IMPROVING WELL-BEING VIA WELL-BEING SELF-EFFICACY: A MIXED METHODS MULTI-STUDY OF FRONTLINE CARE HOME STAFF

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ABSTRACT

Frontline care home (FLCH) staff play a critical role in the effective running of care homes. Previous studies have reported high turnover rates and high stress levels amongst this staff group. Increasingly, the importance of well-being at work has been demonstrated in research. Some studies have also demonstrated an association between the quality of care and the well-being of staff in healthcare settings. Despite these insights, there has been little research to explore the well-being experience of FLCH staff. Much less research has investigated how they maintain their well-being and how they may be supported.

To address this, this thesis utilises the self-efficacy, and the stress, appraisal and coping theories (Bandura, 1997; Lazarus and Folkman, 1984) as frameworks to explore the well-being experience of FLCH staff. Guided by these theories, and applying mixed methods and a multi-study approach, this thesis explores the strategies which FLCH staff deploy to maintain their well-being, and the belief in their ability to deploy these strategies (well-being self-efficacy). It also explores the mechanisms by which this belief improves one's well-being, and investigates a means by which this belief may be enhanced.

The overall findings show that when a difficult situation is encountered at work, shifting one's focus, managing interpersonal conflict, and absorbing the impact of a stressor and restoring oneself, were the strategies consistently deployed. A new measure was also developed to assesses the belief in one's ability to take action towards improve well-being at work (well-being self-efficacy). These findings contribute to knowledge of how FLCH staff improve their well-being, some processes via which self-efficacy influences well-being, and how FLCH staff may be supported. A three-tier system of support based on the findings of this research was developed. It provides a framework for instigating or guiding actions aimed at enhancing the well-being experience of FLCH staff in practice.

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Preface

"I think people need to understand how much of yourself you give when you are a carer… For most of us, it isn't just a job, it's a vocation, it's a commitment you're making, and there should be greater respect and value given."

Michelle Phillips, BBC One (2020)

This thesis is about the well-being experience of frontline care home (FLCH) staff.

At the time of writing (2020), the on-going COVID-19 pandemic has indeed highlighted the critical role of FLCH staff. It has also poignantly drawn our attention to the gravity of ignoring the well-being of FLCH staff. Indeed, this thesis has been brought more alive by the current situation in the world and the United Kingdom (UK) in particular, which is the location of this research. We are currently experiencing a live demonstration of the critical importance of FLCH staff well-being. One of the points made in this thesis is that surprisingly little attention has been given to the well-being of FLCH staff. The evidence of this comes to life in the current pandemic. As an instance, the National Health Service (NHS) staff in the UK have been acknowledged for their incredible and life-threatening work, as they continue to treat infected patients. A national clap for the NHS staff has been organised and this demonstration of appreciation is highly commendable, certainly we must keep this up. However, despite working under similar conditions – putting their lives at risk, having limited personal protective equipment (PPE), and the sheer stress of staff shortage because colleagues have to self-isolate or have left – FLCH staff have not received the same attention as their NHS colleagues.

Dedication

To you,

Yod Hay Waw Hay

Thank you.

Acknowledgements

Participants – you were the core of this thesis. Thank you for giving me a part of your precious, hard-pressed time. Your experiences, and your honest and detailed conversations have truly inspired me. I want to also thank the care home managers for their willingness to participate in this research.

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1 Introduction

1.1 Introduction

From the alarming negative reports, to the billions of pounds of national and personal budgets spent on social care, and the rising pressure to place a loved one in the care of others, elderly care homes have gained prominence both nationally and internationally. Central to the functioning of care homes are frontline care home (FLCH) staff. The substantial focus of this thesis is on FLCH staff.

This chapter presents an overview of the thesis. It begins by setting the scene of the research, and following this, the research questions are presented. The ontological position and the design of the current research are then presented. The chapter concludes by outlining the layout of the thesis and gives a brief content overview of the chapters contained in this thesis.

1.2 Context

Care homes play a vital role in providing care for dependent elderly people in the United Kingdom (UK). Global statistics indicate the number of people aged 65 years and over is expected to double by 2050 (United Nations, 2019a). Figure 1.1 shows this trend in percentage. For persons aged 80 years or over, the number is projected to triple between 2019-2050 (United Nations, 2019b). Furthermore, by 2030 in Europe and North America, it is projected that older persons will account for more than 25% of the populations (United Nations, 2015). Closer to home, national statistics for the UK confirms this trend, indicating that the number of people aged 100 has risen by 85% in the last 15 years (Office for National Statistics, 2018). Although this number makes up only 2.5% of people aged 90 and above, the number of people in this group continues to rise (Office for National Statistics, 2018). Additionally, in the UK, 425,000

of those aged 85 years and above live in care homes (Laing & Buisson, 2010). This rising statistic of older people sets a demand on care home places and unavoidably puts pressure on available resources. In addition to this demand, care homes are mandated to always provide safe and effective care to their residents.

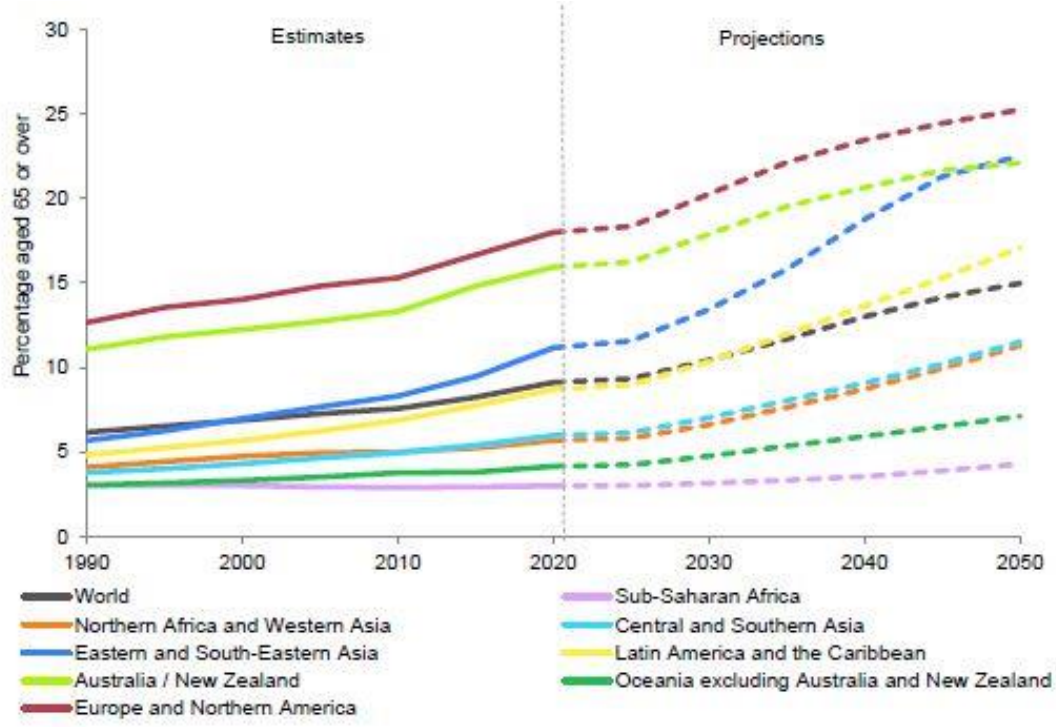

Figure 1.1 Population by region, of persons aged 65 years or over 1990-2050

Source: United Nations (2019)

At the forefront of this demand and pressure are the FLCH staff. FLCH staff are expected to give their best in the administration of high-quality care, expected to be their best in relating to residents, relatives and other professionals, and expected to be up to date on all medical and social conditions relating to the residents they care for. In reality, this is a gold standard, as care homes are faced with the immense challenge of providing such high-quality care whilst

struggling to recruit and maintain staff. Skills for Care (2019) reports a turnover rate of 30.8% in England, translating to 440,000 FLCH staff leaving their jobs within 12 months.

With a rise in figures on dementia and multiple long-term conditions, coupled with the complexity of conditions of care home residents, the expectations on FLCH staff have greatly increased (Centre for Policy on Ageing, 2014; Gordon et al., 2014). In addition, FLCH typically work 12-hour shifts, and with staffing issues this may imply successive long shifts. Moreover, practice guidance and policy documents for care homes undergo frequent changes, and often from multiple policy makers or regulators (for example, the government's National Service Framework for Older People, NSFOP, the Department of Health and Social Care, and the National Institute for Health and Care Excellence, NICE). Indeed, Nakrem (2015) argues that for care homes to be sustainable, they need to be open to learning and continuous change. Inevitably, FLCH are at the forefront of the impact of such frequent changes. Furthermore, with 43% of all jobs in social care paid less than the Real Living Wage (RLW) (Care Workers Charity, 2019), FLCH care do not receive the commensurate wage for their job, and a survey of care workers showed that 30% of respondents stated low pay as an aspect of their job which was least desirable (Care Workers Charity, 2019).

These issues faced by FLCH staff have contributed to workplace stress which has an impact on well-being. Critically, the well-being of FLCH staff has been demonstrated to have an impact on the quality of care (Cooper et al., 2016; Hall et al, 2016; Redfern et al., 2002). In a survey by the Care Workers Charity (2019), 37% of respondents had taken time off work for stress and poor mental health caused by their work. Furthermore, interviews with registered managers and senior leaders revealed that the mental well-being of care staff was their top concern, and that they were interested in how to offer good support to their teams (Care Workers Charity, 2019).

In the light of these statistics and need, it is surprising that there is little research on the well-being of FLCH staff, and sparse guidance on how care home managers and policy makers may support the improvement of the well-being of FLCH staff. Considering the impact of their well-being on the safe and effective care of care home residents (Cooper et al., 2016; Goergen, 2001), it is imperative to explore their well-being experience and the potential means by which it may be enhanced and nurtured.

The aim of this thesis is to investigate the well-being experience of FLCH staff, and to develop a means by which the well-being of FLCH staff can be supported. To accomplish these, the research draws on the stress, appraisal and coping theory (Lazarus and Folkman, 1984). Stress, albeit often reported as an unpalatable experience, is an inevitable aspect of human existence (Lazarus and Folkman, 1984). The nature of FLCH work may indicate that exposure to stressors may be inevitable. The stress, appraisal and coping theory by Lazarus and Folkman (1984) has been employed to examine the experience of the frontline care home staff, from the exposure to a stressor, to reaction, to outcome.

In investigating and developing the means by which the well-being of FLCH may be supported, this research also draws on the self-efficacy theory (Bandura, 1997). Self-efficacy (SE) is a core aspect of Bandura's social cognitive theory (SCT), and a main factor when considering human agency. The SCT proposes that individuals possess a self-system which regulates feelings, thoughts, motivation, and ultimately action (Bandura, 1986). It establishes that individuals have the ability to regulate cognitive pathways which lead to action and development of skills, that they are not merely victims of environmental factors but can take action to bring about desired change. SE plays the role of interacting with various determinants (conditions) to govern a person's thoughts, motivations and actions.

SE is described as the belief in one's capability to organise and execute the courses of action required to achieve a desired outcome, and until a person believes that their actions can produce a desired effect, they are minimally motivated to act (Bandura, 1997). More efficacious individuals are more able to plan, persevere through difficulty, and sustain effort until a desired goal is achieved (Bandura, 1986, Bandura, 1997). In the context of well-being and the care home workplace, FLCH staff with a strong perception of SE will more likely take steps towards improving or nurturing their well-being, albeit within a restrictive environment. They will also more likely persevere through the difficulties they may experience in doing so. This belief in one's ability to take actions towards improving well-being at work, well-being self-efficacy (WBSE), is the chief point of investigation in the current research.

1.3 Research questions

Therefore, in exploring the well-being experience of FLCH staff, and how FLCH staff may be supported in the improvement and the nurture of their well-being, the current research asks the following questions:

1) What do FLCH staff do to improve and/or maintain their well-being at work?
2) Can well-being self-efficacy (WBSE) be measured?
3) Can a participatory intervention, tailored to a care home setting, enhance WBSE, and uncover some mechanisms via which WBSE is enhanced?

1.4 Ontological position

The ontological position of the current research is critical realism (Bhaskar, 1979, 2013). Critical realism draws on elements of both positivism (an objective view of reality), and constructivism (a subjective view of reality). This critical realist stance acknowledges the

existence of an objective reality or a real social world, but also considers that this objective reality or real social world can be interacted with. Such interactions will ultimately lead to some understanding of the mechanisms which drive observable events or actions. Thus, by interacting in this way, we gain a better, but not a complete or perfect understanding of reality.

According to critical realism, such observable events or actions reside in one of three domains of reality, that is, the empirical domain. This is the domain from which tangible empirical data can be gathered. At the other two domains, the actual and the real domains, interactions occur and unseen forces are at play, which ultimately influence what is observable. Thus, underlying all observable events or actions are causal mechanisms, and critical realism engages in explanations and causal analysis to bring us a closer understanding of reality.

1.5 Research design

To answer these questions, this research undertakes a series of investigations, including a review of the literature and empirical studies. The empirical aspect employed a multi-study sequential design, involving three independent but interconnected studies. Study 1 chiefly focused on answering the first research question, and each subsequent study was designed to chiefly answer the subsequent research questions. However, being interconnected, the findings of a study contributed to some aspects of subsequent studies. Figure 5.2 depicts this diagrammatically.

Furthermore, concurrent with a critical realist position, a mixed methods approach, involving both quantitative and qualitative methods, was employed in the gathering of data. This approach offered the opportunity to capture both objective and subjective aspects of reality in order to gain as much understanding as possible.

1.6 Thesis layout

This thesis is set out in the following nine chapters.

Chapter two is a review of the literature. It focuses on key issues identified in the literature on workplace stress and well-being. It explores the current state of knowledge on workplace stress, FLCH staff and well-being, and highlights the gaps in knowledge.

Chapter three presents the theoretical underpinnings of the research and drawing upon these, the proposed conceptual framework of the research is presented. The framework proposes the experience of well-being despite exposure to stressors at work. It does this by demonstrating the effect of a novel individual resource which is based on SE.

Chapter four delineates this novel resource. The chapter outlines key features of this resource, including how it may be measured. Additionally, the means by which this novel resource may exert its influence amidst a challenging work environment is presented. The chapter also explores the means by which this resource may be improved.

Chapter five outlines the overall methodology of the current research. It establishes the research philosophy and design, and presents the assumptions which influenced the design of the research. This chapter gives an overall picture of the research, including how the empirical studies fit together and how they contribute to answering the research questions.

In chapter six, the first of three empirical studies is presented. The study was an in-depth exploration of the well-being experience of FLCH staff. Its aim was to uncover the strategies which FLCH staff deployed in sustaining their well-being at work. The extensive findings served as a bedrock for Study 2.

Chapter seven outlines the process and findings of Study 2, which comprised the development and validation of a novel scale. The scale was designed to measure the novel construct which

was proposed in conceptual framework. The strategies (tools) which were uncovered in Study 1, along with the literature, were created into the items of the new scale.

In chapter eight, a participatory staff-led intervention aimed at improving well-being is presented. It was anticipated that the intervention would be a demonstration of how the well-being of FLCH staff may be improved. The design of the intervention was informed by Studies 1 and 2, and centrally, the novel construct. Particularly, the evaluation of this intervention was not simply focused on whether or not the intervention was successful. The evaluation focused on the extent to which the intervention worked, how it worked, why, for whom, and in what context (a realist evaluation).

Chapter 9 is the overall discussion of the entire research. It brings together the findings of the empirical studies. The findings point to three main approaches of FLCH staff in maintaining their well-being when faced with challenging situations – shifting focus, managing interpersonal conflict, and absorbing the impact of stressors but restoring oneself. These findings were discussed in the light of the overall research. In addition, based on the findings of the research, the chapter concludes by presenting practical guidance to support the improvement of FLCH staff well-being.

Finally, chapter 10 presents a conclusion of the research. It confirms that the well-being of FLCH staff can be improved, and the importance of giving attention to their well-being.

2 Literature Review

2.1 Introduction

The previous introductory chapter set the scene and presented the rationale for the current research. With current statistics and projections on older people and the social care sector, it established the importance of the care home. Care homes are mandated to provide safe effective care but face a number of challenges. One of such issues concerns its frontline staff, evident by reported workplace stress and statistics on high turnover (Skills for Care, 2019). The promotion of well-being is increasingly being demonstrated to have a positive impact in tackling workplace stress for employees in many sectors (Chartered Institute of Personnel and development, CIPD, 2020). However, this insight and mounting evidence does not seem to have translated into action in the care home sector. This chapter explores the current state of knowledge on workplace stress, FLCH staff and well-being.

As it explores the state of knowledge, this review looks at studies which have examined stress and well-being in the workplace, including health settings. The review focuses on key issues identified in the literature on workplace stress and well-being. The chapter begins by exploring the literature on workplace stress in general, and then specifically focuses on workplace stress with regards to frontline care home (FLCH) staff. It then explores the role of well-being in tackling workplace stress. Finally, this chapter concludes by summarising the identified gap and poses the research question aimed to address the gap.

2.2 Workplace stress - background

A well-researched aspect of work is stress (European Network for Workplace Health Promotion, 2010; Health and Safety Executive, HSE, 2019). The vast number of research studies on the subject, across various sectors of work, would support the claim that stress at work is universal. In the current research, Lazarus and Folkman's (1984) conception of stress is adopted. They state that stress occurs when a person perceives the relationship between themselves and their environment (situation) to be taxing, or when a situation is perceived as exceeding their resources and poses a danger to their well-being. In other words, stress arises when a person perceives that there is an inconsistency between the demands of a situation and the resources which they perceive they have to deal with that situation. The situation will be one in which the person believes that something is at stake, what Lazarus and Folkman (1984) refer to as a goal-relevant situation. Lazarus and Folkman (1984) approach stress as a transactional process, that is, an interaction between a person and their environment. This view considers the interaction to be bidirectional and dynamic, having mutual reciprocity, as opposed to a static or unidirectional view of stress.

More specifically related to work, workplace stress can broadly be described as the process by which a person reacts to (applies resources to counteract) demands (stressors) which pose a challenge or threat within their job role (HSE, 2019; Krantz et al., 1985; Zimbardo et al. 2003). Depending on the work sector, some known stressors include those related to organizational difficulties/constraints, personal limitations, interpersonal issues, and other factors (HSE, 1995, 2019; HSC, 2000). In the literature, it is well-established that workplace stress often has a negative impact on employees, including physical and psychosocial health-related issues such as physical illness, burnout, depression, disengagement, and other variations of well-being loss (for example, Heinisch and Jex, 1998; Keil, 2004). There is evidence of absenteeism, loss of productivity, and disability pension costs (Palmer and Dryden, 1994). Furthermore, in the UK

2016/17 financial year, workplace mental health issues cost £34.9bn (Centre for Mental Health, 2017). Clearly, there is a cost, but not solely limited to the individual, the rippling effects of workplace stress extends to the organization also (Cooper et al., 2016; European Network for Workplace Health Promotion, 2010).

Over the years, there have been substantial attempts to understand workplace stress, for instance, by investigating the factors which impact on the process, or ways to manage workplace stress. Such attempts have included empirical studies as well as the development of theories or models to enhance our understanding. Some of these which have significantly advanced our understanding include the job demands-control (JDC)/job demands-control-support (JDCS) (Karasek, 1979; Johnson and Hall, 1988), effort-reward imbalance (ERI) (Siegrist et al., 1986, 2004), conservation of resources (COR) theory (Hobfoll, 1989, 2001, 2011) and the job demands-resources (JD-R) model (Demerouti et al., 2001). Prominent amongst these theories or models are those which predominantly explore demands and resources in relation to stress processes. The COR and JD-R theories particularly fit the interest of the current study.

According to the conservation of resources (COR) theory (Hobfoll, 1989, 2001, 2011), resources refer to elements deemed to be of worth, including objects, personal characteristics, conditions or energies (Hobfoll, 1989). Some examples of these resources have been described as job control, autonomy, job security, social support, coping skills, and efficacy beliefs (Sonnentag and Frese, 2003; Bakker and Demerouti, 2007; de Jonge et al, 2008; Willemse et al., 2012). According to the COR theory the individual is motivated to acquire and/or maintain these resources and will experience stress if these resources are threatened, lost, or there is an inability to acquire a resource after an investment. Whether in an attempt to gain more resources or to defend already acquired resources, the COR theory states that the individual will be required to invest (use) existing resources. This means therefore that, in the event of a

threat or in attempting to gain yet more resources, individuals with low resources have little to invest and those with more resources have more to invest. Furthermore, the theory states that this need to use already existent resources leads to spirals of resource loss and gain. Those with more resources will tend to concentrate on protecting and acquiring more resources, going into a spiral of resource gain, whereas those with little resources concentrate on a defensive approach to protect their few resources so are less able to also invest in acquisition. This makes them more vulnerable to the outcomes of stress (strain), leading to resource loss, and into a spiral of resource loss (Seery et al., 2004).

Although the COR theory expatiates the resources aspect of the stress process, the job demands-resources (JD-R) model (Demerouti et al., 2001) further explores the interactive and dynamic relationship between resources and demands in relation to the stress process. In emphasising the interplay between resources and the demands upon them, the JD-R model concurs with Lazarus and Folkman's transactional view of stress. According to the JD-R theory, job demands are aspects of a job which require considerable physical or psychological effort to address, for example excessive workload or interpersonal conflict. In contrast, resources refer to factors which enable a person to ameliorate the negative impact of job demands, or factors which enable the achievement of goals and which bring about personal growth and enhancement. Resources may be physical, psychological, social, or organizational aspects of the job (Demerouti et al., 2001; Hakanen et al., 2008). Demerouti et al. (2001) point out that demands of the job will diminish one's resources leading to health impairment, whilst resources have a buffering effect on the impacts of job demands, and a motivational effect which can lead to increased work engagement.

While the COR theory and the JD-R model both acknowledge that resources can be of various kinds, the literature has increasingly become more focused on the significance of personal resources in particular. Personal resources are psychological traits such as one's perception of

control, resilience, self-efficacy or other personal traits. Other work (for example Schaufeli and Taris, 2014) have established that there is a dynamic interaction between personal resources, and job characteristics and one's experience at work. In other words, personal resources can influence job characteristics and one's experience at work, and job characteristics can also influence personal resources. The heuristic feature of JD-R model of stress embodies this idea, as it acknowledges the experience of individuals as a critical aspect of the process of stress. This agentic (personal) perspective will be explored later in this chapter. We now consider workplace stress particularly in the light of FLCH staff.

2.3 Workplace stress and the frontline care home staff

The plethora of research on workplace stress points to its prevalence in almost all professions. However, Chudzicka-Czupała et al. (2019) demonstrate that the severity of the impact of workplace stress is higher amongst human services. Published statistics for the United Kingdom (UK) show that the sickness rate of healthcare employees in the UK continues to rise, and is higher than other sectors (HSE, 2019). From recent statistics in 2018/2019, the health and safety executive (HSE) reports that human and social activity jobs record the second highest prevalence of workplace stress, depression or anxiety, second to public administration and defence as one category (HSE, 2019). Such stress often manifests itself as high staff turnover, anxiety, burnout, to mention but a few (Cooper et al., 2016). Some research studies (for example, Farhenkopf et al., 2008; Cooper et al., 2016) have highlighted some concerning findings, that the impact of stress reaches beyond the care staff and their organization, affecting the people they care for. Bakker and Heuven (2006) report that critical consequences such as depersonalisation of patients or residents may result from the impact of stress on staff. Other research (Goergen, 2001) addresses the issue of work quality, demonstrating that high

workload and increased workplace stress is associated with a lower quality of work and abuse or neglect of care home residents.

A report by Skills for Care (2015) showed that in 2015/2016, the overall staff vacancy of care home staff was 11.4%, with turnover rates rising 22.7 to 27.3% over a three-year period. More recent statistics show a 30.8% annual turnover rate (Skills for Care, 2019). Documented stressors in the care home sector include long shifts, staffing pattern, heavy workload, staff shortage, underpayment, physical and emotional exhaustion, burnout, challenging behaviours, dealing with relatives, money worries, quality of leadership, and resident abuse (Abrahamson et al., 2009; Backhaus et al., 2014; Goergen, 2001; Hussein, 2011; Schwendimann et al., 2016; Weech-Maldonado et al., 2004; Zúñiga et al., 2015). Burnout is particularly prevalent in the care sector and is a common outcome of stress in this sector (Cooper et al., 2016). Burnout describes a state of emotional depletion and exhaustion which leads to often negative outputs (Fearon and Nicol, 2011; Grandey et al., 2004; Koolhaas et al., 2011). Demerouti et al. (2010) depict burnout as involving two dimensions – exhaustion and disengagement. Exhaustion is the experience of prolonged cognitive, affective or physical strain from a job, while disengagement refers to an act of withdrawal or emotional distancing from work. If not addressed, frontline care home work may become a classic example of a job which carries a risk of workplace stress, burnout and their consequently negative impacts. As referred to earlier, this can have a vital impact on the quality of care and further consequences for the care home resident.

Care homes are dynamic places, they are home to some, workplace to others, and may also feel like or resemble clinical environments due to the level of care they offer. FLCH staff sometimes operate under similar highly-pressured or simply hospital-like environments (Hauge and Heggen, 2007; Fjelltun et al., 2009), but must at the same time be warm, homely and welcoming. Simultaneously, on the one hand, they work under clinical precision and directives,

and will be held personally accountable for errors in judgement or actions which fall short of this precision or which places a resident at risk. For instance, in the on-going COVID-19 pandemic, the government remarked on care homes not following proper guidance as the reason for the high numbers of infections in care homes, despite the difficult circumstances under which staff have had to work (Gordon and Goodman, 2020; Walker et al., 2020). On the other hand, they work under expectations to create a positive atmosphere and a person-centred experience for each of their residents, to take interest in their personal lives and sometimes to work with relatives to create this positive experience (Kenkman et al., 2017). This contrast can make care homes challenging places to work. In this environment, there seems to be constant hard work to maintain the internal cogs of its daily activities. Simply stated, care homes are a robust and delicate network of systems and individuals co-existing for the optimum benefit of residents. It therefore comes as no surprise that care home staff are continuously exposed to a host of stressors related to the various aspects of their work.

One major stressor is the changing and increasingly demanding role of FLCH staff (Kubicek et al., 2013). The large majority of FLCH staff are mostly unskilled, and seven percent have no qualifications (Skills for Care, 2011). In spite of this, over time, the responsibilities of FLCH staff have become more intensive, more technical and inevitably more demanding. In more recent years, the decision to move to a care home is often made at a point when an individual is unable to physically or mentally take care of themselves. Over the last 30-40 years, care homes have metamorphosed into homes for those with high support needs (Centre for Policy on Ageing, 2014). The average resident in a care home has multiple long-term conditions, functional dependency and frailty, and 75-80% have cognitive impairment (Gordon et al., 2014). It implies that on many occasions, by the time a person moves into a care home (particularly nursing homes), the individual may be significantly dependent, although age may not necessarily mean that people will have long term conditions (see Figure 2.1). Over a period

of time, dependency may also increase. Kingston et al. (2018) confirm this using the Population Ageing and Care Simulation (PACSim) model to estimate that by 2035 there will be a surge in multimorbidity, and double the number of people will suffer from four or more diseases. These changing levels of demands and expectations on care homes inevitably changes the role of the FLCH staff, to adapt and to match the demands. However, the commensurate wages, recognition, and credit of FLCH staff have not been forth coming over the years (Hussein, 2017). In the on-going COVID-19 pandemic, FLCH staff have been placed in positions where they have gone above and beyond in their administration of care, learning new competences and skills to be able to do so (Gordon and Goodman, 2020).

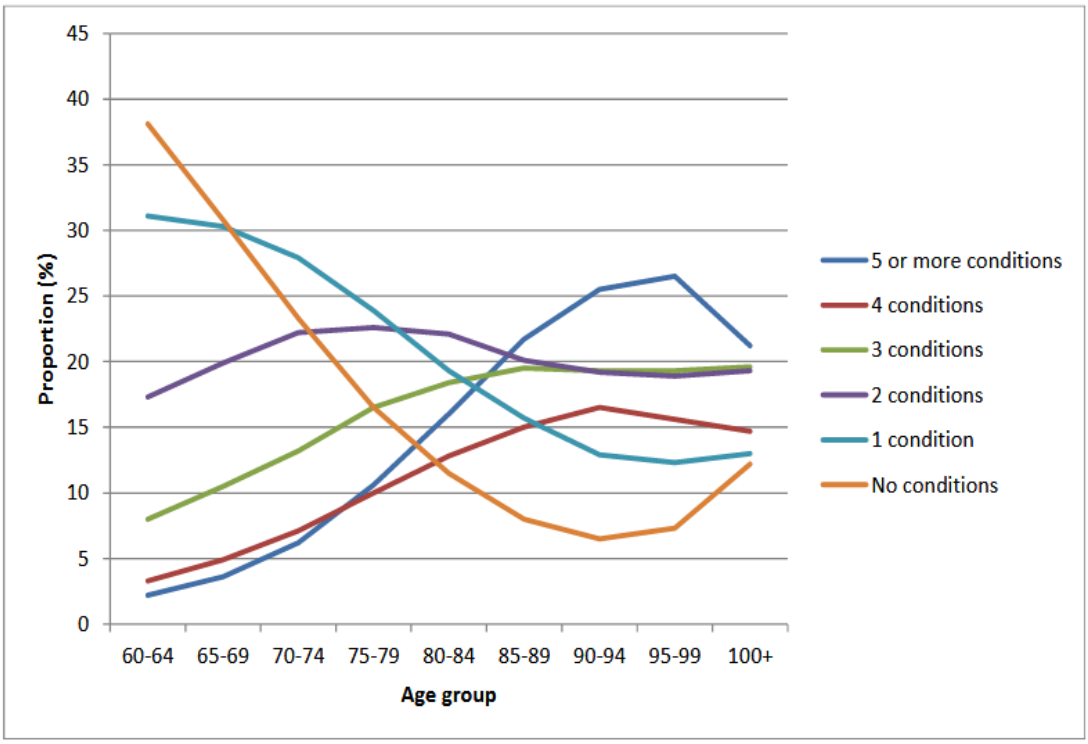

Figure 2.1 Co-existing conditions by age group in England, 2014

Source: Age UK and University of Exeter Medical School (2015); Age UK (2017)

Coupled with changing levels of demands and expectations is the issue of fluctuating standards of practice, exemplified by guidance documents which are published regularly, for example, National Institute for Health and Care Excellence (NICE) publications every year from 2013 (NICE, 2020). In the care home sector, policies, standards, and guidelines are frequently updated by relevant authorities in a bid to improve the quality of care, to address administrative issues, to improve models of care, or to tackle other care home related issues (for example, Care Inspectorate, 2018; the government's National Service Framework for Older People, NSFOP, Department of Health, 2001). In fact, Nakrem (2015) argues that to be sustainable, a care home needs to be open to learning and continuous change. However, change comes with challenges, and change in and of itself can be a demand. Zimmerman et al. (2014) examined policy and evidence related to culture change in care homes. Since FLCH staff have the day-to-day responsibility of caring for residents, Zimmerman et al. (2014) argue that change frequently implies that FLCH staff are not only frontline in administering care, but also frontline in implementing new practices, and dealing with the associated strain. Moreover, there is little or no evidence to indicate that FLCH staff are consulted in the development of best practice guidelines for care homes. In addition to these frequent top-down (strategic) changes, FLCH staff also experience local changes which may be even more frequent. Some of such local changes may be resident-related, for example medical complexity, frequent changes in health conditions, or simply a failure to thrive from day to day (Robertson and Montagnini, 2004). Changes could also be organization-related, for example day-to-day changes in the demand on their time due to staff shortage. This means that with short notice, there could suddenly be a high demand on one's time, leading to rushed or missed care, or higher workload (Knopp-Sihota et al., 2015). Burns et al. (2016), in agreement with Zimmerman et al.'s (2014) argument, showed that frontline care staff are more likely to be the group which experience the most significant, and often negative effects, of such changes. Burns

et al. (2016) investigated the effect of financial cutbacks, demonstrating its negative impact on job quality and subsequently on the quality of care. Reports of burnout, high turnover, sustainability and understaffing amongst care home staff buttress this point (Cohen-Mansfield, 1997; Age UK, 2017, Skills for Care, 2019).

Thus, the changing role of the FLCH staff has brought with it significant pressure and stress (Cavendish, 2013; Lievesley et al., 2011). One may argue that it has also brought about an improvement in skills, knowledge, and expertise for the FLCH staff. However, a commensurate income, recognition, or prestige has not followed (Age UK, 2017; Cavendish, 2013; Hussein, 2017).

2.4 Tackling workplace stress

Having considered the prevalence of workplace stress, and more closely, the experience of the FLCH staff, it may be tempting to assume that work itself is the problem. However, work can be important for well-being. Evidence from the literature shows that worklessness is often associated with poorer mental and physical health and well-being (for example Waddell and Burton, 2006 and Marmot et al., 2010). Moreover, Boreham et al. (2016) point out that work can be considered a conduit through which vital human needs, such as economic security, skills development, and social relationships are met. However, simply being in work does not necessarily confer benefits to the individual. Marmot (2010) argues that the quality of work is important. There are many negative implications of poor well-being at work, and it is important to be in work which nurtures well-being (Goetzel et al., 2002; Burton, 2010; All-Party Parliamentary Group on Wellbeing Economics, 2014). Indeed, the Chartered Institute of Personnel and Development (CIPD) (2016a, 2016b) states that poor well-being at work is one of the key reasons for absence from work. In consideration of workplace stress, however, Black

(2008) points out that workplaces must not only be concerned with the prevention of ill-health, but also the promotion of health and well-being.

The European Network for Workplace Health Promotion (ENWHP) defines workplace health promotion as an involvement of the employer, employees, and society (ENWHP, 2017). It states that workplace health promotion requires the combined effort of these stakeholders for it to be effective. It is not only preventing ill-health, but also enhancing health promoting potentials and well-being. In the UK, the health and safety commission (HSC) is the body responsible for overseeing matters relating to health and safety at work. In 1999, following a public consultation, it published the managing stress at work discussion document (HSE, 1999), to address the growing concern of workplace stress. In 2001, following additional workshops and further discussions, this document formed the basis of national guidance from the health and safety executive (HSE) on tacking workplace stress, HS(G)218 (HSE 2001). In this document a categorisation of stressors in the workplace was outlined – demands, control, support, relationships at work, role, change, and culture. Since its publication, there have been numerous research studies which examine and confirm negative impacts of each of these stressor areas on employees (for example, VonDras et al., 2009; Jeon, et al., 2010; Vassos and Nankervis, 2012; Vassos et al., 2013). The HSE continues to document reports on these stressor areas, and from its figures since 2009/10 to date, across varied sectors, workload is a predominant cause of work-related stress, depression or anxiety (HSE, 2020).

If poor well-being at work leads to work absence (CIPD, 2016a), and if being in work is important to well-being (Marmot et al., 2010), a negative spiral therefore ensues. The employee in a workplace which does not nurture well-being seems trapped. One response is to change jobs, and in the care home sector the annual turnover is 30.8% (Skills for Care, 2019). For the FLCH staff in particular, such a non-nurturing environment and workplace stress can potentially lead to depersonalisation and emotional distancing between FLCH staff and the

residents they care for (Bakker and Heuven, 2006; Daniels et al., 2016). This highlights the significance of tackling workplace stress and promoting well-being. A logical progression is that our attention should be drawn to mitigating the impact of workplace stress.

There have been various approaches to address employee workplace stress. For example, via counselling services, cognitive techniques, the provision of employee exercise and healthy eating support schemes, by regulatory measures to improve certain aspects of work, the provision of financial support such as grant schemes, or via the development of policies to tackle workplace stress in general (Sockoll, 2009). Many other approaches are designed and delivered as training to improve skills at various staff levels, for example, improving communication skills (Sprangers et al., 2015), capacity building (Jeon et al., 2015), change in organisational practice (Barry et al., 2005), adjusting leadership styles and initiatives (Jeon et al., 2010), exploring creativity and learning opportunities (Watson et al., 2018), and job redesign (Cousins et al., 2004). Of the various approaches however, an emphasis on improving employee well-being is becoming a central focus for many organisations. Over the past decade human resource management has increasingly become aware of the importance of staff well-being. Dewe and Cooper (2012) say well-being is the fastest growing area of concern to the public sector and private businesses. Employee well-being has been associated with job performance, quality of care, turnover and patient satisfaction, and holds numerous benefits for both staff and organisation (Daniels et al., 2017; DoH, 2009; Hall et al., 2016; Lopez et al, 2014; Maben et al., 2012; Wright, 2010). Moreover, in year 2011, as a compliment to the gross domestic product (GDP) which is a measure of national prosperity, the National Well-being Index was initiated in the UK by the Office of National Statistics (ONS) (ONS, 2015; Allin and Hand, 2017). This seminal decision implied the importance of well-being and reinforced the need to nurture well-being nationally, including well-being in the workplace.

The growing awareness of the benefits of employee well-being has seen an increase in employer motivation to tackle workplace stress (CIPD, 2019). The CIPD (2019) survey of over 1000 people demonstrates change in attitude towards employee well-being, indicating a more proactive approach to improving staff well-being, beyond the basic or legal obligation to develop policy documents.

2.5 Defining well-being

Well-being is dynamic, meaning different things to different people, and there is no consensus on the definition of well-being. Well-being is a wide-ranging, multifaceted concept and can be interpreted in a vast array of ways. It can mean different things in different fields of study, and even within a field, it means different things to different people (Michalos, 2008). Indeed, well-being can be a challenging construct to absolutely define. McAllister (2005) argues that the construct well-being is so broad and diverse, encompassing various dimensions of life, and that it accounts for some elements of life satisfaction which can actually not be measured. This point is buttressed by Michalos (2008) who argues that human well-being cannot be captured by any single discipline due to its multifaceted characteristics. In fact, Carlisle and Hanlon (2008) describe well-being as a poorly-defined and distracting red herring. In demonstrating the versatility of the definition of well-being, Murray et al. (2015) showed key features which underline the construct according to four key theories.

Despite the lack of consensus on the definition of well-being, it is commonly depicted as comprising of hedonic (feeling) and eudaimonic (functioning) components (for example, Waterman, 1993; Diener, 1984). The hedonic component is concerned with emotions, and particularly focuses on having more positive affect (that is, emotions and feelings) and less negative affect (for example feeling less anxious). In other words, hedonic well-being will

mean happiness, pleasure and a balance of positive and negative emotions (Paim, 1995; Diener et al., 1999; Kahneman and Krueger, 2006). The eudaimonic component of well-being is concerned with a sense of functioning and living life well, including the realisation of one's goals, personal growth, having good relationships, belonging and making contribution to a community (Paim, 1995; Ryff and Keyes, 1995; Ryan and Deci, 2001; Ryan et al., 2008). Therefore, if taken more generally, the concept of well-being can be described as a combination of both the hedonic and eudaimonic components, an approach taken by authors such as Huppert (2009a, b), Seligman (2011), and Huppert and So (2013). Frequently, when the word well-being is used, there is a greater emphasis on the hedonic (subjective) component than the eudaimonic. There is a vast literature on the intricacies of well-being and its definitions (Huppert and So, 2013; Murray et al., 2015), but this review does not attempt to cover these.

Notwithstanding the difficulty in capturing the construct of well-being, Murray et al. (2015) make an attempt, by proposing a definition which captures its multi-faceted nature. They defined well-being as 'a multidimensional construct that comprises the core dimensions of (i) positive affect (ii) personal relationships and social engagement and (iii) a life view that is meaningful and optimistic' (Murray et al., 2015, p2). A consensus on the definition of well-being may or may never be reached, and the debates continue. However, an age-long argument by Sen (1987) holds true in the current research. He argued that researchers and others in the field of well-being must not yield to the need to have a simplified and agreeable definition of well-being, thereby compromising on the wealth embodied in the concept of well-being. The definition of well-being adopted by researchers is often tailored to the specific research aims. This is important. Being so far-reaching, it is important for a study to set boundaries on what constitutes well-being. This approach provides clarity and enables a better assessment of the study's outcomes. As well-being means different things to different people, the current research tends towards a multi-faceted approach, and for the purposes of this research, Murray et al.'s,

(2015) definition is adopted. The overarching conceptualisation of well-being in the current research also takes into account the individualised (personal) perspective.

In line with this theme of personal evaluation, Perry et al. (2017) approached the subject of well-being by investigating the perception of the professional caregiver. In their study, they take an inductive interpretative approach to explore what the frontline care giver considers to be health and well-being. Their participants were a combination of care home and domiciliary care staff. Their findings showed that for this workforce, well-being cannot be defined as a one-size-fit-all description. They found that care staff had not only a holistic interpretation of health, but that there was an individualistic description of well-being. This finding buttresses the point that in conducting research on the well-being of this work force, it is important to take into consideration the role/perspective of the individual.

Thus, defining well-being, from the point of view of care home research, is just as challenging as in other sectors of work. However, while well-being is widely researched, and various definitions have been proposed, the sparse research on the well-being of FLCH staff makes it more challenging to have a grasp of the concept of well-being from their perspective. It is hoped that in answering its research questions, the current research will shed more light on how FLCH staff describe well-being. Having considered its definition, we explore the impact of well-being on work.

2.6 Well-being at work

A plethora of research spanning many decades and industries have investigated the links between well-being and work, often demonstrating that nurturing well-being has a positive influence in tackling workplace stress. Some of these studies have explored detailed aspects such as employee's physical and emotional health, behaviour, environment, productivity,

turnover, management practices, and more (Zimmermann 1934; Reynolds, 1997; Schulte and Vainio, 2010; Whitman, et al. 2010; Wright, 2010; Nabe-Nielsen et al., 2011; Robertson and Cooper, 2011; Roland-Lévy et al., 2014; Binder, 2016). In organizational psychology research and practice, well-being at work has become a critical area of focus (Chen and Cooper, 2014). However, despite the increasing awareness of the role of well-being, workplace stress is a global concern. In its report, 'Healthy Workplaces: A model for action', the World Health Organisation (WHO) makes clear the criticality of improving employee well-being (WHO, 2010). Other national and international initiatives and reports have highlighted the significance of well-being at work, for example 'Working for a Healthier Tomorrow' (Black, 2008), developing management standards for workplace stress (Cousins et al., 2004; HSE, 2008), the WHO Healthy Workplace Framework (Burton, 2010), the on-going Healthy Working Lives Award programme in Scotland (Healthy Working Lives, 2020), and in 2016-2020, the Economic and Social Research council (ESRC, 2016) has prioritised research on mental health.

Luthans and Youssef (2004) argue that human capital is one of the most important assets of an organisation and it confers a competitive advantage. Research studies have demonstrated that a poor state of employee well-being has a negative impact on an individual's life and on the employer. Sears et al. (2013) also show that low overall well-being of employees is characteristically linked with low productivity, and they go on to demonstrate this link. They point out that this characteristic link usually follows a pattern of energy drain, to distractions at work, then negative emotions about work, which eventually culminates in a withdrawal of effort on the job or an inability to perform well or go to work. Other studies have demonstrated this impact, for example Loretto et al. (2010); Christian et al. (2011) and Taris and Schaufeli (2015). Due to the focus of the current research, we consider well-being at work for the FLCH staff in particular.

2.6.1 Well-being at work - the frontline care home staff

As with other sectors of work, there is evidence of the impact of well-being on the work of FLCH staff. The well-being of care home staff has been demonstrated to influence the quality of care (Redfern et al., 2002; Schmidt et al., 2014; Hall et al., 2016) and the safety and well-being of the residents (Bakker and Heuven, 2006; Hall et al., 2016; Chao, 2019). Barry et al. (2005, 2019) concur with these conclusions and demonstrated an improvement in social engagement, and reduction in residents' physical conditions such as pressure ulcer, as a result of nurturing staff well-being via empowerment practices. It is important to note that in several studies, job satisfaction is often indicative of well-being (Zaghloul et al., 2008; De Simone, et al., 2018), and in view of this, low job satisfaction is one of the factors most commonly cited as the reason for leaving a job in long term care facilities such as care homes (Squires et al., 2015).

The stressful experience of being a FLCH staff member cannot be overstated. With sparse research on improving their well-being, the cost of ignoring the well-being of this staff group may hold grave consequences for the care home sector. This is especially salient in the light of evidence which links staff well-being to quality of care as previously mentioned. In fact, Garman et al. (2002) argued that if a nurse is experiencing stress, it is not unreasonable to believe that the care which is administered may be affected by this stress. Furthermore, a longitudinal study by Sears et al. (2013) emphasises this point, showing well-being to be a significant predictor of healthcare, productivity and retention outcomes. They go on to clearly point out that initiatives aimed at improving employee well-being could have significant impact on business performance. More so, the Department of Health demonstrates that when the health and well-being of employees is prioritised, there are improvements in staff retention, sickness absence, productivity and quality of care (Boorman, 2009).

On initial examination of the subject of well-being in care homes, one may observe an abundance of care home research. But on closer examination, one will observe a greater emphasis on residents or relatives' experience. For the majority of research on care homes, there is a theme of pointing out the issues which plague the industry, such as high turnover, difficult recruitment, financial issues, or residents' abuse (for example, Payne and Fletcher, 2005; Stevens et al., 2013; Health and Social Care Information Centre HSCIC, 2013; Cooper et al., 2016; Kings Fund 2018). A number of research studies however (for example Eaton, 2000 and Barba 2002), have addressed this shortfall, pointing out the vital importance of the experience of care staff. These researchers show that care staff will often subtly mirror the treatment they themselves have received, such that if they are respected, nurtured and valued, they often will reflect these in their care giving. Despite this understanding, the literature does not suggest that there are many initiatives specifically designed to nurture the well-being of staff in care homes. In spite of the surge in progressive efforts towards improving staff well-being in other sectors of work, this proactive outlook is not apparent in the care home sector. In particular, there is little evidence of initiatives to nurture the well-being of FLCH staff. This phenomenon is mirrored in the research field by the sparsity of literature on the subject.

As pointed out earlier, although high turnover rates and high levels of stress are noted amongst FLCH staff, and although research has demonstrated that their well-being can influence the well-being of care home residents, the atmosphere in a care home, and the quality of care, there is an apparent disjoint between this knowledge and actual steps taken to nurture the well-being of FLCH staff.

2.7 Looking forward – a different perspective

Barry et al. (2019) argue that meeting the needs of the growing elderly population must include strengthening the workforce. The current research proposes that a focus on the well-being of FLCH staff will enable the care home industry to reap some of the benefits of improved well-being which have been demonstrated in other sectors of work. Having examined the literature, it is clear that the well-being of FLCH staff has not been a priority. Following their systematic review, Hall et al. (2016) argue that although quality of care is vital, having safe care is a prerequisite to quality, and that at the heart of patient safety may lie the well-being of the staff. If a better well-being experience holds significant prospects of improving the well-being of care home residents, and the general atmosphere in a care home (Hall et al., 2016), it follows logically that we invest some effort in exploring and improving the well-being experience of FLCH staff. In addition, other research (for example, Karantzas et al., 2012; Knopp-Sihota et al., 2015; Zúñiga et al., 2015), address the issue of quality, pointing out that to ignore the impact of stress and poor well-being is to potentially compromise care practices. As pointed out by Bakker and Heuven (2006), if workplace stress can potentially lead to such crucial issues as depersonalisation and emotional distancing between FLCH staff and the residents they care for, indeed our attention should be drawn to mitigating the impact of such stress.

Of the research studies which focus on FLCH staff, many concentrate on staff training, such as clinical training, health and safety, person-centred care, to name but a few, and these studies have enhanced our understanding of staff training. The considerable focus on training is not unfounded, since skills are important for a competent performance. Indeed, skills improvement has been demonstrated to be an important determinant of staff well-being in heath settings, and for social care workers (Cohen and Gagin, 2005). In their study, Cohen and Gagin (2005) demonstrated a decrease in emotional exhaustion and depersonalization post training, and also showed increased personal accomplishment of care staff post training. In addition, skills

improvement has been linked to improved quality of care, reduced risk in care homes, and improvement in resident and family experience (Utley-Smith et al., 2009). With such potential benefits, it is no wonder that a scan of extant literature reveals skills improvement, via training, to be a key area of focus for the majority of research studies on care home staff. These findings have made significant contributions to our understanding, for example, in understanding the link between improved skills and the well-being of both care staff and residents. However, a focus on skills improvement is only one aspect of improving the well-being of care staff. Albeit the valuable role of staff training, it does not replace the need to, or limit the importance of investigating other ways to improve the well-being of frontline care home staff.

Arguably, the staff in a care home are not the only aspect of the care home which needs to be addressed in order to ensure and sustain high quality care, and ultimately the successful running of the home. Killett et al. (2013) and Chamberlain et al. (2016), show that organizational factors such as infrastructure, management and procedures, skills, resident population, and the culture of a home, play a vital role in the experience of care in a care setting. However, on closer examination, for most approaches aimed at improving the care experience in a care home, we observe that FLCH staff are central to almost all the findings. Whether in the exercise of leadership, or studying the values underpinning care, or whether in exploring the culture and ethos of the home, FLCH staff can be found playing important roles. This point is buttressed by an earlier study by Forbes-Thompson et al. (2007), who considered the care home as a complex system and applied complexity science principles. Complexity science is concerned with examining systems which have not only multiple but also diverse array of agents interacting (Begun and White, 2008). The aim of its examination is to reveal the underlying principles and dynamics of what makes a non-linear complex system function and thrive (Zimmerman, 1999; Begun and White, 2008). Forbes-Thompson et al. (2007) studied extreme cases of high-performing and low-performing care homes. Their results showed a contrast

between the two groups, and one of the major factors the authors highlight as a reason for the contrast was again related to staff. They highlighted how the leaders of the high-performing care homes fostered staff connectivity, built trust amongst staff, and applied the cognitive diversity of the staff. Therefore, although there are other important aspects to consider when aiming for a successfully run care home, the staff are pivotal in almost all considerations. In the light of this, improving the well-being experience of FLCH staff will be a substantive area of focus in the current research.

