang et al., 2017; Cordier & Wilson, 2014; Milligan et al., 2013; Milligan, et. al., 2015; Wilson & Cordier, 2013). Gendered interventions based on activities amongst men living in care homes for older people seemed to produce similar health benefits (H. Gleibs et al., 2011).

The findings in this study indicated that men placed great importance on their past working life and this shaped their inter-relations with their peers. As residents

living in care homes usually came from diverse professional backgrounds, men in these places may struggle to see themselves as part of a social group. To overcome those differences and to find common ground the male residents often socialised by talking about common interests in more impersonal conversations. Male residents from similar professional backgrounds, noticeably men from the armed forces, tended to share a common group identity and having the sense of comradeship. The findings in this research also showed that men tended to become isolated during the group activities if they were the only male in the group taking part. This may explain previous findings which reported that men are less likely to attend group activities in care homes (Andrew, 2005). The lack of men's attendance in group activities may also be related to the lack of activities designed especially for men.

Similarly, previous research has argued that paid work has a fundamental role for older men in the community to maintain their sense of identity (Bradley, 2013; Thompson, 1994). Men living in care homes often retain vivid memories about their working life even after many years of retirement (Gubrium, 1997; Kaufman, 2000; Moss & Moss, 2007), placing greater importance on their professional background as a mechanism to maintain their self-identity (Moss & Moss, 2007). Work achievements have been found to be an important topic for conversations amongst older men living in care homes (Savishinsky, 1991 in Moss & Moss, 2007). However, it is important to notice that in the future these gender differences are likely to change as there has been a much greater convergence of working lives of men and women as work occupations are far less gendered nowadays.

To some extent, gender was an important characteristic to explain how residents used the spaces in the care home spaces differently and whether they engaged in or avoided certain social events. The health needs of the residents also had an effect. This research identified the mealtimes as an essential social activity when the male residents could create and maintain closer social ties with their peers and could experience the life within the care home community. Being able to socialise intimately enabled most of the female residents to use the communal areas more

frequently, especially the lounge where they found social and emotional support amongst their closer female peers. Men's preference towards undertaking tasks, meant their bedroom was the ideal space where they could be active, autonomous and enjoy moments of solitude. The mealtimes in this sense were pivotal social events for the men's wellbeing because they provided access to the wider care home community while they engaged in the functional activity of eating. As previously stated, the notion of residents' wellbeing is tightly connected with the possibility of exercising agency and therefore being able to determine their social routines. The analysis showed that residents exerted some indirect control over their social routines by exercising the *appropriation* of their seats at the dining room. Thus, residents' appropriation of the seats in the dining room translated into them exercising their agency.

8.6. Summary

In summary, the discussion provided in this chapter highlighted the findings of this research within the context of the wider academic literature about social relations in relation to gender and people living in care homes for older people. In a number of aspects, the findings were supported by those of previous studies regarding gender aspects and differences between men and women socialising in older age. The research presented in this thesis generated novel and relevant knowledge regarding how the communal areas of the care settings tended to be gender orientated and how men were inclined to engage in and prioritise certain activities and avoid others which were popular with the women.

This research also highlighted the importance of the mealtimes in the residents' social lives which has been previously examined by a few studies related to the social significance of the mealtimes in care homes. However, the findings presented in this thesis are original in demonstrating the importance of such social events in men's daily lives. Finally, this research has demonstrated the importance of seating arrangements for the residents' social lives. With this purpose it

formulated a more comprehensive knowledge in how residents regularly occupied this type of space during the mealtimes.

9. CONCLUSION

9.1. Introduction

This chapter summarises the overall conclusions of the research presented in this thesis with respect to the three research questions. The chapter then presents the strengths and limitations of the study before outlining the policy and practice implications of the findings. Some suggestions for future research concerning the gender aspects of people living in care homes and men's social lives in those types of care settings are made.

9.2. Summary of the Key Findings

A summary of the key findings addressing each of the three research questions in turn is provided below.

9.2.1. How do male residents socialise in a care home for older people?

Men living in care homes placed great importance on the ability to control their bedroom spaces. Having control over their bedrooms enabled male residents to achieve two important elements in their routines: the bedrooms offered them greater privacy in which they could enjoy moments to relax and experience solitude. Furthermore, men found their bedrooms a space in which they were able to actively choose and structure their daily routines.

Men's choice in attending the mealtimes demonstrated that they enjoyed meeting their close companions and observing, through social watching, the whole care home community. Most importantly, the mealtimes were social events that involved an activity with the practical purpose of eating. The functional purpose of the mealtimes enabled male residents to attend these social events without social expectations. They could therefore socialise on their own terms by engaging in impersonal conversations with longer periods of time in silence. The alternations

between long periods of time where they could enjoy privacy and solitude as 'back-stage' moments with short periods of time at the meals times as 'front-stage' as articulated in Goffman's (1990) dramaturgical performances were likely to enhance men's wellbeing in care homes.

9.2.2. *How do residents shape their social relations in terms of gender?*

There were stark gender differences in how individuals tended to socialise. Most of the cases, the female residents seemed more competent in employing shared intimacy as a vehicle to socialise. This allowed the women living in the care settings to spend prolonged periods in the communal areas of the care home accompanied by their female peers rather than withdrawing to their private bedrooms.

Female residents were better equipped in engaging in same-sex dyadic relationships while this was not seen amongst the male residents. These types of relationships were useful for people in advanced stages of dementia to acquire emotional and social support. *Same-sex dyadic associations* were especially resourceful for women in advanced stages of dementia to acquire emotional and social support throughout the day. Women's dyadic associations heavily relied on *shared intimacy* to interact. However, the findings presented one negative case for a dyadic association involving a male resident and a female resident, both in advanced stages of dementia. Following others' dyadic associations, the negative case employed shared intimacy as a key component for the residents' association as they were in a romantic relationship.

In contrast, men preferred to socialise by engaging in impersonal conversations while undertaking shared activities. The mealtimes were pivotal for men to socialise because they were social events which had a purpose or function; eating and drinking. Male residents placed greater importance in their past working lives, but this created barriers for them to socialise and find affinity with others. Men who shared the same background, noticeably men who served the armed forces, found in their male peers a greater sense of belonging to a group and a sense of

comradeship. The differences between how men and women tended to socialise shaped the way that they occupied the care home spaces if they were able to access their bedrooms. Female residents were more visible in the communal areas of the care homes and therefore more exposed to social interactions while male residents had less social exposure and were less visible throughout the day in the communal areas.

9.2.3. How does the predominance of women in care home environments impact on male residents' social experiences and their sense of wellbeing?

This study has demonstrated how the communal areas in care homes were gendered spaces where some of the female residents spent long periods socialising with their closer peers and took part in group activities when available. The preponderance of female staff may contribute to the gendered perception of the communal areas and shape social activities that were orientated towards female tastes and preferences. Some male residents, found it difficult to make regular use of the communal areas of the care home due to the overwhelming presence of female residents and staff. Men's absence from these areas was likely to reduce social interactions which might have negative effects on their wellbeing.

The social context of men with advanced stages of dementia seemed more precarious although this was unrelated to the greater presence of female residents. Men in advanced stages of dementia seemed less sociable with others as they did not engage in dyadic relationships through shared intimacy, in contrast to the female residents with advanced dementia.

9.3. Strengths and Limitations of the study

9.3.1. Strengths

This study is innovative in revealing the social dynamics of residents' lives in care homes from a gendered perspective in how men and women related to others

within the care home community. The results generated in this research highlight the importance of gender aspects for people living in care homes which are fundamental to the residents' self-identity and therefore their wellbeing.

One of the real strengths of this study was the ability to engage with multiple care settings. Collecting data from more than one care setting allowed me to compare processes between the three homes and enhanced the potential transferability of the findings. Alongside this, another strength of this research is related to the ability to produce findings related to a population which had been overlooked by research. Finally, it is necessary to state that the results of this research have the potential to produce practical impacts on the care provided by informing policy change and care practices for male residents living in care homes as presented later in this chapter.

9.3.2. Limitations

A limitation which may have influenced the findings related to my social background. To some extent, not being British born created some sense of estrangement which was useful when conducting the ethnography in the fieldwork. For example, some of the participants were empathetic towards me when I was talking with them, explaining the meaning of English words or some expressions with which I was not familiar. However, my relative lack of references related to British culture was on a number of occasions, a limitation to my ability to interact further with participants, especially with the residents. Not being a native English speaker also presented difficulties for me when communicating with residents with hearing impairments as some of the residents struggled to understand my accent and I found it difficult to understand residents who had speech impairments.

A further possible limitation concerned the theoretical stance adopted for the study. Ethnographic approaches, which use broad social categories such as gender, ethnicity and class have been criticised because they often generate narrow interpretations that are disconnected from broader social contexts of the fieldwork

(Emerson, et. al., 2011). This study is limited to the examination of social interactions amongst residents while the nature of the social relations between male residents and their visitors and care staff remained unexplored.

A limitation with regards to the findings related to conducting fieldwork in men's bedrooms. While I was conducting the fieldwork, my priority was to prevent any possible harm or distress to residents. I found that the observations in the bedrooms could be very intrusive and potentially cause discomfort for the men, even though the residents had provided consent for me to do so. Hence, all the observations regarding the bedroom spaces were limited to the period of time in which I interacted with the resident through conversations and interviews.

The findings presented in this research were mostly built on and limited to my own observations of how people acted in their daily routines. This research also explored how male residents perceived the communal areas of the care home – namely the lounge and dining room. However, the findings regarding men's perceptions were based on a limited number of participants in this study, two or three individuals and therefore it was not fully explored.

Finally, the findings of this research were mostly limited to residents who accessed the communal areas in the care homes. The social reasons and implications on residents' wellbeing about residents who never accessed and made regular use of the communal areas in care homes were largely left unexplored in this research. Residents, men and women, who were physically able but opted to not access the communal areas were largely cut off from the social life in the care home community and this could have profound implications for their wellbeing.

9.4. Future research directions

Based on the findings and discussion of this research, three suggestions are put forward to expand the knowledge related to the social aspects of people living in care homes. The ethnography presented in this study found that many residents opted not to use the communal areas of the care homes despite being physically

able to do so. These individuals, men and women, were often segregated in the care homes as they were not part of routine social events such as mealtimes in the dining room and were therefore unable to forge closer ties with their peers and experience the life in the care home community. Thus, these residents might be at greater risk of social isolation and loneliness. Research based on phenomenological approaches could reveal the views and perceptions of these residents about living in care homes for older people and sharing the space with their peers. Different line of enquires could be pursued. For example, such research could explore individuals' views and circumstances when moving into the care home; the perceptions and reactions related to the residents' different social backgrounds; frequenting spaces that are predominantly gendered; and sharing spaces with residents with severe impairments such as people in advanced stages of dementia. All these elements could reveal the underlying reasons for residents avoidance of the communal areas. Such knowledge could inform care practices and policy to prevent social isolation and or integrate residents with his or her peers and therefore improve their wellbeing.

Secondly, residents' autonomy, control and privacy in their bedroom requires further exploration as to how this is negotiated with the care staff when providing the care for residents. Residents' autonomy in care homes is essential for a self-fulfilling life and to enable the feeling of homeliness and attachment to space in care homes. All these characteristics seemed to nurture residents' wellbeing. Hence understanding how control is negotiated in the bedroom while the care staff are providing care is important. Such understanding can inform care practices which enhance and strengthen residents' control over their bedroom, but do not prevent the staff delivering care. Research using observational methods is needed to generate knowledge that addresses these issues. However, such research is likely to encounter ethical challenges. Perhaps, observations based on video recording might provide a less intrusive method to explore such issues.

Thirdly, more research is needed to understand how group activities designed for men can be successfully integrated into in the care practices of care homes.

Interventional research could explore this to determine how best to engage male residents in taking part in these types of activities while observing and examining the practical issues for the implementation at an organisational level.

9.5. Implications for care practice and policy

As men's presence in care homes for older people is likely to increase in the coming years, it is necessary to design care homes which can better attend to men's social needs to improve the wellbeing of this population. The findings of this research highlight the importance of the meal-times for residents' social lives, especially for male residents. In this regard, the care staff team, including care home managers, nurses and carers may benefit from having a better understanding of the consequences of their decisions in assigning residents to particular dining tables. Indeed, mealtimes should not be seen as isolated social events for male residents but as the social event that defines their closer social ties. Care staff should have greater awareness that changes to mealtime routines and to residents' table assignments can have profound implications on the social lives and wellbeing of male residents.

The size of communal areas in care homes should be sufficiently spacious to comfortably accommodate the residents while allowing enough space for the care staff to circulate around the tables. The spaces such as the dining room should not create obstacles which forces residents to change their habits or routines. As referred to in sections 4.2.2. and 7.3, the size and capacity of the dining room found in one of the care homes did affect the care staff's routines during the mealtimes and prevented the residents appropriating their own space in the dining room. The guidance provided by the Care Quality Commission (CQC) in relation to the Health and Social Care Act 2008 - Regulations 2014, item 15(1)(c) states: 'Premises must be suitable for the service provided, including the layout, and be big enough to accommodate the potential number of people using the service at any one time...' (CQC, 2015). I argue that this guidance requires more detail to ensure that the

spaces in care homes are fit for purpose in accommodating residents' needs and routines while enabling the care staff to perform their work.

The provision of care for men in the advanced stages of dementia should take into account the importance of male carers for several reasons: the presence of male carers are likely to increase the overall presence of men in care homes for older people enabling male residents to build social ties with other men. Male residents might find it more comfortable to speak about subjects related to their own interests; a greater presence of male care staff would allow male residents to relate the care home environment as more 'masculine' environments.

Men's presence in the care home workforce is notably small. It has been reported that the reasons for the reduced presence of male carers in the care homes sector is related to the perception that caring duties are related to female roles alongside low wages, working conditions and opportunities to progress in this type of career (Day, 2015). Hence, there is a need to design a public policy to increase the number of male carers through strategies that aim to change public perception about the role of carers and also strategies which might improve the working conditions for those employed in the care sector.

Finally, male residents in care homes require further support to socialise with their male peers, and the provision of care for this population should include social activities that involve tasks, hobbies and activities of particular interest to men. Consideration should be given to making these activities exclusive for men given their 'minority' status in care homes.

9.6. Conclusion

In conclusion, this study was able to demonstrate that the communal areas in care homes and the social activities for residents in those spaces were gender orientated. While female residents made more regular use of these spaces, male residents accessed these areas with the purpose of attending certain activities. The gender distinction in the use of the spaces in care homes is related to the ways that

men and women prefer to socialise. Women used intimacy to socialise in care homes, men opted to socialise by sharing activities.

This research demonstrated that male residents were keen to choose their daily routines. To this end, the bedroom provided a space in which male residents could exert control over their environment and experience privacy and moments of solitude. Residents' bedrooms in this sense were key for the wellbeing for men living in care homes for older people. Moreover, male residents' empowerment over their daily routines enabled them to alternate between periods of autonomy, privacy and solitude in their bedrooms and periods of social interaction during the meal-times. These transitions between private space and public space are likely to benefit the wellbeing of men living in care homes.

Men with advanced dementia are more likely to become socially isolated than women with similar level of dementia. Some or most of the female residents with advanced dementia managed to forge dyadic associations which could provide emotional and social support, but these types of relationships were far less common amongst men. Men with dementia were likely to benefit from being cared for by male care staff as this increases the presence of men in care homes, creating a less gendered environment and enabled male residents to build relationships with other men.

This research concluded that the mealtimes embodied the most important social event in the male residents' social lives. For most of the men living in care homes, mealtimes were the only occasions when they would access the communal areas, experience the life within the community of the care home, and meet residents with whom they had formed close bonds. The routinisation of mealtimes provided certainty for the residents while enabling male residents to own the space in the communal areas in the care home.

10. REFERENCES

- Aizenberg, D., Weizman, A., & Barak, Y. (2002). Attitudes toward sexuality among nursing home residents. *Sexuality and Disability*, 20(3), 185–189. <http://doi.org/10.1023/A:1021445832294>
- Andersson, I., Pettersson, E., & Sidenvall, B. (2007). Daily life after moving into a care home - Experiences from older people, relatives and contact persons. *Journal of Clinical Nursing*, 16(9), 1712–1718. <http://doi.org/10.1111/j.1365-2702.2007.01703.x>
- Andrew, M. K. (2005). Social capital, health, and care home residence among older adults: A secondary analysis of the Health Survey for England 2000. *European Journal of Ageing*, 2(2), 137–148. <http://doi.org/10.1007/s10433-005-0031-8>
- Ang, S. H., Cavanagh, J., Southcombe, A., Bartram, T., Marjoribanks, T., & McNeil, N. (2017). Human resource management, social connectedness and health and well-being of older and retired men: the role of Men's Sheds Management. *The International Journal of Human Resource*, 28(14).
- Appelrouth, S., & Edles, L. D. (2011). *Sociological Theory in the Contemporary Era* (2nd ed.). London: Sage Publications Ltd.
- Atkinson, P., & Coffey, A. (2001). *Handbook of Ethnography*. London: Sage.
- Aukett, R., Ritchie, J., & Mill, K. (1988). Gender differences in friendship patterns. *Sex Roles*, 19(1–2), 57–66. <http://doi.org/10.1007/BF00292464>
- Baltes, M. M., & Carstensen, L. L. (1996). The process of successful ageing. *Ageing & Society*, 16(4), 397–422.
- Barbour, R. (2014). *Introducing Qualitative Research - A Student Guide* (2nd ed.). London: Sage.
- Barnes, S., Wasielewska, A., Raiswell, C., & Drummond, B. (2013). Exploring the mealtime experience in residential care settings for older people: An observational study. *Health and Social Care in the Community*, 21(4), 442–450. <http://doi.org/10.1111/hsc.12033>
- Bartlett, R. (2007). "You can get in alright but you can't get out". *Quality in Ageing*,

8(2), 17–26.