So far, we have explored the need to improve and nurture the well-being of employees, in particular, the well-being of FLCH staff. For the FLCH staff, the nature of their work constantly exposes them to a range of stressors. One may argue that this exposure to varying and seemingly incessant stressors 'comes with the territory'. In other words, inherent within the work itself, is a constant risk of stress. We have seen that this stress has negative impacts on the individual and their work. For the FLCH, this can have adverse effects on other critical dynamics of the care home, including the quality of care. It therefore gives impetus to address the issue. For the FLCH staff, if stressors may not be completely eradicated (although it is vital that other work focus on systemic issues concerned with stressor reduction), then it is important to address the impact on the individual. Moreover, in many countries, it has become a legal requirement that employers address workplace stress which is now recognised to be a hazard (Berridge and Cooper, 2000).

2.8 Moving forward – bridging the gap

So far, the literature on workplace stress and well-being has been reviewed, with particular focus on the care home sector and FLCH staff. One gap uncovered so far is that:

a) Improving the well-being of FLCH staff has not been prioritised in research and in practice, despite increasing evidence of the often-difficult circumstances in which they work. It is well-established in the literature that well-being can have an impact on workplace stress and improve one's experience at work. However, despite the mounting evidence of increasing demand and expectations of FLCH staff, there is sparse research on initiatives to improve or nurture their well-being.

To address this gap, the current research proposes to investigate what FLCH staff do for well-being, and therefore asks the first research question:

1) What do FLCH staff do to improve and/or maintain their well-being at work?

Additionally, in view of its focus on the individual, the current research therefore investigates the potential of improving well-being via personal (individual) resources. Personal resources are psychological traits such as one's perception of control, resilience, self-efficacy or other related characteristics. While the conservation of resources theory and the job demands-resources model both acknowledge that resources can be of various kinds, in the current research, personal resources are the focus. Pointed out earlier in this review, research has demonstrated the influence of personal resources on one's experience at work (Schaufeli and Taris, 2014). The conservation of resources COR theory and JD-R model explored earlier highlight the importance of personal resources, for example one's perception of control or self-efficacy. This highlight is significant to the current research due to its focus on the individual, since the individual plays a critical role in the stress process and its consequent impact. The role of individual resources is explored further in Chapter 3.

2.9 Conclusion

This chapter has reviewed the literature on the experience of the frontline care home (FLCH) staff. It has shown that there is a growing population of older people internationally and nationally, and the need for FLCH staff is pressing. Despite this need, a high turnover is reported amongst this staff group. The chapter has established that the changing landscape of the care home, and the subsequent changes in the role of the frontline care home staff, have brought with them high expectations of FLCH staff and immense workplace stress. FLCH staff are not only frontline in care, but also frontline in the exposure to a host of stressors in the care home as a workplace. The benefits of improving the well-being of employees have been established by numerous studies, and in workplaces across a variety of sectors. However, there is little research on improving the well-being of FLCH staff. Central to the effective running of a care home are FLCH staff, and studies have shown that their well-being can influence vital aspects of the care home, such as the well-being of the residents, the atmosphere in the home, and potentially the quality of care. In the light of this knowledge, this chapter has established the need to nurture the well-being of this staff group. Sparse insight into the well-being experience of FLCH staff was therefore identified as a gap in our knowledge.

The next chapter takes the insights gained in this review and relates this to the conceptual framework of the research and its theoretical underpinnings. It examines the stress process, but in particular it focuses on how an individual may navigate the stress process to attain an outcome of well-being in contrast to strain. Thus, the conceptual framework presents the potential of improving well-being via a moderating effect.

3 Theoretical Underpinnings and Conceptual Framework

3.1 Introduction

As established in the previous chapter, the well-being experience of frontline care home (FLCH) staff has largely not been a priority despite the understanding that they play a key role in the dynamics of a care home, and that their well-being can influence the quality of care. This thesis addresses the well-being of FLCH staff, and the aim of this chapter is to present the theories underpinning this research. These are the stress, appraisal, and coping theory (Lazarus and Folkman, 1984) and the self-efficacy theory (Bandura, 1997). Drawing upon these theories, the conceptual framework of the current research was developed. The conceptual framework presents the possibility of a well-being outcome after exposure to a stressor. It demonstrates the buffering effect of an individual resource which is based on self-efficacy. The chapter begins by presenting the underpinning theories and proceeds to present the conceptual framework.

3.2 Stress, appraisal and coping

The theoretical framework adopted in this research draws on Lazarus and Folkman's (1984) stress, appraisal and coping (SAC) theory. Lazarus and Folkman (1984) present a transactional model of stress. This model considers stress to be a process involving an individual and their environment, and this relationship is bidirectional, dynamic, and operates on mutual reciprocity. According to the SAC theory, there is a logical progression from exposure to a stressor, to (cognitive) appraisal of that stressor, and to coping (Lazarus and Folkman, 1984), and how individuals cope with those stressors can influence their experience of well-being and strain. The previous chapter considered workplace stress and what this means for FLCH staff. We now consider cognitive appraisal and coping according to the SAC theory.

3.2.1 Cognitive appraisal

According to the SAC theory, cognitive appraisal is the initial stage in the perception, or the alleviation, of stress (Lazarus and Folkman, 1984). Cognitive appraisal involves a person's evaluation of an event which they believe has taxed or exceeded their adaptive resources, and this evaluation influences the subsequent process of making decisions. This is a significant stage in the stress process, and it concerns how a person becomes aroused, and how they reduce, enhance or maintain this arousal (Lazarus and Folkman, 1984).

Lazarus and Folkman (1984) identify three kinds of appraisal – primary, secondary and reappraisal. Primary appraisal involves the evaluation of a goal-relevant situation, that is, a situation which is perceived as having consequences for health and well-being. The evaluation will lead to the event being interpreted as harmful (where a damage or loss has already taken place); a threat (having the potential to cause future harm); or a challenge (where the stressor is expected to lead to a positive outcome). Secondary appraisal evaluates the actions to be taken after an event is evaluated as being a threat or a challenge, and whether the action to be taken

will achieve its purpose. A reappraisal refers to making a change to a previous appraisal in the light of new information from the environment or from the person. For instance, a person might have previously judged a situation to be a threat, but in the light of new information, they reappraise the situation to be a challenge. Additionally, if this reappraisal takes place as a result of a cognitive coping effort which the individual has developed since encountering the stressor, then the reappraisal is called a defensive appraisal. A defensive appraisal in essence, occurs when a person makes an attempt to reinterpret a past event in a more positive light or to deal with a current threat by evaluating them in non-threatening or less damaging way. Overall, primary and secondary appraisals will correlate to influence the degree of stress, and the intensity and quality of the consequent reaction. The cognitive appraisal processes however, may not always be conscious, thus a person may be unaware of what antecedents influence their evaluations. Cognitive appraisal will however occur between the event and a reaction to it, thus mediating stress response levels (Lazarus and Folkman, 1984).

3.2.2 Coping

According to the SAC theory, coping is the next stage in the stress process, after cognitive appraisal (Lazarus and Folkman, 1984). Coping is described as a continuous change in either behavioural or cognitive efforts, in order to manage internal and/or external demands which are appraised as taxing or which exceed individual resource (Lazarus and Folkman, 1984). Coping plays a role in the outcome of the stress process. It is an important aspect of human functioning. Peters et al. (2016) state that coping is a behavioural or cognitive adaptation aimed at minimising or counteracting the depletion of personal resources, which is often the effect of stressful situations. These demands will arise from goal-relevant situations, as earlier mentioned. In essence, coping incorporates efforts which an individual employs to manage a taxing demand. According to Lazarus and Folkman (1984), there will be a constant change

between cognitive or behavioural adaptation, thus creating a dynamic application of effort (Lazarus and Folkman, 1984).

Observing the history of developments on coping, different theories have been proposed (see Bottaccioli, 2014; Krohne, 2002). Lazarus and Folkman (1984) argue that although initial postulations on coping have brought some understanding to the concept, their unidimensional approach lacks cognitive-emotional richness, complexity, and variability, all of which are essential to our human functioning. In other words, it portrays a mechanistic view of human behaviour. In contrast, Lazarus and Folkman (1984) explain coping from a psychoanalytic perspective which allows for a more robust explanation of human functioning and navigation, in the face of a stressor. It therefore involves a realistic flexibility of thoughts and actions aimed at solving problems and reducing stress (Lazarus and Folkman, 1984). The emphasis here is the initial coping response to the stressor being a cognitive one, as opposed to this first response being behavioural. This concept of coping is adopted in the current research.

Lazarus and Folkman (1984) posit a process-approach to coping. In considering coping as a process, there is a constant shift between thoughts and actions in the face of a stressful encounter. On exposure to a stressor, the chief outcome of coping is to alter the stressor or to regulate one's emotional response to the stressor. An individual will also shift between different strategies of coping and draw on a variety of available resources, for instance shifting between emotion-focused and problem-focused resources (Lazarus and Folkman, 1984). The notion of coping as a process denotes two major ideas. First, that coping can change relative to a stressful encounter. In other words, from pre-confrontation/anticipation, confrontation and post-confrontation of a stressor, a person will continue to evaluate the situation as it progresses and does not assume a static position. Secondly, while the application of either problem- or emotion-based coping, or indeed the ability to switch between them is an important skill, recognising and harnessing personal resources is also a vital aspect of coping. Coping as a

process concurs with the person-environment fit perspective of stress management (Edwards, 1998). From the person-environment fit perspective, the interaction between the individual and their environment will be the main explanation of behaviour (for example a coping behaviour). In considering coping as a process, the individual plays a prime role in the orchestration of thoughts and actions aimed at achieving a desired outcome (for instance well-being).

With the individual being central to the process, the role of personality may emerge. Indeed, elsewhere, the influence of personality on behaviours and well-being have been demonstrated (for example, DeNeve & Cooper, 1998; Diener et al., 2003; Keyes et al., 2002; McCrae & Costa, 1986; Schimmack et al., 2008; Sheldon & Kasser, 1995). These studies confirm that indeed personality traits will influence coping. However, the current study does not focus on personality. To focus on personality is to deviate from the notion of coping as a process and to take a trait-centred approach, similar to what Dewe et al. (1993) refer to as coping styles. This approach focuses on habits and consistent ways of handing stressors in general (see O'Driscoll et al., 2009). Lazarus and Folkman (1984) refer to this habitual way of acting as automatized adaptive behaviour, which is an automatic adaptive response. Although complicated and skilful, they argue that these automatic responses cannot be classified as coping. Coping rather involves effort, but having said this, our attention must be drawn to the not-easily-distinguishable line between coping and an automatic adaptive response (Lazarus and Folkman, 1984). Without prior knowledge of the frequency of exposure and therefore adaptation to the situation in question, it is difficult to distinguish between an automatic response and coping (process-centred). However, even though automated, it can be argued that all such automated coping initially begins as learned processes which involved effort (Lazarus and Folkman, 1984). In contrast to the trait-centred approach, the behaviour-centred approach, similar to Dewe et al.'s (1993) coping behaviours (or strategies), focuses on behaviours or strategies aimed at addressing a specific stressor. It takes on Lazarus and Folkman's (1984)

notion of a dynamic process, involving a shift between thoughts and actions. Both trait and behavioural approaches are insightful to our understanding of coping. However, the current research does not intend to focus on a trait-centred approach, for instance by examining personality traits. The current research however explores the potential of individual resources.

3.3 Resources

Earlier, in Chapter 2, resources were explored in the light of the conservation of resources theory and the job demand-resources theory. Resources refer to elements deemed to be of worth, including objects, personal characteristics, conditions or energies (Hobfoll, 1989). Resources could therefore be considered as tools which a person selects from in order to tackle various situations (demands). This is in line with the job demand-resources theory (JD-R) (Demerouti et al., 2001) which considers job demands to be job-related strains, while job resources refer to factors which enable a person to ameliorate the difficult or negative impact of job demands. Resources are wide-ranging and have been categorised in a variety of ways. For instance, Lazarus and Folkman (1984) offer an emotion-focused category (including resources such as emotional stamina and endurance) and a problem-focused category (including emotional, cognitive, and behavioural abilities). This categorisation solely considers the individual. Nielsen et al. (2017) categorise workplace resources into four categories - individual (for example self-efficacy and self-esteem), group (for example social support and good interpersonal relationships), leader (for example leadership style and quality of leader-member exchange), and organizational resources (for example autonomy and performance appraisal).

Although Nielson et al.'s (2017) categorisation is more comprehensive, for simplicity, in this framework, we categorise resources into contextual (environmental) and individual (personal)

resources. Contextual resources refer to factors which are external to the individual, for example, group, leader, and organizational resources (Nielson et al. (2017). Individual resources refer to factors related to the person, for example one's perception of control, resilience, self-efficacy, self-esteem, optimism, self-concept, emotional intelligence or other personal traits, and various aspects of motivation (Kasser and Ryan, 1993, 1996; Sheldon and Kasser, 1998; Ryan and Deci, 2001; Xanthopoulou et al., 2007; Yu et al., 2019). Another insightful example of a resource is experience. Despite the reported high stress levels of FLCH staff, having more experience in the sector has been reported to have an impact on well-being. For example, Hussein (2018) demonstrates that for adult social workers work experience had a moderating effect on burnout. With an attenuated impact of burnout, Hussein (2018) points out that improved well-being in turn influences the productivity of care staff. Thus, whether contextual or individual, resources play a role in the experience of well-being. Also, these two categories may interact, for instance, individual efforts can create contextual resources and contextual factors may also create individual resources (such as developing a skill via training and intervention).

In line with the ontology of critical realism (more of this in the methodology chapter), reality can be subjective. This means that an individual can interact with their social world (reality), and this interaction can change their experience and interpretation of reality. According to the epistemology of critical realism, the experience of the individual is critical to gaining knowledge of their social world and their interaction with it. Bhaskar (1979) argued that without human experience, that is, their activities and interpretations, knowledge may not be attained. An agentic perspective (Bandura, 2001b) considers the individual as being centrally positioned in bringing about change. It is however acknowledged that the environment plays a significant role in an individual's behaviour. Gardner and Stern (1996, 2002) capture this point clearly when they draw on cognitive, social, and behavioural psychology to explain individual

behaviour. However, the individual is still seen to 'orchestrate' resources, both in the environment and within themselves, in order to effect change. Thus, the ability to cope with work demands, while managing one's available resources is a common theme within well-being research. This concurs with Lazarus and Folkman's (1984) process-specific coping, where the individual shifts between different strategies of coping and draws on a variety of available resources to tackle a goal-relevant situation. The individual (agent) is key in this process. This suggests that the process can be potentially ill-fated or the outcome negative if the individual (agent) is unable to 'process' appropriately, that is, manage demands and resources in order to bring about a desired change. In the current research, self-efficacy is posited to be an individual resource which will enable a person (the agent) to manage demands and resources and ultimately enable them to improve their well-being.

3.4 Self-Efficacy

Self-efficacy (SE) is the belief in one's capability to organise and execute the courses of action required to achieve a desired outcome (Bandura, 1997). Self-efficacy is a core aspect of Bandura's social cognitive theory (SCT), and a main factor when considering human agency (Bandura, 1977, 1986, 1997). Human agency denotes an individual's aim to exert influence over important aspects of their life. In the endeavour to exercise this sense of agency, an individual will employ cognitive and self-regulatory abilities aimed at achieving a set goal. The SCT states that individuals possess a self-system which regulates feelings, thoughts, motivation, and ultimately action (Bandura, 1986). The theory proposes the interaction between cognitive, behavioural, personal, and environmental factors which ultimately determine a person's motivation and behaviour. According to the SCT, a person acts both as an agent in self-reflection, and as an object in self-influence. It establishes the point that people are not simply at the mercy of environmental factors, with their actions merely a reaction to

something which has occurred. Being simply at the mercy of environmental factors carries the dispiriting conclusion that people are powerless to effect changes in their lives, a description which Bandura (1997) refers to as a prescription for apathy and despair.

The SCT also establishes that individuals have the ability to regulate pathways which ultimately lead to action and development of skills. While the SCT points out certain classes of determinants (such as social influences and personal factors) which motivate and regulate established skills, the self-efficacy theory plays the role of interacting with those determinants to govern a person's thoughts, motivations and actions. The effect of this interaction of SE with these determinants is displayed in the choice of activities and level of motivation. SE will also account for differences in aspirations and expected outcomes of one's effort, thus accounting for how well, or not, a person makes use of their capabilities. If a person has a strong perception of SE, they will take on a difficult task with the determination to use their skills and persevere through the difficult task until they achieve their desired successful outcome. On the contrary, a person with a weaker perception of SE, although possessing good skills, will likely not apply their skills and thus sabotage a successful outcome (Bandura, 1997; Usher, 2015).

As earlier stated, self-efficacy is the belief in one's capability to organise and execute the courses of action to achieve a desired outcome (Bandura, 1997). SE is concerned with belief, a belief which places choice and control in the hands of the individual. It encourages and enables individual ownership of outcomes. Bandura (1997) argues that until a person believes that their actions can produce a desired effect, they are minimally motivated to act. A person with high self-efficacy will effectively control their feelings, thought processes, motivation and behaviour, with a focus on achieving their goal (Bandura, 1995; Cleary and Kitsantas, 2017; Usher and Schunk, 2018). People with a strong perception of self-efficacy are able to plan and successfully achieve an aim (Bandura, 1984). As earlier stated, they persevere through difficulty, exerting and maintaining effort until the desired goal is achieved (Bandura, 1997).

Put in other words, self-efficacy can predict an individual's 'staying power'. In the context of well-being, the frontline care home staff who perceives themselves as having a high perception of self-efficacy will make adjustments, albeit within a restrictive environment, and persevere, in order to experience or nurture their own or collective well-being. Coates and Fossey (2019) demonstrate this in their interpretative phenomenological analysis (IPA) study of highly self-efficacious care assistants working in dementia care.

SE is domain-specific. This means that SE is the belief in one's capability to organise and execute the courses of action to achieve a desired outcome in a specific area. Thus, SE in one area of functioning does not automatically translate as the same level of SE in another area (discussed further in Chapter 4). Although Schwarzer and Jerusalem (1995) and Chen et al. (2001) present SE as being generalised, the belief referred to by its original proponent (Bandura, 1977, 1997) is one which is rather related to a specific domain. Chen et al (2001) point out that their idea of generalised self-efficacy is beneficial in non-specific contexts such as when studying macro performance. However, Barbaranelli et al. (2017) argue that specific SE is critical to understanding the properties and explanatory power of self-efficacy across tasks and in various situations.

SE has been demonstrated by various studies to be significant in influencing behavioural change. For instance, in stress management (Bodys-Cupak et al., 2016, 2019), level of performance in clinical practice (Manojlovich , 2005; Lee and Ko, 2010), job performance in non-clinical settings (Stajkovic and Luthans, 1998); sports performance and physical activity (Allison & Keller, 2004; Ling, 2008), and academic achievement (Caprara et al., 2008). In a care-related context, the study by De Simone et al. (2018) investigated, amongst other variables, the relationship between nurse's self-efficacy and patient satisfaction, where patient satisfaction was an important indicator of quality performance. Besides confirming previous

research findings that SE is positively associated with job satisfaction, their study particularly demonstrated a positive association between SE and patient satisfaction.

3.5 How Does Self-Efficacy Work?

Bandura (1986, 1997) explains that there are four psychological processes via which self-efficacy is perceived. These processes mediate the effects of self-efficacy and impact on a person's performance. These processes are the cognitive, motivational, affective and selection processes.

3.5.1 The cognitive process as a mediator of the effects of self-efficacy

The cognitive process is concerned with the way in which a person's thought pattern can affect their performance. This can be considered to be appraisal in the SAC theory (Lazarus and Folkman, 1984). These thought patterns could be beneficial or detrimental to the quality of performance, and the consequent cognitive constructions will influence SE. Cognitive constructions can be developed based on past experiences or thoughts of the future, envisioning, and setting goals, and consequently these constructions will govern a person's actions. Within this cognitive process, Bandura (1997) points out three main ways in which the constructions can influence SE and performance. These three ways are via the conceptions of ability, of social comparison, and belief in the degree to which one's environment can be influenced.

Firstly, the conceptions of ability explain a person's performance based on whether a person believes that ability is inherent (that is, one is born with an ability), or that it can be acquired. The conception of ability inevitably creates a spiral in both categories of people. On the one hand, a positive spiral is created for people who believe that skill is influenceable, thus

changeable. They are not swayed by failures or setbacks, they put in more effort, tantamount to dedicated hours of training which improves skill and then SE and the spiral continues. On the other hand, a vicious spiral is created for those who consider ability to be inherent and unchangeable. For these individuals, they put off or do not seek opportunities to improve their skills, and will often give up easily in difficult tasks, thereby forsaking the realizable changes (Bandura, 1997).

For individuals who believe that ability can be acquired, Dweck's (2000) theory on mindsets explains this in terms of an incremental (malleable) conception of ability. That is, the individual believes that ability can be increased over time through effort. In their empirical study, Blackwell et al. (2007) demonstrate this effect amongst a group of students. They showed that a malleable conception of ability is linked to stronger learning goals and a more positive belief about their effort. Furthermore, Bandura (1997) states that with a stronger perception of SE, a person will more readily adopt a better cognitive strategy, being more willing to discard a faulty cognitive strategy for a better one. Blackwell et al. (2007) also confirm this, showing that when faced with failure, the students who had a malleable conception of ability chose effort-based and positive strategies to cope, and indeed achieved successful outcomes. Additionally, Blackwell et al. (2007) showed that this effect was sustained over a two-year period. It must however be noted, that although there are positive impacts of having a belief that ability is within one's control, this does not necessarily mean that personal effort can be easily controlled and made to produce a desired effect at all times (Bandura, 1997). For instance, people who exert a high degree or amount of effort with no success, do not always believe that they can constantly keep improving their effort. For those who indeed exert immense effort and achieve success, they do not always believe that this effort can be sustained.

Secondly, the conception of social comparison is concerned with comparing oneself with others. By considering the position in which a person sees themselves in the comparison, their level of self-efficacy can determine their level of performance.

Thirdly, the conception of belief. This is concerned with the belief an individual has about the changeability of their environment and this influences their perception of SE and subsequently performance. This point is similar to the conception of ability, in that a person makes a judgement about their control. However, unlike the conception of ability which concerns the individual, the conception of belief in changeability looks outwards, to the environment. If a person believes that their environment cannot be affected by them and thus cannot be changed, then they make minimal efforts at changing it, or they act, anticipating ineffectiveness in whatever actions they take. Again, as with the vicious spiral we encountered in the conception of ability, this individual short-circuits the potential for improvement, and their performance deteriorates (Bandura, 1997). This is a vital point for frontline care home staff. It would seem gravely difficult to overcome the numerous challenges and stressors they are faced with. For example, the continuous shortage of staff or limited resources to work with. It is thus useful to explore the belief FLCH staff have about their ability to change their environment. A better understanding of this cognitive process has the potential of developing or improving effective support structures for this group of staff.

3.5.2 Motivational process as a mediator of the effects of self-efficacy

Motivational processes involve the cognitive processing of past or future events which results in self-motivation to act in the present. Bandura (1997) argues that this ability to self-motivate and act is rooted in cognitive activity via forethought. Forethought therefore serves as the conduit by which a desired future is brought to the present, and serves as a motivator to instigate

and sustain action. The process begins with a person setting a goal based on a desired foreseeable future, acts in anticipation of the goal to be achieved, or an incentive to be attained (Bandura, 1997).

Via self-regulatory mechanisms, a person will sustain the effort required to achieve the goal, persevering in difficult times. SE plays a key role in the processing of events which inspire motivation and guide action. Bandura (1997) points out three chief cognitive motivators via which SE influences performance - causal attributions, outcome expectancies, and cognized goals. Causal attributions mainly point to effort, ability, difficulty of the task and chance, as the features which can determine the causes of an outcome. SE affects these causal attributions by influencing the weight given to perceived ability, effort, and the difficulty of the task (Bandura, 1997). For example, people with high SE will consider a successful outcome to be attainable due to a strong belief that by regulating their effort, they can control outcomes. On the contrary, those with lower SE may attribute the outcome to ability (fixed), they subsequently do not exert the required amount of effort and interpret a failure to mean their own incapability.

Outcome expectancies refer to the anticipation which a person has for their action. If a person believes that the prospects of their actions are desirable and likely (note that a negative outcome may also be desirable), then they are likely to be motivated and guide themselves towards these actions which lead to the desired prospect (Bandura, 1997). SE also influences the perception of difficulty involved in the actions to be taken. Therefore, in the face of a challenging action, and with a desirable outcome at stake, a more efficacious person will advance to act and persist through the difficulties. Whereas a less efficacious person will consider the action to be too difficult and will be less likely to act despite the potentially desirable outcome.

The third of the cognitive motivators is cognized goals, which is concerned with setting personal goals and reviewing one's performance via self-reactive influences. This, Bandura argues, plays a key role in influencing motivation and self-directedness. Cognized goals, as with outcome expectations, act via anticipation. However, unlike outcome expectations, cognized goals regulate action based on goals which have been achieved and are thus tangible. Furthermore, these theorized goals do not directly regulate motivation and action, but do so via self-reactive influences. In other words, a person sets a goal and sets a standard which interprets whether the goal has been successfully attained, and SE influences the setting of this standard (Bandura, 1997). These personal standards create motivational effects which guide a person's actions. If faring well according to their judgement, a person thus becomes motivated to continue action. If, however, they consider their effort to be below their expectation of themselves, they may or may not improve their efforts in order to reach the standard, depending on the perception of SE. Thus, actions can be regulated as the individual compares their achievement to standards pre-set by themselves. Motivation or demotivation, satisfaction or dissatisfaction is based upon this pre-set standard, and the self-reactive comparison of oneself (Bandura, 1997).

SE exerts its influence in the interpretation of discrepancies between actual attainments and the pre-set standard. On the one hand, an efficacious person will intensify their effort, and attribute the discrepancy to insufficient effort. This perseverance often means that the goal is likely to be achieved. On the other hand, a less efficacious person will be discouraged in the face of the discrepancy between attainment and the pre-set standard, thus likely to give up on the goal. Although, as demonstrated by Campion and Lord's (1982) study, people may change their goals as they approach or surpass the original goals.

3.5.3 Affective processes as a mediator of the effects of self-efficacy

Bandura (1986, 1991a) describes affect as relating to the experience of an emotion, and on some occasions, affect has been described as an automatic and instinctual response. It has been so described because it is believed that this response takes place before the development of a complex emotion which is guided by a cognitive process. SE influences affective states by regulating the nature and intensity of the emotions experienced (Bandura, 1997). For instance, a person's belief in their capability can influence the intensity of negative emotions they will experience when faced with a taxing situation. Bandura points out that this regulation occurs via the exercise of self-control mainly in three ways – the control over one's thoughts, control over action, and the control over affect.

We consider the first of these three, the control over thought. The effect of SE in the control over thoughts is observable in two ways. The first of these is when SE regulates how a person interprets or recalls events, whether or not they do so in apprehensive ways which may arouse anxiety and raise stress levels. The second means of control relates to control over upsetting thoughts which interfere with a person's thought process. The intrusion of these disturbing thoughts is not uncommon, and may occur for both efficacious and non-efficacious people (Bandura, 1994, 1997). What sets out the difference between the two groups, and thus the effect of SE, is the perceived ability to discard these thoughts, in other words, override them or stop the intrusion from becoming a hinderance. For a person with strong SE, there is a higher perceived ability to put off these thoughts, thereby warding off additional biological conditions which arise as a result of thought-induced stress (Roberts and Grubb, 2014). The opposite is the case for a person with lower SE.

The control over action is the second point in our consideration. SE influences the actions which a person takes to modify their environment in such a way that it is less able to arouse upsetting emotions. For instance, SE influences the ability to cope, which in turn regulates the

arousal of upsetting emotions which lead to stress (Bandura, 1991b, 1997). A person with a strong perception of SE is likely engage in actions which may be challenging but will persist through the challenges and exert more effort, with the belief that the results will be a more pleasant environment for them.

Control over affect is the third of the three ways we consider, in which SE regulates the nature and intensity of emotions. The control over affects refers to the belief a person has in their ability to improve the situation when an undesirable emotion has been set in motion (Bandura, 1998). Up till this point, we have considered ways in which a person with a strong SE belief is able to cognitively choose their thought pattern, is able to motivate themselves to attain what they desire, and also how they are able to put off undesirable emotions. With control over affect, the individual is faced with an emotion which has begun, and their SE belief will regulate how the situation is improved. An efficacious individual believes that they can improve/relieve an unpleasant emotional state, and therefore will not be as aversive of the situation as a non-efficacious person (Bandura 1993, 1998).

The exercise of control is central to the mediation of SE via affective processes. This is because the exposure to stressors which can potentially arouse negative emotion is not the problem per se, but the perceived inability to cope with these stressors. This point relates to Lazarus and Folkman's (1984) theory of stress, appraisal, and coping. Lazarus and Folkman point to the individual's capability to cope, rather than a sole focus on the stressor. They demonstrate that cognitive appraisal processes will mediate stress response levels.

3.5.4 Selection process as a mediator of the effects of self-efficacy

Elsewhere, it has been demonstrated that SE is associated with competence and improved performance (for example, Jex and Bliese, 1999; Stajkovic and Luthans, 1998). This can be

explained via its influence on the choices of activities which an individual engages in and the skills which are used. The selection process involves the choices people make as they go through life. In accordance with the agentic view (Bandura, 1986), people play an active role in the outcome of their lives. As an agent, a person is not merely the product of their environment, that is, simply displaying biological/pre-set responses. Therefore, when a person makes a decision to improve their well-being, it influences the course of their lives, and this decision and consequent action will usually be guided by their perceived SE (Bandura, 1997). With a high perception of SE, a person will challenge themselves to take on more challenging activities and persevere at them despite seemingly insurmountable odds. This will enable the development of certain competences akin to the specific environment or role, and with continued exertion of effort, people are likely to shine in their chosen activity.

So far, we have expounded on Bandura's theorised mechanisms via which SE exerts its influence. Indeed, an understanding of these mechanisms can prove vital in the quest to apply the SE theory. Equally vital to understanding how SE works, is understanding how it can be improved. In the current research, there is an aim to improve the well-being experience of FLCH staff via the improvement of SE. It is therefore vital to understand what can be done to enable an individual to develop or nurture SE. We now explore the theoretical groundings of how SE can be improved according to the SE theory.

3.6 The Sources of Self-Efficacy

Bandura (1997) points out four sources of SE; enactive mastery experience, vicarious experience, verbal persuasion, and physiological and affective states. These sources of SE refer to sources of information which influence how people create a perception of their self-efficacy. In other words, they provide the foundational details which shape a person's perception of SE.

An individual's SE may be influenced via any one, or a combination of these sources (Bandura, 1997).

3.6.1 Enactive mastery experience

Enactive mastery experience refers to the development of one's SE by engaging in an action enough times; with perseverance through difficulties, and under varied circumstances to enable the strengthening of SE. To develop SE in this way, one must develop mastery both in doing the standard task, but also in the mastery of difficulties from perseverant effort. Bandura (1997) points out that difficulties provide the avenues to develop the skills which enable a person create success out of failure. Thus, the performance involved in gaining mastery requires engagement in complex performances. Bandura (1997) argues that people do not simply perform complex tasks merely as an act of will or as a programmed reaction to previous rewarding or punishing experience. He argues that rather, complex performances originate from a place of cognitive and other self-regulative subskills. In other words, as a source of SE, enactive mastery experiences will involve a person acquiring cognitive, behavioural, and self-regulatory tools which in turn enable a person to create and execute an effective course of action leading to a successful outcome. The experience of acquiring, utilising and sharpening these skills is unique to the individual. SE does not solely arise from the past experience of performing a task; there is a cognitive analysis of the performance, rather than just a mechanical audit (Bandura, 1997).

Bandura (1997) emphasises that mastery experiences are the most influential of the sources of SE because they provide the most reliable proof that a person can develop and sustain what is necessary to be successful in an endeavour. Furthermore, these experiences serve as indicators which point to a measure of how far along capability has developed (Bandura, 1997). Also

significant to the stress process, Bandura points out that mastery experience not only bolsters one's perception of their abilities but can also extinguish the arousal of fear. In this regard, Bandura (1977) refers to enactive mastery experience as two-pronged.

Enactive mastery experiences are dependent on certain factors. These factors will influence the extent to which a person adjusts their perceived SE resulting from performance (Bandura, 1997). These factors include, any concepts the individual had about their capability, how difficult they think the task is, the amount of effort they put in, the amount of external support they receive, the current circumstances under which the task is performed, the pattern of their successes and failures, and finally, the way in which they cognitively process and reconstruct the memory of their performance. The interplay of these factors under various circumstances is vital to our understanding and prediction of SE, because SE involves much more detail than just simply performing a task (Bandura, 1997).

3.6.2 Vicarious experience

Vicarious experiences refer to the influence of seeing others successfully perform a threatening or challenging task, and attaining desired outcomes. Here, modelling plays an important role, serving as an effective tool in the promotion of personal SE (Bandura, 1997). This means that people will assess their performance in comparison to the performance of others (models). The influence of the model will vary depending on the similarities or shared experience between the model and the observer. If the observer appraises the model as being much like themselves (for example, experiencing the same challenges or having the same goals), then the influence of the model is stronger. The influence is weaker if the model is far removed from the observer. In this research on FLCH staff, vicarious experiences will be a crucial source of SE as FLCH staff regularly work in teams or pairs. Due to the nature of their work, they often encounter

similar difficulties. As Bandura (1997) argues, although mastery experiences are the most influential sources of SE, in and of themselves, mastery experiences do not paint a complete picture. Since people compare their performances with others, modelling serves as a vital element in the development of personal SE.

It must be noted however, that simply exposing people to a model who is deemed to be suitable is not what brings about a change in SE belief. This change in SE belief takes place via four complex sub processes (Bandura, 1997). The first of these sub processes is the attentional process; which influences the selectivity of what is observed, and then subsequently what is extracted. Therefore, amidst the abundance of information 'given off' by the model, the observer, via the attentional process, selects what they deem important (for example, values, cognitive skills and preconceptions).

The second of these processes is the retention process. It involves transforming, restructuring and recalling of registered events. This is particularly important because, people can be greatly influenced by an event even when they do not remember the event (Bandura, 1997). Bandura points out that the recollection of an event is not merely a retrieval of that event, recollection is rather the representation of a past event greatly influenced by a person's preconceptions and affective state.

The third sub process is the behavioural production process; where the construction and execution of behaviours are guided by what has been observed in the model. A person will therefore compare and consequently modify their behaviour based on how closely it matches the model. On some occasions, additional skills must be acquired in order for the observer to reproduce the model's actions.

The last of the four sub processes is the motivational process. This sub process is concerned with what motivates the performance of a previously learned behaviour. People do not always

perform everything they have learnt, and their selection of the things to perform is affected by their motivation (either direct, vicarious, or self-produced motivation). Direct motivation refers to the direct reward or punishment as a result of engaging in a behaviour. Vicarious motivation result from the success or failures of others similar to themselves. Self-produced motivation concerns the self-satisfaction or self-worth which a person derives from engaging in a behaviour. The process of modelling also encompasses self-modelling, where people observe themselves perform and make judgements about their performance which either weakens or enhances their perception of SE.

3.6.3 Verbal persuasion

Earlier, in reviewing vicarious experiences, we considered social comparative inference as a means of influencing perceived SE. In particular, the achievements of others who are similar to oneself can be used as an effective tool to influence the perception of one's capability (Bandura, 1997). Verbal persuasion contributes to this social influence. A belief in one's capability is reinforced when significant people express faith in such capabilities, especially in difficult situations (Bandura, 1997). In the face of a difficult situation, a person who receives verbal persuasion of their capabilities will put in more effort and sustain the effort until they achieve their goal.

As Bandura reiterates severally, the sources of SE do not operate independent of each other. It can be inferred therefore, that on their own, each of the sources of SE is limited. Verbal persuasion for instance, although it can greatly support a positive self-change, it can be limited in its potential to produce an enduring increase in perceived SE (Bandura, 1997). Additionally, the effects of verbal persuasion are not constant, and its impact is strongest when the recipient of such verbal persuasion in fact believes that their actions can produced desired effects. If a

verbal persuader tries to sway a person and raises unrealistic beliefs in their capabilities, this will result in failure, thus placing the persuader in a position of disrepute and more dangerously, the recipient's belief in their own capabilities is undermined (Bandura, 1997). In the acquisition of skills, verbal persuasion is also strongly affected by the stage of skill acquisition; exerting significant impact on perceived SE particularly in the early stages.

Related to modelling which we came across when reviewing vicarious experiences, the characteristics of the verbal persuader (now similar to the model) is of vital importance. Bandura argues that the more believable the persuader, the more likely the potential of changing the belief in one's SE and the increased likelihood of holding strongly to this change in belief. For instance, if the verbal persuader demonstrates great aptitude in a skill, or is known to be knowledgeable or has access to objective predictors of performance, then the recipient of their verbal persuasion is more likely to trust and accept the feedback (persuasion). For the FLCH staff, this could be a team leader or a manager, where a 'simple' word of encouragement, or the acknowledgment of their effort in the face of a difficult task could make a significant difference to the belief in one's capability.

Although an important source of SE, verbal persuasion also has the potential to undermine SE. Verbal persuasion can focus on progress and achievements as previously pointed out, but can also focus on failures, shortfalls, and the inability of a person to attain a set goal. If good work and achievements are taken for granted but shortfalls invite ready criticism, SE is weakened (Bandura, 1997). Although issues regarding the attainment of goals need to be raised (for instance to improve performance), the negative impact usually occurs when verbal persuasion is frequently focused on the shortfalls. It may be done with the intention to bring about improvement, but this strategy can undermine SE due to the constant focus on one's deficiencies (Bandura, 1997). This is a critical point of consideration for FLCH staff, as extant literature point to a known pervasive culture of blame and punishment within healthcare

contexts (for example, Gorini et al., 2012; Khatri et al. 2009), and the stress of failure can have additional consequences (Lazarus and Ericksen, 1952). Moreover, blame can also come from sources external to the care home as demonstrated by Studdert et al. (2011). An experimental study by Gorini et al. (2012) in a healthcare context showed that the fear of being blamed was highly prevalent and affect all staff groups. Significantly, they point out that being blamed breeds the feeling of inadequacy. Gorini et al. (2012) also showed that the fear of being punished varied depending amongst staff groups, with the most junior group in the study (student nurses) most affected by the fear of punishment. Gorini's team point out that the variation could be explained by the hierarchal structure of some occupations which is known to be present in healthcare settings. Therefore, punishment being more tangible than blame, coupled with the possibility of being named for an error, could be the reason for the observed variation in the effect of punishment (Gorini et al., 2012). These findings are insightful since in the care home setting, there are also such hierarchical structures, and the most junior in the hierarchy are FLCH staff. Regarding verbal persuasion therefore, if frequent feedback from one higher on the hierarchy breeds a feeling of blame or punishment, this can undermine personal SE.

Despite the negative impact which verbal persuasion can exert on SE when not channelled appropriately, it must be noted that as a source of SE, it does not operate solely. It functions in tandem with the other sources, and together can positively impact a person's SE belief. We now consider the last source of SE, physiological and affective states.

3.6.4 Physiological and affective states

Physiological and affective states as a source of SE refer to somatic (bodily) information and experiences which influence how a person judges their capability. For example, when a person

experiences a stressful or taxing situation, they may experience an arousal of emotions, different mood states and other physiological reactions like sweating. Such cognitive and bodily arousal will often hamper performance (Bandura, 1977; Woodman and Hardy, 2003). These experiences also serve as sources of information by which people partly rely on to judge their level of anxiety, vulnerability to stress, and ability to perform. People expect to perform better without such a heightened state of arousal. Therefore, in such a state of arousal, they judge themselves as vulnerable and question their capability to perform. Furthermore, through what Bandura (1977) terms as the anticipatory self-arousal, such reactions also fuel an anticipation of further similar experiences. Thus, the individual, via anticipation, can arouse themselves to elevated levels of stress and anxiety which can impede future performance. Overall, they come to judge themselves as not able to perform.

To enhance our understanding of physiological states as a source of personal SE, Bandura (1997) points out three factors which must be considered - the perceived source of physical arousal, the level of activation, and construal bias. The perceived source of activation refers to plausible triggers which result in a physiological reaction. A person will appraise their SE based on the interpretation of this trigger. However, by itself, the perceived source of activation can be insufficient or misleading. This is because a number of triggers could be plausible in any given situation, such that different environmental circumstances can result in varied interpretations of the physiological trigger. This potential for varied interpretations can result in ambiguity or misjudgement (Bandura, 1997). For instance, when a FLCH staff member is faced with a difficult shift, a number of factors during that shift could be considered as the physiological trigger. For example, the challenging behaviour of residents, conflict with colleagues, issues with relatives, or a combination of factors. However, the source of the arousal is not considered independently.

The level of activation also plays a role. It refers to the intensity and the interpretation of the emotion experienced, and the subsequent physical reactions produced. It is expected that a degree of arousal will increase readiness for action, but the optimum level will depend on the task at hand (Bandura, 1997). For some people, past experiences and previous bodily arousal largely brings on a readiness for action. For others however, a previous negative interpretation of bodily arousal may drain their motivation or incapacitate them altogether (Bandura, 1997). In combination with the third factor (construal bias), this readiness for action or incapacitation can reinforce a person's belief in their ability.

Construal bias gives an indication of how pre-existing beliefs of SE influence the interpretation of physiological states. If a person previously perceived their SE to be low in a domain of functioning, there is a greater likelihood that they will be more sensitive to physiological (bodily) arousal when performing a task in that domain. In other words, a person may not initially have a strong belief in their ability to perform a task, therefore in subsequent attempts to perform the said task, they will be more aware of their heightened state of anxiety and bodily response (for example increased heart rate). Such an experience can lead to an individual distrusting their ability to cope, thus influencing their SE (Bandura, 1997). For example, in addressing the abusive behaviour of a care home resident, a FLCH staff from past experience may have judged themselves to be less efficacious in successfully dealing with the situation. In the event that they are again faced with the abusive behaviour, they will be more aware of their arousal and bodily responses as they make an attempt to confront the issue. They may in turn, depending on the other sources of SE and other factors, distrust their ability to effectively handle abusive behaviours of residents. There is therefore a cognitive bias which leads to a misjudgement of SE and/or coping in this particular domain of functioning. As with the other sources of SE, it must be noted that simply obtaining information on a person's physiological state and reaction does not solely enable us to establish their perception of SE (Bandura, 1997).

As earlier stated, the four sources of SE (enactive mastery experience, vicarious experience, verbal persuasion, and physiological and affective states) work in concert. Thus, the information on bodily states and reactions, in tandem with other influences of SE will present a better picture of a person's SE.

Bandura's self-efficacy theory has been validated by a plethora of research studies which have investigated and confirmed various aspects of the theory. For example, studies have established various associations between workplace stress, self-efficacy and well-being (for example, Wanberg and Banas, 2000; Siu et al., 2005; Priesack and Alcock, 2015; De Simone et al., 2018; Fida et al., 2018). Furthermore, other studies such as Yu et al. (2019) have shown SE to be positively related to resilience, where resilience is described as the ability or life force to cope more effectively in a healthy and adaptive way (Grafton et al., 2010; Yu et al., 2019). There is also evidence that low SE is associated with higher levels of anxiety and depression (Jex and Dudanowski, 1992; Stetz et al., 2006), increased turnover intentions and withdrawal behaviours (Hayes et al., 2006; Han et al., 2009), and hampered job performance (Le and Ko, 2010).

Drawing on the self-efficacy theory and its predictive power which has been demonstrated in various research studies, the current research posits self-efficacy to be an individual resource which will improve the well-being of FLCH staff. However, SE is domain-specific, that is, SE is specific to one area of functioning. For instance, a FLCH staff may have a strong perception of SE in administering person-centred care, but a low perception of SE in the administration of residents' medication. In the current research, self-efficacy is applied to the domain of improving well-being. Although the importance of well-being is well-established in the literature, and the need to alleviate workplace stress is also well-established, the care home literature seems to be silent on the improvement of the well-being of FLCH staff.

3.7 The conceptual framework

To address the issue of improving well-being, the current research draws on both the SAC and self-efficacy theories to develop a model (see Figure 3.1). The model is also underpinned by the interactive/dynamic relationship between resources and demands in relation to the stress process (Demerouti et al., 2001). This model depicts the experience of an individual – from exposure to a stressor, to appraisal of the situation, to coping, and finally to the outcome. The interest of the current research is how the individual may experience well-being as an outcome of this process, in contrast to experiencing an outcome of strain. This is critical for FLCH staff as stressors per se may not be avoidable. The nature of their job demands an inevitable exposure to a range of stressors, although it is equally vital to investigate stressor-reducing strategies within care home organizations.

To transition from stressor (input) to well-being (output), the model depicts a moderating influence on the stress process, that is, the 'moderating arm' of the model. Central to this moderating arm is the individual resource of well-being self-efficacy (WBSE). This resource is a novel conception based on the self-efficacy theory and is expounded in more detail in Chapter 4. The current research posits that the link between exposure to a stressor and (cognitive) appraisal, and the link between (cognitive) appraisal and coping can both be moderated by WBSE (an individual resource). It also posits that this resource can be enhanced via an intervention. This moderating arm is illustrated in Figure 3.2. The employment of interventions as a means of improving WBSE is considered in the next chapter (Chapter 4).

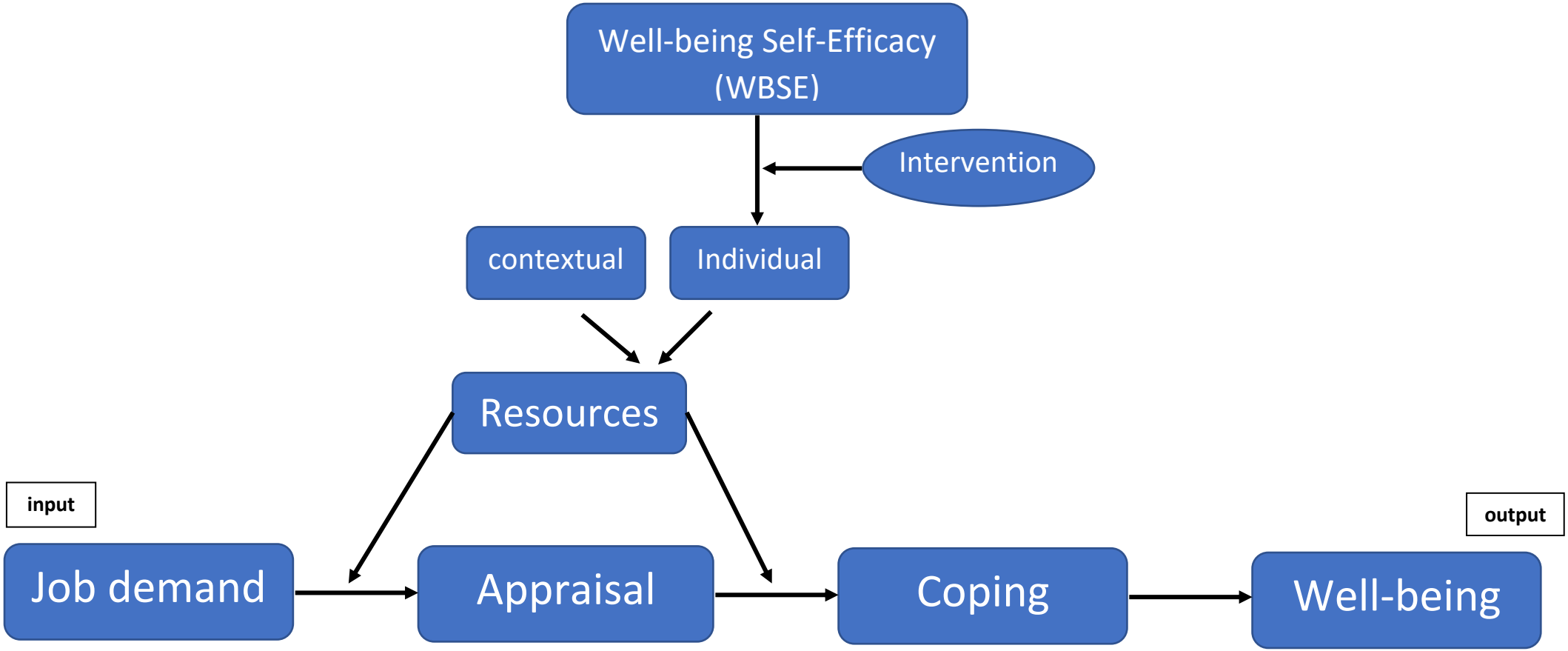

Figure 3.1 Conceptual Framework

The conceptual framework depicts the moderating effect of resources on the stress process, ultimately. These resources are a combination of contextual and individual resources, each making important contributions. However, the interest of the current research is individual resources (WBSE specifically).