- Batt-Rawden, K., & Tellnes, G. (2005). Nature–culture–health activities as a method of rehabilitation: an evaluation of participants' health, quality of life and function International. *Journal of Rehabilitation Research*, 25, 175–180.
- Beach, B., & Bamford, S. M. (2014). *Isolation: the emerging crises for older men*.
- Bear, M. (1990). Social network characteristics and the duration of primary relationships after entry into long-term care. *Journal of Gerontology*, 45(4), S156–62. <http://doi.org/http://dx.doi.org/10.1093/geronj/45.4.S156>
- Bergland, Å., & Kirkevold, M. (2006). Thriving in nursing homes in Norway: contributing aspects described by residents. *International Journal of Nursing Studies*, 43(6), 681–691.
- Bhrolcháin, M. N. (2005). The age difference at marriage in England and Wales: a century of patterns and trends. *Population Trends*, (120), 7–14.
- Blaikie, N. (2000). *Designing Social Research*. Cambridge: Polity.
- Boeije, H. (2010). *Analysis in Qualitative Research*. London: Sage.
- Bogden, D., & Biklen, S. (1982). *Qualitative Research for education*. Boston: Allyn and Bacon.
- Bradley, H. (2013). *Gender* (2nd editio). Cambridge: Polity.
- Bradshaw, S. A., Playford, E. D., & Riazi, A. (2012). Living well in care homes: a systematic review of qualitative studies. *Age and Ageing*, 41(4), 429–440.
- Braun, V., & Clarke, V. (2006). Using Thematic Analysis in Psychology. *Qualitative Research in Psychology*, 3, 77–100.
- Brewer, J. (2000). *Ethnography*. Buckingham: Open University Press.
- Broughton, K. A., Payne, L., & Liechty, T. (2016). An Exploration of Older Men's Social Lives and Well-Being in the Context of a Coffee Group. *Leisure Sciences*, 39(3), 261–276. <http://doi.org/10.1080/01490400.2016.1178200>
- Bryman, A. (2012). *Social Research Methods* (4th ed.). Oxford: Oxford University Press.
- Bundgaard, K. M. (2005). The Meaning of Everyday Meals in Living Units for Older People. *Journal of Occupational Science*, 12(2), 91–101. <http://doi.org/10.1080/14427591.2005.9686552>
- Cacioppo, J. T., Hawkey, L. C., Norman, G. J., & Berntson, G. G. (2011). Social isolation.

- Annals of the New York Academy of Sciences*, 1231(1), 17–22.
- Camarena, P. M., Sarigiani, P. A., & Peterson, A. C. (1990). Gender-specific pathways to intimacy in early adolescence. *Journal of Youth and Adolescence*, 19, 19–32.
- Carter, D. (2000). Quantitative Research. In D. Cormack (Ed.), *The Research Process in Nursing* (4th ed., pp. 165–174). Oxford: Blackwell Sciences.
- Caughy, M. O. B., O'Campo, P., & Muntaner, C. (2003). "When being alone might be better: neighborhood poverty, social capital, and child mental health. *Social Science & Medicine*, 57(2), 227–237.
- Coffey, A., & Atkinson, P. (1996). (1996) *Making sense of qualitative data*. London: Sage Publications. London: SAGE.
- Cooney, A., Murphy, K., & O'Shea, E. (2009). Resident perspectives of the determinants of quality of life in residential care in Ireland. *Journal of Advanced Nursing*, 65(5), 1029–1038.
- Cordier, R., & Wilson, N. J. (2014). Community-based Men's Sheds: promoting male health, wellbeing and social inclusion in an international context. *Health Promotion International*, 29(3), 483–493.
- Cornwell, B., Laumann, E. O., & Schumm, L. P. (2008). The Social Connectedness of Older Adults: A National Profile. *American Sociological Review*, 73(2), 185–203. <http://doi.org/10.1177/000312240807300201>
- Cracknell, R. (2010). *The ageing population - Key issues for the New Parliament 2010*. House of Commons Library Research.
- Cronin, A. M. (2015). "Domestic friends": women's friendships, motherhood and inclusive intimacy. *Sociological Review*, 63(3), 662–679. <http://doi.org/10.1111/1467-954X.12255>
- Crow, G. (2005). *The art of the Sociological Argument*. London: Palgrave Macmillan.
- Curle, L., & Keller, H. (2010). Resident interactions at mealtime: An exploratory study. *European Journal of Ageing*, 7(3), 189–200. <http://doi.org/10.1007/s10433-010-0156-2>
- Davidson, K. (2004). "Why can't a man be more like a woman?": Marital status and social networking of older men. *Journal of Men's Studies*, 13(1), 25–43. <http://doi.org/10.3149/jms.1301.25>

- Davidson, K., Daly, T., & Arber, S. (2003). Older Men, Social Integration and Organisational Activities. *Social Policy and Society*, 2(2), 81–89. <http://doi.org/10.1017/S1474746403001118>
- Denscombe, M. (2010). *Ground Rules for Social Research* (2nd ed.). Berkshire.
- Dolan, A. (2007). “That's just the cesspool where they dump all the trash’: exploring working class men’s perceptions and experiences of social capital and health. *Health*, 11(4), 475–495. <http://doi.org/10.1177/1363459307080869>
- Eagly, A. H. (1987). *Sex differences in social behavior: a social-role interpretation*. Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.
- Elder, G. H., Johnson, M. K., & Crosnoe, R. (2003). The emergence and development of life course theory. In *Handbook of the Life Course* (pp. 3-19). Springer, Boston, MA.
- Elias, J., & Ryan, A. (2011). A review and commentary on the factors that influence expressions of sexuality by older people in care homes. *Journal of Clinical Nursing*, 20(11–12), 1668–1676. <http://doi.org/10.1111/j.1365-2702.2010.03409.x>
- Emerson, R., Fretz, R., & Shaw, L. (2011). *Writing ethnographic fieldnotes* (2nd ed.). Chicago: The University of Chicago Press.
- Falk, H., Post, R. N., Associate, D., Wijk, H., Associate, R. N., & Persson, L. (2012). A sense of home in residential care. *Scandinavian Journal of Caring Sciences*, (27), 999–1009. <http://doi.org/10.1111/scs.12011>
- Fennell, G., & Davidson, K. (2003). “The Invisible Man?” Older Men in Modern Society, 28(4), 315–325.
- Fetterman, D. M. (1998). *Ethnography - Step by Step*. London: Sage Publications Ltd.
- Field, J. (2008). *Social Capital*. New York: Routledge.
- Fleming, A. A. (1999). Older men in contemporary discourses on ageing: Absent bodies and invisible lives. *Nursing Inquiry*, 6(1), 3–8. <http://doi.org/10.1046/j.1440-1800.1999.00002.x>
- Freedman, V. A., Berkman, L. F., Rapp, S. R., & Ostfeld, A. M. (1994). Family networks: predictors of nursing home entry. *American Journal of Public Health*, 84(5), 843–845.
- Gaugler, J. E. (2005). Family involvement in residential long-term care: a synthesis and

- critical review. *Aging & Mental Health*, 9(2), 105–18.
<http://doi.org/10.1080/13607860412331310245>
- Giannakouris, K. (2008). Ageing characterises the demographic perspectives of the European societies. *Eurostat, Statistics in Focus*, 72, 11.
<http://doi.org/10.1111/j.1467-954X.2012.002120.x>
- Giddens, A. (1984). *The Constitution of Society*. Cambridge: Polity Press.
- Gleibs, H., Haslam, C., Jones, J. M., Alexander Haslam, S., McNeill, J., & Connolly, H. (2011). No country for old men? The role of a “Gentlemen’s Club’ in promoting social engagement and psychological well-being in residential care. *Aging & Mental Health*, 15(4), 456–466. <http://doi.org/10.1080/13607863.2010.536137>
- Gleibs, I. H., Sonnenberg, S. J., & Haslam, C. (2014). “We get to decide”: The role of collective engagement in counteracting feelings of confinement and lack of autonomy in residential care. *Activities, Adaptation & Aging*, 38(4), 259–280.
<http://doi.org/10.1080/01924788.2014.966542>
- Gleibs, I., Sonnenberg, S., Haslam, C., J., J.M., & McNeill, J. (2010). Identity continuity in older adults in care: A qualitative study.
- Gobo, G. (2008). *Doing ethnography*. London: Sage.
- Goffman, E. (1990). *The Presentation of the Self in Everyday Life*. London: Penguin.
- Golding, B., Foley, A., Brown, M., & Harvey, J. (2009). *Senior men’s learning and wellbeing through community participation in Australia*.
- Gray, A. (2008). The social capital of older people. *Ageing and Society*, 29(1), 5.
<http://doi.org/10.1017/S0144686X08007617>
- Grundy, E., & Jitlal, M. (2007). Socio-demographic variations in moves to institutional care 1991-2001: A record linkage study from England and Wales. *Age and Ageing*, 36(4), 424–430. <http://doi.org/10.1093/ageing/afm067>
- Gubrium, J. F., & Holstein, J. A. (1995). Individual agency, the ordinary, and postmodern life. *Sociological Quarterly*, 36(3), 555–570.
<http://doi.org/10.1111/j.1533-8525.1995.tb00453.x>
- Gubrium, J. F. (1997). *Living and Dying at Murray Manor*. Charlottesville: University of Virginia Press.
- Gutheil, I. (1991). Intimacy in nursing home friendships. *Journal of Gerontological*

- Social Work*, 17(1), 59–73.
- Halpern, D. (2005) *Social Capital*. Oxford: Polity
- Hammersley, M., & Atkinson, P. (1995). *Ethnography - Principles and Practice* (2nd ed.). London: Routledge.
- Harnett, T., & Jonson, H. (2016). Shaping nursing home mealtimes. *Ageing & Society*, (January). <http://doi.org/10.1017/S0144686X1500152X>
- Harpham, T., Grant, E., & Thomas, E. (2002). Measuring social capital within health surveys: key issues. *Health Policy and Planning*, 17(1), 106–111. <http://doi.org/10.1093/heapol/17.1.106>
- Hawkins, R. J., Prasar, A., Lusambili, A., Ellard, D. R., & Godfrey, M. (2017). “If they don’t use it, they lose it’: how organisational structures and practices shape residents’ physical movement in care home settings. *Ageing and Society*, 1–26. <http://doi.org/10.1017/S0144686X17000290>
- Hearn, J. (1995). Imaging the ageing of men. In A. Featherstone & M. Wernick (Eds.), *Images of Ageing: Cultural Representations of Later Life* (pp. 97–115). London: Routledge.
- Hendryx, M. S., Ahern, M. M., Lovrich, N. P., & McCurdy, A. H. (2002). Access to health care and community social capital. *Health Services Research*, 37(1), 87–103. <http://doi.org/10.1111/1475-6773.00111>
- Hitlin, S., & Glen, H. E. J. (2007). Time, self, and the curiously abstract concept of agency. *Sociological Theory*, 25(2), 170–191.
- Hogg, M. A., & Reid, S. A. (2006). Social identity, self-categorization, and the communication of group norms. *Communication theory*, 16(1), 7-30.
- Holmstrom, A. J. (2009). Sex and Gender Similarities and Differences in Communication Values in Same-Sex and Cross-Sex Friendships. *Communication Quarterly*, 57(2), 224–238. <http://doi.org/10.1080/01463370902889455>
- Holstein, J., & Gubrium, J. (2008). Constructionist impulses in ethnographic fieldwork. In J. Holstein & J. Gubrium (Eds.), *Handbook of Constructionist Research* (pp. 373–395). New York: Guilford Press.
- Hubbard, G., Downs, M. G., & Tester, S. (2003). Including older people with dementia in research: challenges and strategies. *Aging & Mental Health*, 7(5), 351–362.

<http://doi.org/10.1080/1360786031000150685>

- Hubbard, G., Tester, S., & Downs, M. G. (2003). Meaningful social interactions between older people in institutional care settings. *Ageing & Society*, 23(1), 99–114.
- Hurtado, D., Kawachi, I., & Sudarsky, J. (2011). Social capital and self-rated health in Colombia: the good, the bad and the ugly. *Social Science & Medicine*, 72(4), 584–590. <http://doi.org/10.1016/j.socscimed.2010.11.023>
- Iliffe, S., Kharicha, K., Harari, D., Swift, C., Gillmann, G., & Stuck, A. E. (2007). Health risk appraisal in older people 2: the implications for clinicians and commissioners of social isolation risk in older people. *Br J Gen Pract*, 57(537), 277–282.
- Iwase, T., Suzuki, E., Fujiwara, T., Takao, S., Doi, H., & Kawachi, I. (2012). Do bonding and bridging social capital have differential effects on self-rated health? A community based study in Japan. *Journal of Epidemiology and Community Health*, 66(6), 557–62. <http://doi.org/10.1136/jech.2010.115592>
- Kaufman, S. R. (2000). Aging everyday life. In J. A. Gubrium, J. F. Holstein (Ed.) (pp. 103–112). Malden: Blackwell.
- Kingston, A., Wohland, P., Wittenberg, R., Robinson, L., Brayne, C., Matthews, F. E., & Jagger, C. (2017). Is late-life dependency increasing or not? A comparison of the Cognitive Function and Ageing Studies (CFAS). *The Lancet*, 6736(17). [http://doi.org/10.1016/S0140-6736\(17\)31575-1](http://doi.org/10.1016/S0140-6736(17)31575-1)
- Kofod, J. (2012). Building community through meals in the care home setting: Experience from Denmark. *Food, Culture and Society*, 15(4), 665–678. <http://doi.org/10.2752/175174412X13450256411376>
- Lennartsson, C., & Silverstein, M. (2001). Does engagement with life enhance survival of elderly people in Sweden? The role of social and leisure activities. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 56(6), 335–342.
- Luanaigh, C. Ó., & Lawlor., B. A. (2008). Loneliness and the health of older people. *International Journal of Geriatric Psychiatry*, 23(12), 1213–1221.
- Marks, S. R. (1998). The gender context of inclusive intimacy: the Hawthorne women at work and home. In R. G. Adams & G. Allan (Eds.), *Placing Friendship in Context*

- (pp. 43–70). Cambridge: Cambridge University Press.
- Mason, J. (2002). *Qualitative Research Methods* (2nd ed.). London: Sage.
- Mead, G. H. (1962). *Mind, Self and Society*. Works.
- Mccann, M., Donnelly, M., & O'Reilly, D. (2012). Gender differences in care home admission risk: Partner's age explains the higher risk for women. *Age and Ageing*, 41(3), 416–419. <http://doi.org/10.1093/ageing/afs022>
- McKee, K. J., Harrison, G., & Lee, K. (1999). Activity, friendships and wellbeing in residential settings for older people. *Aging & Mental Health*, 3(2), 143–152. <http://doi.org/10.1080/13607869956307>
- McLaughlin, D., Vagenas, D., Pachana, N. a, Begum, N., & Dobson, A. (2010). Gender differences in social network size and satisfaction in adults in their 70s. *Journal of Health Psychology*, 15(5), 671–679. <http://doi.org/10.1177/1359105310368177>
- McPherson, M., Smith-Lovin, L., & Cook, J. M. (2001). Birds of a feather: Homophily in social networks. *Annual review of sociology*, 27(1), 415–444.
- Messerschmidt, J. W. (1993). *Masculinities and crime: Critique and reconceptualization of theory*. Maryland: Rowman & Littlefield Publishers.
- Milligan, C., Dowrick, C., Payne, S., Hanratty, B., Neary, D., Irwin, P., & Richardson, D. (2013). Men's Sheds and other gendered interventions for older men : improving health and wellbeing through social activity - a systematic review and scoping of the evidence base. *Lancaster: Lancaster University Centre for Ageing Research*.
- Milligan, C., Payne, S., Bingley, A., & Cockshott, Z. (2015). Place and wellbeing: shedding light on activity interventions for older men. *Ageing and Society*, 35(1), 124–149. <http://doi.org/10.1017/S0144686X13000494>
- Mitchell, C. U., & LaGory, M. (2002). Social capital and mental distress in an impoverished community. *City & Community*, 1, 199–222.
- Morrow, V. (1999). Conceptualising social capital in relation to the wellbeing of children and young people: a critical review. *Sociological Review*, 744–765.
- Moss, S. Z., & Moss, M. S. (2007). Being a man in long term care. *Journal of Aging Studies*, 21(1), 43–54. <http://doi.org/10.1016/j.jaging.2006.05.001>
- Nihtilä, E., & Pekka, M. (2008). Why older people living with a spouse are less likely to be institutionalized: The role of socioeconomic factors and health characteristics.

- 36.1 (2008): 35-43. *Scandinavian Journal of Social Medicine*, 36(1), 35–43.
- Nilsen, C., Agahi, N., & Shaw, B. A. (2017). Does the association between leisure activities and survival in old age differ by living arrangement? *Journal of Epidemiology and Community Health*, jech-2017-209614. <http://doi.org/10.1136/jech-2017-209614>
- NMDS-SC. (2017). National Minimum Data Set for Social Care. Retrieved August 14, 2017, from <https://www.nmds-sc-online.org.uk/reportengine/GuestDashboard.aspx?type=Gender>
- O'Reilly, K. (2005). *Ethnographic methods*. New York: Routledge.
- Oakley, A. (1972). *Sex, gender and society* (edition 20). Farnham: Ashgate Publishing Limited.
- Oksuzyan, A., Juel, K., Vaupel, J. W., & Christensen, K. (2008). Men: good health and high mortality. Sex differences in health and aging. *Aging Clinical and Experimental Research*, 20(2), 91–102. <http://doi.org/10.1007/BF03324754>
- ONS. (2013). *What does the 2011 Census tell us about the “ oldest old ” living in England & Wales?* Retrived from <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ageing/articles/whatdoesthe2011censustellusaboutolderpeople/2013-09-06>
- ONS. (2014a). *Changes in the Older Resident Care Home Population between 2001 and 2011*. Retrived from <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ageing/articles/changesintheolderresidentcarehomepopulationbetween2001and2011/2014-08-01>
- ONS. (2014b). Health expectancies at Birth and at Age 65 in the United Kingdom: 2009-11. *Statistical Bulletin*, (November), 1–20. Retrieved from http://www.ons.gov.uk/ons/dcp171778_385338.pdf
- ONS. (2015). National Population Projections: 2014-based Statistical Bulletin. Retrieved from <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/nationalpopulationprojections/2015-10->

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- ONS. (2016). Health state life expectancies (general health) for males and females at birth and men and women at age 65, 2010 to 2012: United Kingdom (UK). Retrieved from <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/datasets/healthstatelifeexpectanciesgeneralhealthformalesandfemalesatbirthandmenandwomenatage652010to2012unitedkingdomuk>
- ONS. (2017a). Mid-2016 Population Estimates UK Office for National Statistics. Retrieved August 16, 2017, from <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/latest>
- ONS. (2017b). Statistical bulletin: Population Estimates for UK, England and Wales, Scotland and Northern Ireland: mid-2016. Retrieved from <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/latest>
- Pahl, R., and Spencer, L. (1997) The politics of friendship, *Renewal*, 5(3/4), 100-107.
- Palacios-Ceña, D., Losa-Iglesias, M. E., Cachón-Pérez, J. M., Gómez-Pérez, D., Gómez-Calero, C., & Fernández-de-las-Peñas, C. (2012). Is the mealtime experience in nursing homes understood? A qualitative study. *Japan Geriatrics Society*, 13(2), 482–489. <http://doi.org/10.1111/j.1447-0594.2012.00925.x>
- Parahoo, K. (2014). *Nursing Research - Principles, process and issues* (3rd ed.). Basinstoke: Palgrave Macmillan.
- Parmenter, G., Cruickshank, M., & Hussain, R. (2012). The social lives of rural Australian nursing home residents. *Ageing and Society*, 32(2), 329–353. <http://doi.org/10.1017/S0144686X11000304>
- Patulny, R. V., & Svendsen, G. L. H. (2007). Exploring the social capital grid: bonding, bridging, qualitative, quantitative. *International Journal of Sociology and Social Policy*, 27(1/2), 32–51. <http://doi.org/10.1108/01443330710722742>
- Pearson, A., Fitzgerald, M., & Nay, R. (2003). Mealtimes in nursing homes. The role of nursing staff. *J Geront Nurs*, 29(6), 40–48.

- Philpin, S., Merrell, J., Warring, J., Gregory, V., & Hobby, D. (2011). Sociocultural context of nutrition in care homes. *Nursing Older People*, 23(4), 24–30. <http://doi.org/10.7748/nop2011.05.23.4.24.c8480>
- Pillemer, K., Chen, E. K., Van Haitsma, K. S., Teresi, J., Ramirez, M., Silver, S., ... Lachs, M. S. (2011). Resident-to-resident aggression in nursing homes: Results from a qualitative event reconstruction study. *Gerontologist*, 52(1), 24–33. <http://doi.org/10.1093/geront/gnr107>
- Pirhonen, J., & Pietilä, I. (2018). Active and non-active agents: Residents' agency in assisted living. *Ageing and Society*, 38(1), 19–36. <http://doi.org/10.1017/S0144686X1600074X>
- Pleck, J. H. (1975). Man to man: Is brotherhood possible. In N. Glazer-Malbin (Ed.), *Old Family, New Family*. New York.
- Poortinga, W. (2006). Social relations or social capital? Individual and community health effects of bonding social capital. *Social Science Medicine*, 63(1), 255–270.
- Port, C. L., Gruber-Baldini, A. L., Burton, L., Baumgarten, M., Hebel, J. R., Zimmerman, S. I., & Magaziner, J. (2001). Resident contact with family and friends following nursing home admission. *Gerontologist*, 41(5), 589–596. <http://doi.org/http://dx.doi.org/10.1093/geront/41.5.589>
- Portes, A. (1998). Social capital: its origins and applications in modern sociology. *Annual Review of Sociology*, 24, 1-24.
- Powers, B. A. (1991). The meaning of nursing home friendships. *Advances in Nursing Science*, 14(2), 42–58.
- Putnam, R. D. (2000). *Bowling Alone. The Collapse and Revival of American Community*. New York: Simon & Schuster.
- Prentice, D. a., & Carranza, E. (2002). What women and men should be, shouldn't be, are allowed to be, and don't have to be: the contents of prescriptive gender stereotypes. *Psychology of Women Quarterly*, 26(4), 269–281. <http://doi.org/10.1111/1471-6402.t01-1-00066>
- Prince, M. Knapp, M, Guerchet, M, McCrone, P, Prina, M, Comas-Herrera, A, Wittenberg, R, Adelaja, B, Hu, B, King, D, Rehill, A and Salimkumar, D. (2014). *Dementia UK: - Overview*. Second edition.

- Reed, J., & Roskell Payton, V. (1997). Understanding the dynamics of life in care homes for older people: implications for de-institutionalizing practice. *Health and Social Care in the Community*, 5(4), 261–268.
- Reisman, J. M. (1995). Intimacy in same-sex friendships. *Sex Roles*, 23, 65–82.
- Rockwood, K., Stolee, P., & McDowell, I. (1996). Factors associated with institutionalization of older people in Canada: testing a multifactorial definition of frailty. *Journal of the American Geriatrics Society*, 44(5), 578–582.
- Rosen, T., Lachs, M. S., Bharucha, A. J., Stevens, S. M., Teresi, J. A., Nebres, F., & Pillemer, K. (2008). Resident-to-Resident Aggression in Long-Term Care Facilities: Insights from Focus Groups of Nursing Home Residents and Staff. *Journal of the American Geriatrics Society*, 56(8), 1398–1408.
- Roy, R., Benenson, J., & Lilly, F. (2000). Beyond Intimacy: Conceptualizing Sex Differences in Same-sex Friendships. *The Journal of Psychology*, 134(1), 93–101.
- Rowe, J. W., & Kahn, R. L. (1997). Successful aging. *The Gerontologist*, 37(4), 433–40.
- Rozanova, J. (2010). Discourse of successful aging in The Globe & Mail: Insights from critical gerontology. *Journal of Aging Studies*, 24(4), 213–222.
- Russel, H. (1999). Friends in low places: gender, unemployment and sociability. *Work, Employment and Society*, 13(2), 205–224 in Field, J. (2008). *Social Capital*. New York: Routledge.
- Rubin, L. (1985). *Just Friends: The Role of Friendship in Our Lives*. New York: Harper & Row.
- Rubinstein, R. I., & Parmelee, P. A. (1992). Attachment to Place and the Representation of the Life Course by the Elderly. In I. Altman & S. M. Low (Eds.), *Place Attachment. Human Behavior and Environment (Advances in Theory and Research)* (Vol. 12). Boston: Springer.
- Sackley, C., Levin, S., Cardoso, K., & Hoppitt, T. (2006). Observations of activity levels and social interaction in a residential care setting, 13(8), 8–11.
- Samter, W. (2003). Friendship interaction skills across the life span. In J. O. Greene & B. R. Burleson (Eds.), *Handbook of communication and social interaction skills* (pp. 637–684). Mahwah, NJ: Lawrence Erlbaum Associates, Inc.
- Sarantakos, S. (2013). *Social Research* (4th ed.). Basinstoke.

- Savishinsky, J. (1991). *The ends of time: Life and work in a nursing home*. New York: Bergin and Garvey.
- Shapiro, A., & Yarborough-Hayes., R. (2008). Retirement and older men's health. *Generations*, 32(1), 49–53.
- Silverman, D. (2011). *Interpreting Qualitative Data* (4th edition). London: Sage.
- Sixsmith, J., & Boneham, M. (2003). Older men's participation in community life: notions of social capital, health and empowerment. *Ageing International*, 28(4), 372–388.
- Spradley, J. P. (1980). *Participant Observation*. Belmont: Wadsworth, Cengage Learning.
- Spradley, J. P. (2016). *The Ethnographic Interview*. Waveland Press.
- Stake, R. (1994). "Case Studies." In *Handbook of Qualitative Research* (pp. 236–247). CA: Sage.
- Stanley, L. (1996). "I. The Mother of Invention: Necessity, Writing and Representation." 6.1 (1996): 45-51. *Feminism & Psychology*, 6(1), 45–51.
- Thompson, E. H. (Ed.) (1994). *Older men's lives*. (Vol. 6). London: Sage.
- Tsai, H. H., & Tsai, Y. F. (2008). A temporary home to nurture health: Lived experiences of older nursing home residents in Taiwan. *Journal of Clinical Nursing*, 17(14), 1915–1922. <http://doi.org/10.1111/j.1365-2702.2007.02240.x>
- Tulle-Winton, E. (1999). Growing old and resistance: towards a new cultural economy of old age? *Ageing & Society*, 19(3), 281–299.
- Uphoff, E. P., Pickett, K. E., Cabieses, B., Small, N., & Wright, J. (2013). A systematic review of the relationships between social capital and socioeconomic inequalities in health: a contribution to understanding the psychosocial pathway of health inequalities. *International Journal for Equity in Health*, 12(1), 54. <http://doi.org/10.1186/1475-9276-12-54>
- Walker, K. (1994). Men , Women , and Friendship : What They Say , What They Do, 8(2), 246–265. Retrieved from <http://www.jstor.org/stable/190012>
- Warde, A., Martens, L., & Olsen, W. (1999). Consumption and the problem of variety: cultural omnivorousness, social distinction and dining out. *Sociology*, 33(1), 105–127.

- Watkins, R., Goodwin, V. A., Abbott, R. A., Backhouse, A., Moore, D., & Tarrant, M. (2017). Attitudes, perceptions and experiences of mealtimes among residents and staff in care homes for older adults: A systematic review of the qualitative literature. *Geriatric Nursing*, 1–9. <http://doi.org/10.1016/j.gerinurse.2016.12.002>
- Webster, J. (1995). Age differences in reminiscence functions. In *The Art and Science of Reminiscing* (pp. 89–102). Washington DC: Taylor & Francis.
- Wikby K, F. A. (2004). The willingness to eat: an investigation of appetite among elderly people. *Scandinavian Journal of Caring Sciences*, (18), 120–127.
- Wiles, J. L., Allen, R. E. S., Palmer, A. J., Hayman, K. J., Keeling, S., & Kerse, N. (2009). Older people and their social spaces: A study of well-being and attachment to place in Aotearoa New Zealand. *Social Science and Medicine*, 68(4), 664–671. <http://doi.org/10.1016/j.socscimed.2008.11.030>
- Wilkinson, G. and Pickett, K. (2009). *The Spirit Level: Why More Equal Societies Almost Always Do Better*. New York: Bloomsbury Press.
- Wilson, N. J., & Cordier, R. (2013). A narrative review of Men's Sheds literature: reducing social isolation and promoting men's health and well-being. *Health and Social Care in the Community*, 21(5), 451–463.
- Wright, L., Hickson, M., & Frost, G. (2006). Eating together is important: using a dining room in an acute elderly medical ward increases energy intake. *Journal of Human Nutrition and Dietetics*, 19(1), 23–26.
- Wrzus, C., Hänel, M., Wagner, J., Neyer, F. J., (2013). Social network changes and life events across the life span: A meta-analysis. *Psychological Bulletin*, 139(1), 53–80.
- Zeiss AM & Kasl-Godley J. (2001). Sexuality in older adult's relationships. *Generations*, 25, 18–25.

11. APPENDICES

11.1. Appendix A - Samples of fieldnotes jottings

From (D) Drink
 (C) Helen
 Mary Nick
 Wendy B. Monica
 Gordon
 Paul
 A Wendy Hank

(Back home - 13/07
 lunch-time)

By this time everyone was
 waiting for the meals to
 be served. There was a short
 silence at table B. Nicola
 then pointed to Monica and
 said "She is not drinking
 wine!"

Wendy - It is funny, who
 drinks wine. She is not
 here today.

Nicola - "She looks lovely!"
 (pointing to Monica)

Back H.
 conversation with
 Susan - afternoon
 "One of the stuffs,
 He is a gypsy, com-
 mon women!
 She has a terrible temper-
 ment - um!
 "you can't say a
 thing - we have
 other things to do!
 (He looked away
 and we stay in silence)

Back home -
 conversation with Susan

"One of the stuffs, she
 is a gypsy, common
 women!" She has
 a terrible temper
 - you can't say
 anything!"

"We have other
 things to do!"
 (He looked away - pause)

11.2. Appendix B – fieldnotes sample

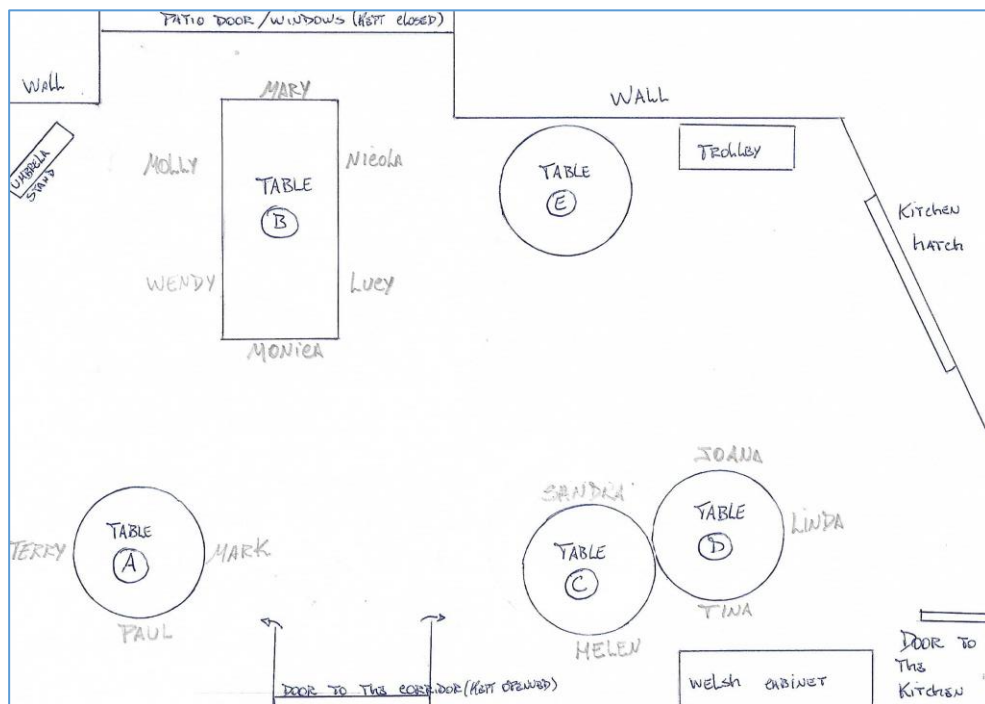
15:30

I found all the residents sat in the dining room waiting for the lunch when I arrived at 12:30. I stood up for an instant in the corridor near to the door looking towards the residents and staff. As usual, the residents were waiting in silence, some observing the staff preparing the things (the meals and trolleys to be taken to the residents in their bedrooms and serving residents in the dining room, serving drinks etc). At that moment there were 4 staff near to the serving hatch standing around. They talk quietly in these occasions, normally only one at a time and the subjects are normally something about work.