In choosing to focus on individual resources, the current study is aware of the issues this may raise. For instance, the concern that taking an individual approach places the onus on the individual to acquire and manage resources for themselves. In addition, sometimes a focus on the individual may create the impression that organisations can relinquish their responsibilities or be minimally involved in the process of employee stress management (Grawitch et al., 2015). Although these arguments are acknowledged, this research argues that the approach to focus on the individual is one way in which the issue of FLCH staff well-being may be addressed. Moreover, managing workplace stress is a joint responsibility of staff and their organization (Hart and Cooper, 2001). Additionally, from extant literature, there is rather a focus on the host of challenges faced by the care home sector, and it is apparent that improving the well-being of FLCH staff has not been a priority. Indeed, it may require time and awareness raising for positive change in this direction to be observed. In reality, positive change will likely require input at all levels, national (possibly international), local government, care home strategic and line management, and from care home owners.

However, while we await these important changes, the FLCH staff currently 'on the floor' (an expression often used in care homes to depict being on-duty working with residents), will need support to alleviate the negative impacts of workplace stress. Well-being is negatively impacted by workplace stress and evidence of this impact for example, is the reported high turnover rate of FLCH staff, anxiety, burnout, and an impact on the quality of care (Shanafelt et al., 2002; Farhenkopf et al., 2008; Cooper et al., 2016). A focus on the individual is one way to influence the well-being experience of the FLCH staff. Moreover, well-being is a wide-

ranging, multifaceted concept which means different things to different people. Focusing on the individual therefore offers an opportunity to particularly tackle well-being from their perspective which potentially increases engagement and the likelihood of a successful outcome.

Whether there is a focus on the individual or the environment (context), for change to occur, the individual often plays a key role. For instance, although an enabling environment (contextual resources) may be created by an organisation which is diligently playing its part to enhance staff well-being, effort is often required of the individual, to harness these resources. This holds true in tackling workplace stress. That is, to alleviate workplace stress and improve well-being, individuals have to effectively manage their stress response, and this again highlights the criticality of the agentic perspective.

3.7.1 The moderating arm of the framework

In the current research we propose that the outcome of the stress process can be changed. We advocate that our understanding of the stress process gives us insight into ways by which the impact of stress (workplace stress) can be alleviated, and the experience of well-being ameliorated. According to the SAC theory, as previously considered in this chapter, when an individual is confronted with a goal-relevant situation or a stressor, there is first a cognitive appraisal which in turn determines the coping strategies employed to tackle the situation. In the conceptual framework presented, this sequence is upheld, but it proposes that there are two possible routes, which lead to two different outcomes (outputs). One of the outputs is strain. This occurs when an individual has insufficient or no resources to tackle a goal-relevant situation. The outcome of their appraisal may be to categorise a stressor as a threat (having the potential to cause future harm), or indeed as harmful (where a damage or loss has taken place in the past). This consequently influences the coping strategies they deploy. With insufficient

or no resources, the outcome is likely strain. Recalling the JD-R theory (Chapter 2), resources have a buffering effect on the impacts of job demands, and also have a motivational effect which can lead to increased work engagement (Demerouti et al., 2001). Demands, on the other hand, will diminish one's resources and can lead to health impairment (strain). The moderating effect proposed, has an influence on both an individual's appraisal and their coping.

Well-being at work has been explored earlier (in Chapter 2), holding benefits for both the individual and their organization. Well-being is therefore a desirable experience, and it is the second possible output proposed in the conceptual framework. To change the first output of the stress process (that is, the strain output), and to have a well-being output, there has to be a moderating influence on the stress process. This influence is presented as the moderating arm of the conceptual framework (Figure 3.2). This moderating arm of the framework includes 'resources', 'self-efficacy' and 'intervention'. For resources however, the focus is on individual resources. Of the individual resources, the interest is self-efficacy, specifically WBSE. To develop or nurture this resource, an intervention is proposed. WBSE and interventions are considered in Chapter 4.

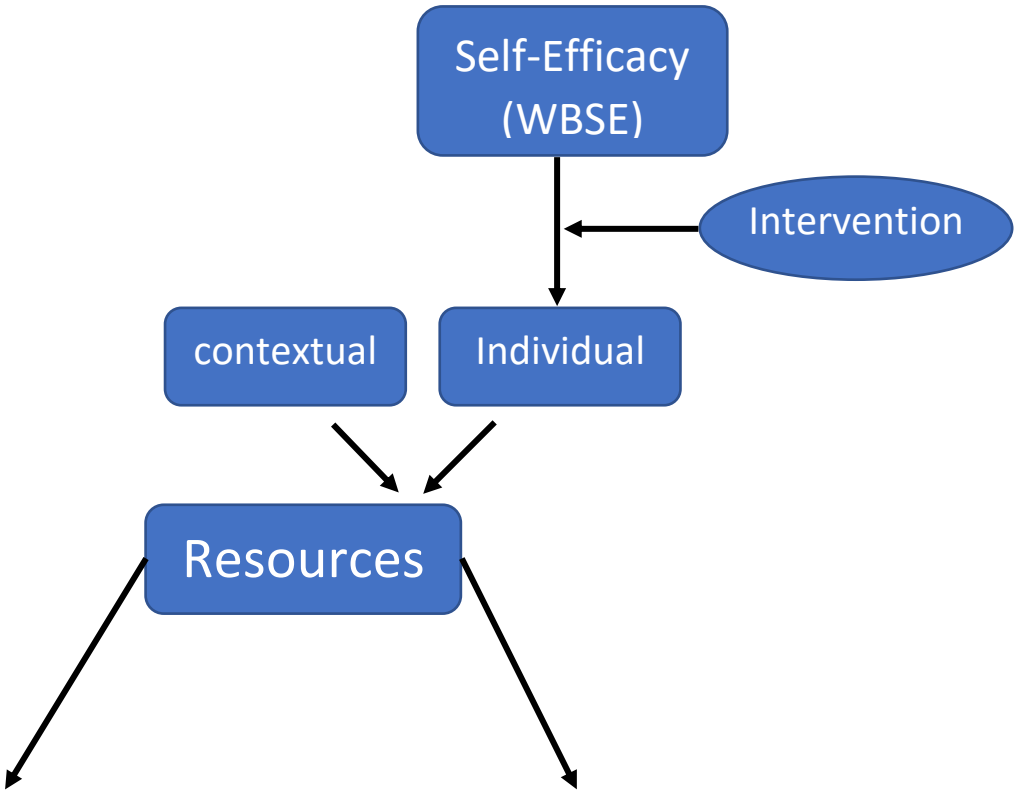

Figure 3.2 Moderating arm of the Conceptual Framework

A critical realist approach (explored further in Chapter 5) seeks to positively transform social, economic, political, and cultural aspects of reality. Thus, in accordance with the critical realist axiology, the current research seeks to explore ways to improve the well-being experience of frontline care home (FLCH) staff (via self-efficacy). Although the literature acknowledges the challenges faced by the care home sector (for example high turnover and high stress), it is silent on ways in which employers and other stakeholders can support their FLCH staff. In some cases, there is an assumption that employers will instinctively know what to do. In this regard, the employer may assume a position of 'knowing what to do', and consequently does not invite employees to participate in the design of workplace initiatives to address workplace stress and well-being.

The SCT theory (Bandura, 1986), states that individuals possess a self-system which regulates feelings, thoughts, motivation, and ultimately action. Being familiar with their role, and the complexities they have to navigate, the current research argues that FLCH staff are in the best position to know what to do, to know what works, to know what is feasible amidst a myriad of challenges. It is therefore logical to explore their well-being experience. Their experiences will be the important element from which any new development/creation is achieved. Thus, in the current research, the first objective is to explore the well-being experience of the FLCH, but to also closely examine what they do to improve or nurture their well-being. In exploring their well-being experience, this research, through the lens of self-efficacy will also examine the underlying belief which a FLCH staff member has in their ability to improve well-being.

3.8 Conclusion

This chapter has specifically focused on the theoretical groundings guiding the current research. Two key theories underpin this research, the stress, appraisal and coping theory (Lazarus and Folkman, 1984), and self-efficacy (Bandura, 1997). Drawing on these theories, this chapter presented the conceptual framework which will guide the research. In a goal-relevant situation, when an individual is exposed to a stressor, a lack of, or insufficient resources in that situation may likely lead to an outcome of strain. The current research takes a critical realist approach of positive change, and seeks to improve the well-being of frontline care home (FLCH) staff (via self-efficacy). Thus, the proposed framework of this research illustrates how the negative impacts of stressors may be attenuated. In other words, presenting the potential of a well-being outcome after exposure to a stressor. According to the model, this buffering effect is via the moderating arm of the framework.

Central to the moderating arm of the conceptual framework is a novel construct, well-being self-efficacy, which is proposed can be improved via an intervention. The next chapter expounds this construct.

4 Well-Being Self-Efficacy

4.1 Introduction

In the previous chapter, the conceptual framework of the current research presented the proposition that the exposure to a stressor may not necessarily lead to an outcome of strain. It proposed that if well-being self-efficacy (an individual resource) is developed or nurtured, a well-being outcome is possible.

The aim of this chapter is to delineate the novel well-being self-efficacy (WBSE) construct. This chapter begins by presenting the nature of WBSE as it considers five dimensions - its domain specificity, contextual link, 'bandwidth' and fidelity, stability, and its distribution and measurement. The chapter also explores how WBSE may exert its influence in a challenging work environment, the role of WBSE in the perception of control, and its influence in the face of change. Finally, interventions are considered as a means via which WBSE may be improved, and the chapter concludes by recapping the identified gaps and the proposed actions to address them.

4.2 Influencing well-being via self-efficacy – the well-being self-efficacy construct

"For in learning to understand, care for and respect your own self and your own well-being, from this naturally comes a deepening care and respect for others happiness and well-being"

- Anonymous

In Chapter 3, we considered the mechanisms via which SE works and the potential influence of SE on the stress process. As discussed in the previous chapter, SE is the belief in one's capability to organise and execute the courses of action to achieve a desired outcome (Bandura, 1997) and it is domain-specific. Indeed, SE in one area of functioning does not automatically translate to the same level of SE in another area. Within the area of well-being, the current research argues for the importance of conceptualising 'well-being self-efficacy'. It is defined as the belief in one's ability to take the steps (cognitive and overt) required to improve one's well-being. In accordance with the conceptual framework (see Figure 4.1), we propose that WBSE will exert influence on an individual's cognitive appraisal, and on their coping efforts. We theorise that high WBSE will be associated with high well-being, in spite of work conditions not significantly improved. Over the course of the studies which will follow in this research, having explored the experience of FLCH staff and what they do for well-being, it is hoped that the definition of WBSE will be better refined, incorporating what the steps may be for FLCH staff.

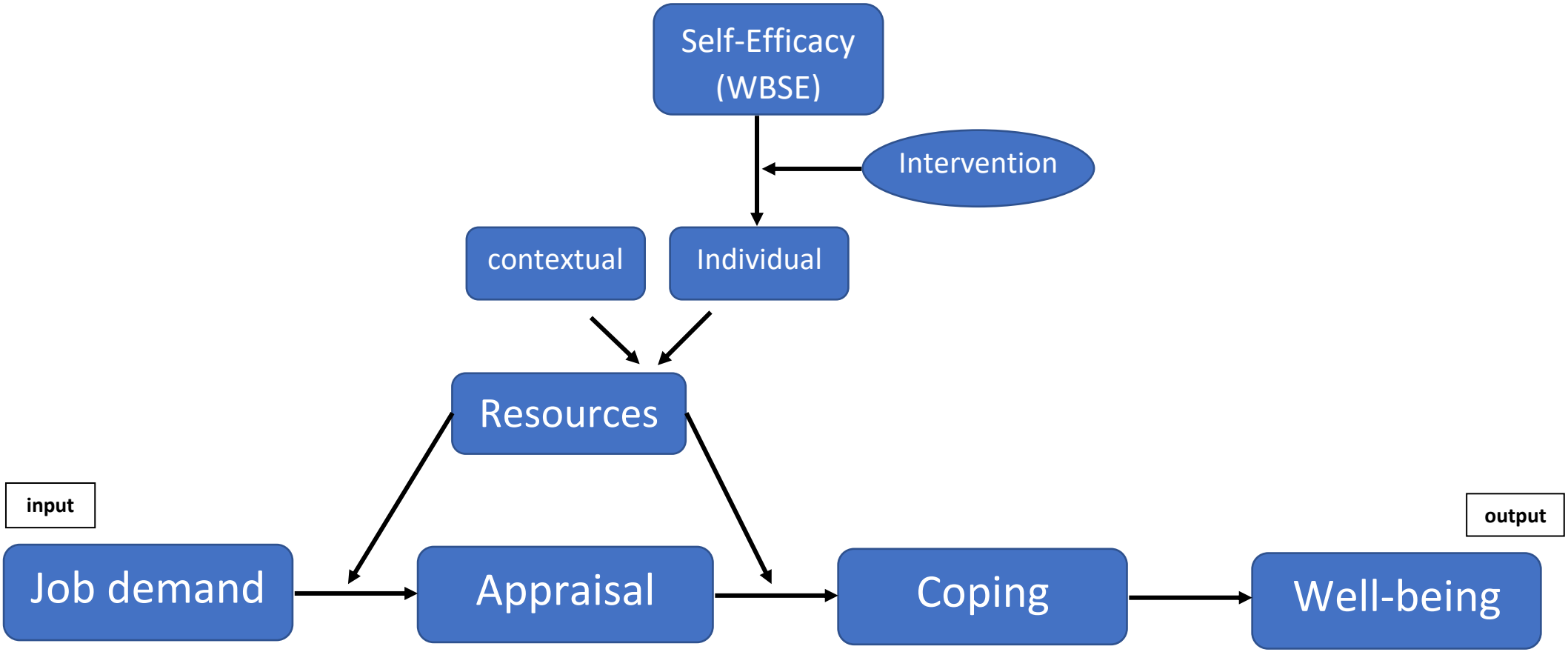

Figure 4.1 Conceptual Framework

4.2.1 The nature of the well-being self-efficacy construct

In delineating the WBSE construct, we explore the following five dimensions; its domain specificity, contextual link, 'bandwidth' and fidelity, stability, and its distribution and measurement.

Domain specificity is a key feature of WBSE. According to the SE theory (Bandura, 1997), SE is specific to a domain. That is, the belief which a person has is related to one specific area of functioning, and with regards to WBSE, this area of functioning is the improvement of well-being. This implies that an individual will be involved in taking steps aimed at improving their well-being. Although the specific area of functioning has been defined as the improvement of well-being, WBSE also applies to a specific context. That is, the steps or efforts of an individual to improve well-being will be undertaken within a particular context. In the current research, this context is the workplace, and more specifically, the care home.

Bandwidth refers to the variability and complexity of the construct in question (Salgado, 2017). A broad construct is one which has a breadth of sub characteristics contained within the construct. Other constructs without this complexity are described as narrow. WBSE is considered a broad construct as it is characterised by varied facets of cognitive function. For example, primary and secondary appraisal, where a goal-relevant situation is cognitively evaluated, and consequent actions assessed. Other cognitive functions related to WBSE are conceptions of ability, of social comparison, and belief in the degree to which one's environment can be influenced (Bandura, 1997) (see Chapter 3). Thus, between the individual and their environment, there is mutual reciprocity, and the individual plays a key role in the interaction as they regulate their feelings, thoughts, and emotions (cognitive function). The variability of complex cognitive functions related to WBSE portray the breath of the construct. Fidelity refers to the specificity of the construct (Salgado, 2017). For instance, whether or not a construct is concerned mainly with numerical ability or verbal ability (a specific construct).

On the other hand, a construct is considered to be imprecise when it is concerned with more general attributes, for example, general mental ability (GMA) (Salgado, 2017). WBSE is classed as being specific, as it relates to a specific belief in an ability which is related to a specified domain.

By stability, we refer to the consistency of the construct over time. The nature of some constructs means that they are relatively stable over time, and typical examples are trait-centred constructs such as temperament (Rothbart and Derryberry, 1981; Derryberry et al., 2003) or personality (including openness, conscientiousness, extraversion, agreeableness, and neuroticism (Goldberg, 1990)). In contrast to being stable over time, other constructs, may fluctuate and change over a relatively shorter period, for example motivation (Schunk & DiBenedetto, 2020). WBSE is not trait-centred, and therefore it can be expected to fluctuate. This malleable nature may be as a result of various influences, for example, differences in perceptions of ability, or regulation of emotions, or varied exposure to sources which may enhance WBSE (Bandura, 1997; Gist and Mitchell, 1992). Additionally, Wood and Bandura (1989) point to the influence of experience, which also contributes to the dynamic and evolving nature of SE. It is expected that exposure to the sources of SE (enactive mastery experience, vicarious experience, verbal persuasion and physiological and affective states), may be the basis of fluctuation in WBSE.

By distribution and measurement, we refer to the kind of change which may be expected and consequently how it will be measured. For example, the measurement of 'satisfaction with life' (Pavot and Diener, 2008) is quantitative and expects change to be noted in a stable and continuous way. Thus, in the measurement of satisfaction with life, a Likert scale is used which depicts an increasing measure/level of the construct in question. Other constructs have a qualitative nature and are often measured categorically. They are typically concerned with the question of whether or not the construct in question is present. The focus is therefore not on an

increasing measure. For example, ‘non-adherence to prescription’, which is concerned with categorising a person as primary non-adherent, secondary non-adherent, and non-persistent (Parker et al., 2015).

WBSE is expected to be measurable, thus an appropriate instrument to measure it will be one which detects incremental difference. The development of a suitable instrument to measure WBSE is considered in Chapter 5 and more specifically in Chapter 6. It is not expected that WBSE will be binary, that is, present or not present. It is expected that people will have some amount of belief in their ability to take steps towards a desired well-being outcome. This outcome is known to the individual and may be personal, since well-being means different things to different people. Furthermore, the abilities upon which the belief of the individual is based may be as a result of first-hand experience on the job, or transferable competences from other aspects of their personal lives. Healthcare and human services are noted to be fraught with some of the highest levels of workplace stress and related sickness (Dollard et al., 2003; Department of Health, 2009). For the FLCH staff in particular, being in such a role, it can be inferred that they develop abilities to help them cope with the nature of their job (the effectiveness of these competences is a separate issue for consideration). Finally, with regards to distribution and measurement, as WBSE is expected to change with exposure to the sources of SE, it is anticipated that an increase on the scale will represent a positive change. An example of this point is demonstrated by the endurance sport self-efficacy scale, ESSES (Anstiss et al., 2018). Increasing scores on the scale represents an increasing strength of belief in physical, psychological and technical abilities relating to endurance sport.

4.3 The influence of well-being self-efficacy at work

WBSE may exert its influence via cognitive appraisal or coping, as specified in the conceptual framework. In Chapter 3, a goal-relevant situation was described as a situation which an individual perceives as having consequences for health and well-being. In exerting its influence via cognitive appraisal, WBSE can potentially influence this perception. For instance, although work conditions for FLCH staff may not be different per se, a strong perception of WBSE may influence an individual's appraisal of a situation at work. For example, the individual may appraise a newly encountered stressor as a challenge (instead of a threat). Also, the individual may reappraise a previously encountered threat (stressor) to be a challenge instead (Lazarus and Folkman 1984). This holds potential benefits for the FLCH staff. In FLCH work, it may not always be possible to eradicate a stressor, for example the challenging behaviour of a resident whose needs have not been fully understood, hence not fully met. Although demanding or difficult, this stressor may be inevitable. If, however, the stressor can be re-evaluated with a more hopeful outcome, there is a possibility of attenuating the negative impact of the stressor. Hence, it is not merely the exposure to a stressor, but an individual's appraisal of the stressor and their coping strategies, which make the difference in the well-being outcome. For FLCH staff, if a strong perception of WBSE enables the re-evaluation of a situation (stressor) as a challenge instead of a threat (that is, having a potential to harm), this re-evaluation can in turn create a sense of control thus alleviating the impact of the stressor instead (Lazarus and Folkman 1984, Bandura, 1986).

Previous studies have documented evidence of the influence of SE on various aspects of the stress process. For instance, how an individual's perception of a stressor can be influenced by their self-efficacy (Bodys-Cupak et al., 2016; Sebastian, 2013). Studies have demonstrated that individuals with higher self-efficacy beliefs are more likely to perceive and report stress levels as being lower, in comparison to individuals with lower self-efficacy beliefs. In their study,

Bodys-Cupak et al. (2016) worked with 394 nursing students undertaking practical classes at a clinical ward. The study aimed to explore how students coped with stress in these ward-based classes, and significantly, whether SE influenced impact of the stressful experiences. The study revealed a significant correlation between participants perception of SE and the level of stress experienced. Students who indicated a higher perception of SE recorded significantly lower levels of stress. Furthermore, the study revealed that the choice of coping strategies employed by an individual was also influenced by their sense of SE. This later point concurs with the study by Jex et al. (2001) who demonstrate that with a higher level of perceived self-efficacy, an individual is likely to take a more proactive approach in dealing with a stressful situation, even at work. SE has also been linked to physiological experiences. Studies have demonstrated that higher levels of perceived self-efficacy modulate a person's physiological response to stress and confer a protective factor on the individual, with positive effects noted on the immune system (O'Leary, 1990).

The second way via which WBSE may exert its influence, as specified in the conceptual framework, is via coping. In papers by Jex et al. (2001), Schwarzer (2001) and Bodys-Cupak et al. (2016), elements of coping are noted. In particular, the act of selecting which coping strategies to deploy is notable. From Chapter 3, we recall that SE can influence a person's behaviour via the selection process. This consequently can influence their choices of activities and the application of their skills (Bandura, 1997, 1986). These choices of activities could be represented by the strategies employed to cope with a stressor. In other studies, SE has been shown to be associated with coping via the selection process. For example, in investigating effective stress management, Bodys-Cupak et al. (2019) examined the experience of 526 medical students in clinical practice. Their study investigated active and avoidance coping. Their findings showed that although participants applied both forms of coping, those with a stronger perception of SE more often chose active coping strategies. On the other hand,

individuals with a lower SE often employed strategies such as denial, the use of psychoactive substances, cessation of actions, and blaming oneself. Active coping was described as the better form of coping, which included the deployment of strategies such as planning, positive re-evaluation, and acceptance, to deal with stress. This was in contrast to avoidance coping, which was considered to be a psychological risk factor in responding negatively to a stressful event. A systematic review by Yu et al. (2019) also found that domain-specific SE was an important resource in the workplace. In the particular domain of well-being, WBSE could also be a useful resource for the well-being of FLCH staff.

4.4 Well-being self-efficacy and the perception of control

As discussed in Chapter 3, there are four psychological processes via which self-efficacy is mediated - the cognitive, motivational, affective and selection processes. They can also have an impact on a person's performance. The notion of control permeates all four psychological processes, each of them having an element of control. We consider each of these processes from the perspective of control, and what this means in terms of WBSE.

The cognitive process concerns the way in which a person's thought pattern can affect their performance, having beneficial or detrimental effects on the quality of performance. According to the cognitive process, these thought patterns can be understood in three main ways, that is, by the conceptions of ability, of social comparison, and by a person's belief in the degree to which their environment can be influenced. For WBSE, it is anticipated that the perception of control will be evident particularly via conceptions of ability and belief in the changeability of one's environment. We recall from Chapter 3 that by conceptions of ability, a person either believes that their ability is inherent (that is, one is born with an ability) or that ability can be acquired. If a FLCH staff member has a malleable conception of ability, that is, they believe

that ability can be increased over time through effort, this confers a sense of control. When faced with a negative situation, the individual is less likely swayed by failures or setbacks, they put in more effort and persevere through difficulties with the aim of improving their well-being (Bandura, 1997). Repeated actions towards improving one's well-being may also improve the individual's ability to strategize, act more effectively, or to develop a certain attitude. We recall from Chapter 3 that this points to enactive mastery experience. Therefore, by mastery experience also, in relation to the cognitive process, WBSE increases. Similarly, if a FLCH staff member believes that their efforts can indeed change their environment, they are more likely to have a stronger perception of control. In essence, they believe that they are not simply at the mercy of environmental/organizational factors, and less likely to feel like victims merely reacting to what comes their way. Without such control a FLCH staff member is likely to feel powerless to effect positive changes for well-being.

The motivational process is concerned with how the processing of past or future events influences self-motivation to act in the present. As considered in Chapter 3, central to the motivational process is the notion of forethought and self-regulatory mechanisms. We recall that forethought serves as the channel via which a person's desired well-being outcome is perceived a possibility. This in turn serves as motivator for action. Thus, an individual will set a specific goal for themselves, one which supports their well-being, and via self-regulatory mechanisms, they will put in the required effort and sustain this effort in order to achieve the goal. The motivational process can be understood via three key factors, that is causal attributions, outcome expectancies, and cognized goals (Bandura 1997, see Chapter 3). Causal attributions are particularly relevant to the notion of control. With high SE, a person considers a successful outcome to be attainable due to a strong belief that by regulating their effort, they can control outcomes. Thus, the person feels in control of what might happen.

The affective process involves the regulation of the nature and intensity of emotions experienced (Bandura, 1997). The notion of control features strongly in the affective process. Unlike the other processes, the affective process is primarily concerned with the notion of control, that is, control over one's thoughts, control over action, and the control over affect. It is anticipated that control over one's thoughts and affect, which are aspects closely related to subjective well-being, will strongly demonstrate the influence of WBSE.

We recall that the control of thoughts is observable in two ways (the interpretation or recollection of events and control over upsetting thoughts). When interpreting or recalling events, an individual may do so in apprehensive ways. An event interpreted or recalled in apprehensive ways may arouse anxiety and raise stress levels. SE can influence control over intrusive upsetting thoughts. Such intrusive thoughts are not discriminative and will occur in both efficacious and non-efficacious people (Bandura, 1997). However, what distinguishes the two groups of people, is the perceived ability to discard these thoughts. Therefore, for a FLCH staff with a strong perception of WBSE, there is a higher perceived capability to put off intrusive upsetting thoughts which come against the desired goal. Being able to discard such intrusive thoughts can consequently ward off additional physiological reactions which arise as a result of thought-induced stress (Bandura, 1997; Testad et al., 2009).

The individual's control over actions has been previously mentioned in various areas of this thesis so far. It is anticipated that WBSE may also exert its influence via an individual's control over the actual steps they may take to improve their well-being. Elsewhere, it has been demonstrated that SE influences the actions which a person takes to modify their environment, in such a way that it is less able to arouse upsetting emotions (Bandura, 1997; Yu et al., 2019).

Finally, the control over affects concerns a person's belief in their ability to improve circumstances when an undesirable emotion has already been set in motion (Bandura, 1998).

In this situation, the individual is faced with an emotion which has already begun, and their perception of SE will regulate how the situation is improved. In relation to improving one's well-being therefore, an individual with a stronger perception of WBSE will believe that they can improve/relieve an unpleasant emotional state, and therefore will not be as aversive of the situation (Bandura, 1994, 1997). These unpleasant emotional states could indeed happen within any individual, however, those with strong WBSE will likely believe that with effort, they can improve/relieve the unpleasant emotional state. This may be by controlling rumination, for example. Rumination can be described as constantly focusing one's attention on unpleasant emotions and the distress caused by it (Nolen-Hoeksema, 1991; Bandura, 1997; Nolen-Hoeksema et al., 2008).

The last of the psychological processes via which self-efficacy is perceived is the selection process. As with the other processes, we note the perception of control at play. The idea of SE influencing an individual's actions has also been previously mentioned. However, before action, there is a selection. With regards to WBSE, an individual with a strong perception of WBSE will not only select actions which will lead to improved well-being, but will likely take on activities which are more challenging, and will persist through the difficulties which they may pose. As well-being means different things to different people, the selection of activities may differ between individuals.

As a process via which SE is mediated, the selection process is of vital importance to the current research, as it is the process upon which all three previous processes depend (that is, cognitive, motivational and affective processes). Only after a person has chosen to engage in an activity, are they able to cognitively develop a pattern of thoughts which either undermine or enhance their performance (Bandura, 1997). Similarly, only after choosing to engage in an activity, is a person able to motivate themselves to exert more effort in it, or for that matter, feel anxious or depressed and give up on the activity altogether. Following the decision to take an action,

continued persistent effort, sometimes enhanced by guided mastery, is what will likely result in the development of a strong perception of WBSE. Guided mastery refers to a structured exposure to threatening tasks by dosing the severity of the threat (Badura, 1994). Guided mastery is often employed to improve SE, for instance improving coping skills in dealing with a threat which impairs functioning. By such guided mastery, a FLCH staff member may be able to better cope with the presence of an 'inevitable stressor'. Although, as mentioned previously, it is also critical to investigate stressor reduction within the organization. Montgomery (2014) for instance, explored burnout amongst physicians and argues that although burnout may be inevitable - the consequence of how systems have been designed - the experience of burnout can be an indicator of how well an organization is functioning.

The perception of control in the stress literature shows that an increased sense of control can influence well-being, and improved well-being can in turn have a buffering effect on the negative impacts of workplace stress, for example in Hatinen et al.'s (2007) study. The perception of control indeed has a part to play in the development and nurture of WBSE. In particular, with the high exposure to stressors at work within the care home sector, an increased perception of WBSE, and potentially the exercise of control, could play a major part in the well-being of FLCH staff. The current research proposes that an increased perception of WBSE will contrast a perception of helplessness in a goal-relevant situation. In essence, it will contrast the perception of inability to control stressors. Furthermore, Gibbons (2010) showed that low self-efficacy is associated with helplessness, anxiety and depression, whereas high self-efficacy is associated with positive feelings which in turn influenced cognitive processes, subsequent motivation and increased confidence. Masoudi Alavi (2014) also argues that SE can enable an individual to function well within in a highly demanding role.

4.5 Well-being self-efficacy and its influence on change

We established in the literature review (see Chapter 2), that the changing role of the FLCH staff, the levels of demands and expectations, and the need to keep adapting to change is a major stressor for FLCH staff. SE has been argued to have an influence on an individual's ability to handle the negative impacts of a changing work environment. For instance, Jimmieson et al. (2004) point out that individuals with a higher perception of SE are more likely to be able to cope with such changes in contrast to those with a lower perception of SE. This is particularly significant for the FLCH staff and the care home sector, where frequent change is a characteristic feature. It is anticipated that if a FLCH staff member strongly believes in their ability to take the steps required to improve their well-being (WBSE), they will evaluate stressors differently, they can develop or deploy strategies that enable them cope better, and ultimately improve their well-being. More practically, we expect to find that individuals with a stronger perception of WBSE will take on more challenging activities/tasks or goals, which they have set for themselves. In addition, we expect to observe perseverance through the difficulties which may arise as a result. We finally expect to observe greater exertion of effort when faced with setbacks, and potential mastery of skills or strategies aimed at improving own well-being. The contrary will be expected, for individuals with a lower perception of WBSE.

4.6 Improving well-being self-efficacy

Having considered WBSE in closer detail, what follows logically is the question of if and how WBSE may be improved. According to the SE theory, we established that WBSE can be improved (see Chapter 3 on the sources of SE). This notion of improving WBSE stems from a central tenet of the SE theory which states that SE can indeed be improved (Bandura, 1986, 1997). This point has been proven by numerous studies (for example, see Chapter 3). In the

current research, it is proposed that WBSE can be improved via an intervention, which will consequently improve well-being, as presented in Figure 4.1.

Although not abundant in the care home literature, there have been various endeavours elsewhere to improve employee well-being in general, for instance, by focusing on employee stress management (for example, Van der Klink et al., 2003), via the development of policies such as the smoking ban in 2007 and its review (Department of Health and Social Care, 2011), organisational restructure or job redesign (for example Pryce, et al, 2006), improving working conditions and support (Galinsky et al., 2004; Jacob et al., 2008) or providing training and resources (Gardiner et al., 2004).

In healthcare settings, interventions have been long used to effect change and to demonstrate impact. Interventions can be described as strategies which are implemented to bring about a specific desired change (Melnyk and Morrison-Beedy 2012). In analysing an intervention, Melnyk and Morrison-Beedy (2012) point out five critical aspects which are required to make an intervention effective. These are, to primarily consider the prevalence of the problem and ascertain the 'so what' factor, passion and sustained effort of the investigator to go through with the intervention, planning, persistence, and patience.

The moderating arm of the conceptual framework (Figure 4.2) includes 'intervention'. The role of the intervention is to serve as a means via which WBSE can be improved or nurtured. Interventions are wide-ranging, and in searching the literature, one observes that the variations are mainly due to differences in the approach, the mode and style of delivery, and the areas of target.

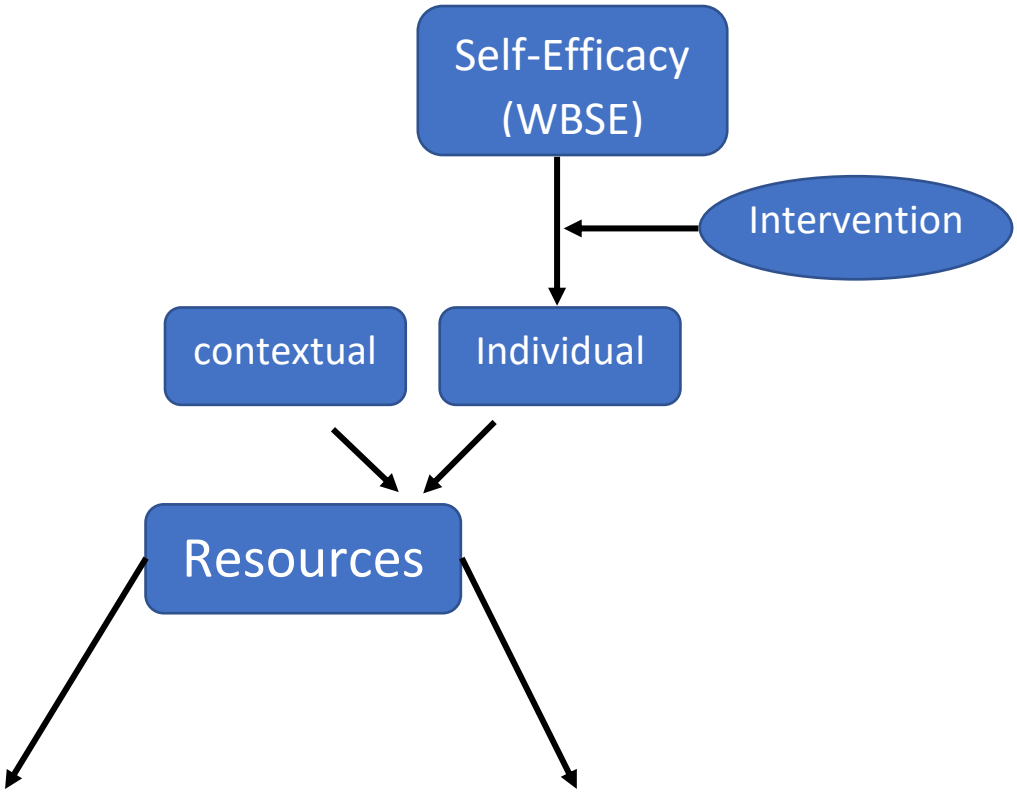

Figure 4.2 Moderating arm of the Conceptual Framework

In the healthcare and care home literature, two styles of delivery are common - training and participation, or a combination of both. Of these two, training is most commonly employed in the care home sector. Training often takes a top-down approach, where an expert, or someone deemed to be knowledgeable about a subject area trains others. Some examples in health care settings and related to well-being are, training on job design (Cohen and Gagin, 2005); training in supervision (Ellis et al., 2015) and train-the-trainer as approach to empowerment (Petterson et al., 2006). Besides delivering an intervention via training, the other common style of delivery is by participation. Participation takes a bottom-up approach, where participants may be involved in various aspects of the intervention, from design, to delivery, and to implementation. In comparison to training, participation is much less used in the care home sector. Some

examples of studies demonstrating interventions which employ a participatory approach include Dahl-Jorgensen and Saksvik (2005), Ayres and Malouff (2007), and Linden et al. (2014).

In particular, taking a participatory approach to well-being interventions at work has been demonstrated to have significant benefits to the success of an intervention. In care home settings, Klaassens and Meijering (2015) showed that otherwise difficult results can be achieved when a participatory approach is taken. For example, unlike Harnett (2010), for whom client-centeredness was difficult to demonstrate, Klaassens and Meijering (2015) in their study pointed out that this was achievable particularly by using a participatory approach with staff. Staff had an input in how the intervention was developed and the day-to-day dynamics of how it was implemented. Klaassens and Meijering (2015) point to a sense of ownership and autonomy as the underlying factors of the positive outcomes of a participatory approach. Brunton et al. (2016) point out that a participatory, hands-on approach has the potential to lead to more successful integration of an initiative. Jagosh et al. (2015) attribute the positive outcomes to the power-sharing feature of a participatory approach. They point out that rather than one party simply being passive recipients, there is a reasonable shared governance and trust between the parties involved in the intervention, and this works out to produce positive outcomes such as effective and sustained solutions. The participatory approach is also seen to be utilised in action research. Action research refers to a research methodology which involves conducting research and taking action on the findings at the same time (Willis and Edwards, 2014). In a care context, Andrews et al. (2012) applied action research to address staff isolation and falls prevention. Their study showed positive outcomes in bringing care staff together and provide evidence to support action learning as a useful tool in translating evidence to practice. Overall, the participatory approach seems to wield greater benefit in care-related contexts.

For each intervention, before a consideration of its approach or mode and style of delivery, there is first a consideration of the specific area(s) of target which the intervention seeks to influence. These areas guide the aims and objectives of the intervention, and ultimately the outcomes. However, as will be explored later in this chapter, these areas are not always made clear and may affect the quality of the intervention. The area of target may also be single or multiple. For example, a single focus on skills improvement and job design (Cohen and Gagin, 2005; Van Wingerden et al., 2017); stress management (Elo et al., 2008; Ellis et al. 2015); or leadership training (Nielson et al., 2010; Biggs et al., 2014). An example of multiple areas of target include a combination of change in job design and training within the same intervention (d'Ettorre and Geco, 2015).

Depending on their approach, mode of delivery and target areas, interventions have sometimes been shown to have positive impacts on work, such as increased job satisfaction (Ayres and Malouff, 2007), improved stress management, and coping (Kawakami, 2006). Even in a treatment setting, for job-related health issues, Hatinen et al. (2007) demonstrated a decrease in burnout amongst workers after 12 months of intervention. Their study compared a traditional treatment intervention with the same traditional treatment regime but included an element of participation. In the participatory group, exhaustion and cynicism significantly decreased in comparison to the traditional intervention group. McCarthy et al. (2011) contribute to the evidence, demonstrating that when staff are engaged in well-being initiatives at work, this not only helps reduce stress levels and improve job satisfaction, but also increases productivity.

Despite their popularity and reported positive impact in care and non-care settings, interventions are not without issues. Evident within the literature are contradictions on the impact/outcomes, and the quality of well-being interventions. A systematic review by Daniels et al. (2017) showed that the effectiveness of staff well-being initiatives has been mixed; sometimes effective, other times not. Some results have been inconclusive, and for others, the

initiatives were simply not evaluated. Such mixed outcomes can make it difficult for organizations to adequately decide on investing in well-being initiatives. Earlier, Bhui et al. (2012) had found these mixed outcomes in their review of reviews. However, Bhui et al. (2012) found that specific types of interventions produced positive and consistent results. At an individual level, they noted that cognitive behavioural programmes produced larger effects consistently in comparison to other types of intervention, for example relaxation. This finding is insightful as it provides evidence base for organizations to invest in well-being initiatives which will have a positive impact (including improving resources) at an individual level.

Nielsen et al.'s (2017) conclusion concurs with this point, but their systematic review and meta-analysis take a slightly different approach of classifying resources. They classify resources into individual, group, leader, and organization levels. This classification means that what may be traditionally considered to be different types of resource, may indeed be grouped into one cluster. For instance, autonomy may be traditionally considered to be related to work engagement (individual level), but according to Nielson et al.'s (2017) classification, this is an organizational-level resource since it is concerned with job redesign. An example of an individual resource according to Nielsen et al.'s (2017) classification is problem-solving. In other words, this classification does not focus on where the effect of a change is observed, but rather focuses on the level at which the change is being made. According to this classification, Nielsen et al. (2017) demonstrate that with regards to resources, there are more studies focused on organizational level resources than the other levels of resources. Thus, they call for more studies which explore individual level resources and how interventions may be used to improve these.

Thus, the conclusions of Bhui et al. (2012) and Nielsen et al. (2017) point to the same focus. They ultimately point to the employee, and they both call for more studies (and potentially interventions), which are implemented at an individual level (for example cognitive

behavioural programmes) (Bhui et al.2012), or implemented at other levels such that the individual is a beneficiary (Nielsen et al., 2017). They both argue that the mixed outcomes challenge of well-being interventions is largely due to minimal, or lack of, research evidence, and thus more studies are needed.

Also, related to mixed outcomes, is the issue of specificity. As stated earlier, well-being means different things to different people, therefore an intervention aimed at improving well-being could potentially affect a variety of aspects. Briner and Walshe (2015) point out that the impact of a well-being intervention may also go beyond the precise intentions of a particular intervention, thus there is a risk of losing clarity on its exact impact. Although such secondary outcomes of an intervention cannot simply be controlled for, Briner and Walshe (2015) point out that a way to tackle this is to state clearly, the aspects of well-being which the specific intervention aims to improve or change.

With regards to quality, various researchers have raised the issue of the quality of well-being interventions in the workplace, calling for high quality interventions. For example, Hill et al.'s (2016) and Williams et al.'s (2018) systematic reviews unmistakably point out the need for high-quality design and evaluation of interventions, especially psychosocial interventions, aimed at improving well-being. Although acknowledging the difficulty in facilitating interventions within care contexts, which are similar to the care home, they point to the poor development and evaluation of interventions as the reason for the lack of meaningful conclusion on the effectiveness of psychosocial well-being interventions. There are key factors which frequently feature in the debates on quality, and Briner and Walshe (2015) capture these clearly. They argue that little research has examined well-being interventions in terms of design, implementation, and evaluation. They further argue that owing to this small body of work on well-being interventions, academic worth and practical value are limited. Although Briner and Walshe (2015) interpret quality in terms of a controlled/experimental design, which

may not always be feasible in a care home context, their argument on the need for clarity in design, implementation and evaluation is echoed by other studies.

Of the various areas highlighted in the literature regarding quality of interventions, evaluation is the most prominent. Karanika-Murray et al. (2016) argue that the evidence of what works is weak. They further argue that when what works is known, there is also a weak link often between the evidence of what works and the implementation of this knowledge. On why the evidence of what works is weak, they particularly point to the use of wrong tools for the job. In other words, evaluating interventions wrongly can lead to various issues including being described as ineffective. Additionally, Karanika-Murray et al. (2016) draw our attention to the point that this weak link presents a missed opportunity to develop evidence-based practice. In line with this point, following a systematic review of psychosocial interventions to improve staff well-being, Hill et al. (2016) pointed out that a number of studies they reviewed showed beneficial secondary benefits to the staff, such as improvement in team building, increased professional fulfilment, improved quality of relationships, and increased emotional awareness. However, the studies were mostly quantitative and did not have these benefits as their primary outcomes. Following Karanika-Murray et al.'s (2016) 'wrong tool' argument, these interventions would consequently be classed as ineffective relative to the delivery outcome. Meanwhile, these secondary benefits all potentially have an impact on well-being, and cannot be simply ignored.

The evaluation of an intervention is a vital component in reporting its outcomes. Having said this, evaluations of subjective concepts such as well-being, in addition to the self-reported measured measures often used, make it challenging for researchers to robustly demonstrate the effectiveness of well-being interventions. Some researchers (for example, Briner and Walshe, 2015) call for the use of randomised control trials (RCT) to improve the quality. However, RCTs may not be feasible for organizations, particularly for care homes with their intricate

interconnections. Moreover, such experimental designs, including RCTs, are used in order to establish causality (Melnyk and Morrison-Beedy 2012). Although the clinical aspects of a care home may benefit from such experimental approaches, the subjective and lived experiences within a care home may not be fully captured via such quantitative means. Thus, with no standardised measures to establish quality, there may be a plethora of criteria to assess the quality of interventions. Indeed, it is a difficult task to determine a standardised set of criteria to assess the quality of an intervention. The current research however argues that a well-evaluated intervention, which demonstrates how change occurred, can help in addressing the 'weak link' which Karanika-Murray et al. (2016) refer to. To address the 'wrong tool' which they also refer to, there is no one-size-fit all approach, and Karanika-Murray et al. (2016) argue that interventions may develop their own fit-for-purpose tool. This 'purpose' however, will need to be clearly stated. As earlier pointed out, such lack of clarity contributes to the issue of quality. Biron and Karanika-Murray (2014) argue that based on the set aims of an intervention, it may be wrongly regarded as unsuccessful or ineffective, whereas it might have made a significant impact in other areas. Evaluating adequately, will provide the opportunity to capture such secondary outcomes and provide alternative explanations to the initial aims.

Despite the issues raised on interventions, there has been an increase in the use of interventions in the health sector to improve staff health and well-being (Williams et al., 2018). In the past six years, there have been almost as many studies on health and well-being interventions published as the entire decade before (Williams et al., 2018). This may be a positive trend, and Williams et al. (2018) argue that this observation demonstrates the increasing awareness of the impact of interventions, however, there is a need for a demonstrable evidence base. In concurrence, Hill et al. (2016) in their systematic review, conclude that there is an urgent need for interventions aimed at improving the well-being of care staff, calling for high-quality

research in the area of palliative care. Islam et al. (2017) in a national survey reiterate this point, highlighting the need for interventions aimed at reducing stress amongst staff in care settings.

In light of the evidence on a participatory approach, considered earlier, the proposed intervention in the current research will take a participatory, staff-led approach. A participatory approach means that participants are involved in various aspects of an intervention such as its design, implementation, evaluation, and subsequent improvement. In the current research, the potential participants, FLCH staff, will be involved partly in the design, strongly lead on the implementation and will be involved in the evaluation of the intervention. The details of these will be outlined in the methodology chapter (Chapter 5).

A staff-led approach is being employed in order to encourage participants to take ownership of the intervention process, which has been proven to improve engagement (for example Klaassens and Meijering, 2015). In addition, the hands-on staff led approach offers the opportunity of mastery. As Bandura (1997) points out, when a person engages in a certain action enough times and under varied circumstances, this experience can strengthen their perception of SE.

4.7 Moving forward – bridging the gaps

The substantive focus of the current research is the well-being of FLCH staff, but in particular, the current research also aims to explore ways to support their well-being. Having considered the benefits of improved well-being (see Chapter 2) and the potential benefits of improved WBSE (see Chapter 3), the current research proposes the employment of an intervention as a means to influence the well-being of FLCH staff, via improving WBSE.

Interventions have been reported to often be of poor quality and have mixed outcomes. From the literature, these assessments of poor quality and mixed outcomes are often related to key characteristics such as aims, design and evaluation.

i. Aims have been described as being ambiguous, with targeted areas of influence unclear.

ii. The underpinning principles and evidence base of intervention design are unknown or unidentified.

iii. Evaluation of the intervention is not conducted or not robust.

To address these gaps identified, the current research aims to clearly present the aims, design and evaluation of the proposed intervention in the appropriate chapters of this research. In addition, this research proposes a realist evaluation of the proposed participatory staff-led intervention (Pawson and Tilley, 1997, 2004). The realist evaluation is an evaluation which is not simply concerned with whether or not an intervention worked, but more concerned with how, for whom, and under what circumstances the intervention worked or did not work (Manzano, 2016; Pawson, 2006b; Pawson and Tilley, 1997; Westhorp, 2013; Nielsen and Miraglia, 2017).

The realist approach to evaluating an intervention focuses on the context, the mechanisms, and the outcomes. In its examination of why it worked or why it did not work, a realist evaluation provides robust information on an intervention. Since a realist evaluation does not simply conclude on the success or failure of an intervention but offers the opportunity to 'see' from different angles, it is hoped that it will help address the gaps identified on well-being interventions in healthcare settings. Details on the realist evaluation are presented in Chapters 5 and 8. It is anticipated that by taking these steps to address the gaps related to interventions, the benefits of interventions will be gained in the current research.

The ‘happy-productive’ worker idea (Wright and Cropanzano, 2000) implies that when employee well-being is high, they consequently perform well, but when well-being is low, the reverse is the case. Should care home owners, managers, and other stakeholders begin to prioritise the well-being of FLCH staff, understanding and guidance will be required in order to support them to take steps towards improving and/or nurturing staff well-being. It is hoped that the current research will contribute to our understanding and offer some guidance on how to better support FLCH staff in their role.

4.8 Conclusion

This chapter focused on delineating well-being self-efficacy, the individual resource of interest in the current research, and considered how it may exert its influence. In accordance with the self-efficacy theory, WBSE can be altered. The proposed means by which WBSE may be developed was via an intervention. The chapter explored the role of interventions in bringing about change and it reviewed the current state of knowledge on interventions mainly within healthcare settings. This chapter showed that although interventions have been demonstrated to have benefits, issues of mixed outcomes and poor quality are predominant in extant literature. The chapter ends by outlining identified gaps and proposed actions to address these gaps, including the application of a realist approach in the evaluation of an intervention.

The next chapter is on the research design and methods of the current research. It presents the overall plan of the research, the research questions, and how each research question will be addressed.

5 Research Design and Methods

5.1 Introduction

The previous three chapters have laid the foundation for the current research. These chapters presented the state of knowledge, gaps in our knowledge, and a proposed conceptual framework to address these gaps.