I found it pretty difficult to make an account of these conversations because I am normally standing close to the residents on the other side of the room. In any case, the conversation between staff may not be as relevant in itself but the effect of their conversations for the residents. I will try to make notes on how the residents react to the staff talking – **this could be a topic in the interviews with the male residents.**

I have noticed from previous observations that Terry seems the most focused in watching the staff working and interacting. Terry always sits at the same place at table A which gives a full view of the dining room (it seems the best place for this purpose). Terry and Mary are the most consistent in sitting at the same place and they are the most mobile in the group (they do require support to stand up and walk though). The other residents sat at tables A and B tend to sit at different places around the same table each meal time. The residents at table C and D don't vary in their sitting arrangements though.

Map of lunch time in the dining area



While I was observing the room from the corridor, staff 1(f) bumped into me as she was walking in to the dining room. We greeted each other and she asked me how my work was going and I replied that it was going a bit slowly at this moment but otherwise well. Staff 1(f) mentioned that I missed the *music activity* in the morning. I commented that I was unaware of the activity and she replied to me that there was a sign on the lounge door listing all the activities for the week. I said that I didn't know about that and Staff 1(f) offered to show me. She then started to walk through the corridor towards the lounge. The corridors are 1.5 metres wide (it easily fits 2 wheel chairs side by side). In that section of the corridor there is no furniture. The corridor extends for a few metres and has a 90 degrees turn to left. In that section of the corridor there is a staff station with two small desks, a computer and shelves with files. The station is placed on left side of the corridor contained in a small but open space. Further down the corridor there is a small chest of draws and the lounge double door is 5 or 6 metres from the chest of draws. Staff 1(f) lead the way. We talked for three to five minutes as she seemed keen to talk to me and interested in my research. Another member close to the station called staff 1, but before she walked away I said to her that she could ask me to help her with simple tasks to support the resident. I noticed that she looked at me a bit impatiently when I held her up for a bit longer.

Back in the dining room, I stood up next to table B, from where I could see all the dining room. As I was near the table, I heard Monica saying to Wendy, "Those flowers look lovely!" while she nodded towards the glass patio door, through which two baskets of flowers could be seen hanging on the wall. The glass patio door leads to a small courtyard which is enclosed by a semi-circular brick wall. In the centre of the courtyard there is a statue of a dark grey painted girl kneeling. The paint is flaking on some parts of the statue exposing the concrete which the statue is made of. Wendy heard Monica's comment, looked at the patio door or the flowers and replied to Monica, "Oh they do!". Later on Wendy commented to Monica - "The lunch is late" as Wendy looked at her watch and pointed. Vi Replied, "It is getting later and later". Throughout the lunch time I didn't see the residents at table A talking to each other. At table B there were long periods of silence with occasional breaks such as:

Wendy – *Look at that big clock on the wall* (pointing to the clock old on the wall)

Monica – *Yes, it is!*

Wendy - *You could not miss that time!*

In both settings B and C I noticed that the residents were quite impatient whilst waiting for the meals as there was a kind of discomfort in these situations.

As the meals were served at different times (it appears there is no order for who is served first, the meals are served as the cook prepares them). One of the members of staff dragged a chair next to Mark to feed him. Mark seemed surprised with the 2 staff approaching who then said hello to him while moving the chair next to him. Mark reacted with surprise and excitement and replied to her with a loud and long "hello!". Mark and staff 2 immediately engaged in a conversation. Their conversation lasted for the whole time that the staff were supporting him. I observed that on many occasions the staff rested the cutlery and kept listening to Mark. Examples of conversations between staff 2 and Mark - "My son bought a flashy expensive car." "The food on the boat was very nice, better than on the plane." (He was talking about his last trip with his family).

When Mark finished what he wanted to say, staff 2 would reply to him and feed him at the same time (but it didn't happen every single time). They were the only people talking in the room for most of the lunch time. It seems to me that for Dereck the meal times are opportunities for a conversation or a social opportunity. I wonder whether these conversations are followed or appreciated by Terry and Paul. I might ask a question in Terry's next interview about the conversations between the staff and Mark. I will try to record a dialogue between the staff and Mark in the coming observations.

There was only one other member of staff in the room who was feeding Molly and they stayed in silence. The rest of the residents could feed themselves.

In this respect, setting A was more chaotic than setting C because of the greater number of residents unable to feed themselves and not having enough staff to do this task at the same time.

As the residents finished their meals, one of the staff started to take the dishes in order to serve the desserts. The hot drinks were served just after the desserts. Today there were only two staff serving the lunch and staff could assist all residents' requests. Nicola seemed confused and kept asking me to call staff 1 (I was standing next to her) as she wanted to rest her feet on a foot stool. Nicola kept pushing her wheel chair backwards but she seemed not be aware of what she was doing. Eventually, staff 1 had time speak to Nicola but she persisted talking about the foot stool. After staff 1 had spoken to Nicola, I asked if today there was a shortage of staff and staff 1 replied that there was 1 resident very ill so there were less people serving the lunch. After we spoke staff 1 asked me to help serving the hot drinks. This is the first time I helped the staff as a volunteer in setting C and I used this opportunity to approach other staff and speak with all residents.

Their drinks were all on one trolley in the centre of the room. She asked me to fill up the cups with the tea from a large thermal bottle. I found the metallic thermal bottle button on the top was very stiff and I struggled to pump the liquid into the cups. Staff 1 then called the two other staff that were standing next to kitchen hatch saying "look at that!" and they all laughed when saw me pumping the tea. I smiled back and kept

serving the teas. Staff 1 knew how each resident liked their tea, she prepared each cup of drink and told me who the drink was for. When I was serving the drink to Mark, he said "Oh you are working now?" Soon the residents started to leave the dining room as soon as they finished their drinks.

I will try to observe in my next observation how the staff approach residents to move them to their bedrooms or to the lounge. I am not sure if the residents are the ones that take the lead to move away from the room or if it is the staff that prompt the residents; perhaps a bit of both.

One of the staff members came to Monica (she was the closest resident to the centre of the room) and asked her, "Are you going to your bedroom?" while pulling her chair. Monica replied, "I am going to the lounge with her." and looked towards Wendy.

All residents at table B remained in silence while Monica was leaving the table with the support of the carer. Before Monica started to walk she made a jerky movement to grab her small red handbag that was hanging on the back of her chair. Mary then commented "And don't forget the handbag!" while having a short laugh; Lucy and Wendy laughed as well.

When Monica had left the room towards the corridor, Wendy looked to Mary and said, "I don't know what she is dragging me for!" and both laughed. Moments later, just before Wendy left the table with the support of the staff, she said to Mary, "I like your curtains" and Mary replied, "These ones?" and pointed with one hand to the curtains in the dining room (there are light red floral curtains fitted on the patio door near to where Mary sits). Wendy then replied, "No, the curtains in your bedroom." Monica then start walking to the lounge with the staff's support.

I noticed that on the whole the men did not have any conversation, or at least none that I observed, throughout the time that I was there. Perhaps the greetings are the main type of interaction for the men. The men appeared to depend on the staff to generate any form of social interaction. The ladies at table B exchanged words more often; the content of which seemed to be about ordinary things, e.g. the flowers on the wall, the delay of the lunch, the curtains etc.

In the lounge, I found Mary next to Helen as is her usual place at that time of the day. I approached Mary and she seemed pleased to see me. I decided to speak to her because she seems the most able to express her opinions about living in the nursing home and I also find that she enjoys my company. When I asked Mary how she was, she promptly replied, "I'm bored to death." She repeated and emphatically that said "I am bored to death" because "there was nothing to do and nobody to talk to". Mary explained to me that it is all the same people and these people do nothing and about also mentioned a problem she has to socialise with people who have mental impairments. She turned away from me and pointed to Helen on her left and said, "She makes the whole conversation; she makes the questions and the answers." Later she added, "These people are not interested in anything really." I let Mary talk freely and she spoke about varied subjects.

At some point she was interested about the University I am attending, where the campus was, how often I go there, what it looks like, etc. Mary commented that her step daughter went to a University in London but could not remember the name. I said the names of a few Universities in London which I could remember but none was the University which Mary was referring to. While we were speaking, a member of staff came to the room and sat at one of the 2 tables in the centre of the room to fill out forms. The staff member was sat around 4 or 5 metres away from us so Mary could not see clearly who was in the room (Mary has very short eye sight).

As Mary could not remember the name of the university and I listed all the names of universities in London that I could think of. The members of staff said to us "Cambridge, Oxford" Mary replied to the staff that none of these were the Universities that her step daughter went to. We moved on in the conversation but later on, after the staff member had left the room, Mary remembered the name of the University which was Goldsmith's University. Mary then commented with surprise that the staff was able to hear our conversation and observed that "we" have to be very careful about what we say here.

I asked whether she enjoys the company at the meal times. Mary shook her head and replied, "I am not interested, the only person I speak with is Wendy, but she is not very bright; she is a kind of yes or no lady."

Later, Mary asked me who was sat at the other side of the room. I told her that it was Wendy and Monica and they were sat next to each other. Mary then told me that Monica's husband passed away around a fortnight ago, but it seems that Monica didn't mourn his death and commented, "I found it very unusual." Mary told me also that she would like to ask more about his death as she used to speak to him quite often and he seemed a nice person. Mary then said "I would not dare to ask!". Mary stopped talking for a moment and then commented: "people here are very secretive". I asked why she thought people are secretive and she replied that they might be afraid to talk because the information goes too far. She then leaned towards me and said, "So what?" with a higher voice and raised both hands in gesture.

11.3. Appendix C – Coding node samples

USE OF SPACES/
COMMUNAL AREAS/ EVENTS/
NON-EVENTS/conversations with residents/
expressing tedium

<Internals\\ethnographic notes\\setting BEECH\\03.10 notes> - § 1 reference coded
[0.75% Coverage]

Reference 1 - 0.75% Coverage

I asked if I could seat next to him and he said “yes”. I then I asked I was he and the fact that I have not seen him for a quite a while. He replied me: “I am bored”

<Internals\\ethnographic notes\\setting A\\09.09 notes> - § 1 reference coded
[1.43% Coverage]

Reference 1 - 1.43% Coverage

Susan asked what did I do or where I went while I was away. I replied that I just had some time off and she added: “anything is better than this place”. I nodded and stayed quiet for a while.

<Internals\\ethnographic notes\\setting A\\17.08 notes> - § 1 reference coded
[3.03% Coverage]

Reference 1 - 3.03% Coverage

I said hello and “how are you” to the Daisy who was sat in another table as I notice she was looking to me when I was talking to the other residents. Daisy replied “well I am here” with a smile. I smiled too and said ‘okay’ but I didn’t add anything to the conversation.

<Internals\\ethnographic notes\\setting BEECH\\20.09 notes> - § 1 reference coded
[1.49% Coverage]

Reference 1 - 1.49% Coverage

Around 8:30 I found Robert sat in dining room having a cup of tea [or coffee] r5a seemed very pleased to see me. I asked how he was and he replied: “I am bored”. Then he carry on talking but I could understand very little what he was saying.

<Internals\\ethnographic notes\\setting BEECH\\notes 24.08> - § 1 reference coded

[1.04% Coverage]

Reference 1 - 1.04% Coverage

Then I said: "well it is almost time for lunch" to which she replied: "it seems that is always time for lunch".

<Internals\\ethnographic notes\\setting BEECH\\notes 25.08 TO CHECK> - § 1
reference coded [3.18% Coverage]

Reference 1 - 3.18% Coverage

I approached Susan and kned beside her chair, having back supported on the wall. The first thing she said to me: "I am bored to death!" I gave an uncomfortable laugh and become and felt embarrassed for the laugh as I could not work out if she said as joke or she was serious about that remark. Then I said: "Um, that is not good, isn't?"

<Internals\\ethnographic notes\\setting BEECH\\notes 26.08> - § 1 reference coded
[2.78% Coverage]

Reference 1 - 2.78% Coverage

I said hello to Grace and she replied "Sundays are so boring" and I replied that today was not Sunday but Wednesday to which she replied – "oh isn't it? Thanks for telling me but it makes no difference"

<Internals\\ethnographic notes\\setting BEECH\\notes 27.08> - § 1 reference coded
[1.15% Coverage]

Reference 1 - 1.15% Coverage

Susan then said: "nothing is going on here". I asked Susan – "do you like dolly Parton?" Daisy then replied to me "do you mean this rattle"

<Internals\\ethnographic notes\\setting BEECH\\notes 30.08 TO CHECK> - § 1
reference coded [8.99% Coverage]

Reference 1 - 8.99% Coverage

When I arrived in the care home I found Robert sat down in a chair in the corridor that leads to the TV and dining rooms. Robert was playing with a wheel chair in which he was trying to dismantle it in pieces as he already managed to take apart one of the arms of the wheelchair. He tried to put back but he could not managed it. He also tried to take the support of the left foot but he could not do it.

Robert was wearing a black hat that didn't seem to fit well to his head and look too small. I said hello to Robert and he didn't reply but he acknowledged me. I asked if he was okay and he said "no" with a tense voice. I observed him for a short time (I think less than a minute) and I decided to leave him alone as I was concerned that my presence could upset Robert even more.

USE OF SPACES/
COMMUNAL AREAS/ EVENTS/
MEAL EVENTS/
conflicts

<Internals\\ethnographic notes\\setting BEECH\\03.10 notes> - § 1 reference coded
[4.30% Coverage]

Reference 1 - 4.30% Coverage

Isaac refused to take a seat in that seat by shaking his head and saying: "I am not seating there that time" – his expressing was grave and the Bertha didn't attempt to convince him otherwise. Instead Bertha offered him the only free seat left in the room on the table with Sarah, Grace and Eve. Isaac said sorry for asking for another space to sit and Bertha replied: "no problem, no problem sir, here we are"

I believe Isaac was particularly upset or irritated with the fact that Robert was at the table. Isaac seems to avoid the companion of the other male residents. R3b avoid the other male residents company perhaps because their mental impairment. Strangely, he doesn't mind the company of female residents who are equally impaired. Especially the company of Grace who I learned he had an incident with. What seems to me is that the male residents do avoid each other company although r3b reasons might differ from the other gentlemen in the care home.

<Internals\\ethnographic notes\\Setting OAK\\THURS - 10 to 13 -10.12 - Peter's
interview> - § 2 references coded [13.50% Coverage]

Reference 1 - 3.66% Coverage

He seemed very upset and said "I am not going back there! I am going back to my room and will have my meal up there!" and "you know that I don't make a fuss about anything but that is too much!" The staff tried to understand what happened and persuade her to go back to the dining room but I could not hear the whole conversation.

Reference 2 - 9.84% Coverage

Theresa who was sat at the other table asked me in loud voice “who is walking over there?” and the conversation at our table stopped. It was interesting to see the reaction of Nelly's who didn't seem impressed with Theresa's interruption. Nelly looked to Theresa and raised her eyes and then looked to me and Frederic subsequently shaking her head not approving Theresa interference in the flow of our conversation. The three [Nelly, Frederic and Simon] stopped speaking as Joan who was sat next Theresa at the same looked to me and shook her head reproving Theresa's manners. I answered Theresa that the person walking on the road was the the manager. Theresa talked to me for a little longer. Then I looked back to people at the table which I was close by [Frederic, Nelly and Simon] and Frederic continued to talk about Christmas but the mood was not so lively though still friendly.

<Internals\\ethnographic notes\\Setting OAK\\TUESDAY - LUNCH TIME 10.11> - § 1
reference coded [7.81% Coverage]

Reference 1 - 7.81% Coverage

I made a comment about liking have salt in my food as well and Simon changed the conversation saying that his son drives to London every day for working. I made comment about his son commutes and the resident changed again the conversation about the time the he used to work. He commented about the get in a aviation company as trainee and retired as the manager in the same company, adding “I was very lucky”. I tried to comment about what he said and he started to talk about the time he was child during the war and hard time that his mother had to look after him. The two ladies seated in front of us seemed bothered as the male resident didn't stop to talk. One of the them kept looking back to us and repeatedly tutted, staring to him and me. Then turned back to watch the TV although both female residents were dozing on the chair. The male resident didn't seem aware that the female residents were upset about his talking a kept talking to me continually. I could not follow his conversation any more and tried to find an opportunity to talk about the research but the male resident was well into the conversation. He was talking to me quiet loud and once, the female resident turned to us and said in very quietly “speak quieter please” while waving her hand downwards and turned to look ahead again. I heard the other Phillipa saying at that moment “...doesn't stop speaking...”

<Internals\\ethnographic notes\\setting CEDAR\\13.05 lunch time> - § 1
reference coded [10.54% Coverage]

Reference 1 - 10.54% Coverage

sw10C, came to the table to help Lucy to move away from the dining room. Before she left the table she said to me: “live your youth because when you get older...” (I could not remember or catch the whole phrase) and after she left the room, Mary turned to me (she was in silence for most of the time) and said to me: “I hate when people say live your youth! People live the life that they can – they don't know

better!" Mary continue to speak to me for a long period. I was surprised with Mary reaction as she seemed very irritated when she did that comment - It seems that Lucy's presence (or perhaps somebody else) put Mary off to talk.

<Internals\\ethnographic notes\\setting CEDAR\\17.05 Lunch time and afternoon> - § 1 reference coded [3.99% Coverage]

Reference 1 - 3.99% Coverage

Lucy – When I look to that statue it reminds Rome to me!

Mary – To me it is just a lump of cement... (could not hear the whole sentence)

<Internals\\ethnographic notes\\setting CEDAR\\22.05 lunch time> - § 1 reference coded [4.85% Coverage]

Reference 1 - 4.85% Coverage

Paul kept looking straight but making facial expressions as he seemed to get chock as he kept making a noise to clean up his throat. For most of the time Paul kept doing this noises during the lunch. This seems to upset or bother Mary who reacted by pooling a face in disgust or shaking her head almost every time that Paul made a louder noise in cleaning his throat [66].

<Internals\\interviews\\setting BEECH\\interview with carer setting A> - § 1 reference coded [100.00% Coverage]

Reference 1 - 100.00% Coverage

I asked to Brenda(S) what has happened for Eve to be so upset. Brenda(S) provided a short explanation to what had happened in the dinner in this **interview**:

Researcher - so Brenda(S) could you tell me what happen in the dinner time today.

Brenda(S) – "well, when that [inaudible] is sat down eating and [pause] she upsets the other people because if she doesn't to eat she will keep saying 'we don't want this' so because she doesn't want it she will get into everybody else's head that they don't want to neither"

Researcher – "okay"

Brenda(S) – "So as soon as Eve picks up food to eat, Grace will say: we don't want this and Eve puts it straight back down so in Eve head she doesn't want to eat when really she will eat if Grace telling her if is not. And [mm...] she also upset them that is why, [mm...] Eve and Sarah are up walking around because Grace sometimes swears and says nasty things so the two get up and walk around. Once they are upset they won't come back."

Researcher – “so...” The interview had to be end because a resident was in need of Brenda(S) her support in the toilet.

<Internals\\interviews\\Setting OAK\\Abel(B)> - § 1 reference coded [0.70% Coverage]

Reference 1 - 0.70% Coverage

Look, I won't have my meals up here

<Internals\\interviews\\Setting OAK\\Luke(B)> - § 1 reference coded [10.44% Coverage]

Reference 1 - 10.44% Coverage

Oh that's great. So, when do you meet... I mean, do you meet Joseph(B) and Eugenia, only on the meals or ...

Mostly on the meals, the worst part about it actually, I shouldn't say this but Phillipa(B), a pain in the neck, she's on our table, up and down, up and down. Anyway I'm not moving so I'm staying where I am down there, I'm quite happy.

<Internals\\interviews\\Setting CEDAR\\Mark(C) 1st interview> - § 1 reference coded [1.30% Coverage]

Reference 1 - 1.30% Coverage

But there's a few here upstairs that very, very rarely move out of their rooms, you know. They stay in their, they shut themselves away like little hermits. *[Laughs]*

USE OF SPACES/
COMMUNAL AREAS/ EVENTS/
MEAL EVENTS/
Conversations at the tables
Between males

<Internals\\ethnographic notes\\setting CEDAR\\16.05 lunch time> - § 1 reference coded [5.58% Coverage]

Reference 1 - 5.58% Coverage

Terry then resumed his walk towards the table A but as he walked next to Mark who was in his wheel chair and seemed to be asleep, Terry tickled Mark's neck making Mark walking up. Mark didn't express any reaction although Terry laughed shortly but no other words were exchanged.

<Internals\\ethnographic notes\\setting CEDAR\\22.05 lunch time> - § 1 reference coded [2.74% Coverage]

Reference 1 - 2.74% Coverage

Terry arrived as we were speaking (walking slowly, stopped behind Mark and tickled Mark's neck. Terry didn't show change in his facial expression and neither Mark show any reaction or made any mention about it.

<Internals\\interviews\\Setting OAK\\Matthew(B)> - § 1 reference coded [2.90% Coverage]

Reference 1 - 2.90% Coverage

Okay, fair enough. So do you have people in a care home that you normally speak with?

That I want to or don't want to?

That you like normally speak with?

Yes, yes, I like particularly Peter(B) you know, the man with the impediment and I find him a very interesting person.

<Internals\\interviews\\Setting CEDAR\\Mark(C) 1st interview> - § 5 references coded [7.57% Coverage]

Reference 1 - 3.83% Coverage

I wonder whether, if you enjoy the guys company, how you feel about it...?

Oh yeah. I get on well with them actually. Terry(B), I've sat at the same table as Paul(B)...

Uh huh.

I've sat at the same table with Terry (B) since the day I came in here.

Okay.

That's, well nearly, it's eight years, nine years, something like that. And Paul(B) the other big chap joined us about, he's been here about three or four years now. But we're all, all three of us are ex-servicemen.

Reference 2 - 0.92% Coverage

I think between us we've got nearly a hundred years of service. So it always makes for good conversation, you know.

Reference 3 - 1.11% Coverage

And they're good people to talk to, you know. And Terry(C) is going a little bit deaf now but at his age what else could you expect? *[Laughs]*

Reference 4 - 1.17% Coverage

All sorts really. We talk about times in the services, we talk about music because both are great music followers, um, we talk about, ooh, anything.

Reference 5 - 0.52% Coverage

Yeah. But they're, it's good company, you know, it's good company.

<Internals\\interviews\\Setting CEDAR\\Mark(C) 2nd interview> - § 1 reference coded [3.65% Coverage]

Reference 1 - 3.65% Coverage

Okay. So, um, okay. But not residents...?

Oh yeah, most of the residents. I sit on the table opposite two chap that I've sat opposite to for eight years now and I get on ever so well with him. It's like we're good old friends that sit opposite one another. We don't do anything else or go anything else but his wife's just been quite ill, um, and he's been very down. And I found out last week what the trouble was and he hadn't told anybody else, so I was sort of quite chuffed about that really.

Because he...?

Because he told me and not anybody else.

Mm hm, about his wife?

Yeah.

Oh that's, yeah.

And Terry(B) is his name. And again we don't do anything except, well a couple of old crumples like us we can't do very much. *[Laughs]* He sits opposite me and we have a little chat and he goes off to his room and I come to my room and that's it til next day and then we put the world to rights again. *[Laughs]*

<Internals\\interviews\\Setting CEDAR\\setting C. Terry int> - § 2 references coded
[10.06% Coverage]

Reference 1 - 3.49% Coverage

Well it's, it's, as I say, we've been doing it for a while and we know each other, you know. One chap's got a problem with his throat, his cough, and the other one's a diabetic who's disabled. He's more of a bother really but.

Reference 2 - 6.57% Coverage

Researcher - So would you told me, could you tell me what are kind of conversations you have with Paul(C) then if you don't, just can you?

Well normally about how his health is and how his eyes is and how is room is, how he sleeps, because if he's not in his bed he's up plonked in the chair so relaxing in the day, you know. Where I sit up more, I sit across and move about as much as I can, you know. I'm lucky I've got a frame, you know.

11.4. Appendix D – Table of preliminary thematic analysis

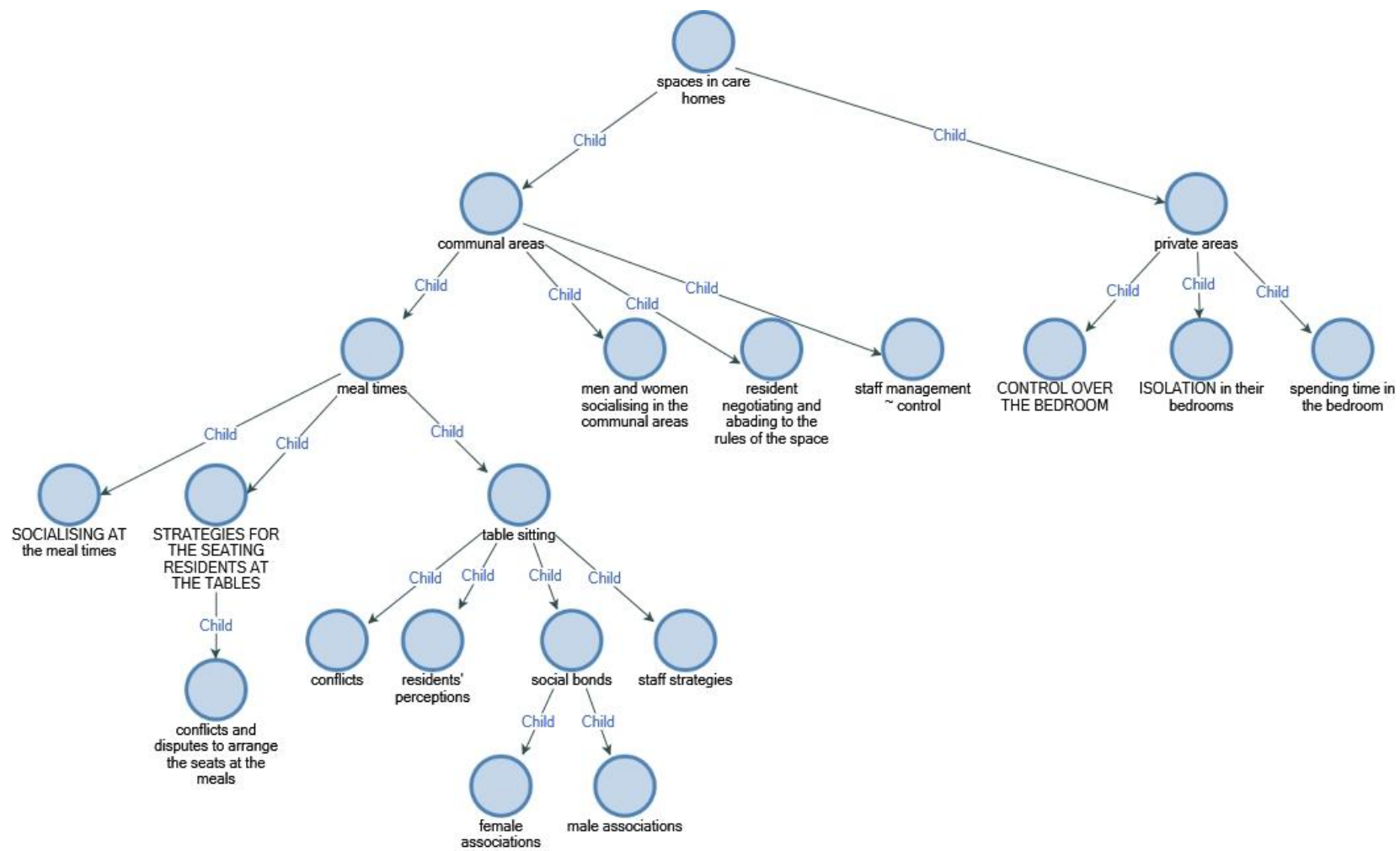
THE USE OF COMMUNAL AREAS BY MALE RESIDENTS IN CARE HOMES			
Types of Communal Areas	Group activities – (craftwork, singing, choir, quizzes)	Mealtimes (eating the meals – breakfast, lunch and dinner)	Sittings times (talking to residents, staff and visitors, watching TV, drinking tea, etc.)
	Structured activities		Unstructured act.
Dining room	<ul style="list-style-type: none"> - The activity events were conducted more fluidly (without routine) compare to the meal activities – engaging in different tasks, the group is freely assembled without seating arrangements - Male residents are not able to have 'ownership' of the space as a consequence of the absence of seating arrangements. - Very often there is only one male attendee or singled – outnumbered and peerless in the group. - Men were focused in doing the activity rather than talking. Men relied on the staff for conversations (one-to-one care) rather than talking to the female residents. 	<ul style="list-style-type: none"> - The meals follow permanent seating arrangements in setting B and C while setting A varied for a good portion of the residents. <p>The activity of eating the meal eased the pressure to socialise for men so they don't feel obliged to talk.</p> <p>While the residents were keen to reinforce the seating arrangement, the staff were in charge to setup new residents at the tables. There were different practices amongst the settings to place the residents. The decision of sitting the resident is very important for men as it will shape their social bonds in small sub-groups throw the table networking.</p> <p><u><i>The dining table is the main platform for men to socialise – table networking concept</i></u></p>	Rarely was used by men

	<p>Female residents seemed more gregarious while doing the activities</p> <p><u>The fluidity (meaning the lack of routine or freely arranged) of the Activity Events do not allow residents to achieve ownership of the space for men and women. However, women acquire the ownership of the TV lounge through the 'sitting-time'</u></p> <p><u>Men focus on the activity and very often being the sole male member in the group led to an apparent isolation in the group in these events. Hence, male residents have a greater dependency on the care staff assistance for these kind of events.</u></p>	<p><u>The regularity of meal events and seating arrangements permit men to own the space in the dining room – ascribing the individual to the group. While women seem to be often more resourceful in ways to socialise and spend time with the group – preventing isolation.</u></p> <p><u>The meal events are social activities which provide opportunities for men to socialise without forcing them to speak. The routinisation of these spaces permit men to gain ownership of the space.</u></p> <p><u>Ownership of the space – is a concept that relates the resident's bond with determined space in the care home, usually a chair or armchair. It is regularly used by the resident and allows attachment to the space (in the sense it becomes part of his home – which comes from another study) but also it is a space that defines the resident in relation to the rest of the group.</u></p> <p><u>These types of events might produce positive effects on their wellbeing by integrating</u></p>	
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		<p><u>them into a group (residents, staff and visitors) and its routinisation was able to create attachment to the space sense of normality.</u></p> <p><u>Care homes had different strategies in setting up residents at the table. Oak Home would place individuals based on the personality and their background and by residents or health needs (the chatty, the trouble maker and from gender for the women in the quiet lounge. Cedar Home placed the residents by gender</u></p> <p><u>And Beech home placed the residents in different areas – one with the most disable (requiring assistance to feed) and less disable (they could feed themselves) in this last space some of the residents were placed as they arrived and other had fixed seats forming groups that sat together in the TV lounge in the sitting-times.</u></p>	
The lounges		<p>Not used for serving the meals for the group.</p>	<p>Men were mostly absent in these areas as there were no structured activities to attend. Men normally only accessed and spent time in this area while waiting for an activity event to start.</p>

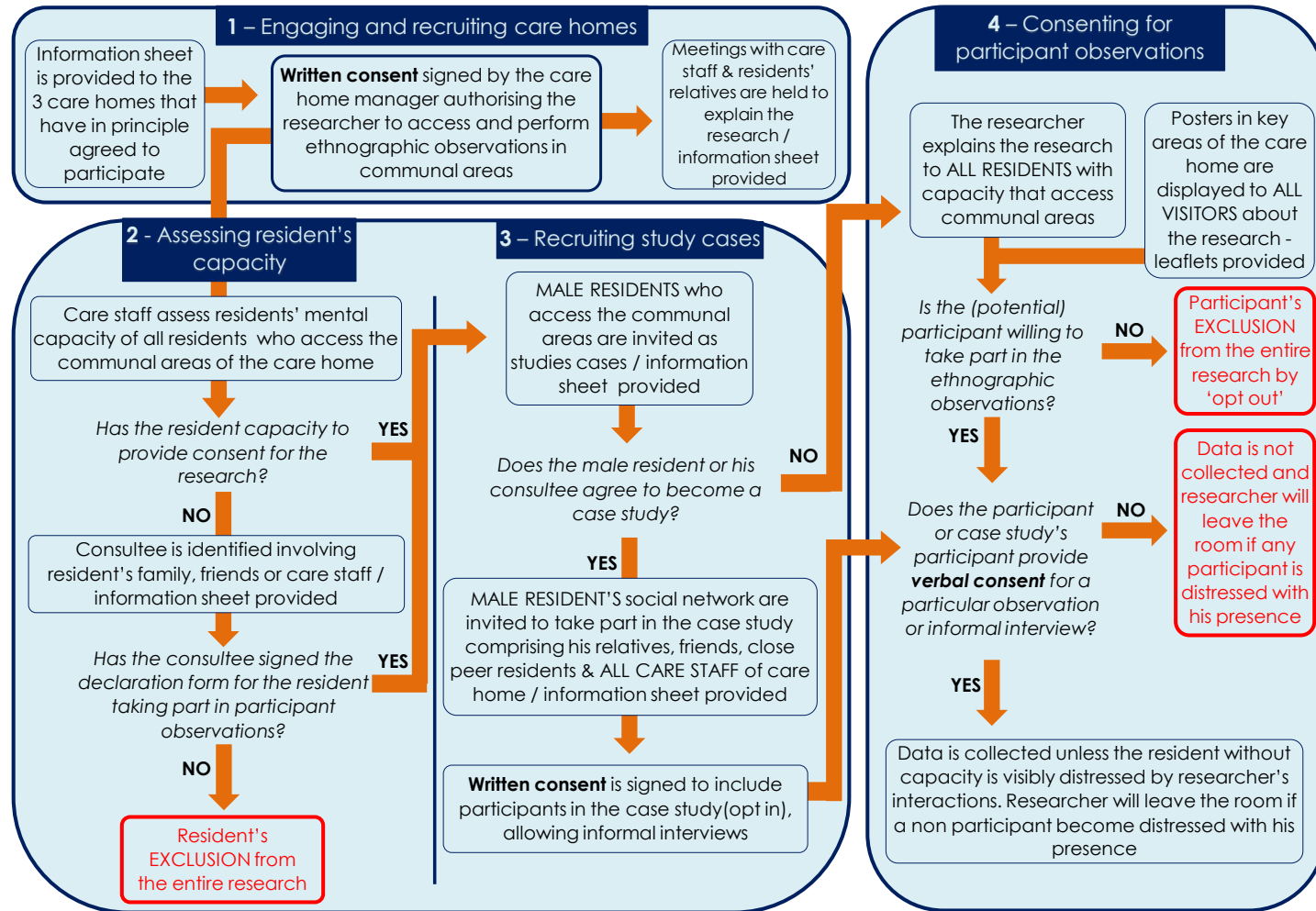
			<p>Men don't have fixed seats in the lounge to use (not having a particular armchair as women did). <u>Men did not 'own' their space in these areas as women did by routinely sitting in the same places at different times of the day.</u></p> <p><u>Overall, men have less opportunity than women to socialise and they are more at risk of isolation. However, the isolation for men does not necessarily lead to loneliness.</u></p>
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11.5. Appendix E - Flow chart of themes