The aim of this chapter is to justify the research philosophy and design of the current research. Research philosophy refers to the assumptions upon which the current research is based, and they underpin the design of the research (Crotty, 1998; Delanty and Strydom, 2003). Research design refers to the design of the studies comprising the current research (Braun and Clarke, 2013), showing the strategy of how each study contributes to answering the research questions, and to the overall research. In the current research, a mixed methods approach was taken, with a sequential design involving three independent but interconnected studies.

The chapter begins by examining research philosophy and its significance. It then considers elements of the research process and the role each one plays. The chapter then presents the philosophical position of the current research. Following this, the chapter proceeds to outline the research strategy of the current research, presenting the three studies of the research.

5.2 Research Philosophy

5.2.1 Why is it important?

When we seek to carry out a piece of research, there are fundamental points which must be addressed. Crotty (1998) describes this as putting in considerable effort to answer the question of what methodologies and methods are to be employed, and why those choices. To begin with, the research question(s) being asked by the researcher will guide the choice of methodology and methods. However, in an attempt to justify our choices, we reach into our assumptions about reality, and into our understanding of what knowledge is, what characteristics it has and the kind of knowledge we can obtain from our research (Crotty, 1998). These assumptions which we bring to the research will influence our understanding of any phenomenon to be studied. It will also influence our decisions in the design details of our research. Thus, an understanding of these assumptions, from the researcher's point of view, gives clarity to the research design. Critically, Crotty (1998) points out that it creates a framework for how our readers regard our findings and the value they contribute. He adds that it brings soundness to research and offers convincing outcomes.

5.3 Four elements of the research process

Reaching into our understanding of reality and knowledge is a deliberation on ontology and epistemology. Epistemology informs the theoretical perspective and subsequently, the methodology and methods employed for a specific research (Crotty, 1998; Delanty and Strydom, 2003; Grix, 2004). In other words, our understanding of the nature of knowledge and how we can attain it (epistemology), will influence our view of the world, of reality and how we make sense of it (theoretical perspective), which in turn influences our decisions on methodology and methods. Crotty (1998) states that these four elements to research (epistemology, theoretical perspective, methodology and methods) are interrelated. With this

understanding, these four elements of the research process are considered, and in doing so, the position of the current research will be presented. Although Crotty does not emphasise ontology as one of the four elements, extant literature shows that ontology is a prominent element of the research process. Ontology is therefore considered alongside the four elements Crotty refers to.

5.3.1 Ontology

This refers to one's ideas about reality. The word is derived from the Greek words 'on' and 'logos', which mean 'being' and 'theory' respectively. Put together, they give the meaning of ontology to be 'the theory of being as being'. In clearer words, 'the theory of the nature of what is' or 'the theory of the nature of reality' (Delanty and Strydom, 2003).

Ontology (implicit or otherwise) is the very first consideration regarding research as it plays a vital role in the rest of the research process. Grix (2004) says of ontology (and epistemology), they are like the footings of a house, forming the foundations of the entire edifice. When a researcher ponders on reality, they consider questions and assumptions about the kinds of reality which exists regarding the entity or phenomenon to be studied. For instance, is there a single verifiable objective reality, or are there multiple subjective realities which are for instance socially constructed (Patton, 2002)? In the social sciences, the dichotomy of subjective versus object reality is prominent. An objective position considers reality to be existent and independent of our knowledge of it. A subjective position considers reality to be constructed subjectively and does not exist independent of our knowledge of it (in other words, it exists because we know of it).

5.3.2 Epistemology

The word epistemology is derived from the Greek words ‘episteme’ and ‘logos’, which mean ‘knowledge’ and ‘theory’ respectively. Together, these give epistemology its meaning, that is, ‘the theory of knowledge’ (Delanty and Strydom, 2003).

Having considered and established what reality is, epistemology is the component of the research process which is concerned with what can be known about this reality (Gall et al., 2003). It primarily concerns the nature of knowledge, that is, the kinds of knowledge that exist, the limits of knowledge, its structure, its origin, and also how we can ensure that this knowledge is legitimate and adequate (Delanty and Strydom, 2003; Maynard, 1994). In addition, epistemology is also concerned with how this knowledge, once obtained, can be communicated to another person (Cohen et al., 2007). There are two common epistemologies in social science research, objectivism and constructionism.

Objectivism is often informed by an objective view of reality (ontology). In objectivism, there is one true reality, and therefore what is to be known and understood is objectified in the people being studied, and this knowledge was already in existence prior to any awareness of it (Crotty, 1998). Empirical investigation and objective measurements will therefore be employed in a research underpinned by objectivism (Sarantakos, 2005), and if done properly, objective truth can be discovered (Crotty, 1998).

Constructionism is informed by a subjective view of reality (ontology). Constructionism does not assume an objective truth, but rather assumes that there are multiple truths, and multiple socially constructed realities exist (Sarantakos, 2005). It assumes that the interaction between us and the realities in our world is what creates truth (or meaning). Thus, there is no objective truth but many, arising from different people creating meaning in just as many different ways (Crotty, 1998). Clearly, the ontological position of a constructivist research will be one which

views reality as being subjective. Qualitative investigations are the favoured approach in this type of research, and the approach places great value on the individual perspective and interpretation.

Thus, it can be seen that an epistemological consideration will be to deliberate on whether knowledge is being objective or not (Patton, 2002). The epistemological stance is informed by the ontological position of the researcher. For example, if the researcher considers reality to be single and verifiable (ontology), this means they consider knowledge to be objective (epistemology), and therefore take a position of objectively detaching themselves and their values from the entity being studied, so as not to interfere with the findings of how things really are or how they really work (Guba and Lincoln, 1994; Crotty, 1998).

5.3.3 Theoretical perspective

The theoretical perspective of a research is strongly influenced by its epistemology. It is also commonly referred to as the research paradigm, or the philosophical stance. Its gives clear insight into the decisions which have been taken regarding the methodology and methods in a research study. There are various theoretical perspectives, and it is beyond the scope of the current research to cover these. However, in extant literature on health and well-being, four of these perspectives are common, positivism (and post-positivism), interpretivism, critical theory, and realism. Positivism seeks to gain an accurate knowledge of the world, where knowledge is grounded in what is clearly observed and not speculated, not interrupted by human experience (Crotty, 1998; Guba and Lincoln, 1994). In contrast, interpretivism aims to gain knowledge through human experience, history and social reality (Crotty, 1998; Blumberg et al., 2014). Unlike interpretivism which seeks to understand, and accepts the findings which are attained from observing interaction and community, critical theory does not simply accept

these observations, but seeks to bring change (Crotty, 1998). A research based on critical inquiry will therefore critique the status quo and aim to transform social, economical, political, and cultural aspects of reality (Perry et al., 1997). Realism views reality as independently existent, however, it cannot be fully discovered or apprehended (Healy and Perry, 2000). This reality can be interacted with, and knowledge of it can continue to improve but cannot be final (Furlong and Marsh, 2002; Westhorp et al., 2011). For further reading on these theoretical perspectives, see Creswell and Poth (2018), Given (2008), and Schram (2002).

5.3.4 Methodology

The word methodology is derived from the Greek words ‘methodos’ and ‘logos’, which mean ‘way/procedure for the attainment of a goal’ (for example the goal of attaining knowledge). Together this gives the word ‘methodology’ its meaning, ‘theory of the way/procedure by which knowledge is acquired’ (Delanty and Strydom, 2003).

The methodology of a research concerns our thoughts on exactly how the research goals will be met or how the research questions will be answered. The methodology lays out the strategy or action plan for the research, and its critical analysis (Blaikie, 2000; Crotty, 1998). The methodology is informed by the ontology, epistemology and theoretical perspective of the research, ensuring that all these elements relate coherently. A mismatch of these elements will affect the clarity of the research, or may cause its findings to be questionable (Crotty, 1998). This element of the research process provides a rationale for the decisions made, as it considers the theoretical underpinnings of the research and the procedures and techniques which are best suited to the theory. Some examples of methodology include survey research, action research or experimental research (Crotty, 1998).

5.3.5 Methods

Having established a stance with regards to ontology, epistemology, theoretical perspective, and methodology, the methods are the exact steps to be taken in order to attain the research goals. Methods are thus the procedures or techniques which are employed in the collection and analysis of data (Blaikie, 2000). The researcher presents the procedure and provides rationale for the decisions made, including a clear demonstration of how the collection and analysis of data enable the research goals to be met, or research questions answered. Some methods of collecting data include focus group, administering questionnaire, and case study. For the analysis of data some examples include thematic analysis and statistical analysis.

5.4 Ontological position and rationale of the current study

The ontological position of the current study considers reality to be both objective and subjective. This is a position of critical realism (Bhaskar, 1979, 2013). It is a departure from the dichotomous view of reality, to one which draws on elements from both positions. Denzin and Lincoln (2011) show that this position developed as an alternative to the positivist and constructivist stance. This alternative ontological position acknowledges objective reality or a real social world which exists independent of our knowledge of it (Danermark et al., 2002). However, this real social world can also be interacted with in such a way that causal mechanisms which drive social events, activities or phenomena can be understood to some extent (Fletcher, 2017), enabling us gain better knowledge of reality. However, this knowledge may be fallible and therefore not a complete picture of reality (Sayer, 2000). This alternative ontological position thus takes the view that what is real cannot be fully captured by human knowledge (Danermark et al., 2002; Fletcher, 2017).

In critical realism (CR), reality is stratified into three domains namely the empirical, actual, and real domains. At the empirical domain of reality, events are experienced and can be observed. Actors have perceptions, sensations, impressions of reality (Lecca and Naccache, 2006). From this domain, a researcher is able to gather tangible empirical data for the specific research. It is important to note that this gathering of information is purely through the experiences of people, and their interpretation of experiences. The actor may express, or the researcher may observe this experience. At the actual domain of reality, events occur independently of human experience and interpretation. In other words, they occur whether or not they are observed or experienced. Lecca and Naccache (2006) point out that some events may escape an actor's perception, but a researcher, due to their focus and training, may be able to identify such events. At this domain, scholars develop theories which explain various phenomena (Lecca and Naccache, 2006). Finally, at the real domain, causal powers and structures are responsible for producing events. Causal powers which are invisible, interact with structures or entities to produce causal mechanisms. These mechanisms then act as the forces which lead to events. In other words, what is observed or experienced at the empirical domain is a result of causal mechanisms possessed by certain entities or structures. These entities or structures may be visible (such as a social care policy) or invisible (such as ideas), although in the social world, they are often invisible. It must be noted that not only the presence, but also the absence of causal mechanisms can produce an event.

From a realist perspective, the world exists, and it does so independently of our ideas, or what we think of it. As such, the causal mechanisms at the real domain are in operation and are not particularly related to the specific study being conducted. Lecca and Naccache (2006) describe this attribute as being transfactual. Figure 5.1 illustrates these domains of reality in relation to the current research.

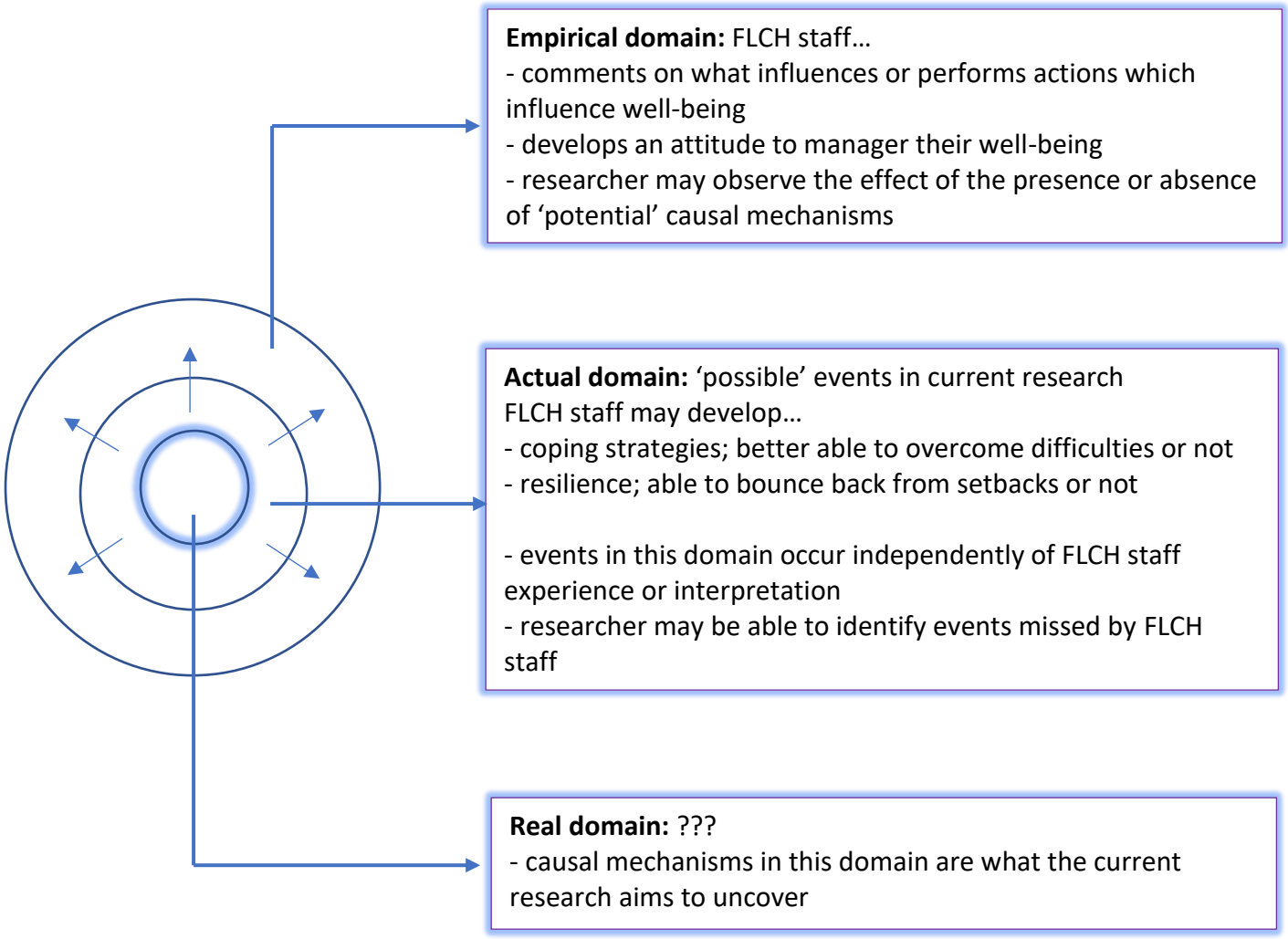

Figure 5.1 Three domains of reality in critical realism
and their relationship to the current research – a possible scenario

Figure 5.1 is an illustration of just one possible scenario. In practice, the social world comprises of multiple and extensive entities or structures, each of which have casual forces (via causal mechanisms). Furthermore, the causal force of one mechanism may initiate another

mechanism, thus causal mechanisms may be interdependent. Therefore, with this extensive web of mechanisms, at any one point, or in any one situation, there is a vast array of mechanisms at play. The CR research aims to uncover these mechanisms as much as is possible within the constraints of the research.

One foundational principle of CR is that the world is not determined by theories, rather, it is laden with theories (Fletcher, 2017). Therefore, in an attempt to gain knowledge about the world, CR engages in explanations and causal analysis (Fletcher, 2017). According to this theoretical perspective, underlying all observable or experiential events, are causal mechanisms (Danermark et al., 2001). Understanding events through the lens of these causal mechanisms brings us closer to understanding reality, and this is the aim of CR. Psillos (2007) also gives further insight by stating that the context in which events (observable or experiential) occur will affect these causal mechanisms. In other words, the mechanisms may be restricted or facilitated resulting in a change of what is observed or experienced. As earlier alluded to, knowledge of these mechanisms is gained by considering human experience, their activities and interpretations. Bhaskar (1979) argues that without such activities, knowledge may not be attained, indeed, it is human experience and interpretation which give insight into the world. The axiology of CR points to the need to analyse and positively transform social, economical, political, and cultural aspects of reality. Applying this axiology to the current research, CR seeks ways to improve the well-being experience of frontline care home (FLCH) staff.

Methodologically, this view of underlying mechanisms serves as a guiding principle. As CR research aims to uncover causal mechanisms, methodologies which will enable the research to achieve this aim need to be employed. Additionally, since knowledge of reality is gained by investigating events, and these events are understood through human experience and interpretation, there is great value placed on an agentic perspective. Although there is a theoretical framework guiding the current research (top-down), the involvement of participants

also gives the research a bottom-up input. This participant involvement is in line with CR principles and enables the agentic perspective to be a primary focus.

In line with this, methods which enable the current research gain answers to questions of what, why, how, for whom, and when, are of importance. Such methods are essential to the CR research. However, CR research is not restricted to either qualitative or quantitative methods, it employs the most suitable means to achieve the research aims. Since it draws from the objectivist and subjectivist stance, often, a mixed method approach is taken in order to gain as much insight into reality as possible (Guba and Lincoln, 1994). In Study 1 of the current research, focus groups are facilitated, in Study 2, a survey is conducted, and Study 3 is a participatory, staff-led intervention study. Additionally, in line with CR, a realist evaluation is employed in the evaluation of the intervention in Study 3. More details on the studies are given later in this chapter.

5.5 Ethics

Ethics approval for this research was granted by the Faculty of Medicine and Health Sciences, University of East Anglia.

5.6 Research strategy

This section of the chapter focuses on the three studies which comprise the current research. It presents the design of each one and shows how evidence from each of these studies answers specific research questions. Each study therefore contributes to the overall research in specific ways. In line with CR, the current research also takes an exploratory and participatory approach as it explores the world, experiences, and interpretations of FLCH staff using the lens of self-efficacy. As a reminder, the research questions of the current research are:

1) What do FLCH staff do to improve and/or maintain their well-being at work?

2) Can WBSE be measured?

3) Can a participatory intervention, tailored to a care home setting, enhance WBSE, and uncover some mechanisms via which WBSE is enhanced?

A mixed methods approach was taken in the current research. From a critical realist viewpoint, the experiences and interpretations of participants are critical to obtaining knowledge, and as earlier pointed out, this knowledge resides in three domains – the empirical, the actual, and the real. In accordance with the critical realist position, data at the empirical domain of reality (see Figure 5.1) represents the experiences of individuals; their perceptions, sensations, and impressions of reality (Lecca and Naccache, 2006). This data gathered at the empirical domain may involve both qualitative and quantitative methods (Pawson and Tilley, 1997). In the current research, taking a mixed methods approach which employed both qualitative and quantitative methods presented a suitable approach to obtain knowledge. This approach, in line with critical realism, draws from both objectivist and subjectivist stance, thus offering the opportunity to gain much insight into the experience of FLCH staff (Guba and Lincoln, 1994).

5.7 Interconnection of the studies

The overall research design took a sequential approach, where some of the outcomes of a previous study inform the development of specific aspects of the following studies. In this way, the studies were interrelated, although each one primarily contributed to answering a specific research question.

This multi-study design of the research also lends its itself to the critical realist position of the research, as CR does not assume a singular, measurable, or observable view of reality.

According to CR what is observed is influenced by structures and mechanisms. Thus, each study contributes to a clearer understanding of reality via providing observed data and/or uncovering mechanisms which potentially influence the observed. Figure 5.2 presents the three studies and their interrelations.

Furthermore, to ensure trustworthiness of the findings, various validation procedures were incorporated into the design of the overall research. This includes the triangulation of data across sources by employing a multiple case approach and a combination of data collection methods, consultation with experts external to the research, and iteration over a period of time. Details of these approaches are set out in the summaries of the studies in sections 5.8-5.10, and in more detail in chapter 6 (Study 1), chapter 7 (Study 2), and chapter 8 (Study 3).

Various validity procedures (Cresswell and Miller, 2000) were also employed to provide a robust assessment of the programme theories (hypotheses) in Study 3. This involved triangulation of data between participants from the same care home, across the care homes, and across time periods. Additionally, the process of analysis was iterative, where the researcher presented findings to participants for further assessment.

5.8 Study 1: Focus groups

The aim of Study 1 was to generate the potential items for a novel well-being self-efficacy (WBSE) scale. To answer research question two, 'Can well-being self-efficacy be measured?', a new scale was developed as no existing scale was appropriate. This is in accordance with the self-efficacy theory. Since self-efficacy is domain specific, an appropriate scale must be used to capture the specific construct under study (Bandura, 2006). To generate the potential items for this new scale, focus groups were employed.

Focus groups involve discussions with participants in a relatively unstructured but guided way (Braun and Clarke, 2013). This option offered the opportunity to gain a deeper understanding of participant's experience. Furthermore, during focus groups, interactions of participants, agreeing, disagreeing, or questioning each other may provide further insight into what is being studied, and the participants can explore a topic deeply and naturally, giving the researcher further insight (Braun and Clarke, 2013). In addition, Wilkinson (1998) points out that novel or unexpected knowledge can be revealed through focus groups. Focus groups are valuable when in-depth and wide-ranging views are desired (Wilkinson, 1998). In the current research, a wide range of views with in-depth exploration was important in the generation of items, thus employing focus groups was a preferred option.

With self-efficacy as the guiding theory, the focus group discussions also involved exploring actions which participants took to improve and/or maintain their well-being. Participants discussed the background to their experience and other situational information which they believed was pertinent to their accounts. Goal-relevant situations (as encountered in Chapter 3) (Lazarus and Folkman, 1984), are situations which are perceived as having consequences for health and well-being. Although participants spoke naturally about their day-to-day experiences, it was important to capture situations which they believed were particularly critical to their well-being (goal-relevant situations). To do this, the critical incident technique (CIT; Flanagan, 1954) was incorporated to the focus groups. The CIT involves collecting information on human behaviours during a critical incident/event, with the aim of using this information to solve problems or develop principles (Flanagan, 1954). This technique was developed from studies involving the United States Army Air Forces in World War II, and aimed to develop procedures for the selection and classification of aircrews.

In the current research, the aim of its use was firstly, to prompt participants' recollection of events, and to further familiarize them with the kind of discussions to expect. Secondly, the

CIT was used to further document first-hand reports of positive and negative events at work. It helped to capture participants' exact actions at the time, their mental state and reasoning at the time. These details gave insight into the belief of the participants as they recounted their experience. Thirdly, by using the technique, participants who were not inclined to deeply analysing their experience openly had the opportunity to document and contribute their experience.

Study 1 was qualitative. The data analysis technique employed was thematic analysis (Braun and Clarke, 2006). The procedure of the focus groups, findings and discussion are detailed in Chapter 6.

Study 1 contributes to answering research questions one and two:

1) What do FLCH staff do to improve and/or maintain their well-being at work?

2) Can well-being self-efficacy be measured?

5.9 Study 2: Scale development and validation

The aim of Study 2 was to develop the WBSE scale and to validate it. Following Bandura's guide for developing self-efficacy measures, the data obtained from Study 1 was used to generate the items for the scale. The behaviours and attitudes described by participants during the focus groups, and those reported in the critical incident forms were developed into actions. These actions became the items for the scale. In answering research question two, 'Can well-being self-efficacy be measured?', this scale was developed. When administered in a survey, respondents will assess the belief in their ability to perform these actions.

Procedures for developing the scale involved:

a. Creating items based on the focus group data: the items were phrased to reflect a perception of ability, that is 'can do', rather than 'will do', where 'can' is indicative a judgement of capability, in contrast to 'will' which is a statement of intention (Bandura, 2006).
b. Domain specification: the items were created to assess behaviours linked to improving well-being. The items also reflected factors over which people could exercise some control.
c. Response scale: a unipolar response scale was employed, that is ranging from 1 (very confident I cannot) to a maximum strength of 5 (very confident I can). In contrast, a bipolar scale with negative gradations was not appropriate as 1 indicated an inability to perform the said task and therefore values below this would not be useful.
d. Adding a preliminary instruction: this involved adding instructions to help establish the appropriate mindset in respondents as they completed the questionnaire. It included a statement regarding what they were being asked to do. Also, in line with establishing an appropriate mindset, scenarios were added to the scale for a group of items. These scenarios were also created from the narratives of participants in Study 1. They were contexts/situations consistently referred to in the narrative of participants.
e. Adding a practice item: a practice item was added to help respondents familiarise themselves with assessing their capability. Although not related to WBSE, it was a valid and sensible question for respondents to answer as part of the set of questions being asked (*"I am able to easily lift a 20 kg (44 lbs or 3 stones) weight"*).

The scale validation process included assessing face and construct validities. This involved an expert panel reviewing the relevance of each item generated for the WBSE scale, and commenting on the construction, clarity, and similar properties of the items. The panel included care home managers and those with frontline care experience, academics involved in care home

research, self-efficacy research, and scale development expertise. The new scale was also administered in a survey alongside other validated scales to further assess validity. A detailed procedure of the scale development and validation process, the findings and discussion are detailed in Chapter 7.

Study 2 was quantitative. This was an appropriate way to test and validate the new scale. The quantitative approach provided the opportunity to reach a large number of participants, and to generalise the scale to similar populations following validation (Johnson and Onwuegbuzie, 2004). Factor analysis was conducted on the data obtained, using the Statistical Package for Social Sciences (SPSS) software.

Study 2 contributes to answering research question two:

2) Can well-being self-efficacy be measured?

5.10 Study 3: Participatory staff-led intervention

The aim of Study 3 was to facilitate an intervention aimed at improving WBSE.

Guided by the review of the literature on interventions (see Chapter 4), the procedure of designing the intervention included identifying the problem, specifying the objectives, specifying the intended outcomes and their measurement, choosing methods and strategies, and finally evaluation.

The problem identified was the need to improve the well-being self-efficacy of FLCH staff. The objectives of the intervention were to expose participants to and/or raise awareness of the sources of self-efficacy over a period. The intervention was also intended to provide an enabling environment (opportunities) for participants to engage in small, intentional, individual behaviours to increase well-being (Lyubomirsky & Layous, 2013).

The primary intended outcome was an improved perception of WBSE. A secondary outcome of improved well-being was also anticipated. The anticipation was that with increased self-efficacy beliefs, an individual will likely initiate actions (taking steps) aimed at improving well-being. Increase in WBSE was noted from participants' self-report, or an increase in steps taken towards improving well-being as documented by the participant (including cognitive steps and actions taken). These steps may also be observed by others, for example, by colleagues or the researcher.

Study 3 involved a combination of qualitative and quantitative methods. This provided the best possible option to capture rich data and data which could be triangulated, thus data collection was via diaries, semi-structured interviews and questionnaires. Diaries are described as a personal documentation regularly made by an individual shortly following an event (Alaszewski, 2006). The diaries enabled FLCH staff to act as self-observers (Alaszewski et al., 2000). In the current study, the diaries were similar to the critical incident forms administered in Study 1, and FLCH staff recorded their well-being experiences following an event or situation which they deemed to be goal-relevant. Forty-two diary entries were collected. The contents of the diaries were analysed using thematic analysis and triangulated with information from interviews.

The semi-structured interviews were designed to explore participants' experience of the intervention, and any impact it may be having. The interviews were designed to also assess the practicalities of implementing the intervention and any suggested amendments which could be made to actions plans. In addition, the interviews offered the opportunity to deeply explore participant experiences whilst remaining in the area of research interest (Denzin and Lincoln, 2000). The semi-structured natured of the interviews also presented the opportunity to probe beyond answers, with the potential of revealing new findings (Flick, 2002). All staff participating in the intervention were eligible, and these interviews were with individuals or a

group of two to three people, depending on participant preference and availability. Interviews were conducted throughout the period of the intervention, at approximately six-weekly intervals.

Methods and strategies of the intervention were informed by the experiences and discussions in the focus groups, the literature, and informal conversations with care home managers and other academic experts engaged in care home research. Choosing the methods and strategies involved a consideration of the context, ensuring that elements of the intervention were tailored to suit the context and accommodate some known challenges (for example time pressures). The intervention also took a longitudinal approach with the consideration that changes in efficacy beliefs are not likely to be instantaneous.

The intervention began with gamified workshops. These were two and a half hours with participants, involving an overview of the research and the intervention, sharing of information on well-being and self-efficacy, playing a game, and developing an action plan for well-being. The gamification aspect of the workshops involved applying the principles of gamification and was designed to facilitate learning and information retention. Gamification is often described as the application of game elements to non-game contexts, although a systematic review by Seaborn and Fels (2015) points out that there is no confirmed definition of gamification. Gamification may or may not involve digitalisation or computerisation of the game. It has been applied in a growing number of research studies on health, well-being and education (for example, Cafazzo et al., 2012; Dennis and O'Toole, 2014; Kharrazi et al., 2012), and some benefits of gamification include increased motivation and making learning enjoyable. In the current study, gamification principles were employed to enable participants recall the information on the sources of self-efficacy and to relate these sources to common 'everyday experiences' at work. These common 'everyday experiences' were used to create pre-set scenarios designed for the game and were based on the data from Study 1. Details of the game

and procedures are presented in chapter 8. At the end of the workshop, it was intended that participants will develop or begin developing an action plan for well-being, as individuals and as a group.

The intervention was assessed using a realist evaluation approach. A realist evaluation focuses on what works, in what context, for whom, and how (Pawson and Tilley, 1997). The approach evaluates an intervention by considering contexts, mechanisms and outcome patterns. This allowed the exploration of the underlying 'real' mechanisms in line with the ontology of critical realism. A realist evaluation begins with the development of hypotheses called programme theories. These are middle range theories, that is, theories which can be tested against actual data. In the current study, the overall development of the programme theories was informed by the findings from Study 1, Study 2, the conceptual framework, the literature, and informal conversations with individuals who work in the care home sector as practitioners and academics. Further details on the development of the programme theories and the realist evaluation are detailed in Chapter 8.

Recruiting care homes for participation involved inviting care homes from Studies 1 and 2. Further attempts to recruit care homes were via contacts and connections made during field work for Studies 1 and 2. Additionally, via a publicly published list of care homes and their contact details, telephone calls and visits were made to care home managers to discuss the research and possible participation. Five care homes initially expressed interest in the research, but only three care homes sustained their interest and prepared to take part. These three care homes then went on to participate in the intervention.

The design of the intervention was primarily aimed at the individual, although some elements involved working with others. Thus, although steps towards improving well-being may be taken in collaboration with others, these steps are solely dictated by the individual. This is in

line with the social cognitive theory (Bandura, 1986), of which self-efficacy is a core component. The social cognitive theory states that individuals possess a self-system which regulates feelings, thoughts, motivation, and ultimately action (Bandura, 1986). It establishes human agency, demonstrating that people are not simply at the mercy of environmental factors, or their actions always merely a reaction to events or situations. Therefore, an increased belief in one's ability to take the steps required to improve well-being will likely lead to actual steps being taken. This point is made clear when Bandura (1997) states that people will not take action unless they believe that those actions have the potential of making a difference. Thus, the participatory staff-led approach is underpinned by this understanding.

Further details on the procedure of the intervention are detailed in Chapter 8. Study 3 answers research question three:

3) Can a participatory intervention, tailored to a care home setting, enhance WBSE, and uncover some mechanisms via which WBSE is enhanced?

So far, the three studies of the research have been outlined. The studies were conducted in succession, and Table 5.1 summarises details of the studies.

Table 5.1 showing details of the Studies

	Study 1	**Study 2**	**Study 3**
Approximate duration of studies	2 months	6 months	9 months
Data collection method	- Focus groups - Critical incident forms	Questionnaires	- Diaries -Semi-structured interviews - Questionnaires
Data collection points	4 focus groups	1 survey	18 support visits (across 3 care homes)
Data collected	- 4 focus group discussions - 20 critical incident forms	142 survey packs	- 26 semi-structured interviews - 42 diary entries
Data collection period	1 month	approximately 6 months	approximately 9 months
Number of participants	21 (across 4 care homes)	142	12 (across 3 care homes)

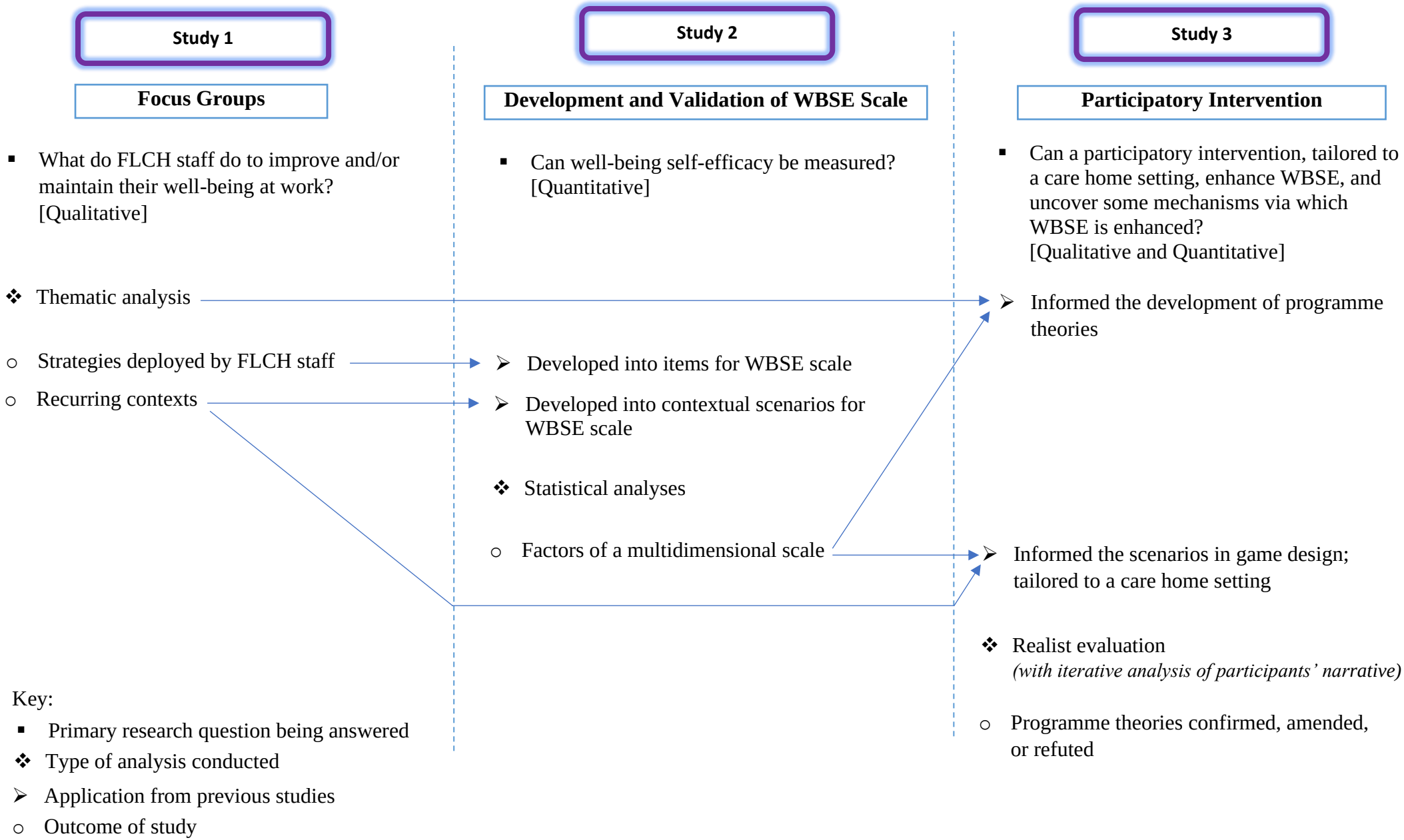

Figure 5.2 Interconnectivity of the three studies

Having considered the details of the three studies and their interconnectedness, Figure 5.3 presents a broader overview of the research strategy in diagrammatic representation. It shows the overarching research focus and how each of the three research studies contributes to addressing the problem. Underpinned by a critical realist ontology, each study employs appropriate methods to answer one or more of the research questions.

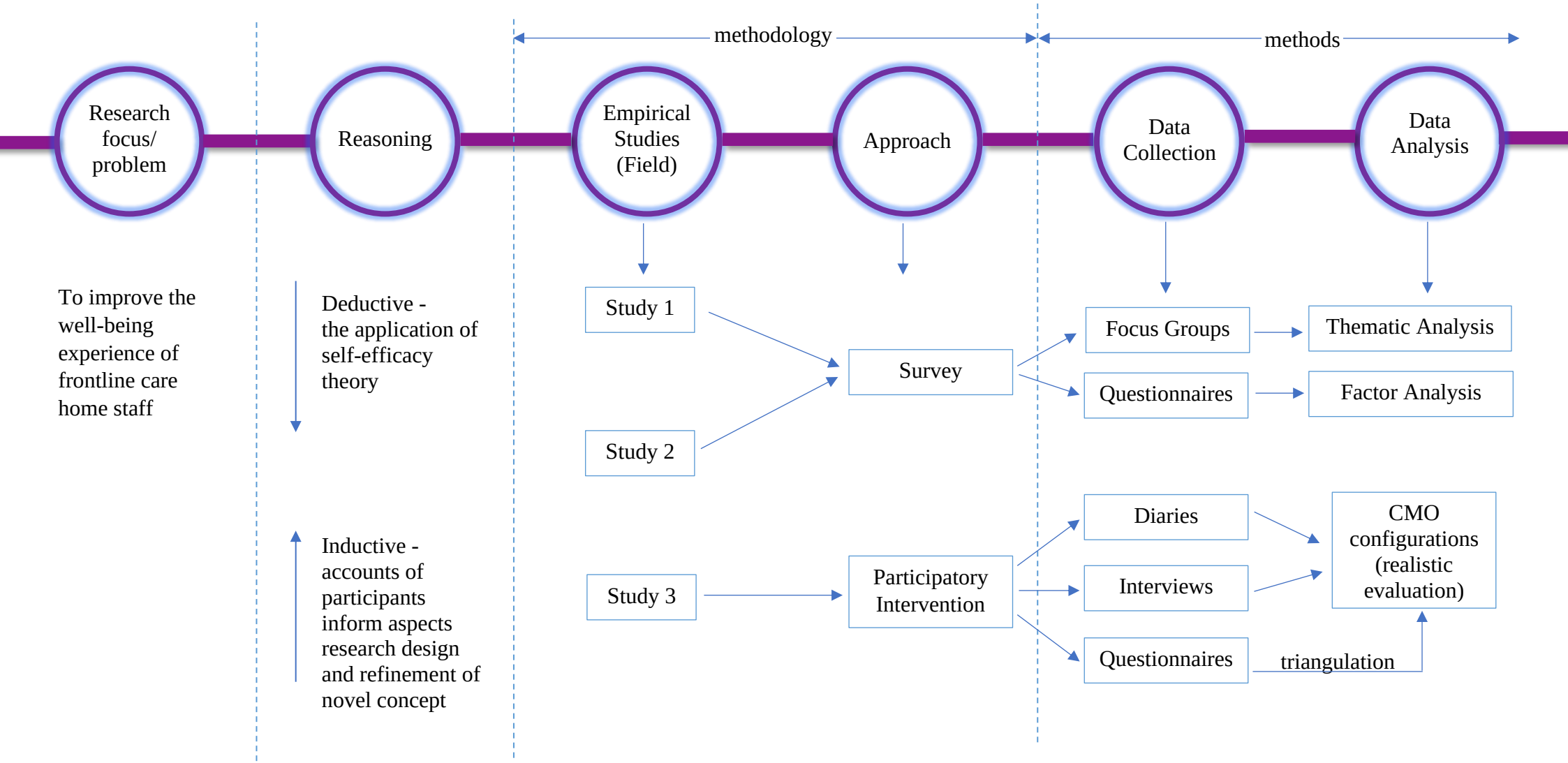

Figure 5.3 Flowchart of research strategy

5.11 Conclusion

This chapter considered the research process by examining research philosophy and research strategy. It began by establishing the importance of understanding a researcher's philosophy. In this chapter, five elements of the research process were examined – ontology, epistemology, theoretical perspective, methodology, and methods. Outlaid as a linear process, each of these elements is influenced by the previous element, and together they provide clarity and coherence in research. This chapter presented the philosophical position of the current research.

Also presented in this chapter was the research strategy of the current research. The strategy outlined the three studies comprised in the research. Underpinned by the critical realism ontology, the methodology and methods of each of these studies were presented, and how each study aimed to address one or more of the research questions. The interconnection of the studies was also presented. This chapter concluded with a flowchart of the research strategy.

In the following three chapters, the three empirical studies of the current research will be presented along with discussions and conclusions. The next chapter is on Study 1.

6 Study 1: Focus Groups

6.1 Introduction

The aim of this chapter is to present the process and findings of Study 1. This study involved an in-depth exploration of the well-being experience of frontline care home (FLCH) staff. The goal was to uncover the strategies which FLCH staff deployed to sustain their well-being at work. This was achieved via focus groups with FLCH staff, and data was examined by thematic analysis. Study 1 chiefly aimed to address research question one.

This chapter outlines the methods of this study, it presents the extensive results, and finally concludes with a discussion of the findings. The extensive results of this study serve as the bedrock for the development and validation of a new well-being self-efficacy scale in Study 2. The findings from this study also inform the development of program theories (hypotheses) in Study 3.

As presented in Chapters 3 and 4, self-efficacy is the lens through which the well-being experience of FLCH staff is examined. We recall, from Chapters 3 and 4, that self-efficacy is domain-specific. To capture well-being self-efficacy (WBSE), the most appropriate instrument must be used. There is currently no validated self-efficacy scale for improving well-being at work in health and social care settings.

Bandura (2006) offers a guide for the development of self-efficacy scales and emphasises that the items for the scale should be based on key factors specific to the domain of interest. The purpose of Study 1 was to explore these key factors. To achieve this, the current research sought

the experience and expertise of FLCH staff. This approach concurs with Bandura's social cognitive theory (see Chapter 3), which depicts individuals as possessors of a self-system which regulates feelings, thoughts, motivation, and ultimately action. Thus, the actions we observe, or those which are experienced are laden with 'reasons'. Furthermore, seeking the experience of FLCH staff is in line with the critical realism position of the current research. Bhasker (1979) points out that the activities, experiences, and interpretations of humans are the gateway to gaining a better understanding of reality.

Therefore, being familiar with their role, the complexities they have to navigate, and having potentially developed ways to nurture and/or protect their well-being, the current research sought to examine the experience of these staff. In essence, to identify the strategies which they deployed to sustain their well-being at work, in the care home context. The current research considered FLCH staff to be in the best position to know what to do, to know what works, and what does not work.

6.2 Methods

6.2.1 Participants and recruitment

Participants were frontline care home staff working in care homes for older people. A total of 21 participants took part. Participants were from all categories of frontline care home work, that is, junior care workers, senior care workers, and team leaders. Participants also comprised of both part time and full-time staff. The care homes where they worked catered for dementia, physical disability, and old age.

Participants were invited to participate in the focus groups via their managers. Contacting the managers was via currently existing channels such as contacting organisers of providers' forums and county meetings. In addition, care homes managers were contacted directly via

publicly available information in care home directories, hard copy and electronic newsletters. Telephone calls and visits were made to care home managers to discuss the research and the possibility of their participation. For managers who wished to be involved in the research, with their permission posters about the research were placed on their notice boards, inviting staff to participate in the focus group discussions. Copies of the information sheet (Appendix A) about the research and the consent form were also left with managers.

A total of four focus groups were conducted with FLCH staff. With no new ideas being shared and data saturation reached (Malterud et al., 2015), no further focus groups were facilitated. FLCH staff were invited to participate in one of the four focus groups, each lasting approximately two hours including welcome and introductions.

6.2.2 Ethical considerations

Ethics approval for this research was granted by the Faculty of Medicine and Health Sciences, University of East Anglia (reference 2016/2017 - 54). Each participant signed a consent form prior to the commencement of the focus groups.

Obligation to take part

If management was willing to participate, there was a possibility that staff members would feel obligated to participate. This issue was addressed by stating clearly on the research posters that staff may participate only if they wanted to do so. Management was reassured of no judgement of them should staff choose not to participate. There were no implications for non-participation.

Confidentiality

During the focus groups, ground rules were established before discussions commenced. One of such rules was that participants had to maintain confidentiality of the discussions which took place. Additionally, information on participating care homes, including their names, was not discussed with other participating homes.

Withdrawal from research

Participants were informed that up until the focus group discussions took place, they could withdraw from the study by cancelling a scheduled focus group appointment.

6.2.3 Data Collection

The Critical Incident technique (CIT, Flanagan, 1954) was used during the focus groups. The CIT involves collecting information on human behaviours during a critical incident/event (Flanagan, 1954). The critical event on this occasion was an experience which the participant considered to have an impact on them and was significant to their well-being at work. Collecting the information was achieved by using a critical incident form (see Appendix B). The technique aimed to collect participants' first-hand accounts of positive and negative experiences of well-being at work. Participants described specific negative and/or positive situations and their experience of these. They described their actions in response to the specific situations, and why they engaged in those actions. Using a critical incident form (Keatinge, 2002) as part of the focus group discussions created the opportunity for participants to write down their thoughts and experiences regarding well-being, in addition to speaking about them. It was anticipated that having the opportunity to speak about their experiences would enable participants to provide richer details of their experience, which writing alone may not capture. The form also served as a prompt, if willing, participants could elaborate on incidents which

they had captured on the form. Participants were shown an example of a completed critical incident form (Keatinge, 2002) to facilitate the task of completing theirs. The focus groups were also guided by a schedule which allowed an in-depth exploration of participants experience (see Appendix C).

From both the discussions and critical incident forms, participants gave insight into what well-being meant to them, what they believed impacted their well-being, and what they did (or did not do) to improve their well-being under various circumstances through the course of their work. The focus groups were facilitated by the researcher.

Debriefing: Following all the focus group discussions, the researcher had a brief conversation with participants, including addressing any further questions they may have about the research. In addition, should the discussions have raised any disturbing issues for participants, each one was given a list of resources and contact information via which they could speak to someone who could help.

6.2.4 Data analysis

The focus group discussions were audio-recorded and transcribed. Critical incident forms also comprised the data collected.

A thematic analysis (Braun and Clarke, 2006) was conducted to identify, analyse and report the themes within the data. This method of analysis provided the opportunity to carry out a robust analysis of the data, ensuring that all aspects of the data were considered in detail, but with a focus and presentation which is readily accessible to a community which is not of academia (Braun and Clarke, 2014). This was relevant to the study as accessibility of the findings of this study to care home managers and other stakeholders was considered to be

important. In exploring the well-being experience of FLCH staff, a thematic analysis offered the flexibility to develop a rich and detailed account of the data (Braun and Clarke, 2006).

Thematic analysis involved identifying and analysing patterns of meanings (themes) within the data. Braun and Clarke (2006) describe a theme as an important aspect of the data which is related to the research question, and shows a somewhat identifiable pattern across the data. This was the aim as the data from the current study was analysed. Additionally, in a thematic analysis, when those important aspects of the data are identified, other decisions may need to be made. For instance, a decision on prevalence, does frequent recurrence of a theme denote its significance? Depending on the research question, frequent recurrence may or may not be an indication of the significance of that theme. Clearly, varying decisions could be made regarding the analyses and reporting of themes, and rightly so. To ensure clarity, Braun and Clarke (2006) point out that the description and development of themes should be as explicit as possible. In analysing the data from this study, every aspect of the data relating to participants' well-being was considered important. For example, the context in which an experience was described, the actions taken by the participant and the reason for their actions were all considered to be important. All such data were captured and coded appropriately, as described later.

Since the current study sought to find out what FLCH staff did to cope or improve their well-being amidst the challenges at work, themes constituted actions and attitudes aimed at improving and/or nurturing well-being at work. Thus, in the accounts of participants, any mention of attitudes, or actions taken was considered to be relevant, even if this appeared only once in the data set. We recall that self-efficacy is the belief in one's ability to organize and take the steps required to bring about a desired outcome. In the analysis of data, prevalence was not a criterion for significance. This approach of not having prevalence as a criterion for significance enabled the study to capture a wide range of potential 'steps' taken to improve

well-being. These ‘steps’ would constitute the items for the new WBSE scale (detailed procedure presented in Chapter 7).

Transcripts of audio recording and CIT forms were read and re-read to get familiar with the data and to note any points of interest. The critical incidence forms were then re-read and initial codes were identified. These initial codes were words and phrases directly related to a participant’s words. The identification was done manually, and these initial codes were written on the critical incident forms next to the participants words. 52 initial codes were generated and were also recorded in a separate document. These 52 initial codes from the critical incident forms were then entered as nodes (the equivalent of initial codes) into the NVivo software programme. The transcripts were then re-read and excerpts of interest were coded to these initial codes. New codes (nodes) were also generated where excerpts of interest were not captured by the existing initial codes. An additional 58 nodes were added, bringing the total to 110 nodes.

Since the question in focus was ‘What do frontline care home staff do to improve and maintain their well-being at work?’, these initial codes captured opinions, actions, attitudes, and other details. In other words, behaviours which FLCH staff deployed under varied circumstances, to improve or protect their well-being at work. These behaviours were either explicit (for instance an action performed) or implicit (for instance having a particular attitude or reasoning).

During the initial reading of the transcripts and critical incident forms, and subsequently, whilst identifying patterns of behaviour across the data, it was noticed that there was a repeating pattern regarding contexts or circumstances as participants gave their accounts. This was noted as a point of interest. Therefore, although the analysis of data was centred on what participants did (or did not do) to improve and/or nurture their well-being, the analysis also involved taking note of the context or circumstance in which well-being experience was described.