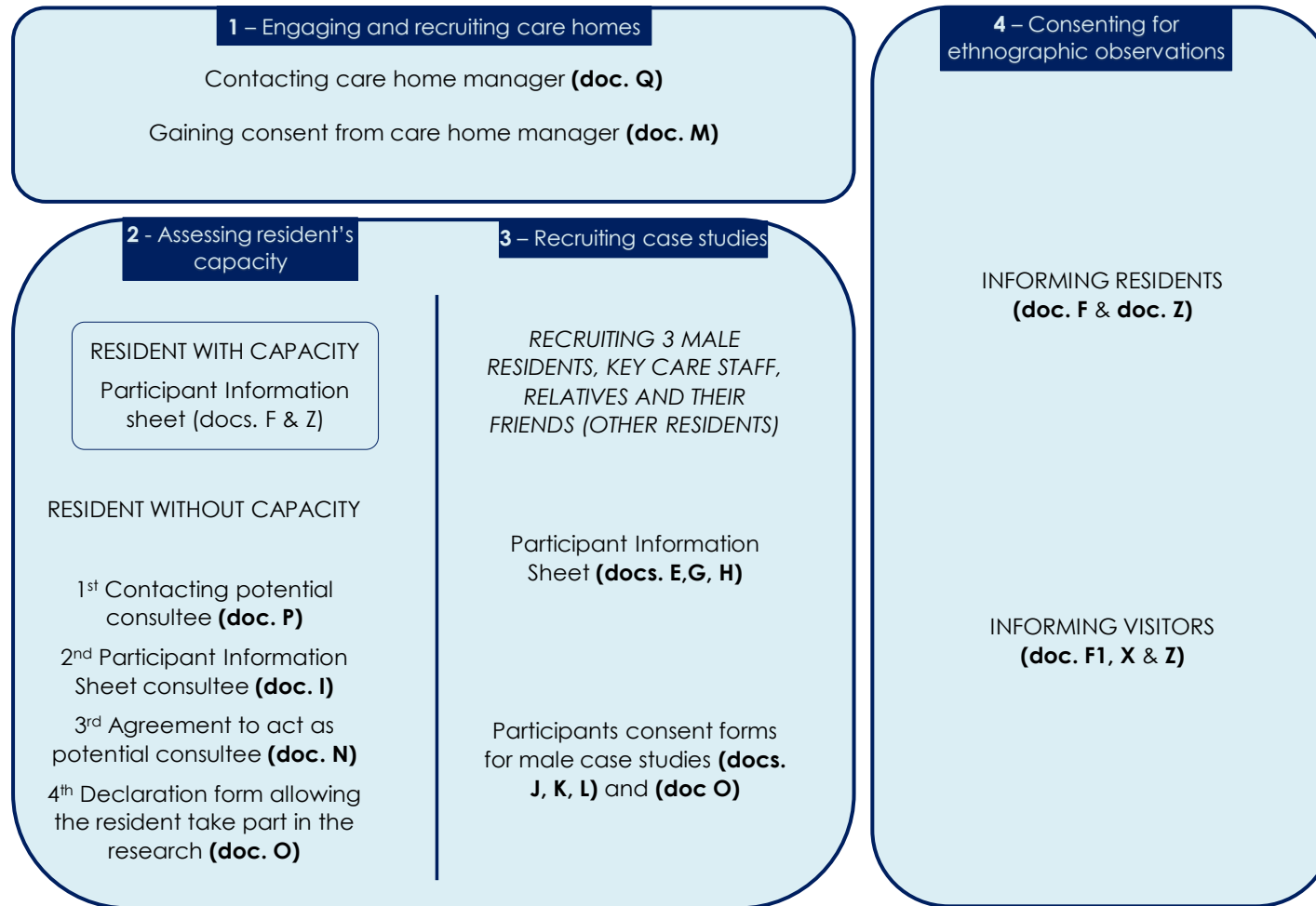


11.6. Appendix F – Research ethical process flow chart

Research ethical process flow chart



Research ethical process flow chart



11.7. Appendix G – Advertising research material

(doc. X)

UNDERSTANDING THE SOCIAL LIFE OF MEN LIVING IN CARE HOMES – A RESEARCH PROJECT

Dear Visitor,

My name is Adriano Maluf. I am a PhD student at University of East Anglia at the School of Health Sciences.

This care home has kindly agreed to take part in my research which explores the social lives of older men living in care homes. I will be visiting the care home to collect data for my study from in the next 2 or three months. My main activity will be having conversations and making observations in the communal areas of the care home with residents, visitors and care staff. I may approach you to ask you whether it is okay if I make notes about you and residents for my research. All notes made will remain confidential and real names will not be used. I will only engage with any of those activities with your knowledge and permission.

You can choose not to take part in the entire study. You can opt-out by communicating your decision to me personally, by phone, or by e-mail, or by letting one of the staff members know. Your contribution in taking part in this research is highly appreciated and will enable us to understand more about social lives in care homes, which could in future help to improve the lives of care home residents.



Thank you

You can find more information about this study on a leaflet available in the key areas of this Care Home or by contacting me on **079 2210**

4686, E-mail: a.maluf@uea.ac.uk

University of East Anglia - UEA, Edith Cavell Building 1.27, School of Nursing Sciences, Norwich Research Park, Norwich NR4 7TJ

Researcher's name: Adriano Maluf

Period of data collection: __/__/__ to __/__/__

The background of this study: although the presence of older men in care homes has increased in recent years, they are still in the minority. This study explores how older men socialise in care home environments and whether being part of a minority can impact their wellbeing.

The design of the study: this study uses qualitative methods based on a few case studies. Although the study is focused on older men, women are also welcome to take part. Adriano will work as volunteer in the communal areas of the care home by helping residents with simple tasks and socialising with residents, care staff and visitors to generate the data for the research.

License: this study has been reviewed and authorised by the Research Social Care Ethics Committee for England and Wales

Outputs: The results of this research will be used for a PhD thesis and academic publications.

(doc. Z)

	Project Supervisor	Project Researcher	
	Professor Francine Cheater School of Health Sciences University of East Anglia Edith Cavell Building Norwich Research Park Norfolk NR4 7TJ 01603 59 7132 f.cheater@uea.ac.uk	Adriano Maluf School of Health Sciences University of East Anglia Edith Cavell Building, 1.27 Norwich Research Park Norfolk NR4 7TJ 01603 59 1019 07922 10 4686 a.maluf@uea.ac.uk	  



This care home has joined a research project that explores the social lives of older men

Your participation is welcome and valuable

Dear Sir / Madam



My name is Adriano Maluf, I am a PhD student at UEA researching social aspects of residents' lives in care homes for older people. My background is in Social Sciences (MSc) and Law (Ba in Law).

This care home has kindly agreed to support my research and allow me to access its communal areas. However, the participation and cooperation of residents, visitors and care staff is fundamental for the success of this project.

You will probably meet me at the care home at some time during the period when I am collecting data.

This leaflet contains the main information about this research and what you should know about becoming a participant. Please take it with you for future consultation. Please contact me if you want to know more this project or you have further questions.

MAIN INFORMATION FOR POTENTIAL PARTICIPANTS:

- Your participation in this research is entirely voluntary, so it is up to you to decide if you want to take part in it;
- Invariably, Adriano will seek your verbal consent before any conversation or observation takes place;
- This research will not affect the support and care received by residents;
- Please inform Adriano if you ever become uncomfortable with the conversations or observations. He will discontinue the conversation, observation or leave the area where your resident relative or friend are;
- Your information will remain strictly confidential and your real name won't be used in the data;
- Your participation is important and lead to producing new knowledge about older men living in care homes which can improve the life of this population;
- You can choose not to take part in the entire study. You can opt-out by communicating your decision to me personally, by phone, or by e-mail, or by letting one of the staff members know.
- If you have further questions or concerns, please find the contact details on the back of this leaflet

THANK YOU FOR YOUR TIME!

11.8. Appendix H – Participant information sheets and letters

(doc. E)



Residents' information sheet (1)

Study title: Understanding the social lives of older men living in care homes and the impact on their wellbeing

Researcher: Adriano Maluf

Institution: School of Health Sciences at the University of East Anglia (UEA)

I would like to invite you to take part in a study that explores the social lives of older men living in care homes.

This information sheet contains the main information about this study. It takes 10 minutes to read.

WHAT IS THE PURPOSE OF THE STUDY?

The aim of this study is to understand how men experience their social lives in care homes and how this affects their wellbeing.

WHY HAVE I BEEN INVITED TO TAKE PART?

The study is interested in hearing from men and women living in care homes.

DO I HAVE TO TAKE PART?

No, you can refuse to take part in this study. This would not affect the care you receive in the care home.

WHAT DO I HAVE TO DO IF I TAKE PART?

If you agree to take part in this research you will need to sign a written consent form.

I will visit this care home in the next couple of months to witness the daily life of the residents.

This will sometimes involve some conversations and observations with you from time to time. I will always ask you to consent before I start a conversation or observation with you.

I may also invite you to take part in interview but only if you are

happy to do so. Interviews could be audio-recorded with your permission. With your permission I will look at your care plans. The interviews will take place in a private area within the home so no other people will hear what you have said. Your wishes and opinions will be respected at all times.

HOW LONG WILL THE STUDY LAST?

I will visit your care home for between 8 and 12 weeks, spending time in different places in the care home with other people.

WHAT ARE THE POSSIBLE RISKS AND DISADVANTAGES OF TAKING PART?

It is possible you may feel uncomfortable with my presence or with conversations or the questions that I ask you. In this case you can ask me to change our conversation, stop collecting data or leave the room.

WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART?

This study can help to improve the lives of men living in care homes for older people.

I will work as a volunteer in the care home, so I could help you with simple tasks in your daily life. Otherwise, there are no direct benefits for you.

WILL MY INFORMATION BE KEPT CONFIDENTIAL AND ANONYMOUS?

Nobody else apart from me and my supervisors will access your information. All the information will be kept in files protected in locked cabinets and by computer passwords.

Everything you say/report is confidential unless you tell us something that indicates you or someone else is at risk of harm. We would discuss this with you before telling anyone else.

WHAT IF THERE IS A PROBLEM AND I WISH TO MAKE A COMPLAINT OR LEAVE THE STUDY?

You can talk to me if you wish to make a complaint or withdraw from the study.

You can leave the study at any time without giving a reason. However, the information collected up to that moment will be used in the study.

If you wish, you can contact my research supervisor Professor Francine Cheater (contact details below) to discuss any concern you may have.

WHO HAS REVIEWED THIS STUDY TO MAKE SURE IT IS SAFE TO CONDUCT?

This study has been reviewed and given a favourable opinion by the Social Care Research Ethics Committee which is a group




of independent people who review research to protect the dignity, rights, safety and wellbeing of participants and researchers.

WHAT WILL HAPPEN WITH THE RESULTS OF THE STUDY THAT I HELP PROVIDE?

This research is part of my post graduate research. The results may be presented in academic conferences. Your identity and data will be protected in all circumstances.

FURTHER INFORMATION AND CONTACT DETAILS

Please feel free to contact me if you have any further questions. Thank you for taking the time to read this information sheet. Let me know if you would like a summary of the findings at the end of the study.

	Project Researcher	Project Supervisor
	Adriano Maluf School of Health Sciences University of East Anglia Edith Cavell Building, 1.27 Norwich Research Park Norfolk NR4 7TJ	Professor Francine Cheater School of Health Sciences University of East Anglia Edith Cavell Building Norwich Research Park Norfolk NR4 7TJ
	01603 59 1019 / 07922 10 4686	01603 59 7132
	<u>a.maluf@uea.ac.uk</u>	<u>f.cheater@uea.ac.uk</u>

(doc. F)



Residents' information sheet

Study title: Understanding the social lives of older men living in care homes and the impact on their wellbeing

Researcher: Adriano Maluf

Institution: School of Health Sciences at the University of East Anglia (UEA)

I would like to invite you to take part in a study that explores the social lives of older men living in care homes.

This information sheet contains the main information about this study. It takes approximately 10 minutes to read.

WHAT IS THE PURPOSE OF THE STUDY?

The aim of this study is to understand how men experience

their social lives in care homes and how this affects their wellbeing.

WHY HAVE I BEEN INVITED TO TAKE PART?

The study is interested in hearing from men and women living in care homes.

DO I HAVE TO TAKE PART?

No, you can refuse to take part in this study. This would not affect the care you receive in the care home.

WHAT DO I HAVE TO DO IF I TAKE PART?

I will visit this care home in the next couple of months to witness the daily life of the residents. This will sometimes involve some conversations and observations with you from time to time. I will always ask you to consent before I start a conversation or observation with you.

Your wishes and opinions will be respected at all times.

HOW LONG WILL THE STUDY LAST?

I will visit your care home for between 8 and 12 weeks, spending time in different places in the care home with other people.

WHAT ARE THE POSSIBLE RISKS AND DISADVANTAGES OF TAKING PART?

It is possible you may feel uncomfortable with my presence or with conversations or the questions that I ask you. In this case you can ask me to change our conversation, stop collecting data or leave the room. Any requests will be respected.

WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART?

This study can help to improve the lives of men living in care homes for older people.

I will work as a volunteer in the care home, so I could help you with simple tasks in your daily life. Otherwise, there are no direct benefits for you.

WILL MY INFORMATION BE KEPT CONFIDENTIAL AND ANONYMOUS?

Nobody else apart from me and my 2 supervisors will access your information. All the information will be kept in files protected in locked cabinets and by computer passwords.

Everything you say/report is confidential unless you tell us something that indicates you or someone else is at risk of harm. We would discuss this with you before telling anyone else.

WHAT IF THERE IS A PROBLEM AND I WISH TO MAKE A COMPLAINT OR LEAVE THE STUDY?

You can talk to me if you wish to make a complaint or withdraw from the study by opt-out.

You can leave the study at any time without giving a reason. However, the information collected up to that moment will be used in the study.

If you wish, you can contact my research supervisor Professor Francine Cheater (contact details below) to discuss any concern you may have.

WHO HAS REVIEWED THIS STUDY TO MAKE SURE IT IS SAFE TO CONDUCT?

This study has been reviewed and given a favourable opinion by the Social Care Research Ethics Committee which is a group of independent people who review research to protect the dignity, rights, safety and wellbeing of participants and researchers.

WHAT WILL HAPPEN WITH THE RESULTS OF THE STUDY THAT I HELP PROVIDE?

This research is part of my post graduate research. The results

may be presented in academic conferences. Your identity and data will be protected in all circumstances.

FURTHER INFORMATION AND CONTACT DETAILS

Please feel free to contact me if you have any further questions. Thank you for taking the time to read this information sheet. Let me know if you would like a summary of the findings at the end of the study.

	Project Researcher	Project Supervisor
	Adriano Maluf School of Health Sciences University of East Anglia Edith Cavell Building, 1.27 Norwich Research Park Norfolk NR4 7TJ	Professor Francine Cheater School of Health Sciences University of East Anglia Edith Cavell Building Norwich Research Park Norfolk NR4 7TJ
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(doc. G)



Information sheet for care staff

Study title: Understanding the social life of older men living in care homes and its impact on their wellbeing

Researcher: Adriano Maluf

Institution: School of Health Sciences at the University of East Anglia (UEA)

I would like to invite you to take part in a study that explores the social lives of older men living in care homes. To help you to consider whether or not to take part, please read the information provided here that explains why you have been invited and what your role in the research would be. It takes around 4 minutes to read and I will explain to you any remaining questions you might have.

WHAT IS THE PURPOSE OF THE STUDY?

The aim of this study is to understand how men experience their social lives in care homes and how this affects their wellbeing.

WHY HAVE I BEEN INVITED TO TAKE PART?

Residents and visitors of the care home you work in are taking part in this study. For this reason you have been invited to also take part in this research and your participation is very important and would be much appreciated.

DO I HAVE TO TAKE PART?

It is up to you if you want to take part in this research. You are free to withdraw at any

time, without giving a reason. This would not affect your work in the care home or the care you provide to the residents.

WHAT DO I HAVE TO DO IF I TAKE PART?