The 110 nodes were extracted from the software and grouped manually. This grouping involved putting related nodes together to form overarching themes. This process involved making several changes and reshaping the themes and sub-themes. Themes and sub-themes were behaviours or attitudes which participants engaged in relation to their well-being at work. In other words, themes represent the various 'tools' which FLCH staff deployed under varied circumstances, in order to improve or protect their well-being at work.

Collecting data via different focus groups, employing the critical incident form, and triangulating the emergent codes between the focus groups and the critical incident forms across participants contributed to ensuring the trustworthiness of the findings.

6.3 Results

In analysing the data from the focus groups, five overarching themes were developed, four of which have sub-themes. The overarching themes, referred to as main themes, were 'regulating emotions (in interpersonal conflict)', 'shifting focus', 'seeking support', 'taking control', and 'self-care'. These main themes and associated sub-themes are shown in Table 6.1. The themes and sub-themes are closely related to the data and have been so named such that they portray the words of the participants as closely as possible. However, to facilitate a clearer understanding of the themes, a description of their meanings has also been provided.

The italicised quotes are excerpts of the discussions or CIFs which most clearly illustrate the themes and sub-themes being presented. In the excerpts presented, pseudonyms have been used to uphold confidentiality. The abbreviation 'FG' and a number indicate the focus group from which a quotation is made. For example, FG2 indicates focus group 2. The abbreviation 'CIF' and a number indicate the critical incident form and a number assigned to each participant who

completed one. For example, CIF8 indicates that the excerpt is from the critical incident form labelled number eight.

Figure 6.1 Main themes and sub-themes of Study 1

Main Themes	Regulating emotions *(in interpersonal conflict)*	Shifting Focus	Seeking Support	Taking Control	Self-Care
Sub-Themes		Cognitive reframing	From colleagues	Exercising autonomy	Understanding one's limits
		Focusing on personal motivation/drive	From significant authority	Managing workload	Building resilience
		Cognitive empathising		Being assertive	Self-appreciation and receiving appreciation
				Being proactive	

6.3.1 Regulating Emotions (in interpersonal conflict)

This theme involved the experience of regulating, or not regulating, one's emotions when faced with challenging circumstances which aroused strong emotions. From participants' accounts, regulation involved thinking or acting in ways which enabled them to avoid an emotional outburst, or which enabled them to reasonably evaluate a situation in spite of the on-going emotional tension. The chief outcome was to keep acting in a socially acceptable manner amidst a difficult experience. Although emotional regulation was demonstrated in a variety of situations, participants' accounts were mostly relational. That is, issues relating to other

persons. Where accounts were task-related, the accounts still involved another individual. Thus, regulating emotions in the context of interpersonal relationships is a key aspect of this theme. Examples of situations highlighted are, being disrespected, reporting issues and no action seems to be taken, colleagues not getting their tasks done, and tasks being completed poorly. With the frequent exposure to stressors and high levels of stress at work, being able to control one's emotions was discussed as a way of protecting well-being. The extract below demonstrates both the positive aspect of regulating one's emotions (reacting graciously), and the negative aspect.

> *With me sometimes I can react so graciously, but sometimes I have a temper and sometimes I'll just, one thing can, one thing, all it takes is one thing, and especially if I've been going through things at home, it takes one thing to push me over the edge… probably going to lose my temper and everyone around me is going to be affected and I'm also going to be the one who looks like an idiot.* FG3

From conflict with colleagues, to issues with residents, to organizational barriers, for the FLCH staff, there seemed to be many reasons to be emotionally aroused negatively. However, the perception that one had control over these emotions brought a sense of empowerment, a sense that one was not a victim to issues. Thus, regulating emotions was demonstrated to be good for well-being. Regulating one's emotions was both an individualised experience and a shared one. As a shared experience, participants talked about moaning to each other after emotion-arousing incidents and how they felt much better afterwards.

Emotions seemed to play an important role in the experience of FLCH staff, a number of participants recalled that they had been so aroused at some point that they decided not to come back to work. "*We moan and moan, we say I'm not going to help them again, that's it. How many times we've said that?"* (FG1). Despite the distress, they still return. Talking to other

people in this ‘moaning’ way was a shared experience from which participants took solace. This was an experience which was mentioned by a number of participants in all the focus groups. Colleagues often understood the experience and being able to vent one’s frustration in a contained and trusted space was one way to regulate emotions.

> *“It’s good that Sophie says these things because it gets it off your chest, you know…well as they say, a trouble shared is a trouble halved…. Well that’s what’s good isn’t it? Because we can all get [things] off of our chests to each other. We’re all worried about it, and [then] say it to each other, and that is quite good.”* FG1

Regulating emotions also involved personally evaluating a situation, but not necessarily with another person. In the account which follows, a participant leaves her job after a hurtful experience. However, after evaluating the issue and considering her love for the job, this participant revisits her decision, made under high emotional tension.

> *I started work, a newbie but I wasn’t happy at all because [of] the way he spoke…not just to me, towards other staff members as well, and I actually left. I told my manager I can’t do it. But then obviously I ended up coming back. Because obviously I wanted to work here, so I spoke to the manger. I was like, no I shouldn’t have done that, I want to come back and obviously he [manager] did give me my job back.* FG2

When colleagues did not co-operate to get tasks completed, participants reported this an experience which often caused emotional tension.

> *Well to be honest, again, I find, and that really irritates me, you have people certain key workers who’d be pulling their weight and others, who, no, they don’t pull their weight, and they’d hide when there’s work to be done, they’d hide or sit down and have so many cups of tea meanwhile the other ones are being left to carry on, and that really gets on my nerves, really gets on my nerves.* FG1

The experience of poorly completed tasks was also noted to be a source of frustration. Dealing with it involved managing one's expectations of colleagues. The experience of having colleagues who did not complete tasks well was described as putting pressure on everyone else and sometimes having to re-do tasks which were not done properly in the first instance. *"It does everyone good if people are doing their work properly"* (FG1). In some instances, the issue was immediately reported to a senior member of the shift team. However, participants mostly described tolerating the behaviour, 'keeping their cool' as much as they could and only reporting it if colleagues did it too frequently. In the following excerpt, the participant had spoken to both management and colleagues, but things were not improving. Clearly a source of negative emotional arousal, but the participant does not have an emotional outburst. This participant rather evaluates the experience and considers the expectations she has of her colleagues, and of herself too, recognising this as a potential source of stress.

> *I think what it is as well with me, because I get so frustrated, because I want…like their rooms and that, personal belongings to keep how I would expect it to be. And when someone else comes in and they don't appreciate that as much as I do that's when I'm stressed. … And I think sometimes you can complain until you're red in the face and it seems to go ['over the head' gesture], not to management but some carers you know…. Maybe I put too much of myself into the place I don't know, but I do get frustrated with it.* FG4

As the excerpts of this theme illustrate, participants experienced strong emotions at work, and on some occasions, they demonstrated a clear strategy in regulating their emotions, for example, deliberately moaning to a colleague knowing they would feel better afterwards. However, on other occasions, the strategy for regulating emotions was not so clear. There was an acknowledgement of the emotions and its negative impact on their well-being, and sometimes self-talk, but no clear strategy. This observation was particular to this 'regulating

emotions' theme, unlike the other themes where the strategies were clearer. It seemed that regulating emotions was a strategy (a tool) used by FLCH, but not fully harnessed. It seemed that more could be done in terms of assessing one's experience and improving one's strategy of dealing with emotional arousal when in conflict.

6.3.2 Shifting Focus

This overarching theme involves changing one's perspective or frame of reference. The theme captures participants' acknowledgement of the sometimes-difficult circumstances in which they work. This theme also captures the notion that participants are not always looking to improve a situation but demonstrate an acceptance that some difficult situations are unlikely to change. The sub-theme 'cognitive reframing' captures how participants shifted their focus by changing the way they viewed things, shifting from focusing on a negative situation and its impacts to one which could be potentially positive. Another way in which participants shifted their focus is captured by the sub-theme 'focusing on personal motivation/drive'. Here participants handled difficult situations which threatened their well-being by concentrating on what motivated them personally. In other words, keeping their eyes on what gave them drive and impetus to keep going. Both these sub-themes show a direct benefit to the participant's well-being. A third sub-theme, 'cognitive empathising' however, captures how participants shifted their focus by considering the perspective of others. Participants experienced improved well-being by focusing on another and not on themselves directly.

The continuous tense, shift(ing), has been used for this theme because it represents an on-going process. This was not a one-off action, and participants did not always adopt a particular strategy when shifting their focus. Instead, different strategies were deployed depending on the situation. This capability to keep shifting (cognitive) focus was a notable one. As illustrated by

the excerpts, when this capability was demonstrated, there seemed to be an associated positive influence on well-being. Some excerpts capture more than one sub-theme, but for the purpose of demonstrating variety (richness), different excerpts are presented.

a. Cognitive Reframing

Participants discussed the importance of surviving in their work environment and enduring difficult situations by choosing to see things differently. This sub-theme is particularly about situations which are categorised by a participant to be clearly negative situations, but intentionally viewed in a positive light. To see things differently often meant a re-evaluation. Such a re-evaluation involved a conscious effort to reconsider a situation in such a way that one sees the positives which have come out of it or which could come out of it. It was a subjective way of interpreting situations, including objective situations. A participant may therefore acknowledge that things may be going wrong regarding a situation, but instead of dwelling on the negatives, they chose to interpret the situation differently. It involved choosing an intentionally positive outlook. A number of participants demonstrated this behaviour.

An example of cognitive reframing being used is captured by Emma's account. Although some colleagues she works with are not happy in their work, she shifts her focus from the issues at work and considers her work to be an opportunity to gain valuable experience. By reframing her experience, Emma also refers to additional benefits gained (receiving a different positive treatment):

> *I'm here and I like to do it, I don't hate the job, I like to do it but this isn't my end goal, I am working towards something here, something else, this is my stop off point and I enjoy my stop off point. And when they realise that you enjoy your job, they treat you differently because a lot of people go to work and are bitter because that's where they*

are. You'll see people in their 60s still working there and, you know, they're so angry, they're so bitter, and although a lot of people don't like it but I'm happy at work. I'm smiling at work. FG3

Cognitive reframing was also illustrated in relation to conflict resolution. Here Jones sees conflict as a natural experience in the care settings workplace. Jones considers this on-going irritation but sees a potentially favourable outcome.

If I'm honest, we all moan about everyone at one point…but it doesn't affect the whole feel of the place I don't think. Well I mean it's just nature that you know, I'm not going to get it right all the time…We're going to do something sometime, it's nature to do something that one of the others doesn't approve of, that's nature. The important thing is, yes you have a moan at me, quite rightly, I deserve it, but she'd have a go at me, and it's forgotten about, we sort the problem out, we move on, and we're back to being our usual friendly selves again. FG1

As FLCH gave accounts of challenging situations, taking the approach of seeing things differently, especially in on-going or difficult situations, seemed to be vital for self-preservation. The idea of self-preservation is explored in the theme 'Self Care'.

To not engage in cognitive reframing was in essence, to keep one's focus on a negative situation and its impacts. Sometimes participants could not mentally get past a situation, hence continued to focus on it. An example of this is captured by Lily's account as she describes her colleagues not properly cleaning an area. The experience often ruins her whole day and has happened on numerous occasions. It is impacting on her well-being at work but her perspective on the situation has remained the same.

…come in and it's not clean and that puts me off for the whole day…it does not make me feel good, so my day is spoiled. I just get on with it. It makes me feel uptight and stressed, so I just get on with it. At the end of the day I know I'm going home soon. CIF13

Another participant, Emily, recounted her experience of being bullied by a group of residents. Although working in a care home which cared for people living with dementia, not all the residents were living with dementia. However, there was a possibility that some residents were experiencing early onset of dementia, but Emily could not see the situation in a positive light, cognitive reframing seemed difficult.

Sometimes you cannot look at a resident and relate yourself to them. Like I have to be honest…sometimes they're bullies… there's like one group of residents, every time I go to work I just, I can't. I just feel like, urgh. …they always have something to say about my hair, and for me my hair is the same every single day…and I always get the "are you going to put your hair up?" And I'll say "my hair is up"… And there was one, I did get one comment, "I don't like your hair" and I'm like "I don't know what you want me to do, shall I cut it all off? Like do you not like my hair or my face or whatever?"…. And it's so, and you know what, it's those little things. For me if someone tells me my hair is wild, I'm offended, like how can you tell me my hair is wild? That's very rude. And if I say I'm offended by it, then they're just like "why should you be offended?" Because you're attacking me. …some days I don't want to go to work because I don't want anyone to attack me. And like even for those silly reasons I will refuse to go to work. FG3

In the next excerpt, a participant felt attacked by a team leader as a result of being perpetually allocated to unfavourable tasks on the shift. This is a particularly difficult situation to be in

because the allocation of tasks by a team leader cannot necessarily be described an attack, as a team leader may allocate tasks as deemed fit. However, due to other underlying issues (for instance, the statement *"This certain lead carer does not like me at all."),* this participant perceives the experience as an attack.

> *This certain lead carer does not like me at all. From the day she met me, she decided she hates me, so she always puts me on certain tasks like emptying the bins, you know like all the tasks that you wouldn't want to do when there're other things to do. And I'm always doing the same thing every time she's leading. And so, you're like 'this is an attack on me', like common.* FG3

The experience is reiterated by a different participant in a different focus group.

> *Team leader shouting at me to carry out work when I was already doing work elsewhere. Due to nepotism, another worker did not want to carry out the work. ...I felt it unfair that this team leader was always picking on me*. CIF15

In these excerpts, there is no reference to seeing the positive in the situations, that is, no reference to cognitive reframing. The situations were on-going and the impact on well-being was continuously negative. As earlier stated, there may not necessarily be a 'closure' to difficult issues. In fact, the quotes above illustrates the point that there may be situations which are difficult to resolve, or which may take a long time to resolve. However, the capability and tenacity to endure the experience, drawing on various supportive resources, including changing one's perspective to see the good (cognitive reframing) was a valuable skill to have. Also, a situation may not always be difficult or dire, but may simply be an on-going irritation which impacts well-being. Whether difficult, dire, or simply irritating, cognitive reframing enabled participants look beyond the particular situation which was having a negative impact on well-being.

b. *Focusing on personal motivation/drive*

Unlike the 'cognitive reframing' sub-theme in which participants aimed to change their viewpoint in order to see the good in a negative situation, the sub-theme 'focusing on personal motivation/drive' was more about reminding oneself of what was personally important. When participants were confronted with circumstances which had the potential to negatively impact on their well-being, but also a circumstance which they could not necessarily change, they handled this experience by looking 'inwards'. They looked 'inwards' to something which motivated them. Something which was described as an internal drive to keep going in spite of difficulties experienced at work which negatively impact well-being. When employed, this behaviour enabled participants to accommodate a difficult situation with minimised negative impact on their well-being.

Participants frequently described situations which seemed overwhelming, but in their discussions, they often talked about what kept them going, making reference to sources of strength which they drew upon. By far the most common source of motivation discussed by participants was the residents. When situations actually made them feel low, or threatened to do so, they considered their residents and the positive difference they believed they were making to their lives. This in turn had a positive effect on participants and gave them the impetus to bear with the said situation. Thus, participants either derived support and encouragement directly from residents or had a perception that they were playing an important role in the lives of their residents. This brought a deep sense of fulfilment which had a positive impact on their well-being.

> *I think what keeps me going through all the positive and negative things is I always think that I'm doing this for them, because some of them are end of life, some of them are in this situation not because they wanted to. End of life and even in palliative care,*

erm, so it's our job, when we are a carer, it's our duty to make sure that they are comfortable, no matter how irritable they are. I think sometimes you just need to put your feelings aside and to be in their shoes, think of why they are acting. FG3

On a positive note, the one thing that keeps me going here, is when you go into a resident's room for something and you get this sweet little old lady *(I'd use the expression), and she beams at you with a great big, sometimes toothless grin and says 'thank you for doing so and so', it makes you think that it is worth putting up with all the muck we put up with here…that's what makes you come back. To me that's what lifts me and keeps me going more often than not.* FG1

When asked about a stressful day at work a participant responded *"when we come in, we get stressed out, we moan to one another and God knows what else. But at the end of the day you think, well, it's for the residents at the end of the day"* (FG4).

Although focusing on residents was the most common source of motivation/drive, having a personal mission was also discussed by participants. Having a personal mission meant that a participant had a personal goal which they were working towards. In the event of a difficult experience at work in which their well-being was negatively impacted, they shifted their focus to their personal goal. For instance,

For me what is behind it is understanding why I'm there. Fair enough I am there because I need to pay the bills but at the end of the day I am also there because I have sought out a career choice in the social care industry, so I need to be there to get more practice, more experience. So, every morning, once it's in my head it's embedded in me that I need to be there…that's when it gets me the motivation to go. FG3

Sometimes, it was not about big goals like career progression, but also 'small' goals. When describing how they get through their shift, one participant said, *"I enjoy making the home a comfortable place to live so I help as much as possible by contributing and making this possible"* (FG4). Again, this statement points back to being motivated by residents. Also, the personal satisfaction of looking after others was mentioned as a personal motivator which had positive impacts on well-being; *[Working] in the care sector makes me feel the positive side [of looking] after others in a difficult time. That's helped me a lot.* (CIF11).

One participant, in conversation with a resident explores a personal motivation as she acts in kindness towards residents. She demonstrates how she kindly normalises the care so that residents receiving care feel more comfortable and less of an imposition.

> *They say to me "oh if I did your job I wouldn't last long, like it's so amazing to see you doing this job, like why do you do it?" They ask me this kind of question. "Do you even like working here?" And everything…Especially when you do personal care for them. They will tell you "why do you like cleaning other people's, uh, you know, personal areas, it's not a nice thing for you, [for] a pretty girl to do it". But then I say to them, I reply to them, "I'm not thinking [of it] as a dirty thing" and I tell them "don't I go to the toilet? When I was born who wiped my bum? My mother. And at the same time when I get older someone may help me". But I just hope that I won't get into that situation, just because I know that those people to who are in that kind of situation didn't want to, didn't plan to be like that, but it's just life that happen for them, yeah.* (FG3)

c. *Cognitive empathising*

Shifting focus was also described as empathising, but specifically cognitive empathising. Cognitive empathising is described as the ability to understand the perspective of another.

Participants described experiences of showing understanding towards colleagues, relatives, and even residents. Caring for another meant that focus was taken off oneself. One participant commented *"You tend to forget about what problems you got…yeah, really helps, helping someone else."* (FG1). Another participant described an experience which captures cognitive empathising, in which they extend their focus to relatives and loved ones. In the first extract, the participant demonstrates an understanding of the natural concerns which relatives may have about leaving a loved one in the care of others. And in the second extract, another participant validates the positive impact this shift in focus can have on a person's well-being.

> *"…like yesterday, with one of our resident's family, she needed to get something off her chest bless her, she was chatting to me and Sally. So, I mean it was our home time, [but] we stayed behind just to talk to her. You know, we took her to Jean [manager] to try to get the situation sorted. And when you see her again, she'd always thank you or whatever, and you know you've helped them, not just the resident but the family also. Because when they leave here, they need to know they're in good hands."* FG1

> *"Being able to support family, 'outside of the usual caring role' brings something to you that helps you deal with your own well-being… you tend to forget what problems you have…because you're helping someone else.* FG3

Another excerpt captures a participant's effort to see things from another's point of view. When faced with the challenging behaviour of a resident which was having an impact on well-being, this participant sees (interprets) the behaviour from (the experience) of a resident. This participant interprets the challenging behaviour to be as a result of loss of control over one's life and the feeling of vulnerability.

> *Mostly for me it's understanding that I am in a setting whereby I want to build a career in and…understand what these people are going through. Say for example…they lack*

control, yes, so when they get into the care setting all the control is taken away from them, that little control that they had. FG3

Still regarding residents' behaviour, one participant recounts the experience of being faced with challenging behaviour by a resident, but instead of feeling distressed, she decided to see things from the perspective of the resident. This decision awakened a realisation that the resident may not understand the experience they were having, and throughout this incident, the participant made a deliberate effort to keep explaining what was happening despite verbal abuse from the resident. On this occasion, it was an account which ended positively.

I explain like the reason why they are getting up and then they're like "oh okay, yes, I want to go to church, yeah, you can help me"…. At the same time, even at the same time…they get frustrated. You still go on with the work, not letting them get, I mean to the point that they are very mad, angry or being aggressive. Once you've done everything, getting them up and everything, they always have this like saying "I'm so grateful to you, thank you so much". Like they may curse at you, especially people who have dementia, but at the end no matter how much they curse you or call you bad names they will say thank you. And that really gives me a big impact because it gives me more, um, what kind of word…motivation to work more for them. Not for the money sake, obviously we all need the money for our living, but…I always think what if it was my grandma or my parent or my relative. FG3

6.3.3 Seeking Support

This overarching theme involved participants actively seeking out the kind of support which they believed would improve or nurture their well-being. Sometimes, this support was sought from a colleague, captured by the sub-theme 'from colleague', where colleagues offered

emotional or task-related support. Although support from a colleague was described as having a notable impact on participants' well-being, sometimes, participants required the kind of support which involved an official action. The sub-theme 'from significant authority' involves participants seeking support from a person or persons holding a position of authority. Together, both sub-themes capture the impact of seeking, or not seeking, support on well-being.

a. *<u>From colleague</u>*

When confronted with a situation which a participant judges as difficult, they may seek out a trusted colleague who lends a listening ear as their fellow colleague vents their frustration or annoyance at something or someone. When such support was actively sought and found, participants described the impact as a feeling or experience of belonging. This fostered a sense of community and trust "…*we all know each other more…You know everyone, everyone knows each other* (FG1). Another participant commented on this kind of community being impacted by the size of the care home.

> *[We] feel that we are a community. We feel like a little village rather than the big town like in some of the other homes in the area, they are too big and people get individually lost. Whereas here are able to feel like we're a little village, little sort of rural village, rather than a big town, sort of thing.* FG1

The feeling of not being alone, having someone to talk to, had a positive impact on well-being. *"If you've worked in care you understand it's nice to let it out."* (FG3). In contrast, other participants described occasions in which they did not feel a part of their community, especially when there were cliques.

> *…one particular staff member said on one occasion to the team, that during the shift no one should talk to me because I talk too much and she was tired of me. I was very angry…I became more stand-offish towards her, very blunt and stern when she approached me. That shift was so difficult for me, I left crying because I had no help. I then had reserved negative emotions towards this staff member.* CIF2

The extract above also captures the impact of task-related support from colleagues. Support from a colleague was not only emotional but was also described in terms of support with task-related duties. Participants described their duties as being sometimes overwhelming, with a lot to be done in a short time. Typically, staff on duty are split into working groups, into pairs, or individually assigned tasks. One group or individual may complete their task while another may have encountered a difficulty leading to a delay in progress (sometimes, this is a source of frustration). In the extract following, a participant describes the impact of task-related support from colleagues, *"We're all there for each other, if anyone's stuck on anything, we're like, can you help us with this, like you know, we do it, you know."* (FG2). One participant had been working in their care home for less than four months, and when asked if they had experienced a particularly difficulty day, the participant responded *"Not really, because [the] staff are really good that's why, yeah, they help you a lot. If you need anything you can ask yeah."* (FG2)

Being able to seek a colleague's support and depend on each other was sometimes a notable demonstration of solidarity, as colleagues sometimes had to come in just to help. For instance, one participant recalls the experience of being asked to help and had to come in from home. *"Came in to help out with residents as…the staff were struggling on duty."* (CIF6)

On the contrary, well-being could be impacted negatively when there was no such support from colleagues, as seen in the extract CIF2 above. In addition, due to the nature of their work, sometimes support from colleagues was expected, and it was critical to have it. A participant described a work situation in which other colleagues did not offer help when needed. This participant had to take two residents to the toilet and *"they were both shouting at me at the same time",*

> *I asked them [colleagues] before, "can you help me?" and they said no. [Then] they said to me "you can't leave them, you can't leave him in the toilet on his own, you need to hold him up, you can't leave her on the toilet on her own because you know you need to be there". And I'm like "they're desperate, they're also human just to let you know, they needed to go, they both don't wear pads so we need to take them to the toilet otherwise there will be an accident, you don't want to help, I'm going to do my best". So, they were just telling me how I shouldn't do it and I just said to them, "so where were you? Because I know you were standing there in the corner eating biscuits. So you know I needed help, you were having a break when it wasn't even your break time, so you don't have the right to tell me how to do the job if you're not even willing to help".* FG3

b. *<u>From significant authority</u>*

Seeking support from a significant authority was important when 'moaning' to colleagues was not enough, and official action needed to be taken. Significant authority included team leaders, care home managers or the care home owners (where they were involved with the day-to-day running of the home). Discussions captured by this theme showed that participants did not particularly focus on a manager's support in terms of technicalities relating to work. There was

a focus instead, on a manager's concern and management of their welfare as individuals or as a collective group. Regarding resolving issues, there was an expectation or belief that such authority figures had resources or capabilities which could impact well-being. *That's what they're there for, that's their job. And if they don't do anything, there's not much point in them being there, is there?* A different participant responds, *Yeah, of course yeah. Yeah definitely, like that's what the manager's there for.* (FG2)

While a person of authority was considered to possess the power to influence circumstances, it was not always easy for participants to seek support from such a person. For example, for some participants, it did not seem natural or easy for them to approach a manger to raise or discuss a complaint. Therefore, when such a person mustered the courage and made the effort to raise an issue, they expressed frustration when it seemed that nothing was being done about it. One participant described approaching a manager as 'going out of our way', *"cause we're going out of our way to come speak to you, that look, this is the problem…It needs to be solved, you can't just leave the problem as it is, with 'well, you know, I didn't see it happen', so, just let it be, basically."* (FG3)

The capability to seek out support from a person of authority seemed to be an important trait. Sometimes, although, a person may not get the particular outcome which they desired, the ability to approach a person with significant authority seemed to still have a positive impact on well-being. Laura, below, describes how stressed she feels when, after accidents (incontinence), residents' rooms are not cleaned immediately, as a matter of priority. Due to the impact of this situation on her well-being, seeking support from management to rectify the issue brought some relief since the situation was sometimes addressed, but there was no complete resolution.

> *Some residents urinate on the floor and it's left…it's not very nice for [a resident] to be left in their room dirty, as to me this is a lack of respect. It leaves me very stressed an I feel like walking out. [I] have reported this to management…sometimes when I've complained, the complaint has been dealt with, then after a short space of time it's back to normal.* CIF13

Being able to approach a person of authority was described as being important, and there seemed to be a lack of trust when such senior figures appeared to be far away, unreachable, or disinterested.

> *Here, within our little bubble here, we work quite well, a lot of the poor feeling, it comes from our parent organisation. It's the lack of care by them for us, is where a lot of the poor feeling comes from. Because, here, most of us here, we go the extra mile to look after our residents. We feel that they don't go the extra mile for us, they do the barest legal minimum. I'm frequently hurt to say, that as far as you know, our parent organisation is concerned, the staff on the floor, we are just lumps of meat. There is no concern for the staff. The fact that we work so well here together, is because we exist in our little bubble. Sometimes, quite often, you see that the major wave of unease in the place you get, will be something that will be a ripple from head office, not something that's happened…in the home.* FG1

Disappointment was also expressed when support was sought from a person of authority, but it was not offered, an experience which had an impact on well-being. Freya below describes the experience saying, *'that's what really gets you'*.

> *"…sometimes you don't get the support you want from the managers. I think we do personally feel that way. Like, sometimes if you go speak with your manager, even though they're telling you [something], but they're not like supporting you as much as*

> *they should be. And obviously that's what really gets you. Because if you go to the senior, and they don't do something, you can go to the manager. But obviously, if they [manager] are not doing anything for you, then what are you supposed to do, because they are your manager you know. They're supposed to be helping you in situations.* FG2

However, when the relationship between staff and senior management/owners was fostered, it had an impact on well-being. It also had an influence on the belief staff had about their skills and performance. For instance:

> *"We are quite close to the directors and to the people who own the building, and they are, most of the time, unless they are stressed where they're going through whatever they're going through, they are really appreciative. And when they say thank you, you know, it means something, and you're like actually, I'm doing a good job"* FG2.

"It goes a long way" (FG2) another participant in the group commented. As one participant comments below, one can see how expectation of support from the top had led to a loss of hope, a loss of faith in an authority. This participant resigns to inaction, *"Ahh (sighs), it's, it's hard because we just ignore it, you know what I'm saying, we don't take no action because we ain't got no time for that…I don't do no action because you're fed up of talking…you can't keep talking, talking about a situation because you're not getting anywhere…"* (FG4)

It seemed frustrating when the desired outcome of seeking support from a person of authority was not achieved. These frustrations give insight to the significance of support from those in positions of authority. Without an easily accessible official and effective route to receive such support, an individual will likely have to seek this support for themselves. Therefore, the ability or courage to seek support from a person of authority was a strategy (tool) which was

significant, although the desired result may not always have been attained, as various excerpts portray.

6.3.4 Taking Control

This overarching theme captures participants' perception of control. Participants described the feeling of being able to positively influence the outcome of a situation at work (especially a potential stressor), and not merely being subject to it. This perception of control seemed to enable participants regulate the impact of a stressor and its influence on their well-being work. Having a sense of control was commonly discussed by participants, and this overarching theme containing four sub-themes. Solving problems, by using one's initiative and operating within one's jurisdiction, was reported as having a positive impact on well-being. 'Exercising autonomy' is a sub-theme concerned with participants making decisions on their own. Being able to handle the pressure of workload was a capability which also influenced well-being and is captured by the 'managing workload' sub-theme. However, participants described how speaking up and challenging, where appropriate, the workload which they were assigned, also had a protective effect on their well-being. Speaking up in various dissatisfying situations is captured by the sub-theme 'being assertive'. The sub-theme, 'being proactive' involved escalating (reporting) issues to a relevant authority figure, although control seemed limited (dependent on another), in comparison to situations when a participant felt fully in charge.

a. ***Exercising autonomy***

The exercise of autonomy was mostly explained with regards to non-technical (that is, not task-related) aspects of work. In these situations, participants described how they felt good when they made a decision on their own, often for the benefit of their residents. Due to the nature of

their jobs, activities and procedures for FLCH staff are often dictated by an authority figure. The opportunity to exercise autonomy at work and the feeling of making a useful contribution had a beneficial effect on well-being. Aimee's account captures this experience.

> *An elderly lady did not have a lot of hair and it was getting her down. I suggested buying a wig. I felt it would make the lady happy. I got a wig brochure and we looked through it and decided on one which we purchased. Every morning, we put on her new wig and it made her very happy. And her family were also happy and called me their family.* CIT15

On some occasions, a group of staff spontaneously organised fun-filled events just for the residents. Sometimes this included fund-raising, planning and implementation all by themselves (that is with no direct influence of management). Despite the effort and coordination required, and some staff having to come in on their days off to make it happen, such experiences were described as having an enhancing effect on their well-being. In the following extract a participant describes organising a fireworks event for their residents after a few residents had seen some fireworks display outside the care home.

> *We did a fireworks night the other day for residents. Something different for the residents. And we realised that when they heard the fireworks outside [November 5th], some of them did like go and have a look. So obviously we thought we'd do our own…. When you organise things for the residents it makes you feel good….the positive sides are when you're doing things for them, and make a difference.* FG2

Two other participants added *"And it's nice to see them happy, that makes you happy." "And we enjoy it as well as them."* (FG2)

Another participant concurs, and describes willingness and intentionality in taking on these additional activities at work,

> *"…you can see the change on their faces, they will talk about this to their family, you know. You know that, oh at least I bring something to this group, to this person [in] particular today, you can see the difference really, you can really see it. I think it comes from the heart really, it's from the heart. It's not like by force, it's not like, you're pushed to do it, you feel like, oh I'll make this person happy, you know.* FG2

In contrast, when participants felt restricted in exercising such autonomy, they described the experience of frustration. Janet who also helps to order items for the home expresses her frustration. On occasions, she finds that due to the tight budget, the same item can be purchased from a different store at a lower price. However, she has no room for negotiation as the policy of the home states that all purchases must be made from particular stores.

> *…given a budget but told [you have] to shop with a specific company. And we had an example recently, ordered 3 kilos of ground almonds, ground almonds yeah? Ground almonds. That's a lot of ground almonds* [being sarcastic]*, 150 quid? For 3 kilos of ground almond?* [Others interject] *what?! That's ridiculous*. £53 a kilo, you can buy it in Sainsbury's for £12, for that amount. FG1

In another instance, regarding a perceived restriction of autonomy, there was an infectious outbreak within a care home, one participant states, *"Now if the place had been given the proper things to clean and everything else that bacteria wouldn't be spreading, would it?* (FG1)

> *I've been buying the Dettol stuff. …[but] they say the Milton, obviously, is watered down bleach isn't it? You see I'm not allowed to use bleach full stop…the thing [is], the health authorities have told us that Dettol is no good, the winter what's it virus is resistant to Dettol. Dettol won't touch it. The only thing which would kill it is Milton.* FG1

Although participants mostly explained the exercise of autonomy in relation to non-technical aspects of their work, the rare opportunity to sometimes exercise this autonomy in technical circumstances was also recounted in a positive light. Although it could be a frightful experience when faced with making a major decision regarding a resident, the experience had the potential of having a positive impact on well-being.

> *[I] was very concerned about one of the residents, thought she required 999. My gut feeling was she wasn't well and needed to [have] proper medical attention. I called 999. Ambulance came and took her to hospital. I felt like I had given her the best care available. I felt good, her son thanked me for providing his Mum with good care.* CIF6

b. *Managing workload*

Typically, daily tasks for the shift are assigned to FLCH staff by a shift leader or other authority figure responsible for the shift. FLCH staff may not have a say on the type of tasks which are assigned to them or the volume of the task. Depending on the level of staff shortage, duties assigned could quickly seem overwhelming, and participants described varied ways in which they managed their tasks. Having the perception of some control over their tasks seemed to have a protective effect on well-being. This perception of control translated into actions aimed at managing one's workload, one of which was asking and relying on colleagues to help with the workload. This enabled participants to create a comfortable pace of work, a sense of being able to complete tasks at a reasonable pace.

When feeling rushed off one's feet or under pressure to complete set tasks, a sense of knowing that one could ask colleagues for help was reassuring and settling. However, this was often possible when teams worked well together. With good rapport and camaraderie, team members felt they could rely on each other to get tasks done, and to be done well. "*We all tend to pitch*

in, there's sometimes I'd pitch in with Sarah if there's jobs she needs doing…they'd jump in and help me with stuff…we work together as a team here." (FG1). As illustrated in this extract, there seemed to be an unspoken agreement or expectation within the team on a shift. They all chipped in until tasks were completed. Additionally, this support often happened whilst on the same shift, but was also offered to colleagues on a different shift. When working on different but successive shifts (FLCH staff typically knew who they were taking over from), workload was managed through a shared understanding between colleagues to complete tasks as thoroughly as possible. This helped colleagues on the next shift to better manage their workload.

Participants described a contrasting experience when colleagues could (or did) not rely on each other to manage their tasks. Participants expressed the frustration of having colleagues who were non-supportive and who also 'did not pull their weight'. This was notable because, not only could FLCH staff not rely on non-supportive colleagues, such colleagues could potentially increase the workload. This was particularly related to poorly completed tasks where, as one participant put it, *"…you come and spend your first hour undoing what they have done."* (FG1). To manage one's workload effectively, it was important that colleagues could rely on each other to do a good job. Due to the interdepended nature of their work, when previous tasks have not been completed well, the next task may not be easily or quickly completed. Regarding colleagues completing tasks properly, one participant commented *"it makes it easier on you"* (FG1). The account of another participant captures the impact it can have on well-being when colleagues do not complete tasks well. It is the dilemma of taking a day off, but having to return to poorly-completed tasks which must be rectified. In other words, taking a break could simply mean more work when you return. However, when it worked well, it was a positive experience, *"because when you're not here, you can have that day off because you know someone's going to be doing the right job as well"* (FG1).

Managing workload by creating a comfortable pace of work was mainly achieved amongst FLCH staff themselves. It therefore seems critical to have good team spirit for colleagues to be able to depend on each other in the management of their workload. Working well as a team was a context frequently referred to in this study. This context, along with others which were frequently referred to are presented later in the chapter.

Working flexibly was also described as a way in which workload was managed. Unlike the goal of creating a comfortable pace of work, working flexibly involved seeking ways to effectively combine responsibilities at work with other external commitments. Participants achieved this by swapping shifts were possible. Although this was not always possible, when it was, the flexibility also provided a sense of control. In other words, if the work can be covered and FLCH staff were able to swap shifts with each other, ensuring a continuity of care delivery, then it reduced the burden of work and its consequential impact on well-being.

> *"... the other thing here is flexibility, working flexibility. I have hospital appointments and I always know there's never a problem, because I'd come in another time, or I'd do an extra day and make up the time, or whatever, there's never a problem. And you need that as well, especially if you've got kids, like some of them have got young children and that, they need that flexibility. Although it's a care home, it's [about] that caring to the staff isn't it? On that sort of basis."* FG1

Although there was still a lot to do on a shift, when the workload seemed somewhat manageable and did not feel rushed, participants recounted having a good feeling. In the extract below, the participant describes working with a different team to their usual team. Again, support and camaraderie of the team played an important role.

> *"For some reason the staff dynamic is much different with the people [residents] with dementia than it is with the people [residents] who are completely compos mentis. So, it's*

like you walk into work and you know you're working in that place and you're like I'm ready for work, like everyone gets along, they talk, the environment's relaxed, you know, there is not too much pressure on you. Obviously, you have to do like the personal care and everything but there's no pressure and you're not running around, you're not being rushed off your feet, you don't leave crying, so it's always good." (FG3)

c. *Being Assertive*

From participants' accounts, 'assertiveness' in this study is described as an attitude in which a participant sought ways to air their views. This was especially in situations in which injustice was perceived. In this study participants' accounts of assertiveness was largely related to issues with others, both relational and task-related. Assertiveness involved seeking out and speaking to a person who the participant perceived as able to influence the outcome of the issue they were faced with. In the extract following, a participant recounts an experience in which they believed that they were called upon too often by a team leader to do things.

> *She tried it and she wasn't getting anywhere with me with that, and I went to the manager and I said I'm not having this….I put up with it for a while but when I found it's kind of like, no, you're taking a piss now, in my opinion, you're taking a piss now. I'm not going to do it, because it's like, oh you Poppy, you go do it. You go do that, you go do it, Poppy do it, Poppy do it. Hello, don't know any other name apart from Poppy?* FG1

When issues were relational, assertiveness was described with an undertone of seeking a kind of resolution to the issue. That is, there was an expectation that the issue would be addressed with the other party in question. This undertone seemed important as on-going issues were described with a negative impact on well-being. It seemed that participants were motivated to

be assertive by the expectation of some resolution. For example, regarding a situation where others were taking a break when it was not break time, a participant recounts their experience.

> *The seniors don't know, because a lot of times they're downstairs or in the office, they don't you know… I've gone in how much times and complained, because I'm like, I said to them my name is not donkey, why should I be doing everything and these people are sitting down there on their mobile, or they're talking or whatever, and I'm thinking…what's going on?! I remember how much times I've gone in to say to a senior, "hello your staff is out there, and I'm the only one that's doing it [the work]". And the other ones out there disappearing or whatever. I just think to myself, are they too scared of saying something. I'm not scared of saying nothing to them…and I'd say something, because I said, at the end of the day, it's not up to me to be carrying everyone, you know, you know. I've told they themselves, I've gone to other people, I've told them, I've gone to the manager, because I just think, no!* FG1

One participant recounted the experience of the manager encouraging her to be assertive, *"I remember Ellen [manager] told me, 'if you've got something on, you're allowed to say no'"* (FG1). When assertiveness was not exercised, that is not seeking out and speaking to a person who could influence the outcome of a situation, participants expressed unhappiness. Some participants described how they had not raised issues of concern, and consequently, such unresolved issues festered and affected well-being and/or working relationships. *"Sometimes, I know I'm guilty of it sometimes, someone will niggle me, and I'd sit there and let it fester, until it reaches a stage, it bursts and then, the effect is ten times worse than if I had actually mentioned something to somebody two weeks earlier."*(FG1). This participant speaks with a sense of awareness, an awareness of a need to bring things up. This awareness seemed to be a shared understanding amongst participants, as others in different focus groups assented to it.

Although assertiveness was often described in relation to staff-staff relationships, issues concerning residents were also raised. The following quote highlights this point, and on this occasion, one FLCH staff was being assertive on behalf of another. Some participants reported having a difficult time with specific residents. This participant handled the issue by being assertive.

> *"They were going to her, 'you don't understand English, why are you in England?'. It was not being said to me, but just hearing somebody say that, I was very, I was very vexed and angry, and I said, I said to them excuse me, if you've got any problems any concerns, you should raise it with the lead carer. And I went and got the lead carer, and she straightaway went and adjusted this. It was not a personal experience, but witnessing it alone was so horrid, it's very painful."* FG3

d. *Being proactive*

This theme describes participants' taking control of a situation before it deteriorated into a more difficult experience. Although this sub-theme relates to 'being assertive', it encompassed more general situations. It is also distinct in that participants' actions were not simply about reacting to a negative situation. The actions captured by this theme involved taking steps to deal with a situation which could be averted or improved. One action often described was actually avoiding a potentially negative situation.

> *Being on your feet all day, after a 14-hour shift, when another member of staff speaks to you rudely, not wanting an argument/conflict, [you] just carry on with your job. Not allowing another's behaviour to impact how you do your job/conduct yourself.* CIF4

However, ignoring an issue (for instance by not bringing it up with the relevant parities) did not always help, as seen in a previous extract; *"Sometimes, I know I'm guilty of it sometimes,*

someone will niggle me, and I'd sit there and let it fester, until it reaches a stage, it bursts and then, the effect is ten times worse than if I had actually mentioned something to somebody two weeks earlier."(FG1). Addressing the issue earlier may prevent it deteriorating and negatively impacting well-being any further. However, participants' experience showed that in some instances, protecting one's well-being was indeed to avoid confronting a situation at a specific time. Therefore, being able to asses and avoid a situation which negatively impacted well-being was to be proactive.

Sometimes, avoiding or ignoring was employed when previous attempts to resolve a situation had not been successful. Further attempts were having a negative impact on well-being, therefore a person chooses to avoid or ignore the situation. For example, when one or more strategies had been employed to tackle an issue (such as reporting to a relevant person of authority), and there were no positive outcomes. For the participant in the following extract, there was an issue which was clearly still unresolved. Their experience at work and their well-being now seemed to hinge on this particular issue. The thought of 'nothing' being done about it was a source of frustration. To protect their well-being, they resorted to ignoring it. Silence on the issue seemed a better price to pay for well-being. When asked about any positive thing about work, this particular participant responded,

> *"I can't think of anything really because I don't really care. When I've had enough I just, you know, block them out of my mind, that's me all over. I don't go on and on and on. After a while, I just get fed up, I just say nothing, just leave it. I don't like to keep talking and talking and talking, it don't do no good."* (FG4).

When asked how they dealt with this experience in terms of well-being, the participant responds, *"My well-being is to go home."* (FG4).

Taking control by 'being proactive' also involved taking the lead on projects which were deemed beneficial. For example, a participant recounts an experience where the care home management had stated that there were not enough funds to purchase a new vehicle to take residents on outings. This was distressing and a source of irritation. FLCH staff typical have concern for the residents, and often have a desire to see them happy (as demonstrated in previous quotes). In the following excerpt, a participant describes how proactive steps were taken to do something about the situation.

> *We have a recently refurbished minibus. But we had to put on things all the time here, so we can get the money, to raise the money for it. They've not given it to us, it wasn't them that done it. We had our first outing in our new minibus, I mean it was brilliant. We've worked hard fundraising for the last couple of years and very recently we had one of our residents who very, very graciously, a matter of days before she actually died, made a massive donation to the home for the minibus. And as a result, we've gone from a minibus that was what, nearly 30 years old, to one that's three years old…. And it wasn't done through management, it was done through staff and residents….That's what I'm saying, does that mean that every time we want [something] we've got to do it ourselves?* (FG1)

The last statement, in the extract above was spoken with a tone of frustration, *"That's what I'm saying, does that mean that every time we want [something] we've got to do it ourselves?"*. It clearly demonstrates that the issue was a source of irritation which had a negative impact on well-being. It is important to see that this issue was not the same as simply implementing a good idea to raise funds, but a good idea which stemmed from an issue of frustration which could potentially have deteriorated.

6.3.5 Self-Care

This overarching theme involved participants taking care of themselves in a role which demanded much of them. On many instances, participants recounted how they gave themselves to their jobs, went the extra mile, endured stress, and put up with ill-treatment and several organizational stressors. Participants recounted how the demand of the role negatively impacted their well-being. They described how giving so much of oneself, without an understanding of one's boundaries, could make the experience of caring an unhappy one. Manging the negative impact which a frontline care home role had on well-being involved knowing how much one could take on before it was too much. This is captured by the sub-theme 'understanding one's limit'. Self-care was also described in terms of resilience. The sub-theme 'building resilience' captures experiences which involved improving one's ability to endure or persevere through the difficulties in one's role on the frontline. Participants discussed the impact of taking the time to appreciate oneself. The experience of self-appreciation, receiving appreciation from others, and the impact on well-being is captured by the sub-theme 'self-appreciation and receiving appreciation'.

a. *Understanding one's limits*

Giving so much, going over and beyond the expectation was a common narrative by participants. This brought a sense of satisfaction. Participants recounted how the feeling of making a useful contribution to the lives of residents was important to their well-being. For example, when asked about a stressful day at work a participant responded, *"when we come in, we get stressed out, we moan to one another and God knows what else. But at the end of the day you think, well, it's for the residents at the end of the day"* (FG4). Participants' accounts resonated a sense of commitment to residents. The intensity of this commitment is captured by

the following extract, *"It's when you're not in the building, that's when you get the negative sides, but the positive sides are when you're doing things for them, and make a difference."* (FG2). Being present in the care home and seeing the residents was a motivation for FLCH staff, which often had a positive influence on well-being. This sense of commitment to residents and drive could keep a FLCH staff going in spite of emotional or physical drain. One participant recounted *"I was very tired and could barely do anything, but…I had to come into work, I just came"* CIF1.

However, this drive and motivation may have side effects. Participants discussed the importance of knowing one's limit, and knowing when to stop. One participant demonstrates this awareness and explains, *"I feel like doing more, more, but there's a limit to it."* (FG2)

Knowing one's limit was not only discussed in relation to the positive experience of giving of oneself. It was also discussed in relation to understanding how much one was able to bear when faced with a situation which could not be changed. For instance, when faced with a challenging resident behaviour. One participant recounts a negative racial experience from a resident who did not have mental capacity. Although the resident's behaviour could not easily be stopped, and although the participant might have understood that a person with capacity may not speak in this way, this participant demonstrated an awareness of how much of the behaviour they could bear with.

> *"Oh she [resident] said to the managers in the care home to talk to us especially, and she quote in quote used "the coloured girls"….I literally stopped working on that floor because I can't do it anymore…I say I'm not coming in to work today because like I can't take it today, because I'll end up having a breakdown or something like that…*(FG1)

Sometimes such negative experiences involved colleagues. As described in the sub-theme 'being proactive', some participants confronted relational situations in order to get them

resolved, but others ignored or avoided them. Depending on the participant, both strategies could have a positive or negative influence on well-being. Knowing one's limit however, sometimes served as a prerequisite to making the judgement on whether to confront a situation or to avoid it. For instance, after having a series of difficult issues with colleagues on the afternoon (day) shift, one participant states, *"I find it hard to work in the day [with them], so now I work night shift and will sacrifice money just to not work on that floor."* (CIF2). This participant avoids the situation for the sake of their well-being, knowing they could not handle the situation any longer. In contrast to avoiding the situation, another participant confronts a negative experience with a colleague.

> *"…a staff member…treated me badly, [often] speaks to me in a very disrespectful way! Thinking (s)he is better than everyone else. Everyone should be treated with respect in the workplace. Spoke to a senior staff member on shift that I am not happy [with] the way I have been spoken to. Staff member was pulled into the office and had a chat with."* CIF7

It was important to know one's limit when exercising judgement on when to confront an issue and when to avoid it.

b. *Building resilience*

As in the sub-theme 'understanding one's limits', participants demonstrated an awareness of the demand of their roles. They talked about a personal responsibility to build oneself. This was described this as building up some kind of inner confidence *"just to help you deal with work"* (FG3). One participant illustrates this inner strength, *"I've been in care for a very, very long time, I've seen ups and down, people have upset me, but yet I have the energy to push myself up, do you know what I'm saying."* (FG2). As exemplified by this participant, the

outcome of building oneself was described as a strength which must come from within, and which keeps you going. The process by which one builds this inner strength was also discussed.

> *"With this industry, I feel that if you don't take time for yourself, and you don't take time to try and improve yourself, and you don't take time to really think about who you really are and really come into your identity, it's going to break you, and that's the most honest thing, it's going to break you"* FG3

This process as described, constitutes cognitive processing, evaluation, and taking control, elements of which can be found in some previous themes so far presented. One participant commented on the care staff role,

> *"If people are closed-minded especially in care, there's no where they are going [that is, making no progress]. You need to be open-minded, open-minded, thick-skinned, open-minded.* [Researcher: what do you mean by open-minded?] *Be ready for anything, yeah, changes. You can go into the care home, you've not slept there, they may wake up in a bad mood or good mood, so you don't know."* FG3

This excerpt illustrates an attitude of readiness, a mind prepared to take on challenges. In a job role where the state of your residents (that is, your principal focus) could change very frequently, to develop this inner strength was to develop an attitude of preparedness and adaptability to the frequent change. The word "thick-skinned" used in the extract also denotes toughness, a notion of being able to withstand the difficulties of working as a FLCH staff. As previously illustrated by other themes, the challenges to be prepared for were not only resident- or task-related, but also colleague related.