If you agree to take part in this research you will need to sign a written consent form. The data collection will sometimes involve conversations and observations with you from time to time. This would take place in the communal areas of the care home where I will be working as a volunteer, helping the residents with simple tasks. Also I may invite you to take part in interviews which will be recorded as long you are happy to do so. You can refuse to take part in the interview without a reason.

I will only perform these activities after you have given expressed consent to ensure my presence is not interfering in your work.

There are no “right” or “wrong” to any information you provide. Your feelings will be respected. There are no goals or aims that you have to achieve by participating in this research, just act as you usually do.

The care you provide to the residents will NOT be assessed.

HOW LONG WILL THE STUDY LAST?

I will visit your care home for 8 and 12 weeks. During this period I will spend time in different places in the care home with people that agree to take part in the study - other residents, staff and visitors. The amount of time spent with you depends on how much time you are happy provide and how busy I am with the other participants in the care home.

WHAT ARE THE POSSIBLE RISKS AND DISADVANTAGES OF TAKING PART?

It is possible you may feel uncomfortable with my presence or the subject of conversations or the questions that I ask you. In this case, you can ask me to change the topic of the conversation or discontinue the data collection or leave the room. You do not need to give any justification.

WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART?

Your participation in this study would increase our understanding of the social aspects of living in care homes and may lead to future improvements in the care and the social support for older men living in care homes. Otherwise, there are no direct benefits for you.

WILL MY INFORMATION BE KEPT CONFIDENTIAL AND ANONYMOUS?

Everything that you say or do will remain strictly confidential. Your details and data collected during this study will not be accessed by your employer or care home. This means only I and my supervisors will access any information you provide and you will

not be identifiable by name in any of the information given. Your data will be identifiable by a code instead of your name. The information collected for this study will be recorded in a notebook kept in locked cabinet and computer protected by password in my office in UEA.

Everything you say/report is confidential unless you tell us something that indicates you or someone else is at risk of harm. We would discuss this with you before telling anyone else.

WHAT IF THERE IS A PROBLEM AND I WISH TO MAKE A COMPLAINT OR LEAVE THE STUDY?

You can speak to me if you wish to make a complaint or withdraw from the study. I am also available on my mobile or via email. I will try to answer any questions or solve any problems that you have with the research.

You can leave the study at any time without giving a reason. However the data collected up to that moment will be used for analysis. You have the right to access the information generated from your interviews. However, your information obtained in the observations and conversations will not be disclosed to you because the data is likely to involve other participants' information.

Alternatively you can contact my research supervisor Professor Francine Cheater.

WHO HAS REVIEWED THIS STUDY TO MAKE SURE IT IS SAFE TO CONDUCT?

This study has been reviewed and given a favourable opinion by the Social Care Research Ethics Committee. A Research Ethics Committee is a group of independent people who review research to protect the dignity, rights, safety and wellbeing of participants and researchers.

WHAT WILL HAPPEN WITH THE RESULTS OF THE STUDY THAT I HELP PROVIDE?

This research is part of a post graduate research degree and the results will be published in a PhD thesis. Results may also be published in scientific journals or presented in academic conferences. Your identity and data will remain confidential in all circumstances.

FURTHER INFORMATION AND CONTACT DETAILS

If you have any further questions, please feel free to contact me. Thank you for taking the time to read this information sheet. If you would like a summary of the findings at the end of the study please let me know and I will provide them when the research is completed.

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	Adriano Maluf School of Health Sciences University of East Anglia Edith Cavell Building, 1.27 Norwich Research Park Norfolk NR4 7TJ	Professor Francine Cheater School of Health Sciences University of East Anglia Edith Cavell Building Norwich Research Park Norfolk NR4 7TJ
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(doc. H)



Information sheet for residents' family members and friends

Study title: Understanding the social life of older men living in care homes and its impact on their wellbeing

Researcher: Adriano Maluf

Institution: School of Health Sciences at the University of East Anglia (UEA)

I would like to invite you to take part in a study that explores the social lives of older men living in care homes. To help you to consider whether or not to take part, please read the information provided here that explains why you have been invited and what your role in the research would be. It takes around 5 minutes to read and I will explain any remaining questions you might have.

WHAT IS THE PURPOSE OF THE STUDY?

The aim of this study is to understand how men experience their social lives in care homes and how this affects their wellbeing.

WHY HAVE I BEEN INVITED TO TAKE PART?

Your relative or friend who lives in the care home has been considered to take part in this study. For this reason you have been invited to also take part in this research and your participation is very important and would be much appreciated.

DO I HAVE TO TAKE PART?

It is up to you if you want to take part in this research. You are free to withdraw at any time, without giving a reason. This would not affect the care and support that your relative or friend receives in the care home.

WHAT DO I HAVE TO DO IF I TAKE PART?

If you agree to take part in this research you will need to sign a written consent form. The data collection will involve conversations and observations with you from time to time. This would take place in the communal areas of the care home where I will be working as a volunteer, helping the residents with simple tasks. Also I may invite you to take part in interviews which will be recorded as long you are happy to do so. You can refuse to take part in the interview without a reason.

Also, I may invite you to take part in interviews which will be recorded as long you are happy to do so. No justification is necessary if you refuse the interview invitation. All these activities will become the data for my research.

Please let me know if you feel uncomfortable with my presence during data collection at any time. I will then change the subject of the conversation or questions, leave you alone or even leave the room where you are.

There are no “right” or “wrong” answers and your feelings will be respected at all times.

HOW LONG WILL THE STUDY LAST?

I will visit your care home for 8 to 12 weeks. During this period I will spend time in different places in the care home with people that agree to take part in the study - other residents, staff and visitors. The amount of time spent with you depends on how many times you visit the care home and how busy I will be with the other participants in the care home.

WHAT ARE THE POSSIBLE RISKS AND DISADVANTAGES OF TAKING PART?

It is possible you may feel uncomfortable with my presence or the subject of conversations or the questions that I ask you. In this case, you can ask me to change the topic of the conversation or discontinue the data collection or leave the room. You do not need to give any justification.

WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART?

Your participation in this study would increase our understanding of the social aspects of living in care homes and may lead to future improvements in the care and the social support for older men living in care homes. My presence may benefit your relative of

friend who lives in care home by helping him with simple tasks as part of my work as volunteer. Otherwise, there are no direct benefits for you.

WILL MY INFORMATION BE KEPT CONFIDENTIAL AND ANONYMOUS?

Everything that you say or I've seen will remain strictly confidential. This means only I and my two supervisors will access your data and you will not be identifiable by name in any of the information you provide. Your data will be identifiable by a code instead your name. The information collected for this study will be recorded in the University's electronic file system protected by a password and notebook kept in a locked cabinet. Everything you say/report is confidential unless you tell us something that indicates you or someone else is at risk of harm. We would discuss this with you before telling anyone else.

WHAT IF THERE IS A PROBLEM AND I WISH TO MAKE A COMPLAINT OR LEAVE THE STUDY?

You can speak to me if you wish to make a complaint or withdraw from the study. I am also available on my mobile or via email. I will try to answer any questions or solve any problems that you have with the research.

You can leave the study at any time without giving a reason. However, the data collected up to that moment will be used for analysis. You have the right to access the information generated from your interviews. However, your information obtained in the observations and conversations will not be disclosed to you because the data is likely to involve other participants' information.

If you wish, you can contact my research supervisor Professor Francine Cheater (contact details below) to discuss any concern.

WHO HAS REVIEWED THIS STUDY TO MAKE SURE IT IS SAFE TO CONDUCT?

This study has been reviewed and given a favourable opinion by the Social Care Research Ethics Committee. A Research Ethics Committee is a group of independent people who review research to protect the dignity, rights, safety and wellbeing of participants and researchers.

WHAT WILL HAPPEN WITH THE RESULTS OF THE STUDY THAT I HELP PROVIDE?

This research is part of a post graduate research degree and the results will be published in a PhD thesis. Results may also be published in scientific journals or presented at meetings or conferences. Your identity and data will remain confidential

in all circumstances.

FURTHER INFORMATION AND CONTACT DETAILS

If you have any further questions, please feel free to contact me. Thank you for taking the time to read this information sheet. If you would like a summary of the findings at the end of the study please let me know and I will provide them when the research is completed.

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	Adriano Maluf School of Health Sciences University of East Anglia Edith Cavell Building, 1.27 Norwich Research Park Norfolk NR4 7TJ	Professor Francine Cheater School of Health Sciences University of East Anglia Edith Cavell Building Norwich Research Park Norfolk NR4 7TJ
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(doc. I)



Information sheet for consultees

Study title Understanding the social life of older men living in care homes and its impact on their wellbeing

Researcher: Adriano Maluf

Institution: School of Health Sciences at the University of East Anglia (UEA)

We would like to invite your relative or friend who lives in the care home where this research is taking place to take part in this study about the social lives of older men living in care homes. This information sheet takes around 10 minutes to read and I will clarify any remaining question that you may have.

WHAT IS THE ROLE OF A CONSULTTEE?

We feel your relative/friend or the person who you provide professional care or assistance to is unable to decide for themselves whether to participate in this research. The terms of the Mental Capacity Act regulates that before involving a resident who cannot consent to take part in this study, it is necessary to seek advice about this issues from someone who knows the resident well enough. This is called a consultee.

To help decide if he/she should join the study, we would like to ask your opinion as a consultee whether or not, in your view, the person wants to be involved in this study. We would ask you to consider what you know of their wishes and feelings, and to consider their interests in taking part in this study.

Please let us know of any 'advance decisions' they may have made about participating in research. These decisions should take precedence.

If you decide that the resident would have no objection to taking part, we will ask you to read and sign the consultee declaration on the last page of this information leaflet and return by post using the pre-paid envelope and retain a copy for yourself.

We will keep you fully informed during the study so you can let us know if you have any concerns or you think the resident should be withdrawn from the study.

The standard of care received by the resident will not be affected in any way if you decide that he or she would not wish to take part in it.

If you are unsure about taking the role of consultee you may seek independent advice.

We will understand if you do not want to take on this responsibility. If you do not wish to be a consultee or you believe the resident does not want to be included in the research, we would appreciate it if you could inform us by ticking the 'NO' boxes in the respective questions of the declaration form or inform us of your decision by phone or e-mail.

WHAT IS THE PURPOSE OF THE STUDY?

The aim of this study is to understand how men experience their social lives in care homes and how this affects their wellbeing.

WHY YOUR RELATIVE OR FRIEND HAS BEEN INVITED TO TAKE PART IN THIS STUDY?

This study is interested in hearing from men and women who live in residential care homes regardless of their mental and physical health.

DOES THE RESIDENT HAVE TO TAKE PART?

As a consultee you are asked to provide advice about whether the resident would like to take part in this research.

WHAT WILL BE THE RESIDENT'S PARTICIPATION?

If the resident takes part in the research, I would engage in conversations with the resident. I would observe the resident in the communal areas of the care home as well (living room or dining room for example) when interacting with other individuals (other residents, care staff and visitors) as he or she normally does as part of their daily activities in the care home. All these activities will be noted down and become the data for my research.

I will ask the resident if he or she is happy with my company before any activity takes

place and will be vigilant for any signs of distress, discomfort or tiredness that I may be causing. In such instances, I would stop making notes and leave the resident alone or even leave the room if necessary.

The conversations and observations will take place in the shared areas of the care home (living or dining room for example). Intimate, personal care will not be observed. I will not be judgemental about his or her conversations, actions or answers. His or her feelings will be respected.

HOW LONG WILL THE STUDY LAST?

I will visit the care home for between 8 and 12 weeks. During this period I will spend time in different places in the care home with other participants - other residents, staff and visitors. The amount of time spent with the resident depends on how much he or she is willing to have me around and how busy I am with the other participants in the care home.

WHAT ARE THE POSSIBLE RISKS AND DISADVANTAGES FOR THE RESIDENT IN TAKING PART IN THIS STUDY?

It is possible that the resident may feel uncomfortable with my presence. I will remain vigilant for any signs of distress, discomfort or tiredness that my presence or the research activities are causing. In such instance, the resident will be withdrawn immediately from the entire study.

WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART IN THIS RESEARCH?

The participation of the resident in this study would increase our understanding of the social aspects of living in care homes and may lead to future improvements in the care and the social support for older men living in care homes. I can also help the resident with simple tasks as part of my volunteer role in the care home. Otherwise, there are no direct benefits for resident.

WILL RESIDENT'S INFORMATION BE KEPT CONFIDENTIAL AND ANONYMOUS?

Everything that the resident say or do will remain strictly confidential. This means only I and my two supervisors will access your data and your data will be identifiable by a code instead of resident's name.

The information collected for this study will be recorded in the University's electronic file system, protected by password and in notebook kept in a locked cabinet.

Everything that the resident say/report is confidential unless he or she tell us something that indicates him or her or someone else is at risk of harm. We would discuss this with you before telling anyone else.

WHAT IF THERE IS A PROBLEM AND I WISH TO MAKE A COMPLAINT OR LEAVE THE STUDY?

You can speak to me if you wish to make a complaint or withdraw from the study. I am also available on my mobile or via email. I will try to answer any questions or solve any problems that you have with the research.

The resident can leave the study at any time without giving a reason. However, the data collected up to that moment will be used for analysis and his or her data will not be disclosed to you because the data is likely to involve other participants' information. If you wish, you can contact my research supervisor Professor Francine Cheater (contact details below) to discuss any concern.

WHO HAS REVIEWED THIS STUDY TO MAKE SURE IT IS SAFE TO CONDUCT?

This study has been reviewed and given a favourable opinion by the Social Care Research Ethics Committee. A Research Ethics Committee is a group of independent people who review research to protect the dignity, rights, safety and wellbeing of participants and researchers.

WHAT WILL HAPPEN WITH THE RESULTS OF THE STUDY THAT I HELP PROVIDE?

This research is part of a post graduate research degree and the results will be published in a PhD thesis. Results may also be published in scientific journals or presented at meetings or conferences. Your identity and data will remain confidential in all circumstances.

FURTHER INFORMATION AND CONTACT DETAILS

If you have any further questions, please feel free to contact me. Thank you for taking the time to read this information sheet. If you would like a summary of the findings at the end of the study please let me know and I will provide them when the research is completed.

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(doc. F1)

Visitors' information sheet

Study title: Understanding the social lives of older men living in care homes and the impact on their wellbeing

Researcher: Adriano Maluf

Institution: School of Health Sciences at the University of East Anglia (UEA)

I would like to invite you to take part in a study that explores the social lives of older men living in care homes. To help you to consider whether or not to take part, please read the information provided here that explains why you have been invited and what your role in the research would be. It takes around 4 minutes to read and I will explain to you any remaining questions you might have.

WHAT IS THE PURPOSE OF THE STUDY?

The aim of this study is to understand how men experience their social lives in care homes and how this affects their wellbeing.

WHY HAVE I BEEN INVITED TO TAKE PART?

The care home you are visiting has taken part in this study. Anyone in the care home are welcome to take part in this study including visitors and your participation is very

important and would be much appreciated.

DO I HAVE TO TAKE PART?

It is up to you if you want to take part in this research. You are free to withdraw at any time, without giving a reason.

WHAT DO I HAVE TO DO IF I TAKE PART?

The study will involve me being around in the care home for the next couple of months to find out from the residents what day to day living is like here. This will sometimes involve some conversations and observations with you from time to time.

I will always ask you to consent before I start a conversation with you.

There are no “right” or “wrong” answers and your feelings will be respected at all times.

HOW LONG WILL THE STUDY LAST?

I will visit your care home for between 8 and 12 weeks. During this period I will spend time in different places in the care home with people that agree to take part in the study such as other residents, staff and visitors.

WHAT ARE THE POSSIBLE RISKS AND DISADVANTAGES OF TAKING PART?

It is possible you may feel tired or uncomfortable with my presence or the subject of conversations. If so, you can ask me to change the topic of the conversation, leave you alone or leave the room. You do not need to give any reason.

WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART?

Your participation in this study would increase the understanding of the social aspects of living in care homes and may lead to future improvements in the care and the social support for older men living in care homes. Otherwise, there are no direct benefits for you.

WILL MY INFORMATION BE KEPT CONFIDENTIAL AND ANONYMOUS?

Everything that you say or do will remain strictly confidential. This means only I and my supervisors will access your data and you will not be identifiable by name in any of the information you provide. Your data will be identifiable by a code instead of your name. The information collected for this study will be recorded in the University’s electronic file system, protected by password and in notebook kept in a locked cabinet.

Everything you say/report is confidential unless you tell us something that indicates you or someone else is at risk of harm. We would discuss this with you before telling anyone else.

WHAT IF THERE IS A PROBLEM AND I WISH TO MAKE A COMPLAINT OR LEAVE THE STUDY?

You can speak to me if you wish to make a complaint or withdraw from the study. I am also available on my mobile or via email. I will try to answer any questions or solve any problems that you have with the research.

You can leave the study at any time without giving a reason. However the data collected up to that moment will be used for analyses and you will not have the right to access your data because the data is likely to disclose other participants' information. Alternatively you can contact my research supervisor Professor Francine Cheater.