> *Other members of staff can impact on other caregivers. Carers can impact on your attitudes towards care…[they] could also be an impact to you, your well-being at work*

because they're the people you relate with most…one of the things that could be a huge threat to your well-being as a carer. (FG3)

As exemplified by this extract, participants demonstrated an awareness of the impact of their colleagues, and their accounts demonstrated attitudes deployed to mitigate the negative impact which their colleagues could have on their well-being. For instance, one participant stated, *"Don't let people pull you down."* (FG2). This was particularly relevant in the situation where there was a breakdown in relationship. For instance, after escalating an issue to management, one participant recounts *"I'm still getting abuse on a daily basis, you know, people are still saying things about me, even behind my back."* (FG3). Another comment connotes a deliberate attempt of colleagues to sabotage one's well-being, *"Don't let the other staff see that you're weak. That is something that I really had to work [on]. If they see that you're weak they play on it."* (FG3). Although this may sound dramatic, when relationships were broken down, the accounts were so described.

Another participant describes the strategy used to build resilience. This participant was faced with an on-going situation, that is, caring for certain challenging residents and colleagues were continuously negative about the experience. Having to work with colleagues in this situation, the strategy deployed by this participant involved changing the narrative in conversations with colleagues. The strategy draws on the idea of shifting one's focus, and it comprises of positive thinking and empathy. The outcome was a confident attitude, which also deescalated an issue that would typically be amplified by colleagues.

I don't let them [colleagues] take over my mood just because their mood is bad. What I do is, you know some people when they are stressed they will just talk about negative stuff, "oh that resident…the resident that we are going to the room now is really this and that". Like they are stressing more, yeah, on top of their stress, just like they are

adding more fuel, yeah. And what I do, I always like think and say to people, like, "think positive, [at least] it's not your grandmother, it's not your grandfather, and maybe these people were not like that before [compared to] how they were now. Think about their age, [perhaps when] they were younger they were…like us, enjoying, thinking life is so positive, but now that they are older they get easily irritated because they don't have anything in their life to do now, just being of high dependency on carers. The only thing they can do is like try to control us, try to control us". But I'm not saying it to give them the chance to control us…[but we can] compromise with them and everything. (FG3)

When this inner strength as described by participants was lacking, or not sufficient to tackle a situation, well-being was adversely affected. In the following extract, a participant recounts the impact of being called names, the issue was reported but no clear resolution had been reached, particularly that it involved residents with sometimes no mental capacity.

I'm a tall girl, you know, I'm a big girl, I wouldn't say like I'm big but, you know, I'm a big girl and a lot of them have to make a comment, because I don't suit the [skinny] British standard girl they'll always have to say "oh you're a big girl" and they describe me, "the big girl"…like I don't like that….I look in the mirror, I'm just a label, and it's hard…you say like, to your manager or something, "I don't want to be here because I'm starting to form this picture of myself that other people have told me that I am. Now every time I go to work I think everyone's looking at me because they think I'm this, you know, everyone's looking at me because they think I'm that". There was like…one whole week where I was just scared to eat in front of everyone because I was afraid what they were thinking about me…I've found it hard to accept myself and now I'm trying to accept myself and then next thing you know every day at work somebody's telling me what I am. It's not what I think I am, it's "you are a big girl, you are this, you are that"…. When you're being attacked personally on a regular basis you also go

home and you look in the mirror, I don't want to get emotional, you look in the mirror, and all the comments that have been thrown at you all day, it's so hard. FG3

c. *Self-appreciation and receiving appreciation*

In the midst of a difficult work terrain, one act which was demonstrated to have a notable positive impact on participants' well-being was appreciation. Appreciation was shown to have positive effects whether it was given to oneself or given by others. It lifted participant's mood and bolstered motivation. Appreciating oneself was often described in relation to doing a good job. When a person felt that they had accomplished a task to a standard they approved of, they took pride in the job well done and experienced a sense of accomplishment and satisfaction.

I do most shifts at 6am in the morning, nice to say hello to everyone with a smile. [I do this to] make the residents' day nice and happy. I feel happy to see everyone in a nice mood. I feel good when I finish the day. CIF10

This excerpt demonstrates self-appreciation which was self-driven and independent of others' compliments. That is, the participants did not appreciate themselves or their work only after they had received a compliment from someone else. However, self-appreciation which was triggered by the compliments received from others was also demonstrated to have a notable impact on well-being.

I get satisfaction with the residents' clothes looking nice and the residents thank me, it's rewarding. …I respect all the residents, and if it was my parents in a home, I would want them to look clean and tidy. [I get] great satisfaction, and [it's] nice when residents thank me, it's a nice feeling. …I feel appreciated, makes my job worthwhile. CIF17

> *A resident's family member told me that I was doing a good job. I was happy and content and wanted to better myself at my job. I felt happy and content with myself.* CIF4

Receiving appreciation in general was a key influencer of well-being. Being appreciated for the work they do, for going the extra mile, for positive outcomes amidst difficulty, and for numerous other things, was discussed as being important. Particularly important because participants considered appreciation to be a significant factor which affected how they worked and their well-being in general. *"We're quite close to the directors and the people that actually own the building…they are really appreciative and when they say thank you, you know, it means something, and you're like I'm actually doing a good job. It goes a long way.* (FG2). This kind of appreciation from the leadership was also highlighted as playing an important role in self-sacrificial efforts by staff. For instance, when participants have to do something extra (like coming in on a day off to help), they often described it as being done willingly, as an extract in the sub-theme 'exercising autonomy' demonstrates *"It's not like by force, it's not like, you're pushed to do it, you feel like, oh I'll make this person happy"* (FG2). However, appreciation from leadership seemed to also play a significant role. Describing an incidence where staff had to come in to help with an event which was organised for the resident, one participant recounts.

> *Some people were working, but then a few of us come in on our day off to help out. We actually wanted it, we actually arranged it...because we wanted to do something nice for the residents. So, we were happy to come in on our day off, and luckily the manager that we had at the time was very thankful and said, thank you very much, and appreciated the effort we put in. But if he hadn't have, then we wouldn't have felt so great about it.* FG2

Appreciation also came from colleagues, *"They appreciate what you do, they do, they do, and they are so nice. It's just the one or two that are a bit grumpy at times."* (FG1). As illustrated, appreciation came from relatives, residents, management and from colleagues. Although appreciation from varied sources was delightful and energising, appreciation by residents, when possible, was greatly valued. A resident's appreciation was valued as a special experience and often recalled fondly.

> *"I remember once…I knocked on a resident's door and said it's only me, and she said, 'it's not only you, you do an important job'. Oh, that was really nice of her to say that, it makes you feel appreciated"* FG1

A participant gave some insight into why the appreciation from residents might be so highly valued, especially from those living with a degree of dementia. This participant described it as being a pure expression of appreciation, in other words 'no strings attached'. The resident is not aware that it is a job being done, and that the staff has to do it. They simply appreciate the effort or time, whether duty-bound or not. This expression of thanks perhaps momentarily takes one's attention away from the strain of the job to see the good that it is - the considerate act of caring for another in need.

> *When you help one of the residents and they appreciate you, it does go a long way. Say for example somebody, like people who've got dementia especially, they don't know what you are doing…they say, "oh thank you". …You know you have to do it for them but for them, they don't…. I mean it's really good and I feel like it's a positive thing when people with low mental capacity, yeah, can actually say thank you to you for something that you're doing, because I know you [resident] don't have to do it, yeah.* FG3

This idea was discussed by another participant. That is, residents' appreciation being genuinely innocent. Receiving this kind of appreciation played a key role on well-being as often times, participants did not see their role as being significant or important.

> *I think, with the residents, you don't always see that [they] appreciate it. One of the residents, she was dressing up and she couldn't do her bra yeah…I went, and I said can I help you? And she said, 'can you?', and I did. And every time her daughter-in-law comes…she goes 'you know she's nice, she came all the way to help me with that'. And I thought that was nothing, it was just a little thing, but after a long time she still remembers that.* FG1

This excerpt is one illustration of how participants downgraded their efforts. They often thought of themselves as just 'ordinary'. When they do their work in thoughtful ways, or sometimes in exceptional ways, or when they went out of their way to do outstanding things, they habitually downplayed their efforts. They used expressions like, *'Those things we don't really think of them as positive we just think it's normal'* (FG1). However, it was clear that appreciation was important to participants. It seemed to make a difference to the entire experience of caring.

> *I think as long as you've got a good support around you and if you do something nice and you are appreciated that's all that matters, but if you're not appreciated and it's just expected of you then that's when it becomes really negative and you don't want to do it and you're like, well if you don't bother, well then, why should I, sort of thing. [Say] "thank you, you did well", yeah. But when people don't say that, especially from the people that are higher up, then you think, "well if you're not going to appreciate me then there's no point", yeah then that's when people start, like they can't be arsed*

and they go, "well I'm not going to come back in this building" sort of thing that's when that happens. FG2

So far, the themes and sub-themes which were developed from the data have been presented. In the section which follows, specific contexts are presented. These contexts where most frequently referred to in all the focus groups, and frequently mentioned in the CIFs.

6.3.6 Prevalent contexts

While the thematic analysis was being conducted and the themes and sub-themes were being developed, it was noted that participants almost always gave a detailed description of the context of their account. They gave examples, and described scenarios to explain what they meant and how they felt. As the transcripts and critical incident forms were analysed, it was noted that certain scenarios were described repeatedly. The researcher took note of these scenarios alongside the identification of codes/nodes. These contexts/scenarios are presented below with a brief description of each one.

1. Conflict in relationships between colleagues

   Contexts which described relational difficulties with a colleague
2. The experience of a busy shift – high demands and high pressure

   A feeling of being rushed and 'not having breathing space'
3. Teamwork and team spirit

   When participants felt there was good rapport amongst their team
4. Quality of relationship with manager, team leader or supervisor

   A feeling that leaders were like colleagues, approachable and dependable
5. Quality of relationships with residents and relatives

   A *sense of commitment to residents, a spontaneity of going the extra mile for them*

6. Experiencing a low mood at work

   Feeling weighed down by various aspects at work, and not one in particular

7. Other general situations at work

Following the analysis in which the themes and sub-themes were identified, the researcher then considered each theme and sub-theme in light of the identified contexts. It was noted that each of these contexts contained all or most of the main themes and sub-themes. The significance of these contexts was taken into account. In Study 2, these contexts would inform the design of the survey; where they were used to create contexts specifically related to the questions which immediately followed. In study 3, these contexts enabled the intervention to be tailored to the domain of FLCH work in relation to well-being. Tailoring the intervention in this way specifically involved creating scenarios for the game to be played during the initial workshops (see Appendix J). These contexts also informed the development of the programme theories in Study 3.

6.4 Discussion

From the analysis of the data, from the focus groups and critical incident forms, five main themes were developed, four of which have associated sub-themes (see Table 6.1). Themes and sub-themes represent actions and attitudes which FLCH staff deploy in the face of a difficult situation at work. This is typically a goal-relevant situation which poses a threat to their well-being. Additionally, seven contexts were identified during the data analysis. These were the most common situations participants described as they recounted their experiences. The themes and sub-themes were found to be interrelated, and participants' description of the contexts highlighted these interrelations. The findings of this study are discussed in terms of 'defending or protecting well-being', and 'enhancing and nurturing well-being'.

6.4.1 Defending or protecting well-being

The overarching theme of 'regulating emotions (in interpersonal conflict)' involved FLCH staff handling their emotions in a reasonably acceptable way when in conflict with others. It was one of the most frequently recounted experience by participants and was often denoted as an emotionally difficult experience. This concurs with other research on workplace stress, which indicate the significant impact of interpersonal conflict. For example, as captured by Overton and Lowry (2013).

Emotion regulation was described as taking actions, or having a mental attitude, which positively influenced one's emotions in the event of interpersonal conflict at work. The conflicts mostly referred to by participants was between colleagues and not with others such as residents. This theme captured the regulation of emotions where it involved direct personal issues and task-related issues. This theme has links to the other four themes as there were elements of emotion regulation in some of the other sub-themes. Perhaps a reason for this prominent link to all the other themes is that emotions play a significant role in human services roles. Chudzicka-Czupała et al. (2019) allude to high impacts of workplace stress in human service sectors (see literature review, Chapter 2). Furthermore, this link to the other themes perhaps could be explained by the desired outcome of some of the other sub-themes. Sometimes, the desired outcome involved feeling better emotionally, which was ultimately due to being able to regulate one's emotions. For example, when a FLCH staff seeks support from a colleague, by 'moaning' to them, not necessarily to resolve an issue but to be heard.

Managing one's emotions in a conflict or managing what was perceived to be a difficult relational issue, was discussed as an issue which affected mental state and subsequently impacted on well-being and work. The theme was described as having so much undercurrent,

that if you did not deal with it, *"it will explode"* (FG1). In other words, leaving relational conflicts unresolved could lead to even bigger issues, which may require more effort to be invested to regulate emotions. Thus, being able to address the situation as reasonably quickly as possible was beneficial in regulating one's emotions. Although some argue that workplace conflicts can be advantageous (Janss et al., 2012), the accounts of participants did not reflect this, and conflicts were more likely to negatively affect one's well-being and work.

Under this theme, some of the issues described by participants were mostly on-going and therefore a persistent source of frustration. Regulating emotions may not always be equated to resolving an issue, and participants' accounts demonstrated that it was possible that an issue was on-going, but they were able to endure it. Indeed, in their paper which focus on healthcare settings, Overton and Lowry (2013) point out that some conflict may not necessarily be avoided but can be managed. They discuss the potential of training and skills development in the management of conflicts. Indeed, conflict resolution skills may be an important tool for FLCH. Unlike the other themes, participants' strategies for managing conflict were mostly not clearly defined. A number of participants' accounts illustrated the impact of interpersonal conflict on well-being, strong emotions were expressed but not many accounts of resolution.

Participants alluded to how unresolved conflict made their shifts drag and felt longer. Sometimes it left participants either feeling demotivated about going into work, or outright dreading it. The implication of such conflict amongst FLCH staff comes to bear significantly. This is particularly so because they have to work well as a team to ensure an efficient and safe delivery of care on every single shift. Sometimes, the quality of care, or even the life of a resident could depend on it.

Other situations, for instance feeding, assisting, or washing, which may not be life-threatening, must all still be well-coordinated such that no resident is neglected, or placed in harm's way at

any point during the shift. On some occasions, such as when caring for a resident with high dependency, FLCH staff have to work in pairs (a double) to take care of one resident. Working so close together in caring for a vulnerable person, whilst in conflict with each could have crucial consequences.

This close-knit way of working is paramount to the work of the FLCH staff. Although each person is allocated a set of duties on a shift, each FLCH staff on the shift is often aware of what has been covered and what is outstanding. Participants discussed how on finishing their jobs, they would go to help their colleagues on other duties which still needed to be done (creating a positive experience). In contrast to a positive experience, some participants discussed the frustration of colleagues not doing their part of the overall job. Or, having finished their own assigned tasks, refusing to help with other duties which might be more difficult, or refusing to help with general tasks which may not have been assigned to any particular person.

Ambrose Bierce said, “speak when you are angry, and you will make the best speech you will ever regret”. Although resolving an issue may be ideal, this was not always possible. Holding back and avoiding frequent outbursts of emotions enabled staff to feel in control. However, it is important to find a means to address these emotions and not bottle them up, as exemplified by the theme ‘seeking support’. Chapman et al. (2006) particularly highlight the danger in supressing or avoiding these emotions. Although finding the right time to bring them up is important, Feldman et al. (2007) point out that under-engagement with one’s emotions may be a sign that one is experiencing difficulty in regulating one’s emotions.

In the care home work environment, stressors seem incessant (Chao, 2019), which supports the need to have issues addressed, and not allowed to build up. Unaddressed issues of conflict can take their toll on staff and may affect how they view their work and themselves. Thus, in an

environment where one is frequently exposed to interpersonal conflict, being able to regulate one's emotions is a critical ability to possess.

Participants discussed the importance of surviving in their work environment and enduring difficult situations. One way they did this was by shifting their focus, in other words, choosing to see things differently. To see things differently often meant a re-evaluation. Such a re-evaluation involved a conscious effort to reconsider a situation in such a way that one sees the positives which have come out of it or which could come out of it. It was a subjective way of interpreting situations, including objective situations. A participant may therefore acknowledge that things may be going wrong regarding a situation, but instead on dwelling on the negatives, they chose to interpret the situation differently.

This concurs with what Lazarus and Folkman (1984) describe as reappraisal (see Chapter 3). Re-appraising, or deciding to see things differently is a useful strategy in frontline care home work particularly because of the conditions of some of the residents which staff have to care for. Often with the cognitive decline and/or behavioural challenges, there may not always be a resolution of some of the issues related to residents or their behaviours. As seen earlier, this could also hold true for issues with co-workers, where there may not always be a resolution of a conflict. The notion of choosing an intentionally positive outlook is captured by Throop and Castellucci (2010) who describe it as finding alternative ways of perceiving a situation. Often the situation in question is negative and new interpretations are found for it. In clinical settings, Vernooij-Dassen et al. (2011) consider this alternative outlook to be one which helps individuals to change self-defeating and distressing viewpoints into those which will enable them cope with a situation.

Conversely, a situation could be interpreted negatively, even if there are some positive aspects to it. From the discussions of participants, most of such negative interpretations of a situation

were often linked to an unresolved issue. On-going issues are particularly difficult since there may be no resolution in sight. For example, being picked on and 'bullied' by residents who may not have full mental capacity as recounted by one participant. In another account, a participant felt attacked by a team lead as a result of being perpetually allocated to unfavourable tasks on the shift. This is a difficult situation to be in because the allocation of tasks by a team leader cannot necessarily be described an attack, since a team leader may allocate tasks as deemed fit. However, due to other underlying issues, the participant clearly felt picked-on and could not easily justify their feelings. Other situations may not be difficult or dire but are simply an on-going irritation. Additionally, there just may be situations which are difficult to resolve, or which may take a long time to resolve.

Whether dealing with difficult, dire, or simply irritating situations, shifting one's focus can be an attitude which empowers endurance. Here, endurance means the acceptance that something will always be an issue, nonetheless, one which can be well-managed in order to cope with it. Where there is a stressor which may not be easily resolved, or which cannot be resolved at all, tenacity to endure the experience is required in frontline care work. Participants illustrated how they focused on a personal motivator or tried to understand the experience of others as a way of protecting their own well-being. There were numerous examples of participants enduring difficult situations and making it work as best as they could. Thus, developing or strengthening the capability to shift one's focus, especially in on-going or difficult situations, was also a vital capability for survival and well-being. To not possess the capability of easily shifting one's focus, or to minimally engage this capability, meant that one's focus was habitually on an issue.

6.4.2 Enhancing and nurturing well-being

Deploying strategies to defend or protect one's well-being, including emotion regulation and shifting one's focus were one way to survive the difficulties of frontline care experience. However, participants discussed not only survival, but also well-being enhancing and nurturing strategies.

Being able to seek out someone to talk to, either a colleague or other senior members of one's team was an important action which influenced the well-being of participants. Having one trusted colleague, or a network of colleagues who lent a listening ear or offered some kind of useful support was an important resource to have. Although being in the midst of a crowd, amidst the constant buzz at work, it is possible for FLCH staff to feel alone, having no one to turn to, or not feeling a part of a team. Support at work can be critical to well-being, and this has been demonstrated by several studies. For instance, Woodhead et al. (2016) showed that having social support attenuated the negative impact of stress and burnout.

When a participant was unable to seek support, or the feeling of belonging was lacking, they felt low and out of place, or sometimes offended. But when present and nourished, the individual felt good. Participants discussed how it helped their well-being to know that they could approach a colleague or senior to discuss anything about work. For some however, who did not particularly want to talk to anyone about work, or may not be inclined to 'moan' about things, feeling connected to a good team was just as important for their well-being. Participants' accounts showed that working well in a team fostered this kind of support.

However, being a part of a team in itself, was not enough to be considered a resource, it was being a part of a good team that counted. A good team implied one which fostered well-being, where each person chipped in their part to sustain the comradeship. It seemed hurtful when some people were considered to not be playing well on the team, or not 'pulling their weight'.

This often led to interpersonal conflicts between FLCH staff. Due to the workload, and the shared nature of work, the issue of playing well on the team is a vital aspect of the teamwork. The experience of poor teamwork was described as putting pressure on everyone else. Sometimes this involved having to re-do tasks which were not done properly.

Participants' accounts give the impression that the experience of actual work (that is, tasks to be done) was intertwined with the camaraderie between co-workers. Being able to seek support and offer support aided team spirit and well-being. As demonstrated by various excerpts from participants, the feelings of pain, annoyance, frustration, delight and thankfulness, were just as important as the experience of work itself. Thus, when emotionally hurt, and FLCH staff did not or could not assertively air their views, issues are left unaddressed. They continued to fester, damaging well-being, and impacting work. Although it can be a difficult experience to bring up issues, to keep it quiet and festering may have negative consequences. This is crucial for FLCH staff due to the continuous contact they have with each other during their shifts, and the criticality of mutual respect, common goals, and shared problem solving in the delivery of safe and efficient care (Gittell et al., 2008; Anderson et al., 2014; Toles and Anderson, 2011).

Whilst it is one thing to air one's views, it is another thing to seek the right audience, which sometimes was an authority figure. Participants talked about the importance of being able to raise issues which were of concern to them to their superiors. This capability and opportunity to raise issues is of significance as other studies have demonstrated its impact on performance levels. If a person does not feel confident enough to raise a concern or seek help, they are likely to take no action in addressing the concern. Pearson et al. (2006) describe this in terms of a perceived cost of seeking support, which means that if the cost of seeking support is perceived to be high, there is a lower likelihood of seeking such support. Pearson et al. (2006) also found perceived cost to be negatively associated with the level of performance.

The support of a manager or supervisor has also been shown to have an impact on the performance of staff/subordinate. For example, the systematic review by Pearson et al. (2006) showed a positive correlation between a supervisor's support on the performance of nurses. The discussions of participants in the current research did not particularly focus on a leader's support for task-related duties. There was a focus instead, on a leader's concern for and management of their welfare, as individuals or as a collective group.

In seeking support from a significant person of authority, participants demonstrated an expectation of their leaders. There was an expectation that leaders will act when issues were reported to them. For instance, when an issue of concern was reported, participants expressed frustration when there seemed to be inaction by a senior person. Sometimes it required courage and assertiveness for a FLCH staff to raise an issue which was of concern to them. Although not confirmed by participants, there did not seem to be a regular 'forum', one simply dedicated to discussing 'deep' issues regularly enough. Perhaps, this might create the opportunity for FLCH staff to air their views and relieve some of the tension of feeling unsupported. Importantly, this may bolster the confidence of FLCH staff to take steps towards improving their well-being.

For some participants, it did not seem natural or easy to approach a manger in order to raise or discuss a complaint. Therefore, when such a person mustered the courage and made the effort to raise an issue, they expressed frustration when it seemed that nothing was being done about it. When participants' felt let down by their leaders, anger was sometimes expressed and so was a loss of hope, a loss of faith in an authority figure. On some occasions, the participants simply resigned to inaction. This was a way of coping, that is to ignore or avoid the situation. However, as Chapman et al. (2006) point out, this could have even more dangerous impacts on well-being.

Support from the top may not always involve a manager or team leader taking an action. Their presence and continuity provide a sense of security and support. Just as the high turnover rates of FLCH staff can affect the well-being of residents, so could the turnover of management and senior staff affect the work and well-being of FLCH staff. As earlier mentioned, FLCH staff work closely and interdependently in teams, engaging in shared problem solving, building rapport and camaraderie. When your team leader or manager leaves, there can be a sense of loss for some staff who appreciated them. In addition, whether appreciated or not, such a loss causes a break from the familiar. The familiar (knowing your manager's style, their expectations, their preferences, and the like) can be settling. You know what is expected, and what to do if you fall short. When a new manager/team leader comes on board, there is a change in the terrain of the familiar, which can bring with it, additional stress.

In coping better with stressors, a sense of control also played a significant role. It was a feeling that one was in charge and that the outcomes of a situations were not merely left to chance. Taking control had an effect of attenuating the negative impacts of a stressor, and one way to take control was to manage one's workload. One way in which workload was managed was by having flexibility and working at a comfortable pace, although this option was not often possible. Such flexibility and a comfortable pace of work were mainly achieved amongst FLCH staff themselves. There seemed to be an unspoken agreement or expectation within the team on a shift team. They all chipped in until tasks were completed. Since a care home runs for 24 hours, care is continuous, where one team stops, the other takes over. The teams are often labelled day and night shifts, and there is sometimes conflict over tasks which had been left undone by a previous shift. When these 'day-and-night' relationships work well, a feasible pace (of day-to-day activities) could be achieved. In such an amicable relationship, there is an understanding amongst staff that various incidents could occur in the care home to slow down the pace of work. Therefore, if a task is left undone, there is a good reason for it. Day shift may

leave duties for night shift and vice versa and there is tolerance. In this harmonious environment, control over tasks, pace of work and flexibility is achievable. However, the contrary occurs when the relationships do not work well. The flexibility of working at one's pace is beneficial, yet, to avoid issues within or between shifts, work still has to be done in such a way that tasks were not completed too slowly, or left forgotten.

Nurturing well-being was also described in terms of 'self-care', where the importance of taking care of oneself was highlighted. Although it was beneficial to feel supported and be 'looked after' by others, participants discussed the personal responsibility of building oneself. Building oneself referred to developing a kind of inner confidence, one which emboldened participants. Self-care also involved appreciation, including appreciating oneself. A sense of commitment to doing a good job, and the satisfaction derived thereafter were nurturing to well-being, and it was important to take the time to self-appreciate. This was distinct from being appreciated by others, and distinct from appreciating oneself only after someone else had taken notice. It gives the impression that those who engaged in self-appreciation (especially when not triggered by another person), had an internal reservoir from which they could draw well-being enhancing benefits. Not many participants discussed this kind of self-appreciation which was not triggered by someone else. Although a number of participants recounted appreciating themselves and their work, it was mostly after someone else had appreciated them. Despite this, being appreciated by someone else had immense impacts on well-being. Appreciation was important, and it could come from anyone who cared enough to take notice.

So far, this study has highlighted various defensive and enhancing strategies which FLCH staff deploy for well-being while at work. The absence and presence of these strategies, and the consequent effect on well-being have been illustrated by participants' accounts.

This study aimed to reach FLCH staff directly and to provide the opportunity for them to speak as extensively as possible, about what they do for well-being. The employment of focus groups was useful in facilitating this aim. However, this approach also has limitations. For example, the recruitment of participants may have created a bias. Participation was voluntary, and the study might have attracted participants who were already motivated and interested in improving the resources they already had. Discussing about well-being with a group of people may not have been attractive to a person who felt they were not managing well at work. Therefore, it is possible that some of those who were already resource-poor may have been missed. To mitigate the effect of this bias, it was anticipated that further data would be obtained by participants completing the critical incident form to enable any such individuals who participated in the focus groups to share their experience and express themselves as freely as possible.

6.5 Conclusion

In this chapter, the methods, results, analysis and discussion of Study 1 were presented. The study chiefly aimed to address research question one by undertaking an in-depth exploration of the well-being experience of frontline care home (FLCH) staff via focus groups. Study 1 sought to uncover the strategies which FLCH staff deployed in the face of a situation which posed a threat to their well-being. The findings are five main themes and sub-themes comprising of well-being defending, and well-being enhancing strategies. In addition, specific contexts were found to be recurrent in the accounts of participants, in all focus groups and most critical incident forms. These contexts seemed to trigger the deployment of the strategies described by participants.

In the following chapter, the findings from this study (Study 1), both themes and recurring contexts, are used in the development and validation of a novel well-being self-efficacy scale.

7 Study 2: Developing and Validating the Well-Being Self-Efficacy (WBSE) Scale

7.1 Introduction

Study 1 in the previous chapter explored the well-being experience of frontline care home (FLCH) staff via focus groups. With the lens of self-efficacy, the study sought to uncover the strategies which FLCH staff deploy in the face of difficult experiences which challenge their well-being at work.

The aim of this chapter is to present the process and findings of Study 2 which aimed to develop and validate a novel well-being self-efficacy (WBSE) scale. Study 2 chiefly aimed to address research question two. It is expected that this scale will enable the assessment of a person's belief in their ability to improve their well-being. The development of the scale was guided by Bandura's (2006) guide to developing self-efficacy scales.

The chapter begins by presenting the process of item creation, and subsequently presents the new scale. The procedure of data collection and data analysis are then outlined, and the results are presented. The chapter concludes with a discussion of the findings.

7.2 Items generation

The items generated for the WBSE scale were directly derived from the themes and sub-themes of Study 1 (see Chapter 6). This means that each item of the scale was grounded in the themes and sub-themes. As described in Study 1, themes and sub-themes represent actions or attitudes which FLCH staff deployed when faced with situations which challenged their well-being. Participants described their actions or attitudes under various negative, challenging or positive

circumstances at work. In conjunction with the literature, and the theoretical framework of self-efficacy, these particular 'action/attitude' responses informed the creation of the items for the scale. See Table 7.2 for the WBSE scale. Each item on the scale represents an action or an attitude. For example, '…sort out tasks which have not been done correctly by your colleagues, without being overwhelmed by negative feelings'.

To demonstrate how the items were created from the themes, two examples are given. First, theme one is 'Regulating emotions (in interpersonal conflict)', one item informed by this theme is '…keep your cool while discussing the issue'. A second example is theme four, which is 'Managing workload'. An item informed by this theme is '…work at a pace that does not make you feel under so much pressure'. These two examples illustrate how all the items were created. Table 7.1 shows each item and the theme which informed the creation of that item (numbering matches Table 7.2). T1 represents theme one, T2 represents theme two, and so forth.

Table 7.1 Items of the WBSE scale and their links to the themes from Study 1
*originally item 25 **originally item 34

Item	Theme link		Item	Theme link		Item	Theme link
1	T4		15	T3		29	T5
2	T2		16	T1		30	T2
3	T3		17	T4		31	T2
4	T1		18	T1		32	T1
5	T1		19	T1		33	T1
6	T4		20	T4		34	T5
7	T1		21	T2		35	T1
8	T4		22	T1		36	T1
9	T4		23	T4		37	T2
10	T4		24	T4		38	T2
11	T1		25	T5		39	T1
12	T4		26	T2		40	T1
13	T4		27	T4		41	T1
14	T3		28	T1		42*	T4
						43**	T2

Besides the themes and sub-themes developed in Study 1, in the analyses of Study 1 data, specific contexts were identified as being prevalent in participants' narratives. When participants discussed what well-being meant to them, and what they believed impacted their well-being, their responses gave context to the strategies which they deployed. These prevalent contexts were mentioned in all the focus groups and frequently referred to in the critical incident forms. The contexts were employed in the development of the WBSE scale, being presented as scenarios. These scenarios were considered useful as they provided a frame of reference for the respondent. Thus, the scenarios were designed to trigger the experience of a survey respondent, placing them in a specific context. It was expected that this would achieve an effect similar to preliminary instructions (described later in this chapter), that is, creating the appropriate mindset before questions are answered. Therefore, the set of items immediately following a scenario were closely related to that specific scenario. Seven scenarios/situations were developed around the following areas:

1. Conflict in relationships between colleagues

   Contexts which described relational difficulties with a colleague

2. The experience of a busy shift – high demands and high pressure

   A feeling of being rushed and 'not having breathing space'

3. Teamwork and team spirit

   When participants felt there was good rapport amongst their team

4. Quality of relationship with manager, team leader or supervisor

   A feeling that leaders were like colleagues, approachable and dependable

5. Quality of relationships with residents and relatives

   A sense of commitment to residents, a spontaneity of going the extra mile for them

6. Experiencing a low mood at work

   Feeling weighed down by various aspects at work, and no one in particular

7. Other general situations at work

Wording the items

The items of the scale were worded in such a way that they were a judgement of capability (can do), rather than a statement of intention (will do). Bandura (2006) points out that although perceived self-efficacy is an important determinant of intention, self-efficacy and intention are conceptually and empirically separable. Therefore, items were worded to reflect a judgement of capability. For example, 'Rate your confidence to be able to approach your colleague to discuss an issue when you do not like the way you have been treated by them'.

Gradations of response

Each item was presented in such a way that it could assess an individual's appraisal of the belief in their ability. Respondents will rate their level of belief in performing the action or maintaining the attitude represented by each item.

Preliminary instructions

Preliminary instructions (Bandura, 2006) are those which are given to a respondent before they commence to rate their strength of belief. Such preliminary instructions help establish the appropriate mindset in which respondents should be when rating their belief. A preliminary instruction will include a clear statement to the respondent, pointing out that they are being asked to make a judgement of their capabilities at the present time, and not potential or expected future capabilities. In addition, the scenarios were to aid participants' understanding of the questions being asked and the strategies being investigated.

Practice item

Bandura's (2006) guide advises on the addition of a practice item. A practice items is an item not directly related to the scale, but a valid and sensible question to which a respondent will

answer. A practice item was added at the beginning of the WBSE scale to help respondents familiarise themselves with how they are expected to assess the belief in their ability. Adding a practice item also gives the opportunity of highlighting any misunderstanding about how to use the scale (Bandura, 2006).

Minimizing response bias

To minimize response bias is to set safeguards which will minimize potential motivational effects of self-assessment. In other words, measures are put in place to encourage honest/truthful responses. Bandura (2006) points out that these safeguards can be successfully built into the instructions and administration of the scale. He suggests for instance, to label a scale as 'Appraisal Inventory' instead of 'Self-Efficacy'. Other safeguards include assuring respondents of confidentiality and pointing out the important value of their contribution to the research. Therefore, attached to the new WBSE scale given to each respondent, was an information and consent sheet which explained the value and significance of the respondent's contribution. Also, on this sheet, confidentiality was assured, and the respondent thanked for their valued contribution.

Creating the items based on the results of the focus groups described in Chapter 6, and guided by the principles outlined above, the new WBSE scale was developed. The initial generation of items yielded 43 items. These many items were generated with the aim of creating an initial item pool containing more items than the final scale.

The expert panel review

Following the creation of the items and the grouping into categories, an expert panel assessed the face validity of the WBSE scale. Face validity is an indication of whether a scale actually measures what it intends to measure (Fitzpatrick et al. 1998). The expert panel comprised of 14 individuals purposively selected for their expertise in care home management, frontline care experience, and academic expertise in scale development, organizational behaviour, and the social-cognitive theory. Their years of expertise ranged from 2 - 35 years. Each member of the panel was invited to participate in reviewing the new WBSE scale and was informed that they had been selected due to their expertise. They were informed that the list of items to be reviewed had been developed from focus group discussions with FLCH staff.

The panel was informed that the new scale was intended to assess the self-efficacy of FLCH staff with regards to well-being. The definition of self-efficacy was given to the panel, as the belief in one's ability to organize and execute the courses of action required to achieve a desired outcome (Bandura, 1997). On this occasion, the desired outcome was the improvement of well-being at work, therefore, the panel was informed that the steps taken by the FLCH staff on this occasion were towards the improvement of well-being. Against this background, the panel members were subsequently instructed to rate the relevance of each item on a scale of 1 (not relevant) to 5 (highly relevant). The panel was also given the opportunity to make additional comments on any particular item or on the scale in general. For instance, any areas of ambiguity, double-barrelled questions, the style, clarity of statement, readability and so forth.

Following the review by the expert panel, some items were re-worded, for example '… moan with my colleagues when things are not right at work' was changed to '… share your negative thoughts/feelings with your colleagues when things are not right at work'. Some scenarios were also reworded for clarity. For example, the scenario, 'The shift patterns at work are so tight, it

feels like I have no breathing space, or just so much to do', was changed to read as, 'There is so much to do, it feels like you have no breathing space'.

A decision was made to remove two items from the list based on comments received from the expert panel. For the first item (number 1 below), some experts commented on it having an assumption that respondents have made a deliberate choice to work in the sector. Since this assumption will not relate to all respondents, the item was removed. For the second item (number 2 below), all experts in the care home sector commented on the inappropriateness of the item, commenting that relationships with relatives outside of work hours is not encouraged due to issues of favouritism and other concerns. Since the new WBSE scale is related to competencies which can be developed and/or improved for well-being at work, this particular item was removed so that it is not construed as being a competency which may be developed or improved by FLCH staff. Thence, these two items were removed, bringing the scale to 41 items. The two items removed were:

1. (Situation: when I feel down about work) … press on in the challenges I face at work when I recall that I chose to work in this care sector (item 34)
2. (Situation: on relationships with residents and relatives) ... easily maintain a positive relationship with relatives outside of work hours (item 25)

Table 7.2 The WBSE scale with 41 items

Situation	**An issue has arisen at your place of work which has resulted in a conflict between you and a colleague and you are dissatisfied/feel disrespected about it**					
	Rate your confidence to be able to…					
1.	… approach my colleague to discuss the issue when you do not like the way you have been treated by them	1	2	3	4	5
2.	… understand my colleague's point of view; seeing why they acted in a certain way	1	2	3	4	5
3.	… approach a senior person (manager, team leader or other) to bring up the issue	1	2	3	4	5

Table 7.2 Continued

4.	… keep your cool while discussing the issue	1	2	3	4	5
5.	… patiently wait for actions to be taken after reporting the conflict, even when it seems like nothing is being done about it	1	2	3	4	5
6.	… find ways to remind your manager or team leader of the issue if you believe nothing is being done about it	1	2	3	4	5
7.	… find ways to somehow get along with this colleague while the issue is being resolved	1	2	3	4	5
Situation	**There is so much to do, it feels like you have no breathing space**					
	Rate your confidence to be able to…					
8.	… tell your manager/team leader/supervisor that you are not able to do a task at a particular time because you are busy with other tasks *(please consider this to be the leader who regularly allocates your tasks)*	1	2	3	4	5
9.	… sort out tasks which have not been done correctly by your colleagues, without being overwhelmed by negative feelings	1	2	3	4	5
10.	… swap your shifts with your colleagues	1	2	3	4	5
11.	… shut off either the pressure or annoyance you may feel at work, when you leave your workplace	1	2	3	4	5
12.	… work at a pace that does not make you feel under so much under pressure	1	2	3	4	5
13.	… still do your work effectively as a result of either the training you have received or the experience you have acquired	1	2	3	4	5
Situation	**When you feel that you and your colleagues get along, and you work well as a team**					
	Rate your confidence to be able to…					
14.	… share your negative thoughts/feelings with your colleagues when things are not right at work	1	2	3	4	5
15.	… talk to a colleague about issues outside of work if you need to	1	2	3	4	5
16.	… maintain a happy feeling/mood at work even when I am under pressure	1	2	3	4	5
17.	… help your colleagues out on a shift when there are a lot of things to do	1	2	3	4	5
18.	… take on the stress during the shift with little or no negative feelings/moods	1	2	3	4	5
Situation	**You feel that your manager/team leader/supervisor keeps giving you a significant workload** *(please consider this to be the leader who regularly allocates your tasks)*					
	Rate your confidence to be able to…					
19.	… get on with a task assigned by your manager/team leader/supervisor even when you feel negatively picked on	1	2	3	4	5
20.	… tell your manager/team leader/supervisor that you are not able to do a task when you believe others are doing ‘nothing’ at the moment	1	2	3	4	5

Table 7.2 Continued

21.	… ignore preferential treatment you perceive towards certain staff at work	1	2	3	4	5
22.	… work well even when you feel that you are being treated unfairly by your manager/team leader/supervisor	1	2	3	4	5
23.	… go the extra mile at work when you do not feel appreciated by your manager/team leader/supervisor	1	2	3	4	5
Situation	**You are relating with a diverse population of residents**					
	Rate your confidence to be able to…					
24.	… develop positive relationships with the most difficult/demanding residents	1	2	3	4	5
25.	… appreciate your own work even when you are not complimented or appreciated by residents or relatives	1	2	3	4	5
26.	… "put yourself in the residents' shoes" even when you have a lot to do	1	2	3	4	5
27.	… go the extra mile in your work even when you cannot "put yourself in your resident's shoes"	1	2	3	4	5
28.	… be happy when you go the extra mile for your residents	1	2	3	4	5
Situation	**When you feel down about work**					
	Rate your confidence to be able to…					
29.	… do things to help pick yourself up	1	2	3	4	5
30.	… carry on when you have thoughts that you are doing it for your residents	1	2	3	4	5
31.	… see the good in a bad situation at work	1	2	3	4	5
32.	… snap out of a negative experience at work	1	2	3	4	5
33.	… put off any feelings of regret of working in this care sector	1	2	3	4	5
34.	… still believe that you are making a useful contribution at work	1	2	3	4	5
Situation	**On a regular working day**					
	Rate your confidence to be able to…					
35.	… maintain a happy mood even when things are not going well	1	2	3	4	5
36.	… complete your tasks to a high standard even when you feel you are not enjoying your work	1	2	3	4	5
37.	… do things that make you enjoy your work no matter how difficult it is	1	2	3	4	5
38.	… overlook any clique groups at work if you are not a part of them	1	2	3	4	5
39.	… continue to work well even when you feel that you are being treated negatively (for your opinions, personality, or something else)	1	2	3	4	5
40.	… maintain a positive mood even when you feel that have been blamed unfairly for an error	1	2	3	4	5
41.	… ignore the worry of possibly being named for an error following an on-going investigation	1	2	3	4	5

7.3 Hypotheses

From the findings of Study 1, and from the items created for the WBSE scale, it is hypothesised that the WBSE scale will have multiple factors. It is also hypothesised that items of the scale will load in clusters which are related to the themes from Study 1. There were five themes from Study 1 - regulating emotions, shifting one's focus, seeking support, taking control, and self-care (see Chapter 6). Furthermore, the literature on self-efficacy at work points to a multidimensional trait. From the findings of Study 1, FLCH staff deploy a variety of strategies in nurturing and/or protecting their well-being, it is therefore expected that the WBSE scale will have the multidimensionality of self-efficacy (also see Chapter 4).

Discriminant validity will be assessed via correlations between the new WBSE scale and the scales of associated constructs. These scales are the job-related affective well-being scale (JAWS) (Van Katwyk *et al*., 2000), work self-efficacy scale (Fida et al. 2014), emotional intelligence (Cooper and Petrides, 2010; Petrides and Furnham, 2006), and the general health questionnaire (Goldberg and Williams, 1988; Jackson, 2006). It is hypothesised that the WBSE scale will have a positive correlation with these scales. Positive correlations will indicate the relatedness. As presented in Chapters 3 and 4, self-efficacy will influence an individual's behaviour, attitude, and choices. Subsequently the coping strategies which they deploy, and their overall experience is impacted by their perceived self-efficacy. It is anticipated that this association will account for a positive correlation between the WBSE scale and affective well-being (JAWS) and general health (GHQ). Furthermore, in Chapter 2, we see a relationship between work and well-being. Work self-efficacy concerns an individual's perception of their work capability. Efficacious behaviour may likely be portrayed as sustained perseverance during difficulties, sustained effort when faced with a challenging work situation, or adaptability to unexpected changes such as emergencies, which are not uncommon in a care home setting. It is therefore anticipated that work self-efficacy will be positively associated

with the belief in one's ability to take steps to improve well-being at work (WBSE). Also, in previous studies (for example, Behjat and Chowdhury, 2012), emotional intelligence has been linked to self-efficacy beliefs. As interpersonal conflict and emotion regulation feature strongly in Study 1, the relationship between emotional intelligence and WBSE will be assessed, and a positive correlation is anticipated.

In spite of the positive correlations anticipated between the WBSE scale and these scales, it is anticipated that variance between the WBSE scale and other scales will show that the scales are sufficiently different, an indication that they clearly measure different constructs.

7.4 Methods

7.4.1 Participants

Frontline care home (FLCH) staff working in care homes for older people in Bedfordshire, England.

7.4.2 Method of contact

Participants were invited to participate via their managers. Contacting the managers was via currently existing channels such as providers' forums, county meetings, and via word of mouth. In addition, there is a publicly published list of the contact details of all care homes in the county. The researcher used this channel to contact additional care home managers and offered to visit managers if required. Posters about the research were placed on the notice boards in care homes and care agencies with manager's permission.

7.4.3 Procedure

Following an expression of interest, the researcher gave managers the survey pack (information sheet, questionnaires, and the offer of free post return envelopes if needed), to be distributed to their staff members. The researcher also offered to visit care homes and agencies to collect the survey responses after the delivery of the survey pack, in order to facilitate an increased response rate. Care homes which were initially approached to participate in the focus groups were also invited to participate in the survey. The survey was administered via paper-and-pencil. An electronic survey would have been quicker and easier, but FLCH staff do not typically have work-related email addresses. Thus, conducting an electronic survey would have required staff to individually provide personal email addresses. The researcher considered that this could potentially minimise participation. Alternatively, an electronic link to the survey could be distributed to managers who could then disseminate to staff. These layers of contact were also considered to be a factor which could minimise participation.

Some questionnaires were sent via post and the researcher also made approximately 60 visits to various care homes across Bedfordshire, England, and followed up with telephone calls. Approximately 450 questionnaires were delivered. A secure postal box was placed in some care homes. Managers and administrative staff supported by reminding staff of the survey during staff or other appropriate meetings. A suitable date was arranged for collection and this date was clearly written on the box. On some occasions, the date had to be extended due to low uptake.

As an incentive for participation, there was a £50 prize draw (for three winners). Interested participants provided contact details on a detachable frontpage of the survey and were to be conducted after the survey was completed. A random number indicating the winner of the prize draw was generated using the ‘randbetween’ function in excel. All entrants were numbered, and this number entered into the excel formula to generate the winners.

7.4.4 Measures

The survey pack distributed included the new WBSE scale, and four additional scales which examined negative emotions, work self-efficacy, emotional intelligence, and general health. These scales were used for construct validity evidence.

Negative emotion was measured using the job-related affective well-being scale (JAWS) (Van Katwyk *et al*., 2000). This was a 20-item scale which captured a range of emotions experienced at work. Respondents rated their experience in the last 30 days on a five-point scale from 1 = 'never' to 5 = 'extremely often'. A sample item from this scale is 'my job made me feel angry'. Adequate reliability was demonstrated in the current study as the JAWS scale Cronbach's alpha reliability coefficient was .796.

In previous studies, emotional intelligence and perceived stress have been shown to be associated. Emotional intelligence involves using information from emotions, and employing emotional abilities to effectively adapt or cope with stressful events (Salovey and Mayer, 1990). As emotion regulation featured strongly in participant's accounts, emotional intelligence was examined. Emotional intelligence was measured using the trait emotional intelligence questionnaire – short form (TEIQue-SF) (Cooper & Petrides, 2010; Petrides & Furnham, 2006). It comprised of 30 items with a seven-point response scale, from 1 = 'completely disagree' to 7 = 'completely agree'. An example of an item is 'I usually find it difficult to regulate my emotions.' High emotional intelligence is a positive attribute which has been linked to improved well-being in other research, thus it was expected that a respondent will rate highly on both the WBSE and emotional intelligence scales. In the current study, the TEIQue-SF scale demonstrated adequate liability at $\alpha = .824$.

Work self-efficacy was measured using an eight-item work self-efficacy scale (Fida et al. 2014). As a self-efficacy scale, respondents rated the degree of confidence in their ability to do

the specified activities. A sample item from this scale is ‘engage fully in activities I undertake to reach an intended goal’. Response options ranged from 1 = ‘cannot do at all’ to 7 = ‘very certain I can do’, on a seven-point scale. The alpha reliability score of the WSE scale in the current study was .886.

General health was examined using the general health questionnaire (GHQ-12) (Goldberg and Williams, 1988), a 12-item scale which measures a respondent’s recent general health. A sample item is ‘have you recently felt you couldn’t overcome your difficulties?’. The response options on a four-point scale were ‘not at all, no more than usual, rather more than usual, or much more than usual’. The Cronbach’s alpha reliability coefficient in the current study for the positive items was .761 and for the negative items it was .857.

7.4.5 Data Analyses

The data was first cleaned by ensuring that the electronic copy was a replica of the hard copies. Data analysis was conducted using the Statistical Package for Social Sciences (SPSS), version 25. Screening of the data was first conducted to identify missing data. Inter-item correlation and assumptions of statistical techniques were assessed, and an exploratory factor analysis (EFA) was subsequently conducted. Examination of the scree plot of eigenvalues and a parallel analysis were used to decide the number of factors to be retained. Factors were extracted using principal axis factoring, and the rotation was oblique oblimin as the factors were expected to be correlated. The criteria for assessing the quality of the factor solution included an assessment of cross loadings and the difference between primary and secondary loadings. Cross loading items and items which had the difference between primary and secondary loading (alternative factor loadings) less than .20 (Hinkin, 1998) were removed. Internal consistency of the WBSE scale was assessed by computing the Cronbach’s alpha of the sub-scales. Correlation analyses

involved examining the association between the WBSE scale and other measures specified above. These steps constituted a preliminary validation of the WBSE as the study did not achieve a larger sample size to conduct a confirmatory factor analysis (CFA) using new data.

7.5 Results

7.5.1 Sample description

Of the 450 survey packs distributed, 142 FLCH staff returned the completed packs (31.6% response). The majority were female (84.5%), and Table 7.3 shows additional demographic data of respondents.

Table 7.3 Demographic details of respondents

Variable	N	%
Gender		
Female	120	84.5
Male	20	14.1
Missing	2	1.4
Qualification		
Primary	4	2.8
Some secondary	17	12.0
A-levels/GCSE/equivalent	62	43.7
Bachelors/equivalent	18	12.7
Postgraduate	16	11.3
Missing	25	13.7
Type of care home		
Residential	101	71.1
Nursing	28	19.7
Combined residential & nursing	11	7.7
Missing	2	1.4
Size of care home		
Small (up to 10 staff)	20	14.1
Medium (11-20 staff)	46	32.4
Large (above 20 staff)	70	49.3
Missing	6	4.2
Work pattern		
Part time	50	35.2
Full time	83	58.5
Other	1	0.7
Missing	8	5.6

Table 7.3 Continued

Age		
19-20	4	2.8
21-40	66	46.2
41-60	39	27.3
>60	3	2.1
Missing	30	21.1
Years working in care		
<1 year	9	6.3
1-10	88	62
11-20	15	10.5
21-30	7	4.9
31-40	2	1.4
>40	1	0.7
Missing	20	14.1
Location		
Bedford	17	12.0
Central Bedfordshire	10	7.0
Luton	112	78.9
Missing	3	2.1
Role		
Carer	103	72.5
Nurse	8	5.6
Team leader	26	18.3
Missing	5	3.5

7.5.2 Preliminary analyses

In case screening of the data, missing data was assessed as responses below 40% of the items, and thus five participants were removed. An additional respondent was removed as there was response to only 16 out of 41 items, and for the items answered, there was an alternation between only two response. The analysis of the pattern of missing values revealed 1.6% of the values were missing and these were imputed using multiple imputation. Barlett's test of sphericity was significant at $p < 0.001$, indicating that the correlation matrix was not an identity matrix (that is, having a complete lack of relationships within the data set) (Tobias and Carlson, 1969; Howard, 2016). The Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy was .961 which is above the recommended .60 minimum indicating that latent factors may be present, and that EFA may be performed (Dziuban and Shirkey, 1974; Kaiser, 1970;

Tabachnick and Fidell, 2001). Hutcheson and Sofroniou (1999) rate the KMO value for the current research in the 'Marvellous' category. The corrected inter-item correlation ranged from .48 to .92, above the recommended .40 cut off (Gliem and Gliem, 2003; Howard, 2016). Table 7.4 shows the descriptive statistics of the items.

Table 7.4 Descriptive statistics of WBSE items

Items	M	SD	Skewness	Kurtosis
WBSE1	3.51	1.353	-0.613	-0.798
WBSE2	3.62	1.288	-0.630	-0.625
WBSE3	3.97	1.290	-1.083	0.011
WBSE4	3.80	1.271	-0.912	-0.210
WBSE5	3.75	1.219	-0.797	-0.249
WBSE6	3.77	1.270	-0.834	-0.371
WBSE7	3.72	1.274	-0.742	-0.516
WBSE8	3.72	1.318	-0.710	-0.610
WBSE9	3.53	1.282	-0.504	-0.819
WBSE10	3.55	1.363	-0.532	-0.949
WBSE11	3.52	1.338	-0.512	-0.835
WBSE12	3.49	1.286	-0.585	-0.629
WBSE13	3.93	1.228	-1.132	0.363
WBSE14	3.53	1.439	-0.509	-1.079
WBSE15	3.27	1.493	-0.230	-1.383
WBSE16	3.82	1.288	-0.911	-0.253
WBSE17	4.05	1.272	-1.284	0.491
WBSE18	3.58	1.278	-0.492	-0.879
WBSE19	3.56	1.263	-0.495	-0.764
WBSE20	3.40	1.319	-0.390	-0.980
WBSE21	3.34	1.224	-0.309	-0.756
WBSE22	3.48	1.327	-0.409	-0.967
WBSE23	3.57	1.331	-0.571	-0.779
WBSE24	3.95	1.330	-1.097	-0.039
WBSE25	3.87	1.265	-1.003	-0.062
WBSE26	3.88	1.345	-0.948	-0.351
WBSE27	3.80	1.284	-0.810	-0.502
WBSE28	4.04	1.371	-1.201	0.009
WBSE29	3.64	1.272	-0.676	-0.577
WBSE30	3.93	1.287	-1.100	0.082
WBSE31	3.63	1.280	-0.701	-0.539

Table 7.4 Continued

WBSE32	3.69	1.233	-0.692	-0.465
WBSE33	3.74	1.288	-0.765	-0.541
WBSE34	3.91	1.284	-0.947	-0.324
WBSE35	3.74	1.317	-0.797	-0.510
WBSE36	3.89	1.273	-0.976	-0.109
WBSE37	3.74	1.282	-0.832	-0.324
WBSE38	3.54	1.264	-0.568	-0.649
WBSE39	3.64	1.325	-0.686	-0.684
WBSE40	3.38	1.356	-0.381	-1.003
WBSE41	3.22	1.433	-0.230	-1.252
Valid N (listwise)	136			

7.5.3 Results of exploratory factor analysis

To explore the factorial structure of the WBSE scale, all 41 items comprised of the scale were subjected to exploratory factor analysis (EFA) using principal axis factoring with oblique oblimin rotation.

Different from what was hypothesised for the number of expected factors, both the scree plot (see Figure 7.1) and parallel analysis suggest the extraction of three factors. An additional comparison of the suggested three-factor solution with the expected five-factor solution further attested to the three-factor solution. This was confirmed by many cross loadings in the five-factor solution, and the difference between primary and secondary loadings (alternative factor loadings) not meeting the criteria of less than .20. A three-factor solution was therefore decided on.

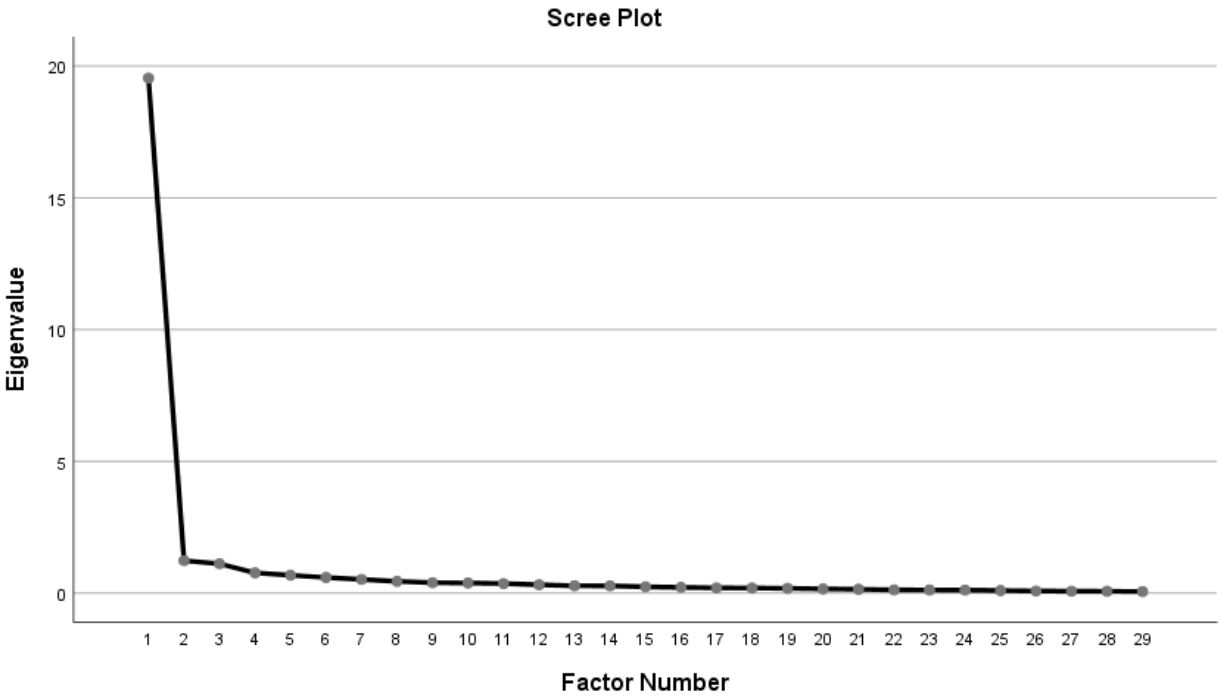

Figure 7.1 Scree plot

With a three-factor solution, all items loaded onto their primary factor at .40 and above (Hinkin, 1995, 1998). One item had a loading of .32 on its factor, however, this item was retained due to its theoretical contribution to the well-being self-efficacy construct. Items which did not meet the criteria for assessing the quality of the solution were removed one at a time, re-running the analysis with each removal. This resulted in the removal of seven items. Furthermore, there were some items which loaded onto the same factor, they captured the same strategy but were worded differently. For simplicity of the scale, when there were two of such items one of them was removed. The analysis was then re-run with each removal. On removal, the overall factor loadings, structure, and variance accounted for were maintained, having only minimal changes. Therefore, the three factors extracted accounted for 72.52% of the variance. The percentage variance explained by factors one, two and three are 66.51%, 3.17% and 2.85% respectively. Table 7.5 shows the factor loadings after rotation. Table 7.6 shows the correlation between the factors.

Table 7.5 Factor loadings after rotation

			Rotated Factor Loadings		
			1	2	3
Item	**M**	**SD**	Maintaining/ developing a tenacious attitude	Speaking up	Shielding
4)… keep your cool while discussing the issue **T1**	3.80	1.27	**0.972**	-0.018	-0.121
2)… understand my colleague's point of view; seeing why they acted in a certain way **T2**	3.62	1.29	**0.969**	0.006	-0.147
33)… put off any feelings of regret of working in this care sector **T1**	3.74	1.29	**0.903**	-0.139	0.06
7)… find ways to somehow get along with this colleague while the issue is being resolved **T1**	3.72	1.27	**0.862**	0.061	-0.004
5)… patiently wait for actions to be taken after reporting the conflict, even when it seems like nothing is being done about it **T1**	3.75	1.22	**0.846**	0.033	-0.024
3)… approach a senior person (manager, team leader or other) to bring up the issue **T3**	3.97	1.29	**0.832**	0.151	-0.1
34)… still believe that you are making a useful contribution at work **T5**	3.91	1.28	**0.825**	-0.044	0.097
29)… do things to help pick yourself up **T5**	3.64	1.27	**0.804**	-0.136	0.178
13)… still do your work effectively as a result of either the training you have received or the experience you have acquired **T4**	3.93	1.23	**0.788**	0.023	0.067
6)… find ways to remind your manager or team leader of the issue if you believe nothing is being done about it **T4**	3.77	1.27	**0.778**	0.225	-0.113
25)… appreciate your own work even when you are not complimented or appreciated by residents or relatives **T5**	3.87	1.27	**0.774**	-0.014	0.149
26)… "put yourself in the residents' shoes" even when you have a lot to do **T2**	3.88	1.35	**0.772**	0.077	0.074
17)… help your colleagues out on a shift when there are a lot of things to do **T4**	4.05	1.27	**0.731**	0.068	0.166
16)… maintain a happy feeling/mood at work even when I am under pressure **T1**	3.82	1.29	**0.706**	-0.041	0.22
37)… do things that make you enjoy your work no matter how difficult it is **T2**	3.74	1.28	**0.679**	0.021	0.277
1)… approach my colleague to discuss the issue when you do not like the way you have been treated by them **T4**	3.51	1.35	**0.653**	0.053	0.09

Table 7.5 Continued

36)… complete your tasks to a high standard even when you feel you are not enjoying your work **T1**	3.89	1.27	**0.647**	0.077	0.244
9)… sort out tasks which have not been done correctly by your colleagues, without being overwhelmed by negative feelings **T4**	3.53	1.28	**0.603**	-0.028	0.328
27)… go the extra mile in your work even when you cannot "put yourself in your resident's shoes" **T4**	3.80	1.27	**0.568**	0.055	0.292
15)… talk to a colleague about issues outside of work if you need to **T3**	3.62	1.29	-0.071	**0.811**	0.101
14)… share your negative thoughts/feelings with your colleagues when things are not right at work **T3**	3.74	1.29	0.343	**0.635**	-0.02
20)… tell your manager/team leader/supervisor that you are not able to do a task when you believe others are doing 'nothing' at the moment **T4**	3.72	1.27	0.199	**0.319**	0.288
40)… maintain a positive mood even when you feel that have been blamed unfairly for an error **T1**	3.75	1.22	0.003	0.033	**0.92**
22)… work well even when you feel that you are being treated unfairly by your manager/team leader/supervisor **T1**	3.97	1.29	0.089	0.14	**0.733**
31)… see the good in a bad situation at work **T2**	3.91	1.28	0.252	0.047	**0.636**
39)… continue to work well even when you feel that you are being treated negatively (for your opinions, personality, or something else) **T1**	3.64	1.27	0.373	0.011	**0.591**
23)… go the extra mile at work when you do not feel appreciated by your manager/team leader/supervisor **T4**	3.93	1.23	0.093	0.294	**0.58**
41)… ignore the worry of possibly being named for an error following an on-going investigation **T1**	3.77	1.27	0.079	0.004	**0.556**
11)… shut off either the pressure or annoyance you may feel at work, when you leave your workplace **T1**	3.87	1.27	0.347	0.091	**0.383**

Contrary to the hypothesis, items did not load in clusters according to the themes from Study 1. That is, one factor did not solely represent one theme. The factors identified were a mixture of the themes. By an intentional consideration of each of the items which loaded on to the factors, and considering the literature and the focus group discussions, the labels for the factors were developed. In the three-factor solution, 19 items loaded on the first factor labelled 'maintaining/developing a tenacious attitude' (α = .982). Three items loaded on the second factor labelled 'speaking up' (α = .779). Finally, seven items loaded on the third factor labelled 'shielding' (α = .932). The Cronbach's alpha values for these subscales were above the recommended .70 threshold (Nunnally and Bernstein, 1994).

Table 7.6 Correlation between the factors of the WBSE scale

	Maintaining/developing a tenacious attitude	Speaking up	Shielding
Maintaining/developing a tenacious attitude	-		
Speaking up	.521	-	
Shielding	.791	.390	-

The first factor, 'maintaining/developing a tenacious attitude' refers to a determined and persistent attitude. The strategies captured by this factor are those which demonstrate a tenacity aimed at improving, or indeed defending one's well-being. It has a carriage of persistence, an attitude which portrays, 'I see the challenges, I know there are issues, but I'm determined to make it work'. The second factor, 'speaking up', captures proactivity, complementing factor one. Although factor one has an element of proactivity, this second factor, 'speaking up' chiefly involved speaking up and advocating one's well-being in a more direct way. Unlike the other factors of the scale, all strategies captured by this factor involve others directly, they were not simply private strategies and not internal (that is not simply attitudinal). The third factor,

'shielding' captures the essence of holding a defensive or protective position. Similar to the second factor, it has items which involve others. However, strategies captured by the 'shielding' factor involve protecting oneself (well-being) from the negative impact of others.

Between the first factor (maintaining/developing a tenacious attitude) and the second (speaking up), there is a correlation of .521, indicating a moderate positive relationship between them. There is also a positive lower correlation of .390 between the second factor (speaking up) and the third factor (shielding). Both these correlations point to the relatedness of the factors, but clearly distinct from each other. Between the first factor (maintaining/developing a tenacious attitude) and the third factor (shielding), there is also a positive but much higher correlation of .791, indicating that further analysis is likely required to assess the distinction between them. As a means of an initial assessment of the distinctiveness between factor 1 and 3, further analysis was conducted using the same sample. Although a CFA will need to be conducted on a new sample, this additional analysis served as an initial assessment to provide evidence of likely distinctiveness between the two factors. The analysis was conducted to obtain some indices of fit. Although some fit indices can be affected by sample size, the results of the analysis (see Table 7.7) showed a slightly better solution in favour of a three-factor model in comparison to a two- and one-factor model. Suggested cut-off points are TLI $\geq$ 0.95; CFI $\geq$ 0.95; RMSEA $\leq$ 0.08; chi-square/df ratio $\leq$ 3 (Browne and Cudeck, 1993; Kline, 2016).

Table 7.7 Fit indices of models for the WBSE scale (N=136)

Model	Chi-square	Chi-square/df	TLI	CFI	RMSEA
3-factor	600.739	1.87	0.914	0.932	0.08
2-factor	700.662	2.01	0.899	0.914	0.09
1-factor	868.282	2.29	0.872	0.881	0.10
df = Degrees of freedom; TLI = Tucker Lewis Index; CFI = Comparative Fit Index; RMSEA = Root Mean Square Error of Approximation					

7.5.4 Discriminant validity

Table 7.8 is a report of the correlations between the WBSE scale and the scales of associated constructs.

Table 7.8 Descriptive statistics, reliability, and correlations between the factors of the WBSE scale and other scales

		M	SD	1	2	3	4	5	6	7	8
1	WBSE_maintaining/ developing a tenacious attitude	71.96	21.11	-							
2	WBSE_speaking up	10.21	3.55	.682**	-						
3	WBSE_shielding	24.44	7.92	.873**	.654**	-					
4	WSE	49.51	6.76	.429**	.326**	.403**	-				
5	JAWS	73.73	9.57	.361**	.169*	.331**	0.103	-			
6	EI	152.94	22.45	.434**	.303**	.345**	0.156	.438**	-		
7	GHQ_positive	18.62	2.58	-0.123	-0.136	-0.057	0.051	0.022	0.13	-	
8	GHQ_negative	10.60	3.66	-0.009	0.018	-0.035	-0.111	-.257**	-.210*	-.463**	-

**Correlation is significant at the 0.01 level (2-tailed).
*Correlation is significant at the 0.05 level (2-tailed).

Discriminant validity was investigated by examining the pearson product-moment correlation between the factors of the WBSE scale and associated scales. Overall, the analysis of correlations (Table 7.8), showed positive and significant correlations between the three WBSE factors and the WSE, JAWS, and EI scales. There was a negative and non-significant correlation between the three WBSE factors and the positive items of the GHQ scale. There was no correlation between the negative items of the GHQ scale and the three factors of the WBSE scale.

7.6 Discussion

In developing the WBSE scale, it was hypothesised that the scale will have multiple factors, that is, multidimensional, and that these factors will be related to the themes from Study 1 – regulating emotions, shifting one's focus, seeking support, taking control, and self-care (see Chapter 6). Although these were hypothesised, there was an openness to what the results of the survey response would reveal. The analysis indeed resulted in a multidimensional construct with three factors. Different to what was hypothesised, each factor did not singularly represent one theme from Study 1, but each factor had a mixture of themes. By considering each of the items which loaded on to the factors, alongside the literature and the focus group discussions, the three factors were labelled.

The WBSE scale represents actions which FLCH staff engage in to improve their well-being. In the three-factor solution of the WBSE scale, the first factor, named 'maintaining/developing a tenacious attitude' was a dominant one. This factor comprised of actions which demonstrate tenacity. Tenacity here can be described as having a determined or persistent attitude, and items of this scale capture varied circumstances in which FLCH staff demonstrate this attitude. Considering the challenges faced by FLCH staff, as presented in the literature review (see

Chapter 2), this is an especially important factor. In a job role where there is frequent exposure to stressors, and where well-being is not prioritised, having, or not having, the tenacity to keep going can indeed have an impact on one's well-being.

With little attention given to the well-being of FLCH staff, one can infer that there has been an assumption that this staff group is equipped to handle the difficulties which they experience on the job. In some ways, this assumption is verified by the finding of the first factor. The analysis indicates that FLCH staff indeed exhibit a tenacious attitude in coping with work. The factor also captures an element of FLCH staff making attempts to adapt, that is, making changes in their approach to circumstances in order to achieve a positive outcome for well-being. In some ways, it points to an ability or willingness to engage in actions which may involve stepping out of one's 'comfort zone', in order to improve one's well-being. As pointed out in the literature review, if frequent exposure to stressors is 'understood' as an experience which 'comes with the territory', FLCH staff will therefore need support where necessary to maintain or develop tenacity.

The second factor, 'speaking up', can be described as exhibiting a degree of proactivity. This survey of FLCH staff showed that although they demonstrated tenacity and endured varied difficult situations, being proactive about personal issues is also important for well-being at work. From Study 1 (see Chapter 6), some participants gave accounts of how they did not speak up when there were issues, and the outcome was eventually not positive. Although deciphering when to speak is also an important aspect to consider, it seems that ultimately speaking up is an important action to take for well-being. 'Speaking up' also captures the notion of having support. Perceived support is a well-documented resource for enhancing well-being, and this finding is in line with the literature on social support at work in care settings (for example, Woodhead et al., 2016).

‘Shielding’ was the third factor and can fully be described as shielding well-being. This factor in essence, captures strategies which FLCH deploy to protect their well-being. The strategies captured by this factor mostly involved dealing with the negative impact of other people. Although this factor shares some characteristics with factor 1, most strategies captured by this factor point to permanent or on-going situations which are largely out of the control of the individual. In some ways, this third factor involves holding a position of defence, where FLCH staff engaged in actions aimed at ‘warding off’ the negative impacts of stressors, of which they have minimal or no control over.

It was noted that there is a high correlation of .791 between factor 1 (maintaining/developing a tenacious attitude) and factor 3 (shielding). Further confirmatory factor analysis (CFA) with a new sample will be useful in providing empirical evidence of the distinctiveness of these two factors, and to confirm the overall factor structure of the WBSE scale. Additionally, high correlations have been linked to low sample size (Dormann et al., 2012), which is a limitation of this study. Despite this limitation, further analysis of fit indices was conducted to provide some empirical evidence of distinctiveness, or not, between factor 1 and 3. The results of this analysis favour a three-factor solution and suggest distinctiveness between these factors. Thus, due to the exploratory nature of the study, and the theoretical contribution of the separate factors, factors 1 and 3 have been retained as distinct.

Additionally, the results presented are considered a preliminary validation of the WBSE scale. As previously stated, the results (model) can be fully validated in later studies with a different and larger sample.

It was anticipated that WBSE would show a positive correlation with similar attributes, but distinct enough to demonstrate that it is a different construct. There was a positive and significant correlation between the WBSE scale and the associated scales, except for the GHQ.

There was a strong significant correlation between the WSE scale and the WBSE scale. Both scales being concerned with self-efficacy, a strong correlation is not surprising. This correlation however shows enough distinction to indicate that both constructs are related but different. Moreover, although both scales are concerned with the work context, the WBSE scale presents the opportunity for the more nuanced measurement of well-being improvement in particular, based on self-efficacy. The positive and significant correlation between WBSE and EI, concurs with other studies which demonstrate an association between self-efficacy, emotional intelligence, and well-being (for example, Behjat and Chowdhury, 2012; Sanchez-Alvarez et al., 2015). Given interpersonal conflict featured strongly in the well-being experience of FLCH staff (as seen in Study 1), the role of emotional intelligence is thus evident. The findings from Study 1 give some insight into the significant positive correlation between WBSE and EI. Furthermore, items relating to emotion regulation did not cluster into one factor, implying the association of emotion regulation with various strategies deployed by FLCH staff for well-being. This observation of emotion regulation featuring across strategies concurs with the presentation of emotion regulation in the literature, as a core component in personality functioning (for example, Gross 2008).

As expected WBSE positively correlated with well-being at work (JAWS). The positive significant relationship implies that with increased WBSE, positive emotions at work also had an increase. Of the general health (GHQ) and the job-related affective well-being (JAWS) measures, JAWS was considered in the current study to be a more direct indication of the well-being of participants at work. It was however useful to assess if there was a correlation with general well-being. GHQ measures well-being in general and not specifically related to work. The GHQ scale has both positive and negative items and these were correlated separately with the factors of the WBSE scale. The positive items showed a non-significant correlation with WBSE, whilst the negative items showed no correlation. The non-significant and no correlation

findings were unexpected. One way in which these findings have been interpreted is that they are a demonstration of the non-global characteristic of self-efficacy. In other words, it demonstrates that WBSE at work may not automatically translate to WBSE outside work, although it is possible that the strategies employed at work could be adopted in dealing with situations outside of work. This concurs with the theoretical position of the self-efficacy theory, that self-efficacy is not a global trait but domain-specific. Therefore, improving one's well-being at work is not the same as improving one's general health. A further interpretation of the non-significant correlation between the WBSE scale and the GHQ is that perhaps the WBSE construct is more related to subjective well-being than other facets of well-being. As seen in Chapter 2, well-being is multifaceted, meaning different things to different people. However, due to the sample size of this study, caution is taken with these interpretations, as further validity of the scale will enhance interpretations.

Earlier, in Study 1, frequently described scenarios by FLCH staff were presented. In four of the seven the scenarios, all three factors can be identified, and in the other three scenarios, at least two factors can be identified. Also, when each factor is considered on its own, it can be seen that each scenario can trigger the deployment of strategies described by the particular factor. Furthermore, the items of the dominant factor one, 'maintaining/developing a tenacious attitude', are distributed across six of the seven scenarios. Overall, the findings suggest that when faced with goal-relevant situations at work (which threaten well-being), FLCH deploy a multidimensional approach to handle the situations. Thus, the strength of belief which a person has in their ability to deploy these strategies can give insight into their state of well-being.

This study presents several implications. For the progression of research on the well-being of FLCH staff, there is now the possibility of using a scale to assess the belief which a person has in taking actions to improve their well-being. These potential actions of FLCH staff which are

represented as the items of the new WBSE scale have been developed using a bottom-up approach aimed at capturing the real-life experience of those directly involved. WBSE can thus be considered to be an individual resource which can be quantified. As presented in previous chapters, self-efficacy is a trait which can be enhanced (Bandura, 1986, 1997). Therefore, the WBSE scale offers the opportunity for managers, other significant persons, or FLCH staff themselves to assess personal belief in the ability to take steps to improve well-being. For instance, using a longitudinal approach, a new (or current) staff member may initially complete the WBSE questionnaire, and do so annually afterwards, using it as a support tool. As pointed out in Chapter 3, self-efficacy can give insight into a person's 'staying power'. Those with a strong perception of self-efficacy will plan, take steps, and persist until they achieve their goal (in this case, improve their well-being at work). Furthermore, given its positive relationship with job-related affective well-being, emotional intelligence, work self-efficacy, and general health, the WBSE scale can offer useful insight into additional ways to support staff, or develop programmes aimed at enhancing WBSE and consequently well-being.

However, the current findings need to be interpreted in view of some limitations. Firstly, the sample size achieved was not large. The size was also not large enough to conduct a CFA. This study is thus considered a preliminary validation of the WBSE scale. Therefore, further research can be undertaken to verify the factor structure of the WBSE scale. Albeit, factor loadings and sample size contribute to the robustness of an EFA, and the factor loadings in the current study were strong (see Table 7.5). Additionally, the study was conducted in one region of England, a study which incorporates respondents from across the country and internationally will provide further credence to the scale. Also, besides the assessment of face validity with the expert panel, the study did not include a pilot which might have provided opportunities to adjust the process of data collection. For instance, providing the opportunity to understand why the expected number of respondents was not reached. Despite its limitations, this is the first

known attempt to develop a scale of its kind. This attempt contributes to future research in this area. Further, it is anticipated that Study 3 can support the validation of the WBSE construct. The findings from this study, along with findings from Study 1 informed the development of program theories (hypotheses) in Study 3.

7.7 Conclusion

This chapter has presented the development and validation of a novel well-being self-efficacy scale, guided by Bandura's (2006) principles of developing self-efficacy scales. This was Study 2, which chiefly aimed at addressing research question two. The new scale aims to assess the belief which a person has in their ability to take steps towards improving their well-being at work. Preliminary results indicate a likely three-factor solution of the WBSE scale, and other psychometric properties were shown to be strong compared to acceptable standards. Correlations with the other constructs showed expected validity except with the GHQ. The WBSE scale shows promising signs and possibly more closely related to subjective well-being. Although further analysis will be required to validate the new scale, the preliminary validation of the scale which has been presented contributes to the much-needed research on frontline care home staff well-being.

The next chapter presents Study 3, which is a participatory intervention with frontline care home staff. The intervention aimed at improving well-being self-efficacy.

8 Study 3: Designing, Implementing, and Evaluating the Intervention

8.1 Introduction

The two previous chapters outlined the details of empirical Studies 1 and 2 of the current research. These studies and their findings provide the bedrock of Study 3 and informed the design of the intervention. Furthermore, the program theories (hypotheses) of Study 3 were also informed by findings of the focus groups in Study 1, the factors in Study 2, and the literature.

The aim of this chapter is to present Study 3, which was the development, implementation and evaluation of a participatory staff-led intervention aimed at improving well-being self-efficacy (WBSE). The primary aim of Study 3 was to address research question three. A realist evaluation was particularly employed in this study to uncover the interaction between contextual and individual factors which contributed to the outcomes. The intervention was tailored to suit the context of each implementing care home, therefore there was a need for an evaluation approach which could handle this variation. In addition, a realist evaluation does not simply ask if an intervention was successful or not, it explores the extent to which an intervention worked, how it worked, why, for whom, and in what context.

This chapter begins by outlining the design of the intervention, and the realist approach to evaluating it. The chapter then presents the methods, data analysis and results. It concludes with a discussion including the researcher's experience of implementing the intervention on the field.

8.2 Designing the intervention

The intervention was designed to improve WBSE, and potentially well-being, over the course of six months originally (although due to logistics, this became approximately nine months). The intervention comprised of two core objectives. The first was to expose participants to the four sources of self-efficacy beliefs – mastery experience, vicarious experience, verbal persuasion, and (awareness of the role of) physiological states, in accordance with the self-efficacy theory (Bandura, 1997) (see Chapter 3). This was achieved during initial 'well-being workshops' and throughout the course of the intervention. The second objective was to facilitate an enabling environment for personal and collective action towards improving well-being. This was achieved via developing and executing personal and collective actions plans.

As discussed in Chapters 3 and 4, Bandura (1986, 1991a) states that individuals possess a self-system which regulates feelings, thoughts, motivation, and ultimately action. The anticipation was that having been introduced to the concept of self-efficacy and its potential influence on well-being, and with exposure to the sources of self-efficacy over a period of time, participants' WBSE and subsequently, their well-being at work will be enhanced. It was intended that this will be an intervention whereby people developed themselves, rather than an intervention being 'done to them'. By facilitating collective and individual action plans, the intention was to focus on practical ways in which individuals can apply their knowledge as they discover and develop their own subjective ways of improving their well-being.

Additionally, informed by the review of the literature on interventions (see Chapter 4), the design of the current intervention involved a participatory and staff-led approach. Participation implied that elements of the design, implementation, and evaluation of the intervention involved the contribution of participants. The design also had a whole-home approach, therefore participation was opened to staff from all departments of the care home (that is including kitchen staff, administrators and others).

Bandura (1997, 2006) argues that until a person believes that their actions can produce a desired effect, they are minimally motivated to act. A person with a high perception of self-efficacy will effectively control and adjust their feelings, thought processes, motivation and behaviour, with a focus on achieving their goal (Bandura, 1995). People with high perceived self-efficacy are more likely to be able to plan and successfully achieve an aim, and they persevere through difficulty as they exert and maintain their effort until the desired goal is achieved (Bandura, 1997) (see Chapters 3 and 4).

The design of the intervention was underpinned by certain assumptions. Firstly, although one's perception of self-efficacy can change (Bandura, 1997), it was anticipated that change would be gradual, hence the intervention was designed to span a duration of six months. Secondly, it was anticipated that over the course of the intervention, change in perception of WBSE will be noticeable. Albeit their high-stress low-support work environment, it was expected that participants will demonstrate an increasing improvement in WBSE by taking actions and persevering through difficulties, in order to experience and/or nurture their well-being.

This intervention was primarily aimed at the individual. Although there were aspects of the intervention in which participants worked in teams, team experiences were designed to have an impact at the individual level. Albeit, there were benefits at team level too.

8.3 The intervention

The intervention began with well-being workshops. The content of these workshops provided participants with insights on the importance of well-being at work, knowledge on self-efficacy, its sources, and its impact on well-being. There were discussions around how this information might be translated into practice. In order to enhance the learning process, the workshop design involved playing a game related to the content. The game was designed to allow participants

reflect on the experience of well-being, and to potentially create an awareness of how their responses to situations may or may not facilitate WBSE. For the game, pre-set scenarios were provided along with 'response cards'. The development of these scenarios was informed by the findings of Study 1. They were tailored to the care home context, enabling participants to consider self-efficacy in the care home work context and in relation to well-being specifically. The response cards contained possible responses to the situation described in the scenario cards. These responses included potential impacts of the situation on well-being and work, with elements of the sources of self-efficacy woven into the possible responses. Participants would discuss these possible responses and which source of self-efficacy may have influenced the response. See Appendix J for an example of a scenario with response cards. Over the course of six months, participants applied this knowledge in their everyday work practices. For example, considering how they could do things differently based on their knowledge of well-being and self-efficacy.

After this, participants were encouraged to develop a feasible action plan for well-being – a collective plan and individual plans. The aim of this was to create opportunities for exposure to the four sources of self-efficacy beliefs, that is, mastery experience, vicarious experience, verbal persuasion, and an awareness of physiological states. The aim of the plans was also to create opportunities (an enabling environment) for participants to take actions which could enhance WBSE and potentially well-being. Although participants were encouraged to relate what they had learned to their everyday work experiences, having action plans provided an immediate intentional activity they could focus on and assess. Individual plans were also encouraged as it was possible that engagement with, and success of, the collective plan may be affected by other underlying issues (such as lack of time, broken down relationships, or other organizational issues).

Change in both WBSE and well-being were captured using self-reported measures, diaries and interviews. It was anticipated that the diaries would enable reflection on one's actions and enable the researcher to more consistently observe any changes in WBSE over a period of time. Participants were also encouraged to document in the diaries their experience of engaging with the collective action plan, if they wished to. The researcher undertook support/progress visits in each care home throughout the period of implementation, during which data collection took place.

The overall participant experience of the intervention was thus:

i. Attend a well-being workshop which:
   - briefs participant on the research in general and the details of the intervention
   - discusses well-being and introduces participant to the concept of self-efficacy and its association with well-being
ii. Work on a well-being plan developed with colleagues
iii. Work on an individual plan for well-being during the intervention period
iv. Record experiences (and share with researcher and colleagues if desired)

Ethical approval for this research was granted by the Faculty of Medicine and Health Sciences, University of East Anglia (reference 2017/18 - 47).

8.3.1 Evaluating the intervention

The design of the intervention was exploratory, and its evaluation was an iterative process, that is, data collection and analysis occurred in tandem. This was done by applying a realist evaluation approach (Pawson and Tilley, 1997). Unlike a quasi-experimental design, a realist evaluation does not compare outcomes for participants or non-participants as a means of evaluating an intervention. Instead, it examines the extent of how well an intervention works

and seeks to uncover why and for whom (Wong et al., 2016). This is particularly suited to the aim of the current study as it allows for the exploration of underlying mechanisms. The realist evaluation is expounded further in the next section of this chapter.

For the current intervention, the purpose of a realist evaluation was to identify mechanisms that lead to improvement of WBSE and potentially well-being. These mechanisms are the drivers which underly reasoning, attitudes, decisions and actions of participants in the current study. In accordance with the critical realist perspective, these mechanisms act as forces which lead to events (see Chapter 5). This implies that what is experienced or observed is potentially as a result of these mechanisms. Therefore, understanding events by looking through the lens of these causal mechanisms potentially brings us to a closer understanding of reality.

Furthermore, in the social world, which is much the focus of the current study, there is indeed an extensive web of mechanisms in action (see Chapter 5). For example, many mechanisms may result in an event (mechanisms may also trigger one another), and the event in turn may have many consequences. The current study is set in this social world and designed to create change. A realist evaluation presents the opportunity to bare the underlying mechanisms of this change as much as possible, in a way that a typical participant/non-participant controlled design does not offer. To ensure a rigorous report of the findings, a realist reporting procedure was followed, guided by the RAMESES (Realist And Meta-narrative Evidence Syntheses: Evolving Standards) II reporting standards for realist evaluation (Wong et al., 2016).

8.3.2 The realist evaluation

A key feature of the realist approach is that it goes beyond simply asking if an intervention worked or not. In line with its realist philosophy, it seeks to explore what works, for whom, in what contexts, and how. The realist evaluation is particularly suited to the current study as

different intervention strategies (action plans) were implemented in the different care homes (contexts) of this study. The iterative process of evaluation uncovers the mechanisms which may have brought about change. This approach to evaluation provides insight and enlightens our understanding of reality incrementally. Central to this evaluation are contexts (C), mechanisms (M), and outcomes (O) configurations, commonly referred to as CMOc.

A CMOc is a hypothesis. It will state that a program/intervention works (O) due to specific mechanisms (M) which are triggered in specific contexts (C) (Pawson and Manzano-Santaella, 2012). See Figure 8.1. This hypothesis will be tested during the course of a study.

In a realist approach, two realism axioms underpin the questions which are asked by the research:

a. What are the mechanisms for change triggered by a program and how do they counteract the existing social processes?
b. What are the social and cultural conditions necessary for change mechanisms to operate and how are they distributed within and between programme contexts?

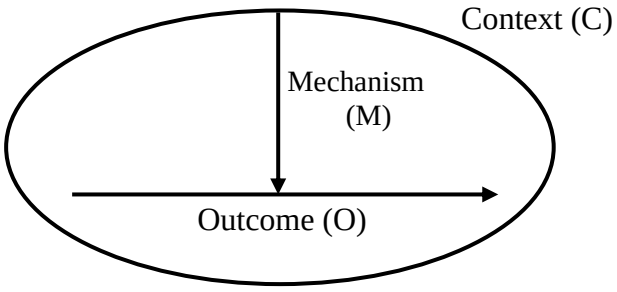

Figure 8.1 The basic ingredients of the realist social explanation
(Pawson and Tilley, 1997)

Dalkin et al. (2015) extend Pawson and Tilley's (1997) idea by introducing a two-part component of the mechanism. They state that a mechanism may be a resource (which is introduced by an intervention), but it may also be reasoning (which is influenced by the intervention). In their new formula, M (resource) + C → M (reasoning) = O, an intervention may introduce resources to a context, which in turn influences reasoning, and ultimately leads to an outcome (Dalkin et at., 2015). This distinction provides clarity between context and mechanism which can otherwise sometimes be confounded. The current study adopts this adapted version of the CMO configurations.

Using the CMO configuration and informed by previous knowledge, the realist evaluator develops the hypotheses for a program/intervention, stating how change may occur. Prior to evaluation, the evaluator states what outcomes are expected to occur, which mechanisms will be triggered for these outcomes to occur, and what context will favour the trigger of the mechanisms (or not favour them). The realist evaluation approach considers participants to be central to the outcome, and that outcomes occur due to the decisions which participants make (Pawson and Tilley, 1997, Pawson et al., 2005). Thus, the current intervention aims to provide an enabling environment for participants, for example by providing options, opportunities, and resources.

The hypotheses referred to in realist evaluation are called program theories. These theories are referred to as middle-range theories, as opposed to grand theories (Pawson and Tilley, 1997). Middle range means that these theories can be tested against actual data, unlike grand theories which are more abstract theories that address larger social or cultural forces (Jagosh et al., 2015). A realist evaluator may develop these theories from conversations with various stakeholders prior to evaluation, from prior research, from the literature, or potential participants of an intervention (Pawson and Tilley, 1997). The programme theories may also guide the collection of data and its subsequent analysis, as is the case in the current study. Data

collected is then used to develop, support, refute or refine the theories or specific aspects of them (Wong et al., 2016).

8.3.3 Developing the programme theories for the intervention

In the current research, the programme theories were used to define the focus of the evaluation. The development of these theories was informed by the findings of the focus groups in Study 1, the factors in Study 2, the conceptual framework, and the literature. Additionally, the theories were informed by informal conversations with care home managers, care quality managers, and academic experts specialising in care home research. The researcher seized opportunities to discuss with people with expertise in care homes and their staff. Some of these conversations took place during recruitment visits to care homes. Managers discussed their experiences and the dynamics of implementing changes within their home, their successes, difficulties, and staff attitudes. Other academics involved in care home research discussed their experiences on the field and the nuances of documenting and 'measuring' impact. These conversations served an exploratory purpose (Pawson and Tilley, 1997; Pawson, 2006a), and influenced the development of programme theories which explain how WBSE may be developed in a care home context.

During the analysis of data in Study 1, contexts were noted. Also noted from participants' narratives were possible mechanisms and how they might interact with each other and/or with contexts, to produce specific outcomes. Participants' narratives pointed to both positive and negative outcomes for well-being, and their descriptions around these negative and positive outcomes were examined for mechanisms. On conclusion of the factors of Study 2, these mechanisms were then compared with the items which loaded on to the three factors of Study 3.

Context: The context in the current research refers to the care home setting in general. However, each care home is unique, characterised by a unique set of features which may positively or negatively influence the outcome of the intervention. For example, size of staff group, number of residents, model of funding, or target population. Therefore, in working with three different care homes, it was expected that the context would be different enough to be able to observe different mechanisms at play and the consequent outcomes. Context may also refer to specific characteristics in a care home (for example, shift patterns) or may refer to contexts at an individual level (for example, commitment to personal development). Moreover, as a study progresses and outcomes are observed, the outcome at one point during the intervention may become the context of a subsequent period. When outcomes at one point in an intervention influence the context at a different point during the intervention, thus contributing to the mechanisms which are triggered, this is referred to as a ripple effect (Hawe et al., 2009; Jagosh et al., 2012; Trickett and Beehler, 2013, 2017). For example, in the current study, if WBSE increases midway into the intervention, this will be a contextual factor which may influence the trigger of mechanisms.

Mechanisms: as explained earlier, the current study adopts Dalkin et al.'s (2015) approach to mechanism, that is, as resource and reasoning. For example, the study distinguishes between resources (for instance, opportunities to be exposed to the sources of self-efficacy), and reasoning (for instance cognitive re-appraisal).

Outcome: the goal of the intervention was to improve WBSE. Reports on improved well-being were also anticipated. Therefore, a primary outcome was an expressed or observable increase in well-being and/or actions which may imply improved WBSE. Secondary or unexpected outcomes different to the program theories were expected.

The programme theories developed for the current research were:

1. In a work environment characterised by stress (C), by engaging in a participatory staff-led intervention which is aimed at improving well-being via self-efficacy, a frontline care home staff will have multiple opportunities to be exposed to the sources of self-efficacy (M) which will enable them re-evaluate/re-appraise stressors at work (M). The individual will subsequently behave (M,O) in ways which demonstrate (improved) confidence in their ability to plan and take action (O) which consequently leads to improved, nurtured or protected well-being (O).
2. In a work environment like the care home, where there are numerous reasons for interpersonal conflict due to the close working culture and shared problem solving (C), participating in the current intervention (C) will improve trust and camaraderie (M,O). As perceived WBSE increases with participation (O), individuals will take more proactive steps towards resolving conflict (M), or do so more often (M), to improve, nurture or protect their well-being.
3. In a care home work environment where the expectations and demands of frontline care home staff are constantly increasing (C), improved WBSE (O) will enable staff to develop or maintain a tenacious attitude (M) which will enable them increasingly override stressors (M) and improve, nurture or protect their well-being (O).
4. In the face of difficult situations at work (C), a frontline care home staff with a strong perception of WBSE (C) will more likely focus on personal motivations or find new ones (M) and this will have a protective effect on well-being (O).

8.4 Methods

Research sites: The intervention was implemented in three care homes for older people. See Table 8.1.

Table 8.1 Features of participating care homes

	Type of service	Care category	Number of residents	Staff group size	Ownership
Care home 1	Residential care (long term or respite)	• Dementia care • Mental health condition • Old age • Physical disability	26	11-20	Private
Care home 2	Residential care (long term, respite, day care)	• Dementia care • Learning disability • Mental health condition • Old age • Physical disability	20	11-20	Private
Care home 3	Residential care (long term or respite)	• Dementia care • Old age • Physical disability	25	11-20	Private

Sampling: Three care homes were considered to be a manageable number due to time and resource restrictions. The location for the intervention was chosen due to proximity and access to the researcher. Although the intervention was based on a whole-home approach, only FLCH staff participated which included night and day staff.

8.5 Implementing the intervention

Implementing the intervention comprised of three stages:

Stage 1 – Recruiting care homes and meeting with staff

Stage 2 – Facilitating well-being workshops

Stage 3 – Undertaking support visits and collecting data at specified intervals

8.5.1 Recruiting care homes and meeting with staff

Care homes which participated in Studies 1 and 2 of this research were invited to participate in the intervention (although none participated).

The participating care homes in this study were those whose managers gave a positive response to taking part following visits to the care home and an invitation letter left with managers (see Appendix D). Five care homes initially responded but two did not follow through to participation (in one of these the manager had changed before the intervention was to begin). It was anticipated that more care homes would express interest such that the researcher could select care homes to aid variability. However, each care home is a unique 'organism', with characteristics unique to itself, and therefore deemed to offer sufficient variability. The managers of participating care homes signed a gatekeeper consent form (see Appendix E).

Two pre-intervention meetings were arranged. These were considered important to improve the success of the recruitment process as recruiting care homes and staff for research is challenging. The first was a meeting with the manager to discuss the research, the logistics of implementing the intervention, and the commitment of the home. Following engagement with care home managers, there was the second pre-intervention meeting with staff. This was to explain the overall research and the intervention, to ascertain their willingness to participate,

and to negotiate consent. These introductory meetings were given an allocated slot during a regular staff meeting, or a brief organized session for staff (a maximum of 30 minutes including time for questions). This approach was employed as a means to inform but not overburden potential participants. Information sheets and consent forms (Appendix F and G) were made available to staff, which were to be completed and brought back during the workshops if they were willing to participate. Following this, suitable dates were booked for the well-being workshops and staff could book on to them. Posters about the research were placed on the notice board of participating care homes, so that staff were aware of the on-going research at their care home. For staff members who were not present at the initial introductory meeting, the research information sheet was left with the manager or administrator to be displayed on the care home's notice board.

8.5.2 Facilitating well-being workshops

The intervention began with workshops, which were labelled 'well-being workshops' (see Appendix I). One objective of the well-being workshops was to introduce and discuss with participants the concept of self-efficacy, well-being, and the relevance of their association. Another objective was to enable participants to practice some of the information which had been received during the workshops. A final objective was for participants to develop individual and collective action plans to improve well-being.

To apply their knowledge, following the initial introduction to the concept of self-efficacy, a game was designed for participants to play. This gamified approach was employed in order to reinforce understanding, to improve the retention of the information acquired during the workshop, and to make the learning experience enjoyable. This was a non-digitalised role-play game which was developed by the researcher for the current research. The development of the

game was based on gamification principles from research and industry (for example, Johnson et al., 2016; Marczewski 2015, 2018; Oprescu et al., 2014; Seaborn & Fels, 2015). The game development was also guided by the six key features of games as outlined by Juul (2003). These features were:

a. Rules; that games are based on rules
b. Variability and quantifiability; that outcomes are variable and can be quantified
c. Outcomes which are value-laden; that outcomes have values, such as being positive and negative
d. Player effort; that a player can influence the outcome through their effort
e. Player attachment; that the outcomes of the game can make a player happy or unhappy (for instance if they win or lose)
f. Negotiable consequences; that the game may or may not have real life consequences on the player

All participants signed a consent form prior to commencement of the workshops. Each participant attended only one workshop. Originally, two well-being workshops were to be offered to each care home as not all staff may be present at a single workshop. Additional sessions had to be offered in order to accommodate the staffing schedule of the participating homes. Each workshop lasted for approximately 2.5 hours.

Collective and individual action plans: one outcome of the well-being workshops was for participants to develop an action plan for improving or nurturing staff well-being in the care home. To aid collective action, the development of the action plan began during the well-being workshops and was to be facilitated by the well-being champion following the workshops. This was an action plan which participants would work on together as a team. The intention of this collective action, where participants worked on their own designed project, was to provide an

enabling environment for exposure to the sources of self-efficacy. Additionally, each participant set individual goals for well-being. As with the collective action plan, individual goals enabled an on-going practice of what had been learned during the workshop. As participants undertook collective and individual well-being plans, they were encouraged to also be more aware of their physiological state and potentially observe its influence on their ability to take actions towards their desired goals. Over a period of approximately six months, participants recorded their experiences in diaries, and their experiences were also captured in interviews.

To provide another avenue for participants to capture their experience and to encourage a positive atmosphere in the care home, a 'well-being tree' was to be put up in each participating care home. These well-being trees were to be designed to suit each care home. For example, it could simply be a large tree-shaped vinyl sticker on a prominent wall in the care home, or a free-standing artificial plant. On these well-being trees, participants would place leaves which celebrate the positive impact of their well-being plan, and commend the positive actions of others. Although participants were keen on this idea, none of the participating care homes implemented this aspect of the intervention.

At the end of the workshops, a well-being champion was to be nominated or individuals could volunteer. The champions emerged from a combination of colleagues suggesting and individuals choosing to perform the role. For support, the researcher aimed to see the well-being champion during each visit to the care home, where possible, to discuss any challenges or to offer specific support. No champion requested specific support throughout the intervention. For peer support, it was aimed that there would be two champions in each home. However, this occurred only in one of the three care homes. The role of the well-being champion was intended to be simple and minimally disruptive to their regular staff role. The role would involve (where applicable):

- Be a liaison person on well-being (e.g. can explain the aim of the well-being tree, the action plan and related matters to visiting professionals, relatives, or others). The champion will be a contact person in the home whom others could ask questions about the tree, the well-being agenda, or the research in general.
- Taking leaves off the tree when too full, and handing over to the care home manager (these could then be given to the persons commended on the leaves, or used for other positive well-being enhancing purpose depending on the care home)
- Supporting the 'planting' of the well-being tree (painting it, drawing it, or otherwise)

8.5.3 Undertaking support visits and data collection

Support (or progress) visits were undertaken throughout the implementation of the intervention. These visits took place at approximately six-week intervals depending on staff availability. They were with individuals or in groups, and were scheduled to include both night and day staff.