WHO HAS REVIEWED THIS STUDY TO MAKE SURE IT IS SAFE TO CONDUCT?

This study has been reviewed and given a favourable opinion by the Social Care Research Ethics Committee. A Research Ethics Committee is a group of independent people who review research to protect the dignity, rights, safety and wellbeing of participants and researchers.

WHAT WILL HAPPEN WITH THE RESULTS OF THE STUDY THAT I HELP PROVIDE?

This research is part of a post graduate research degree and the results will be published in a PhD thesis. Results may also be published in scientific journals or presented at meetings or conferences. Your identity and data will remain confidential in all circumstances.

FURTHER INFORMATION AND CONTACT DETAILS

If you have any further questions, please feel free to contact me. Thank you for taking the time to read this information sheet. If you would like a summary of the findings at the end of the study please let me know and I will provide them when the research is completed.

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(doc. P)

Care Home head paper
Care Home head paper

Address
Telephone number

Letter contacting potential consultee

Dear (Name of the person)

The Care Home is collaborating with the Adriano Maluf who is a researcher at the School of Health Sciences (HSC) at the University of East Anglia (UEA) in a research project. The research project is called Understanding the lives of older men living in care homes.

An important aspect of the research project is that all participants have the choice about whether to volunteer or to refuse to take part. Some of the residents living in care homes may lack in capacity to make an informed decision about participating in research. In such cases is necessary to seek advice from someone who knows the resident well to decide whether he or she should take in the study. This is called a personal consultee.

I feel that (name of the resident) is unable to make a decision for him or herself and I would like to take the consideration of becoming a consultee if you think that is appropriate for you.

Please find attached to this letter a participant information sheet that explains the role of resident as participant in the study and your role as a consultee for the resident. I also have enclosed a declaration form that requires your signature if you decide that is appropriate for you to become the consultee for this person.

Adriano, the researcher, would be happy to explain further questions that you may have (contact details provide in the end of the information sheet).

Thank you for your interest in the project and taking time to read the information.

(Signed)
Manager/consultant

(doc. Q)



(Care Home Name)
(Address)
(Telephone)

Dear (Care Home manager's name)

My name is Adriano Maluf, I am PhD student at the School of health Sciences (HSC), UEA. I would like to invite your care home to take part in academic research that explores the social life of older men living in care homes.

Please read the information provided here to help you to make the decision regarding taking part in this research project. You can also contact me to clarify any remaining questions:

The aim of this study is to understand how men experience their social lives in care homes and how this affects their wellbeing and your care home has been invited because it matches the features which this study is interested in.

It is the care home manager decision whether or not to take part in this study. The main information about the research activities in the care home is provided in this information sheet. The researcher will answer any remaining questions. The consent form must be signed by the care home manager and business owner for this research take place.

In agreeing to take part in this research, the researcher will be allowed to have conversations with and make observations of residents, visitors and care staff in communal areas of the care home. Notes of these conversations and observations will serve to build a dataset for the whole study, which will be analysed in the later stages of the research.

Information about the research will be available to all participants throughout the time that the researcher is in this care home. Participants who agree to take part in this research will be asked to provide written and or verbal consent.

Information about the study will be available in posters placed at the entrance of the care home to allow the visitors to learn about this research. The placement of the poster(s) will be supervised by the care home manager.

In the initial phase, a member of the care home staff, with the manager's agreement, will assess whether the residents who frequent the communal areas have the capacity to make an informed decision to take part in this study.

The care home staff member would also liaise with the residents' family members and friends about choosing a 'consultee' for residents who lack the mental capacity to decide for themselves whether to take part in this research. During the time spent in the care home, the researcher will seek and follow guidance from the care manager and care staff to reduce the risk of disruption to residents, care staff and visitors as much as possible. The researcher's role in the communal areas will be that of a volunteer, helping the residents with simple tasks.

The care home manager will inform the researcher if there is a change in participants' mental capacity during the data collection.

The research at your care home will last for between 8 to 12 weeks. The researcher will spend 3 hours daily in the care home for 5 days a week in different periods of the day (9:00 to 20:00) on different days in the week (Sunday to Saturday).

It is possible that residents, visitors or care staff may feel uncomfortable with the researcher's presence or the topics of interviews. Therefore, the researcher will conduct the research in a sensitive and tactful way at all times. Potential participants will be informed about the right to refuse to take part in the research or withdraw their participation at any time without a reason.

The participation of your care home in this study would increase the understanding of the social aspects of living in care homes and may lead to future improvements in the care and the social support for older men living in care homes. Residents may benefit in taking part in this research because of the researcher's role as volunteer worker will help the residents with simple daily tasks. Otherwise, there are no direct benefits for the care home.

All the data collected in research will remain strictly confidential. Only the researcher and his two supervisors will access the data and the names of participants will be replaced by a code or fictitious names.

The researcher only would break confidentiality if he witnesses a situation which leads to harm of anyone in the setting. In this case the researcher would report the problem to his supervisor and to the care home manager.

All the information collected for this study will be recorded in a notebook and computer software which only the researcher and his supervisor can access. To protect the confidentiality of all participants, the name of the care home and its details will not be disclosed in the PhD thesis and publications in scientific journals.

You can directly contact the researcher if you wish to make a complaint or by email or phone.

Alternatively you can contact my research supervisor Professor Francine Cheater at the School of Health Sciences, University of East Anglia, Edith Cavell Building, Norwich Research Park, Norfolk NR4 7TJ, phone 01603 59 7132, e-mail f.cheater@uea.ac.uk.

This study has been reviewed and approved by the Social Care Research Ethics Committee. A Research Ethics Committee is a group of independent people who review research to protect the dignity, rights, safety and wellbeing of participants and researchers.

This research is part of a post graduate research degree and the results will be published in a PhD thesis. They may also be published in scientific journals or presented at academic conferences.

If you have any further questions, please feel free to contact me. Thank you for taking the time to read this information sheet. If you would like a summary of the findings at the end of the study please inform the researcher.

Kind regards

Adriano Maluf

PhD student / researcher
School of Health Sciences
University of East Anglia
Edith Cavell Building, 1.27
Norwich Research Park
Norfolk
NR4 7TJ
01603 59 1019
07922 10 4686
a.maluf@uea.ac.uk

11.9. Appendix I – Consent forms

(doc. M)

CARE HOME MANAGER CONSENT

(Name of the care home)

Project title: Understanding the social life of older men living in care homes and its impact on their wellbeing.

Please tick the
appropriate boxes

1. I confirm that I have read and understood the letter containing the information about this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐ YES ☐ NO
2. I understand my role in supporting this study in this care home. ☐ YES ☐ NO
3. I agree for the care home to take part in this research project as described in the research information sheet, allowing the researcher Adriano Maluf to access the communal areas of the care home. ☐ YES ☐ NO
4. I understand that the care home participation is entirely voluntary. ☐ YES ☐ YES

Care home manager name	Date	Signature
Adriano Maluf (researcher)	Date	Signature

When completed – one copy to be retained by the care home, one copy for the researcher.

(doc. L)

PARTICIPANT CONSENT FORM FOR RELATIVES AND FRIENDS

(Name of the care home)

Project title: Understanding the social life of older men living in care homes and its impact on their wellbeing.

Please tick the appropriate boxes

1. I confirm that I have read and understood the participant information sheet about this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐ YES ☐ YES
2. I agree to take part in this research project and agree for my data to be used for the purpose of this study. ☐ YES ☐ YES
3. I understand my participation is voluntary and I may withdraw at any time without my legal rights being affected. ☐ YES ☐ YES

Participants' name	Date	Signature
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When completed – one copy to be retained in care/health records, one copy for the participant, one copy for the researcher.

(doc. L)

NOMINATED CONSULTEE DECLARATION FORM

(Care Home Name)

Project title: Understanding the social lives of older men living in care homes and the impact on their wellbeing.

Please tick the
appropriate boxes

1. I confirm that I have read and understood the information for consultees for this study and have had the opportunity to ask questions about the study and my role as a nominated consultee by providing advice for the resident to take part in this study. I understand the purpose of this study and what the resident's participation would be.

☐ YES ☐ YES

2. I agree to act as nominated consultee for _____ as

☐ YES ☐ YES

I know this person well enough because of my professional duties (care worker, nurse, etc) with regards to this person and I am aware that this person has no close relative or friend who could undertake the role as personal consultee.

☐ YES ☐ YES

3. In my opinion, he or she would agree to take part in the study.

4. I understand that the participation in this study is voluntary. I understand that the resident will be withdrawn from the study if I request or they do not wish to continue participating. No justification is necessary for the withdrawn of the study.

☐ YES ☐ YES

Relationship to participant:

Name of the consultee	Date	Signature

“If returning by post, please use the envelope enclosed, sending two signed copies of this document and retaining one copy for yourself. Alternatively you can deliver them by hand directly to the researcher or a member of care home staff”

(doc. N1) **NOMINATED CONSULTEE DECLARATION FORM**
(Care Home Name)

Participant Identification code: _____

Project title: Understanding the social life of older men living in care homes and its impact on their wellbeing.

Please write your
initials if you agree

1. I confirm that I have read and understood the Information for Consultees for the study and had the opportunity to ask questions about the study or my role as a personal consultee. I understand the purpose of this study and what the resident’s participation would be.

2. I agree to act as nominated consultee for the (name of the resident) _____ as I know well enough this person because my professional duties (care worker, nurse, etc) with this person and I am aware this person has not a next of kin who could undertake the role as personal consultee.

3. In my opinion, he or she would agree to take part in the study.

4. I agree for the resident’s personal care plan to be accessed for the purpose of this study.

5. I understand that participation in this study is voluntary. I understand that my partner, friend or relative will be withdrawn from the study if I request or they do not wish to continue participating. No justification is necessary for the withdrawn of the study.

Relationship to participant:

Name of the consultee	Date	Signature
Adriano Maluf (researcher)	Date	Signature

When completed – one copy to be retained in care/health records, one copy for the Consultee, one copy for the researcher.

If returning by post, please use the envelope enclosed in the correspondence, sending two signed copies of this document and retaining one for yourself.

(doc. O)

PERSONAL CONSULTEE DECLARATION FORM

(Care Home Name)

Project title: Understanding the social life of older men living in care homes and its impact on their wellbeing.

Please make a circle in the appropriate answer

1. I confirm that I have read and understood the Information for Consultees for the study and had the opportunity to ask questions about the study or my role as a personal consultee. I understand the purpose of this study and what the participant's (my partner, friend or relative's) involvement would be.

☐ YES ☐ YES

2. In my opinion, he or she would agree to take part in the study.

☐ YES ☐ YES

3. I understand that participation in this study is voluntary. I understand that my partner, friend or relative will be withdrawn from the study if I request or they do not wish to continue participating. No justification is necessary for the withdrawn of the study.

☐ YES ☐ YES

Relationship to participant:

Name of the consultee	Date	Signature
Adriano Maluf (researcher)	Date	Signature

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When completed – one copy to be retained in care/health records, one copy for the
Consultee, one copy for the researcher.

(doc. O1)

PERSONAL CONSULTEE DECLARATION FORM (1)

(Care Home Name)

**Project title: Understanding the social life of older men living in care homes and its
impact on their wellbeing.**

Please make a circle in
the appropriate answer

1. I confirm that I have read and understood the Information for
Consultees for the study and had the opportunity to ask questions
about the study or my role as a personal consultee. I understand the
purpose of this study and what the participant's (my partner, friend
or relative's) involvement would be.

☐ YES ☐ YES

2. In my opinion, he or she would agree to take part in the study.

☐ YES ☐ YES

3. I understand that participation in this study is voluntary. I
understand that my partner, friend or relative will be withdrawn
from the study if I request or they do not wish to continue
participating. No justification is necessary for the withdrawn of the
study.

☐ YES ☐ YES

4. I agree for the resident's personal care plan to be accessed for the
purpose of this study.

☐ YES ☐ YES

Relationship to participant:

Name of the consultee	Date	Signature
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Adriano Maluf (researcher)	Date	Signature
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When completed – one copy to be retained in care/health records, one copy for the Consultee, one copy for the researcher.

If returning by post, please use the envelope enclosed in the correspondence, sending two signed copies of this document and retaining one for yourself

11.10. Appendix J - NHS - Research Ethics Committee study approval letter

Social Care REC

Ground Floor
Skipton House
80 London Road
London
SE1 6LH

Telephone: 0207 972 2568

16 July 2015

Mr. Adriano / AM Maluf
PhD student
Health Sciences School (HSC) at University of East Anglia (UEA)
Edith Cavell Building 1.27,
Norwich Research Park,
Norwich
NR4 7TJ

Dear Mr. Maluf

Study title:	Understanding the social life of older men living in care homes and its impact on their wellbeing – an ethnographic study
REC reference:	15/IEC08/0039
IRAS project ID:	177009

Thank you for your letter of 09 July 2015, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

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

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

A Research Ethics Committee established by the Health Research Authority

Mental Capacity Act 2005

I confirm that the committee has approved this research project for the purposes of the Mental Capacity Act 2005. The Committee is satisfied that the requirements of section 31 of the Act will be met in relation to research carried out as part of this project on, or in relation to, a person who lacks capacity to consent to taking part in the project.

Conditions of the favourable opinion

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

- The Chair thought the size of the font on the resident consent form was too small. Please increase the font size and resubmit to the Committee.
- Please add to the poster that people can opt-out of the research by contacting either yourself or staff. Forward the revised version to the Committee.

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

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

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Guidance on Research Governance approval for social care organisations is available from the Research Governance Framework: Resource Pack for Social Care, 2nd Edition, April 2010 and can be found at:
<http://www.hra.nhs.uk/resources/before-you-apply/non-nhs-recs/national-social-care-research-ethics-committee/>

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

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

Sponsors are not required to notify the Committee of approvals from host organisations

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Registration of Clinical Trials

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

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

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

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

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

Ethical review of research sites

Site Specific Assessment

Non-NHS sites

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

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Copies of advertisement materials for research participants [doc X - poster]	2	09 July 2015
Copies of advertisement materials for research participants [Doc. X1 - Observation Poster]	1	09 July 2015
Copies of advertisement materials for research participants [doc Z - leaflet]	2	09 July 2015
Covering letter on headed paper [document A]	1	18 May 2015
Evidence of Sponsor Insurance or Indemnity (non NHS Sponsors only)		
Interview schedules or topic guides for participants [doc V - schedule of observations]	1	18 May 2015
IRAS Checklist XML [Checklist_22052015]		22 May 2015

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IRAS Checklist XML [Checklist_10072015]		10 July 2015
Letters of invitation to participant [doc P - letter to consultee]	2	09 July 2015
Letters of invitation to participant [doc Q - letter to the care home]	2	09 July 2015
Non-validated questionnaire [doc W - sample of questions]	1	18 May 2015
Other [document D - academic supervisor CV]	1	18 May 2015
Other [Covering Letter to the Chairperson of the Social Care REC]	1	09 July 2015
Participant consent form [Doc. N1 - nominated consultee declaration form (case study)]	1	09 July 2015
Participant consent form [doc J - resident]	2	09 July 2015
Participant consent form [doc K - care staff]	2	09 July 2015
Participant consent form [doc L - relatives and friends]	2	09 July 2015
Participant consent form [doc M - manager consent]	2	09 July 2015
Participant consent form [doc N - act as consultee]	2	09 July 2015
Participant consent form [Doc. O - Personal Consultee Declaration Form]	2	09 July 2015
Participant consent form [Doc. O1 - Personal Consultee Declaration Form (case study)]	2	09 July 2015
Participant information sheet (PIS) [doc E, PIS resident(1) case study]	2	09 July 2015
Participant information sheet (PIS) [doc F - PIS resident]	2	09 July 2015
Participant information sheet (PIS) [doc F1 - PIS visitor]	2	09 July 2015
Participant information sheet (PIS) [doc G - PIS care staff]	2	09 July 2015
Participant information sheet (PIS) [doc H - PIS relatives and friends]	2	09 July 2015
Participant information sheet (PIS) [doc I - PIS consultee]	2	09 July 2015
Participant information sheet (PIS) [doc I1 - PIS consultee (case study)]	2	09 July 2015
REC Application Form [SC_Form_22052015]		22 May 2015
Referee's report or other scientific critique report [doc S]	1	18 May 2015
Research protocol or project proposal [document B]	1	18 May 2015
Summary CV for Chief Investigator (CI) [document C]	1	18 May 2015
Summary, synopsis or diagram (flowchart) of protocol in non technical language [doc T- ethic flow diagram]	1	18 May 2015
Summary, synopsis or diagram (flowchart) of protocol in non technical language [doc U - research design figure]	1	18 May 2015

Statement of compliance

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

After ethical review

Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed

A Research Ethics Committee established by the Health Research Authority

guidance on reporting requirements for studies with a favourable opinion, including:

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

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

User Feedback

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

<http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at

<http://www.hra.nhs.uk/hra-training/>

15/IEC08/0039

Please quote this number on all correspondence

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

Yours sincerely



Dr Martin Stevens
Chair

Email: nrescommittee.social-care@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: Ms Deborah / DG Graver