The initial design for the data collection was to have regular support visits/discussions with participants throughout the implementation of the intervention. These were also intended to be with individuals or in groups, and participants would decide on their participation or not in these discussions. However, to ensure that robust data could be collected, semi-structured interviews were also planned at the beginning, middle, and end of the intervention, in case none or only few participants joined the discussions. All participants were eligible for the interviews. During the initial workshops, no participants opted out of the interviews, with most indicating an interest to be interviewed at some point during the intervention period. To make the opportunity available to all interested participants, the design for data collection was amended to conduct semi-structured interviews at each data collection period if participants were

available, and not only at three points. Thus, these visits were presented to participants as discussion/interviews. The researcher rang the home to make arrangements, depending on staff availability, in advance of a visit. Sometimes, based on staff rotas, arrangements for the next visit could be made during a current visit. Other times, participants gave an indication of their availability, and suitable times were confirmed with a supervisory lead or administrative staff. Table 8.3 shows the number of data collection periods for each care home and how many interviews were conducted over the period.

The discussion/interviews involved reiterating the sources of self-efficacy and the link to WBSE. Participants discussed their experience of the intervention, its impact on their work, and how they felt about it. They discussed any benefits, challenges, and other ideas for well-being (personal and/or collective plans). The researcher asked general questions such as how participants had found the intervention so far (see Appendix K for the initial interview guide). The researcher also asked specific questions about the progress of the collective and individual action plans. This also included asking participants to describe a situation they believed to have an impact on their well-being, if they were handling it any differently due to the intervention, and how. Some questions were similar in approach to the diaries, with the aim of observing differences in actions and/or attitudes related to the programme theories.

Analyses was an iterative process, and as findings emerged through the data collection periods, the researcher also presented findings from the previous data collection periods. Findings were from analyses of the data across all sites and related to various aspects of the programme theories. In this iterative approach, participants had the opportunity to comment on findings emerging. For instance, the subject of conflict with colleagues (programme theory 2), if the participant had not referred to it, the researcher asked what the participant thought about the actions which others were taking or their attitudes towards conflict resolution (findings which emerged from previous data collection periods). The semi-structured nature of the interviews

was to be guided by the programme theories but to allow for further exploration of the participant's narrative. Thus, the overall aim was to pay attention to participants' experiences in order to test the programme theories. There was focus on identifying mechanisms, contextual elements, and how the interaction between these produced outcomes. The iterative process of data analysis and checking in with participants, checking their experience of the intervention process, and noting any change, formed the core aspects of the discussions/interviews. Additionally, the sources of self-efficacy and the link to WBSE and potentially well-being were also reiterated during each visit with participants.

During the period of implementation, participants also documented details of their experience in a diary which was intended to be completed every two weeks, taking approximately 15 minutes. Due to the 'burden' of paperwork and time constraints, the design of the diary was to ensure that it did not feel burdensome and that participants were motivated to complete it (see Appendix H for the diary template). Participant code identifiers were used in order to compare participant experience through the course of the intervention. Additionally, at baseline, mid and post intervention, a set of questionnaires were administered (see questionnaires below). Collecting the varied types of information via different methods was to aid triangulation (Pawson and Manzano-Santaella, 2012).

Data collection methods and periods:

Data was collected in the form of questionnaires, diaries, discussions/semi-structured interviews, and field notes. It was intended that each of these methods would provide richness to the data collected, giving a perspective that a single method may not provide.

Data collection points were:

- At baseline (questionnaires)

- At approximately two-week intervals (diary completion)
- At approximately six-week intervals (group or one-to-one discussions/semi-structured interviews)
- At approximately 3-4, and 6-7 months after initial workshops (questionnaires repeated)
- On-going (field notes)

The following are the questionnaires which participants of Study 3 completed as part of the data gathered during the Study. These were completed at baseline, mid-, and post-intervention.

- Well-being self-efficacy (WBSE) scale – the new measure developed in Study 2 of the current research
- Job-related affective well-being scale (JAWS) (Van Katwyk et al., 2000). Captures the feelings of pleasurable and displeasurable emotions in relation to work. This was a 20-item scale which captured a range of emotions experienced at work. Respondents rated their experience in the last 30 days on a five-point scale from 1 = 'never' to 5 = 'extremely often'. A sample item from this scale is 'my job made me feel angry'.
- Interpersonal Conflict at Work Scale (ICAWS) (Spector and Jex, 1998). Captures the experience of disagreement or poor treatment at work, ranging from minor disagreements to physical assault on others This was a four-item scale which measures conflict between people at work. A sample item is 'How often are people rude to you at work?'. The scale has a five response options ranging from 1 = 'never' to 4 = 'very often'.
- Social Support at Work (Haynes et al., 1999; Eisenberger et al., 2002). Captures helpful behaviours (perceived or offered) from co-workers or supervisors. This was a seven-item scale which measures a person's perception of the support they receive form colleagues and supervisors while at work. A sample item for co-worker support is 'My co-workers

listen to me when I need to talk about work-related problems.' A sample item for supervisory support is 'My supervisor is willing to extend himself/herself to help me perform my job.' The four-point scale ranges from 1 = 'strongly agree' to 4 = 'strongly disagree'.

- General health questionnaire (GHQ-12) (Goldberg and Williams, 1988). This was a 12-item scale which measures a respondent's recent general health. A sample item is 'have you recently felt you couldn't overcome your difficulties?'. The response options on a four-point scale were 1 = 'not at all', 2 = 'no more than usual', 3 = 'rather more than usual', and 4 = much more than usual'.
- Organizational Constraints Scale (OCS) (Spector and Jex, 1998). Captures situations or things which hinder employees from exerting their efforts and skills, translating into high quality performance at work. This was an 11-item scale which measures the impact of organizational constraints on employees' ability to do their job. A sample item is 'How often do you find it difficult or impossible to do your job because of poor equipment or supplies'. The five response options ranged from 1 = 'less than once per month or never' to 5 = 'several times per day'.

Data management:

Interviews took a realist interview approach (Manzano, 2016). They were audio recorded and transcribed.

8.6 Data analysis

8.6.1 Quantitative

Analysis of the quantitative data would involve a comparison of the means of the WBSE scale at baseline, mid- and post-intervention. The correlation between the WBSE scale and all the other scales was to be examined at baseline, mid- and post-intervention.

8.6.2 Qualitative

As previously mentioned, programme theories are first developed for the intervention/phenomenon being studied. In the current research, this development was done prior to the commencement of the intervention (informed chiefly by Studies 1 and 2, and the literature). Following the development of the initial programme theories, in Study 3, the iterative process of data analysis involved the programme theories being assessed in the light of data collected. This analysis of data aimed at the assessment of the programme theories, and this involved proving, amending or refuting the theories. The objective of the analysis was to identify patterns of CMO configurations which were recurrent (Astbury and Leeuw, 2010; Wong et al., 2016). Various validity procedures (Cresswell and Miller, 2000) were employed to provide a robust assessment of the programme theories. This involved triangulation of data between participants from the same care home, across the care homes, and across time periods. Additionally, the process of analysis was iterative, where the researcher presented findings to participants for further assessment.

Table 8.2 shows the links to the themes and factors in Studies 1 and 2. Although all the programme theories can find a link, albeit indirectly, to the outcomes of Studies 1 and 2, the table only shows direct links.

Table 8.2 Programme theories and links to Studies 1 and 2

	Study 1					**Study 2**		
Programme Theory	**Regulating emotions *(in interpersonal conflict)***	**Shifting Focus** *-Cognitive reframing -Focusing on personal motivation/drive -Cognitive empathising*	**Seeking Support** *-From colleagues -From significant authority*	**Taking Control** *-Exercising autonomy -Managing workload Being assertive Being proactive*	**Self-Care** *-Understanding one's limits -Building resilience -Self-appreciation and receiving appreciation*	**Maintaining/ developing a tenacious attitude**	**Speaking up**	**Shielding**
1. Reappraisal influencing attitudes and actions	*	*	*	*	*	*	*	*
2. Improved trust and camaraderie aiding proactivity in conflict resolution	*	*	*	*	*		*	
3. Tenacity and overriding stressors	*	*			*	*		*
4. Personal motivators protecting well-being		*		*	*	*		

Transcripts were analysed for experiences/narratives which highlighted the contexts, mechanisms and outcomes theorised in the programme theories. The transcripts were read and re-read, and the C, M, and O in each transcript were colour-coded. These were then extracted from the transcripts into an excel spreadsheet and organised into a C, M, and O chart. Each programme theory was then compared against this chart.

Further analysis then involved assessing the program theories across all data sources. An excel spreadsheet was used to organise the data from the transcripts, diaries and fieldnotes in such a way that the programme theories could be assessed across the data and across the timeline. Additionally, being an intervention which was implemented over a period, it was beneficial to assess any evidence of ripple effects, and this involved observing how previous outcomes influenced subsequent contexts. The overall aim of the analysis was to examine the data in relation to the program theories, focusing on how, for whom, to what extent and in what context did the intervention work or not (Pawson and Tilley, 1997; Wong et al., 2016).

8.7 Results

Quantitative

A total of 40 questionnaire packs were completed – 22 at baseline, 13 mid-intervention and 5 post-intervention. The number of responses for the quantitative data was not substantial enough to conduct robust quantitative analyses as expected. The aim of the quantitative analyses was to serve as a means of triangulation. Albeit triangulation was achieved through the different sources of qualitative data (diaries, interviews, and support visits).

Qualitative

A total of 36 FLCH staff attended the initial well-being workshops. However, due to staff shortage and the logistics of staffing, 12 continued with the intervention. All who started the intervention (after the initial well-being workshop) continued to the end. A total of 26 interviews and support visit discussions were conducted, and 42 diary entries received. Although no participant completed all the diary entries expected throughout the duration of the intervention, all participants completed some, an average of one diary entry (instead of three) per six-week period. Table 8.3 shows the number of visits made to the care homes during the period of the intervention.

Table 8.3 Visits made to intervention sites

	Intervention site 1	Intervention site 2	Intervention site 3
Manager's meeting	1	1	1
Staff visits	1	1	1
Workshops	4	2	2
Support visits*	10	4	4
Interviews conducted (over six-month period)	17	4	5

*sometimes multiple visits were made in the same data collection period to accommodate participant availability. Numbers also indicate actual visits, sometimes visits were cancelled due to staffing issues.

T1-T6 represent the data collection points. The notation T1:3 denotes the data collection point T1 and interview/discussion number 3. If the discussion involved more than one participant, this is denoted by T1:3p2 or T1:3p3 and so forth. Diary entry numbers are also presented next to quotes, they denote diary entries which support the quotes. For richness of supporting data, these diary entries were mostly not related to the same participants in the discussion. DE1 denotes diary entry number one, DE2 and so forth.

The results presented are in the light of the programme theories initially developed. The CMO configurations for each programme theory are first outlined, and results are presented against the backdrop of these initial programme theories. Participant quotes which most clearly demonstrate the CMO configurations are presented for illustration. Diary entries which illustrate a C, M or O similar to the quotes are presented along with the quotes.

8.7.1 Programme Theory 1 (PT1)

> *In a work environment characterised by stress (C), by engaging in a participatory staff-led intervention which is aimed at improving well-being via self-efficacy, a frontline care home staff will have multiple opportunities to be exposed to the sources of self-efficacy (M) which will enable them re-evaluate/re-appraise stressors at work (M). The individual will subsequently behave (M,O) in ways which demonstrate (improved) confidence in their ability to plan and take action (O) which consequently leads to improved, nurtured or protected well-being (O).*

As previously encountered in the literature review chapter, the care home as a work environment is characteristically described as highly stressful. In managing the impact of stress on well-being, the theoretical framework of the current study points to cognitive appraisal as

playing a key role (see Chapter 3), and this was demonstrated by the findings of Study 1. PT1 focuses on this cognitive ability or action, which can influence an individual's adaptation to a highly stressful environment. It also focuses on the role of WBSE in this interaction, and the impact of the intervention on WBSE. The behaviour of an individual, was described as both a mechanism and an outcome. A mechanism because this may lead to the outcome of well-being, but may also be an outcome, for instance an outcome of a re-appraisal.

The context of a stressful environment described by this theory was confirmed by participants. Stressors varied, for example task-related stressors or situations with residents. This stressful context was persistent through the course of the intervention, that is, participants did not describe it as less stressful at later points during the intervention.

> *We were all sort of sitting round…and then somebody said, 'we need a prayer room'. And I said, 'well we'd never come out of that prayer room if we had one of them'…I mean you go home, and you cry.* T1:1p2

> *…especially when you're on a long day, if you're doing a 13/12-hour shift, you're here, you're disrupted, you're watching, you're listening for the buzzers… I tell you what, it does take its toll. It really, really does.* T1:1p1 + DE38

> *You're in a situation, you've got residents walking about and they're opening emergency doors, you haven't got time to stop, you've just got to react, you don't always have that time to step back and think, 'what am I going to say?', you know, you just crack on… And then again, if it's not the residents sometimes it's the staff, because they don't leave you alone either. You know, and I think sometimes, it's like, [for] well-being, sometimes you just need to switch off.* T1:1p2

> *Especially when they're walking down the stairs with a toilet cistern in her hand, the actual top of the toilet she's taken off, literally the top part of the toilet and I'm thinking, 'good god', you know, and she's walking down like it's a handbag.* T1:1p3 + DE25
>
> *You know, this care job is very stressful, it's too much stressful.* T3:6 + DE23
>
> *It's been quite stressful…the residents have been changing, like sometimes they can be quite challenging, and like last week, which is what I wrote down [in my diary], not last week the week before, one of them actually hit me…I mean yeah, it can be stressful,* T3:11

Another participant, later into the intervention remarks *'If like somebody falls, yeah, they hurt themselves, or someone has broken [something], suddenly you have so much pressure and stress'* (T4:19). In other words, when you seem to be keeping things under control and managing your stress levels, the situation at work may rapidly change. You suddenly have to manage more stressors, and the need to constantly adapt can be a stressful experience.

The mechanisms captured by PT1 are exposure to the sources of WBSE (engagement with the intervention), re-appraisal of stressors and engaging in certain behaviours. When participants pointed out that they had not really been actively engaging with the intervention, that is, not working on a collective or individual action plan, their narratives were often centred around the context (stressful or negative work experience) and not on attempts to improve well-being. In other words, they seemed to be 'caught up' in the difficulties of their work. When asked about how they were finding the intervention, one participant responded, *'I've completely forgotten, if I'm honest, work overtook everything else. Work does take over everything and you just, shoom, [well-being] goes over the top of your head. Everything else just goes to the back of your mind.'* (T1:1p1). *'Well, because it's stressful.'* (T1:1p2). This was a common finding across participants in the early part of the intervention. However, by about T3, the

accounts were more about participants' actions and/or attitude to improve their well-being, which included cognitive re-appraisal of stressors.

These behaviours were both a mechanism and an outcome. Mechanism because they demonstrated the pathway via which participants' well-being improved. However, they were also outcomes because they were an indication of increased WBSE. Illustrated by the accounts of participants, as they engaged more with the intervention, there were more behaviours and attitudes which depicted improved WBSE. When asked about what they now do about a stressor, one participant recounted,

> *'Before I was too much stressed right here, you know, why are they thinking about this, why are they saying some things to me, this and that. And now I always ignore it. Ignore it and keep focused on my job and keep focused on myself as well, you know, and others as well…feeling more confident… Because, you know, I'm coming to work, yeah, I don't need to gossip and things like that. I just focus on my job, I'm coming for residents, these poor people I'm helping and caring for. I'm more, you know, thinking about them, I'm not thinking about the other staff, yeah…. I always remember, you [your words] you know. Because when my stress level is going up, then I say 'no', I have to calm down. It is, yeah, it's very helpful.'* T4:2 + DE41

Cognitive appraisal was also demonstrated by participants as they engaged with the intervention, '*[After] the first session we had when we went back to work, we just kept thinking well-being, well-being, think think!'* (T4:4p1).

As participants engaged with the intervention, they seemed to take more notice of the dynamics of the situations which produced stress and what they could do about it. They gave accounts of planning and taking action, which were widely varied. These varied actions were often related to the themes from Study 1, for example, managing workload, being proactive, and

understanding one's limit. There were also actions which related to the factors from Study 2, for example defending or protecting well-being or developing or displaying a tenacious attitude.

> *After you came [reference to well-being workshops] that's when, after that I bought my journals and stuff…I write at the bottom, I write health and well-being, so that's like medication, pamper sessions, things to look after myself, even though it's like two minutes a day, something just to concentrate on just you, like on my break or something, I'll just relax, calm down.* T4:22

The account which follows demonstrates improved confidence to take action. In this account, the participant had a demanding role at work. Due to the stressful experience and its impact on well-being, following a period of contemplation, the participant decided to change their role to a more junior role, but not leave the care home. This participant made the decision to change about four months into the intervention, and felt that they were able to keep a job they loved, without the added stress.

> *It's taken me, it's been a right nightmare to try [to change]…. I didn't [leave], do you know why? Because I love, I love my job…I'm not going to be pushed out of something that I love to do, because, it's like the residents, you get to know them, you know, and when they pass away you also know the families of the residents and everything and that's a big thing to give up really…But, if it starts affecting my health and my outside life, because I think when you work in care you don't [switch off], with some people they can switch off, I know what I'm like, I don't switch off, I will go to bed thinking about things, 'oh have I done this, have I done that?'…I know myself that I take on too much and…of course I did take on too much… But it's also one of them jobs that you*

don't, you can't, you can't just walk away, you can't walk away because it's a lovely job. T3:5

8.7.2 Programme Theory 2 (PT2)

In a work environment like the care home, where there are numerous reasons for interpersonal conflict due to the close working culture and shared problem solving (C), participating in the current intervention (M) will improve the development of trust and camaraderie (M,O). As perceived WBSE increases with participation (O), individuals will take more proactive steps towards resolving conflict (M), or do so more often (M), to improve, nurture or protect their well-being.

The context of interpersonal conflict was recurrent in Studies 1 and 2. This was confirmed here in Study 3. Participants gave accounts of the impact of interpersonal conflict on their well-being, their ability to complete tasks and on the quality of their job.

If you know you've got people putting knives in your back it is stressful, it's like, 'well what have I done to you'? It's a different kind of stress because then you have another million and one questions going through your head. 'Oh what have I done to them? How did I upset them that much'? You know, 'did I say something that was taken out of context'? Or whatever, you've got all these questions going through your mind and then you're trying to do your job as well and yes, all that builds up, it builds up and eventually you're going to blow, that steam's going to come out and you're going to blow. T3:7 + DE19

An anticipated mechanism was engagement with the intervention. This was confirmed when in their accounts, participants made reference to how the intervention influenced their actions. As in PT1, the actual actions taken in relation to interpersonal conflict differed amongst participants, as each one aimed for their personal well-being outcome.

> *I've got better relationships with my colleagues now I feel, because there was, remember the one I mentioned the last time you [researcher] came in, I said there's one I still have tension with, well I spoke to her a couple of days ago actually and I said to her 'you seem happier within yourself and you are just nicer to work with', so we've actually apologised to each other, so right now at this moment, there's no tension I've got at work with my colleagues so I'm happy coming to work…Massive! It's like a massive weight off because I used to dread my shifts when that person was on.* T6:24

In accordance with PT2, it was also anticipated that as participants engaged in the intervention, trust and camaraderie will develop. This was confirmed. At one of the intervention sites, the staff earlier recounted how they had hardly gone out together and would like the opportunity to.

> *I think going for a meal or going to a party you know, one day we have to, you know, for just staff to have it together. Just chat and have a cup of tea together and, you know, enjoy yourselves. Sometimes you're just coming to work, doing, doing, doing work, it's stressful and then go home and your mind is, you know, yeah. You don't have a time to, you know, understand each other, yeah. Maybe the other person is right, you are wrong, you know?... Yeah, this is when you are together, chatting, and you know each other, you know how I think and I know how you think. Then, you know, the relationship is developed.* T4:2 + DE3

> *It's made me to work more in a team. Because usually, I work, I like to work on my own, but it's actually a gain, like for me to work in a team now.* T6:25

For their collective action plan, the staff at this intervention site decided to plan an outing on a day which was suitable, seeing they could not all be off at the same time. They went shopping together and then had lunch. One member of staff did take a day off for the outing, and participants reported that this had not been done in the care home for many years. For some staff, they had never known it to happen since they joined the care home. One participant, commenting on suggesting more of such outings says, *'I never use the suggestion box, but I always used to think what do I need it for, why do I need it, and then now I realise that staff bonding is the key to a healthy workplace. Definitely.'* T3:14. Another participant comments on the outing,

> *That was really good because it made, it lifted everybody's spirits, it was like yeah we've had a day out, we're not at work, yeah we all spoke about work but we also, anybody who had their other frustrations they could also talk about it as well, and it made us all feel better, I'm not the only one that feels frustrated, it is everybody feeling the same. So that was good, it was good.* T4:16 + DE 27

In this care home, staff went on to organise a staff bonding quiz night, a birthday kitty for staff birthdays, and had two other events planned for staff which extended beyond the intervention period.

> *We've got a birthday kitty now, that's nice because we've never had that before, so when it's somebody's birthday we get a present and whatever, and that's bringing us more together as well and that's really nice. And it's not just a workplace, I've always said this place is home from home and it's getting more like that now than what it was*

before. We're not all total strangers just working with each other, it's more like a friendship, yeah, which makes a difference. T4:16

The mechanism of taking proactive steps towards conflict resolution, also demonstrated by other participants, is illustrated by the extract following.

[Before], I would keep it in, but now as soon as an issue arises in my head and is affecting me in a slightly negative tone, I would go straight to either my senior or if it's the senior that's bothering me, then I'd go to the manager, but I need to fix it on the day, because I can't let it progress…colleagues are more often the issue, more stressful than the residents…[now] I would go straight to the senior or the manager as soon as a problem arises… usually l just let people walk all over me, but now I feel, you should be settled where you work, not uncomfortable, so I'd go straight to the senior or manager. T4:22 + DE16

I have mentioned that on the note [research diary], the negative experience and positive experience and there was a situation that I got dragged into an argument, yeah…. Anyway, but then…I turned that negative into positive. I did that myself and I'm proud of that. That was the experience I learnt from, actually, it was quite good. You know, everything happens for a reason and now, [as] I was being positive about it, that person is so close now. Sometimes it's good to open [up], even if there's aggression, even if there's crying, it's good to open [up]…don't bottle it. T4:14 + DE14

Unexpectedly, positive relationships were also developed from participants recognising the need to maintain a healthy distance between themselves and some colleagues. This was not necessarily due to on-going negative experiences. In the following excerpt, the participant discusses supportive friendships at work, but knowing the limits.

Not with everyone, there are certain people that I would consider friends rather than colleagues…The ones I'm getting along with now that I didn't before, I'd say they are colleagues but we're working at building the trust, the same as building [a] muscle…this is the same thing, trust has to be built…. If I lose the trust, I will strictly leave it as a colleague. There's no room for being friends, it's just, I'm here for the residents, I'll work with you to meet the residents' need, I'll be polite with you, I'd be cordial with you, but I'm not taking it any further to discuss anything else. But that would give me peace of mind knowing it. Before it wouldn't I'd be like 'no, I have to be friends with everyone', but I've learnt you can't, there are some people you're not compatible with. You can learn to be but that will take a lot of time and you're not everyone's cup of tea, you're really not, you can't be friends with everyone. T6:24 + DE38

8.7.3 Programme Theory 3 (PT3)

In a care home work environment where the expectations and demands of frontline care home staff are constantly increasing (C), improved WBSE (O) will enable staff to develop or maintain a tenacious attitude (M) which will enable them increasingly override stressors (M) and improve, nurture or protect their well-being (O).

The context of PT3 captures the increasing demand on the role of the frontline care home staff. Participants' experience illustrated this increased expectation not only regarding tasks, but also in the level of training 'covertly' required, as illustrated by T6:25 below.

We have a change of residents, don't we? And when I first started 27 years ago, it was the walking wounded which means they weren't too bad with the dementia and they had, you know, maybe high blood pressure or something like that, the starting of dementia. But now, we're getting the full-blown ones that really, just blow you away sometimes. T1:1

We're not medical. A lot of like family members they seem to think that we're medical, we're not medical, you know, we are what we are, we're carers. But you're supposed to know, just like that, about every single resident and what their needs are, which you should know, but you need time to look at their care plans. T3:6

I remember we used to work without NVQ, and when it started, they said, if you do your NVQ2 you get more money when you finish [it], but it never happened. T6:25 + DE4

In accordance with PT3, one potential mechanism by which improved WBSE would be demonstrated is by the development or maintenance of a tenacious attitude. This was demonstrated as participants gave accounts of their attitude when faced with a challenging situation. It was observed that narratives which demonstrated this tenacious attitude were more frequent in the later part of the intervention. These situations varied, for example persevering through a difficult task, handling conflict with colleagues, dealing with difficult relatives, or simply speaking up about issues which were of concern. Talking about a determination to improve one's well-being and to be happy, a participant recounts,

Yeah, you can improve it, you just go in with the mindset of like, okay it might not be a good shift but you're going to make it a good shift because you just jolly yourself along don't you, you concentrate more on other things rather than what's going on, or who you're working with. So, take yourself out of that situation and put yourself somewhere else basically, yeah. T4:16

Demonstrating a confidence to now complete tasks at own pace in spite of what they deemed to be undue pressure, another participant explains,

> *You'll go home and you'll think…I could kick myself, I wish I'd stood up for myself or something, do you know what I mean? I won't work like that and I will not let anybody kick me out of doing something that I love…I mean I can't wait for 2 o'clock to come round, don't get me wrong, because it's like after having 7 days off and then coming back in and not having a clue what's gone on, and then like you just feel dumped on. You know, we've got a new lady in, I don't know anything about her, the medication's changed and it's like, other people could do the medication quicker because they do it more often, I've had 7 days off, I haven't got a scooby of what's got on. So, it doesn't matter how long a job takes me, I will do it and if nobody likes it then tough. But as I say, your well-being is a lot of it, it really, really is.* T3:5 + DE22

Also, when colleagues did not carry on with shared tasks, this was often raised as a source of annoyance (also encountered in Studies 1 and 2). Due to the shared nature of the work, tasks uncompleted by some staff will mean that their colleagues are left to complete them. In the account following, this participant felt bold enough to speak up, with a resolution on fairness.

> *When I find like other staff are being unfair, why, why should they, sometimes if you're not feeling well then it's fine, we understand, sometimes I'm not feeling well. But if they do continue, I don't tolerate it anymore because after all the boss is paying everyone the same. Maybe some people don't like me, but when I'm on shift I make sure everything's like, before I go, whatever we have to do is done…I told them…when I'm on shift I'm going to make sure everything is safe…If there's someone who doesn't do it I do tell them, sometimes people are annoyed because I've told them but I don't care because the resident is first. So, if I see like somebody has left something or doing*

nothing, I do tell them, or if I have time I do it, I don't talk to them, I just do it. T3:8 + DE8

Some narratives pointed to an increased awareness over the course of the intervention, and a resolve to take action to deal with stressors, overriding them before they took hold and negatively impacted on well-being. At T4, when asked if and how the intervention was making a difference, a participant responded,

Of course, yeah. Because when you came in, you were speaking about, like, the stress levels and everything at work, there wasn't anything in place for us, but now after you came in that's when I started speaking to Fiona [manager]. 'Cause before I wouldn't go to the manager. It has helped, definitely has helped…because now obviously I'm thinking like why didn't I go in the first place, like what was I scared of. It was no one stopping me it was myself. So it's definitely taught [me], everyone has it in them, because I used to be a very shy, reserved person but then you're not going to get anywhere by doing that, so you have to speak up. So you need to relax yourself, figure out what the problem is, and then tell her [manager] exactly what the problem is. Don't go around it, don't bash the other person, just say what the problem is and see what you can fix. 'Cause sometimes you can't fix it, you have to work together to fix it. T4:22

8.7.4 Programme Theory 4 (PT4)

> *In the face of difficult situations at work or the difficulty of the job (C), a frontline care home staff with a strong perception of WBSE (C) will more likely focus on personal motivations or find new ones (M) and this will have a protective effect on well-being (O).*

As in the previous programme theories, the context of difficult situations in the job also had an influence on the mechanisms which were triggered in PT4. For PT4 in particular, it was expected that a ripple effect will be observed. That is, an improvement in the perception of WBSE (a previous outcome), would serve as a context in PT4. To illustrate this, participants' accounts would exemplify a stronger perception of WBSE, they will keep motivated to improve or maintain their well-being, and do so by remaining focused on old or new motivators.

However, from the data, the ripple effect anticipated in PT4 was observed in PTs 1-3. As participants engaged more with the intervention on a personal and collective level, their subsequent narratives demonstrated improvement in their belief to plan and take actions for their well-being (improved WBSE). Therefore, this was not unique to PT4. Furthermore, although participants indeed discussed their motivations (mainly a commitment to the residents and their faith), their accounts were closely related to cognitive re-appraisal or re-evaluation, whereby they reconsidered a difficult situation and decidedly focused on a motivator.

Thus, in PT4, focusing on a motivator as a mechanism, in the context of a difficult task, was not observed to be uniquely different to PT1. For example, according to PT1, in difficult situations, participants engage in various actions to improve well-being, including focusing on one's motivations. In other words, PT4 is embodied in PT1 particularly, but also in PT1-3. Therefore, PT4 was dropped.

8.8 Participants' evaluation of the intervention

Although the findings of the intervention have been presented using the realist CMO configurations, the researcher thought it was important to have participants' overall perspective on the impact of the intervention. Two key findings were observed, and both were in relation to awareness. First was the awareness of the impact of stressors, as there seemed to be oblivion with regards to the impact of stress on well-being and even the quality of their work. Stress and its negative impact seemed to be normalised. The second notable finding was an awareness that one could do something about well-being, and it did not have to involve taking huge and impractical steps. Participants became aware of the gradual increase in one's belief in the ability to take action, and more conscious that over time they could make a significant difference to their well-being. Both these observations represent a shift in cognition.

> *It's been interesting, because I've never thought about my well-being whatsoever, never ever, you just plod from one day to the next and you never, it's like, I don't like, I never used to like talking about [it], it's feelings isn't it?* T4 [Intervention site 1]

> *I didn't realise how much work actually stresses you out…you know what, all this stuff that was on that first survey we filled in* [referring to the new well-being self-efficacy scale, see Chapter 7]*, I was like that's so crazy! Because everything is listed there, but our mind doesn't even think [that], because it thinks it's normal to be stressed at work. But you shouldn't! It's actually crazy, since you [researcher] started, how much I've learnt about myself at work. It's so weird you don't even, before you were here, I didn't even think about stuff like that but now, my attitude has actually changed in the like, last, probably 8 months. It's like from when I started, I was really 'stressy'. I was taking everything home. I could not shake it, I could not get rid of it, but now even like the mechanism I'm using to cope here I can use it elsewhere too. So, it's actually nice. I love it.* T6 [Intervention site 3]

Referring to the ability to improve well-being, another participant recounts,

> *Well I think mine's definitely improved, yeah. Yeah, it's making you more aware, because we do things and don't realise you're doing them, so it's like self-reflection…It's more self-belief isn't, yeah…I think it's a slow process but yeah, again it depends on who's around you and everything, doesn't it? Yeah, I think it's making me more aware. I think the way I look at it now, I'm not so stressed, I'm just busy, it's a different way, you can mix up the two. So yeah, changing it round. So, stress is negative, just being busy isn't.* T4 [Intervention site 2]

> *Erm I mean it has helped. Like everyone here, it has helped to have someone different to talk to about it [work]. Because I think really people may not have really thought about stuff before, like about opening up to others or about their own well-being to be honest. They just may think of other people rather than themselves. I think it is good having you [researcher] here…. It has helped a lot of people here.*
>
> *…It's good filling out diaries. It makes you think of what's been good, or what's also been negative at the same time. It has been good doing the diaries. It's a good idea doing diaries* T5 [Intervention site 1]

Armed with the awareness of self-efficacy, well-being, and the potential association between them, another participant, referring to the simplicity of how to take the steps towards improving well-being states,

> *Some days that's all you need, two minutes at the feet of a resident with a cup of tea. It is the simple things that really make this job, really, it really is.* T3 [Intervention site 1]

Participants were asked if they believed they could improve their well-being and why?

Yes. Because I've improved lots of things, yeah. T4

Yes. I think I've done well… The goal I set was just getting on with my work, and I've done that. T4

Oh, yes on some days and no on others. I never talk about my feelings if I'm having a good day or a bad day, and you never pinpoint it to any one thing, but now when you look at it, it makes you think. T4

Yeah. I have the motive to do, get up there and…to do the tasks they ask me and everything like that. T6

8.9 Perspectives on well-being

Although it was not the focus of this study, or indeed the current research to investigate the definitions of well-being, it was noted that participants' definition of well-being encompassed both hedonic and eudaimonic descriptions (see Chapter 2).

Also notable was that definitions changed depending on the situation being narrated. Sometimes, the same person described well-being differently depending of what they were talking about. When the context was relational, that is, interaction with others, the hedonic (feelings) description of well-being was most referred to. Although feelings were not always related to others.

[Well-being means] No stress at work, completely getting along with colleagues, work being distributed equally and like not having any stress of who you're working with, like waking up and thinking who am I working with, and if it's someone you don't get along with, that could affect your shift negatively, and not letting that bother you. That's what it would be. T4:22

[Well-being means] feelings of satisfaction, positivity. It promotes your physical health. T4:20

When the context of the discussion was related to tasks or the job role, the eudaimonic description of well-being was mostly used, for example, completing a task to a high standard of quality or reaching a goal.

I think, like you've achieved your goals, yeah, self-achievement, something like that, yeah. T4:20

Interestingly, the description of well-being as related to goals and accomplishments involved making others feel happy. There were many references not just to feeling happy in oneself, but a kind of commitment to keeping up a good mood so that others around could be happy also.

For me it's just like how you feel and everything, and how you make others feel as well. Yeah, like I just think well-being is like, it is to do with you, but it's to do with others as well, and obviously, if you made someone else happy that's going to reflect on you and how you are, and how you do things really. Yeah, because it gives you a positive mood really. So, say if you're upset about something, it takes your mind off it, then you're doing something else, then you improve how you feel. And it'll spread on to everyone else as well. T3:11

Feeling good in yourself…If you feel good then that rubs off on others, and then everyone feels good. T4:18

Although participants described well-being based on situations, well-being was also described as being a holistic experience.

It's the whole holistic thing. It's mind and body. Feeling better in yourself, healthier thoughts, less depression, less stress. T3:13

To me, it means how work and everything else affects my body, my mind, my health and everything around me. So how everything around me affects me as a person. T4:22

8.10 Discussion

The findings from the data directly confirmed the CMO configurations outlined in PTs 1-3. The findings show some of the mechanisms which underly the association between WBSE and well-being. In addition, the data showed that the mechanism anticipated in PT4 was not different to PT1 in particular. Since PT4 could be explained by PT1, PT4 was dropped. As participants aimed to improve their well-being, they took on and engaged in a variety of attitudes and behaviours. These were mostly similar to the findings of Study 1, and not the focus of Study 3. However, Study 3 gives insight into how those actions come into play.

As presented in the literature review (see Chapter 2), well-being means different things to different people. Therefore, the well-being goals for participants varied. Nonetheless, participants' accounts demonstrated that the intervention did increase their awareness of well-being and the improvement of well-being. Although participants described well-being in both subjective and functioning terms (see Chapter 2), the subjective definition of well-being was most common. This may offer some support to the findings in Study 2. In Study 2, there was no or non-significant correlation between the WBSE scale and general health (GHQ), whilst there was a significant correlation between the WBSE scale and the job-related affective well-being (JAWS). A possible interpretation was that the WBSE scale may be more related to subjective well-being. Here in Study 3, the frequent reference to well-being in a subjective manner potentially offers some support to this interpretation.

In line with critical realism, what is observed may be triggered by and/or may trigger a host of other mechanisms, thus the findings of this study contribute to our understanding of reality,

and this understanding may indeed be improved. However, the impact on participants' well-being is noteworthy. It appears that when FLCH staff are supported with the necessary tools to improve well-being, they indeed can. This concurs with the findings from Studies 1 and 2 and is an important link, as that the participants in the current study did not take part in Studies 1 and 2.

A realist evaluation seeks to answer the questions for whom, to what extent, in what context, and how does an intervention work?

For whom and to what extent did the intervention work? It is believed that the participatory element of the intervention played a key role. All the outcomes outlined in the programme theories and supported by evidence from the data all stem from actual activities/actions, undertaken by FLCH staff. At the beginning of the intervention, when staff had not fully engaged with the intervention, there were fewer outcomes reported. This was demonstrated by one participant's account (under PT1), when they admitted that they had forgotten to engage with the intervention and had not quite done anything.

In what context did the intervention work? The context of the intervention was mainly a stressful one. As in the literature, and confirmed by participants in the current study, the continuous exposure to stressors is an overarching characteristic of the context. However, embedded within this overarching context are other contexts such as interpersonal conflict and increasing work demands and expectations.

How did the intervention work? The current study identified some mechanisms which triggered others and/or were triggered. In combination with the context, these mechanisms appear to underly the outcomes which were observed. Put together, the mechanisms were:

- exposure to the sources of self-efficacy

- re-evaluation/re-appraisal of stressors at work and subsequently acting towards improving well-being
- engagement with the intervention (cognitive or practical)
- development of trust and camaraderie amongst FLCH staff
- proactive steps taken towards resolving conflict, or doing so more often
- development or maintenance of a tenacious attitude
- override of stressors

This study contributes to our understanding of how an intervention may improve the well-being of FLCH staff. In the busy and often highly pressured environment of the care home, it is important that an intervention is well-suited to the care home and participants. This current intervention was designed to provide an enabling environment which exposed participants to the sources of self-efficacy.

Although participatory in its approach, which could initially be considered an addition activity to the already 'over-worked' staff, it was informed by Lyubomirsky and Layous' (2013) small, intentional and positive steps. That is, taking simple steps towards a desired goal. In the current study, both the steps and the goals were defined by the individual. The study also has implications for practice and policy, as care home managers, owners and policy makers may build upon these findings to provide suitable support for the well-being of FLCH staff.

8.11 Field experience of implementing the intervention

Observing the impact of the intervention brought a sense of satisfaction and accomplishment. It was encouraging to observe participants engage with the intervention and to note 'growth' (improved WBSE, actions, and well-being at work) as data was analysed. However, the

experience of implementing the intervention was not without challenges. For instance, although the intervention was free and aimed to improve a vital aspect of the experience at work, more FLCH staff did not join the intervention as it progressed. Conversations with managers through the course of the intervention revealed that participants had good reviews of their experience. This however did not translate to more staff being encouraged to join as anticipated.

One possible reason for this was the staffing levels. Staff shortage is a known issue in the care home sector (Age UK, 2017, Skills for Care, 2019). Having a majority of staff on the intervention (although there would have been staggered attendance) seemed too much of a commitment at all the sites. This was proven by several visits being rescheduled as participating staff could not leave the 'floor' due to staff-resident ratios. During visits to the care homes, non-participating staff will speak to the researcher expressing their desire to attend after hearing the experiences of colleagues. The researcher asked one manager and some lead FLCH staff about other staff joining, to which they responded, '*they are too busy*'. Their words indeed illustrate the need for a change in approach to caring for FLCH staff. The 'busyness', and potential increase in stress, could have instigated the need to encourage more staff to join the intervention. This however was not so. Issues regarding staff shortage and the logistics of staffing also resulted in the extension of the intervention, from six months to approximately nine months across all intervention sites. Another challenge encountered was that towards the end of the intervention, there was a change in management at one intervention site which led to restricted access to participants and the post intervention surveys and diaries could not be retrieved.

Following the facilitation of this intervention, there are two aspects which could be changed in a further study. The first is that the game played during the initial workshop could have been piloted. A pilot could provide more time to explore participants experience of the game itself

and how much it aided the retention of information. A pilot could also provide insight into the time allocation for the game play. In the current study, the researcher felt that more time could have been allocated. To cater for this, the design of the study was changed slightly, where the content of the initial workshop (particularly the sources of self-efficacy) were reiterated during subsequent discussions/interviews with participants. The second aspect which can be improved is how the diary entries were collected. In the current study, the diary entries were designed to be completed every two weeks, in approximately 15 minutes, with the intention to minimise the burden of an extensive write-up. Despite this, completion rate was about a third of what was anticipated. Other forms of diary entry could improve this, for instance the use of audio diaries (Crozier and Cassell, 2016; Williamson et al., 2015).

In conducting this study, the researcher noted some assumptions of personal beliefs and values. One of these is a personal belief that positive change is possible, and that diligence is to strive for this goal, especially if one focuses more on the positive to be achieved rather than negative experiences. This belief could introduce a bias in the way participants narrated their experiences (especially the negative ones), not wanting to be viewed as being a negative person. As a researcher, this bias could also potentially create a tendency/pressure to want to 'move' participants beyond their difficulties to a focus on the positives. To mitigate against this, the researcher ensured that as much as possible, open questions were asked, for instance during interviews, and in designing the format for the diary entry. Participants were given the opportunity to express themselves freely even if they thought they were being negative.

Another researcher assumption noted prior to field work was the assumption that, if there was a current difficulty being experienced, when people are offered the opportunity to have a better experience, that they will likely take it. In other words, if there is high workplace stress, and there is an opportunity to improve this, individuals will be more willing to try than not. This assumption could introduce the bias that the researcher is offering something which is already

assumed to be good. This could create high or false expectations at management level, leading to staff being coerced to participate. To mitigate against this, the research was designed to ensure that participation was only voluntary, especially at the individual level. That is, if managers wanted their homes to participate, the individual FLCH staff also had to be willing to participate. This approach consequently meant that the study could not have all staff participating in each of the care homes, which may have provided further insight into the findings.

Overall, implementing the intervention was a challenging, yet rewarding experience. Melnyk and Morrison-Beedy (2012) point out five 'Ps' considered to be essential when launching an intervention (see Chapter 4) – prevalence of the problem; passion on the part of the researcher which is critical for engagement and sustainability; planning; persistence; and patience, a virtue which is developed in the building of research which makes a difference in outcomes. Indeed, the passion to see individuals realise that something can be done for well-being, and that their inherent desire to care (referred to by some participants as a 'calling'), need not be stifled or quenched, was a driving force and a motivation for the researcher. The iterative process of analysis provided the delightful opportunity to see real-life change whilst on the field, to see individuals having a better experience at work, and to observe the research making a difference in outcomes as Melnyk and Morrison-Beedy (2012) describe it. It indeed was a rewarding experience.

8.12 Conclusion

This chapter presented the process involved in the development, implementation and evaluation of a participatory staff-led intervention aimed at improving well-being self-efficacy (Study 3). This study was aimed at addressing research question three primarily. A realist

evaluation was conducted to examine how, for whom, to what extent and in what context does a participatory staff-led well-being intervention work?

In summary, the intervention appeared to work because participants were aware of the stress levels they worked under, were interested in the possibility of improving that experience and once supported, actually took action to improve their well-being at work.

The next chapter presents the overall discussion of the current research.

9 Discussion

9.1 Introduction

The previous three chapters presented the empirical studies of the current research, which together aimed to explore what frontline care home (FLCH) staff do for well-being, to develop and validate a scale to measure well-being self-efficacy (WBSE), and finally to investigate the underlying mechanisms via which WBSE is improved and its potential influence on well-being.

The aim of this chapter is to bring together the findings of these three studies, and to discuss them with reference to the conceptual framework, in particular WBSE, the literature and the research questions.

The chapter begins by presenting a definition of WBSE, the central construct of the current research, based on the information gleaned throughout the research. Following this, the research questions are reviewed, and a summary of the findings of each empirical study, which aimed at answering the research questions, is presented. The findings of the research are then discussed as three traversing themes, which have been persistent through all three empirical studies. The role of WBSE is also discussed alongside these traversing themes. The contributions and practical implications of the research are then presented, and thereafter a suggested application of the findings to practice is presented.

9.2 Defining well-being and WBSE

WBSE was a central construct in the current research. It was anticipated that its definition would be further refined by the process of the research. Additionally, although defining well-being was not a primary goal of the current research, the way in which well-being is described or perceived has a bearing on the definition of WBSE. WBSE captures a belief in an ability which is related to well-being. Therefore, before considering the refined definition of WBSE, the description of well-being is first considered.

As presented in the literature review (Chapter 2), well-being can mean different things to different people, and a universal definition of well-being has proven to be elusive. Although it was not the primary aim of the current research to explore the definitions of well-being, participants' accounts on well-being pointed to both hedonic components (feelings) and eudaimonic components (functioning). Interestingly, depending on the situation which they were describing, participants' account of well-being seemed to change. For example, when referring to a situation involving colleagues and the challenges of working with others, well-being was usually described in terms of feelings (hedonic). However, when the context of discussion was about their jobs or tasks related to the residents, the description of well-being was related to achieving goals and doing a good quality job (eudaimonic). Other participants' description of well-being included both feelings and functioning in the same description. Although, the most frequent description of well-being was subjective in nature.

These varied descriptions of well-being concur with the challenges of defining well-being as highlighted in Chapter 2. However, Murray et al.'s (2015) attempt to define well-being (see Chapter 2), is supported by the findings of the current research as it captures the descriptions used by participants in this research. Murray et al. (2015) describe well-being as a multi-faceted construct with the core dimensions of (i) positive affect (ii) personal relationships and social engagement and (iii) a life view that is meaningful and optimistic. The findings of the current

study also concur with the findings of Perry et al. (2017) who studied paid caregivers and their perspectives on health and well-being (see Chapter 2), and concluded that the definition of well-being was individualised.

The individualised nature of the experience of well-being does not affect the definition of WBSE. This is so because WBSE focuses on the belief in one's ability to take specific steps towards a desired outcome, and not a focus on the outcome or its definition. Therefore, WBSE does not focus on the definition of well-being, and accommodates the varied possible definitions of well-being. However, in accordance with the self-efficacy theory, WBSE is related to the belief in a skill or competence. For instance, self-efficacy in regulating emotions. In the current research, this skill or competence broadly means taking steps towards improving one's well-being. To the best of the researcher's knowledge, no one has investigated this important competence. Until now in the current research, WBSE has been broadly defined as the belief in one's ability to take the steps towards improving well-being. It was anticipated that over the course of this research, there may be the possibility of refining this definition. From listening to and reading the accounts of FLCH staff over the course of undertaking this research, and from extant literature, I present a particular ability related to the well-being of FLCH staff. This ability informs the definition of WBSE and has been recurrent in the research. This is 'the ability of a FLCH staff to create a balance between their desire to care and the almost incessant bombardment of stressors'.

From the accounts of participants, frontline care home work seems to provide an inherent satisfaction. This concurs with Boreham et al. (2016) who point out that work can serve as a conduit via which some critical human needs are met (see Chapter 2). Some participants described their work as a 'calling'. Concurrently, the stresses of the job seemed to take its toll on a person's well-being, challenging this inherent satisfaction. As pointed out in Chapter 2, Marmot (2010) argued that the quality of work is an equally important factor. It seems to be

that when the balance or sync, between deriving satisfaction from one's work and the demands of the job is lost, well-being is adversely affected. From the findings of the current research, this ability to create a balance seemed to run through participants' accounts of their well-being experience. It was not necessarily about how they found the balance but that they demonstrated the ability to do so in a variety of situations. For example, a participant in the intervention study made the decision to take on a more junior role due to the level of emotional stress they were exposed to in their current position. Another participant made the decision to cut down their hours and not work too many successive long shifts.

This ability to create one's balance informs an updated definition of WBSE, one which incorporates this specific competence, in relation to FLCH staff and workplace stress. This updated definition therefore states that 'WBSE is the belief in one's ability to create a balance between an inherent desire to care and the frequent exposure to stressors at work'. It must be noted however, that this updated definition relates to the specific context of frontline care home work, and possibly even more specific to the current research, until it can be confirmed by similar care home studies.

9.3 Research questions and summary of findings

In light of the challenging work environment of FLCH staff and their underexplored well-being experience, as presented in the review of the literature, the aim of the current research was to investigate the well-being experience of FLCH staff, but to also offer ways in which well-being may be improved. This research therefore asked three questions; 1) What do FLCH staff do to improve and/or maintain their well-being at work? 2) Can well-being self-efficacy be measured? 3) Can a participatory intervention, tailored to a care home setting, enhance WBSE, and uncover some mechanisms via which WBSE is enhanced? Empirical studies were

undertaken to contribute to answering these questions. Indeed, the findings from the three empirical studies of this research have offered insights into the well-being experience of FLCH staff, and details on some mechanisms via which the WBSE of FLCH staff may be improved.

Study 1 was chiefly aimed at addressing research question 1, that is, 'what do FLCH staff do to improve and/or maintain their well-being at work?'. This Study uncovered five main themes relating to the strategies which FLCH staff deployed for well-being. These themes were developed from the data analysis of focus group discussions with FLCH staff. The themes were 'regulating emotions (in interpersonal conflict)'; 'shifting focus', 'seeking support', 'taking control', and 'self-care'. All but one of these themes had sub-themes (see Chapter 6). These themes represented actions and attitudes which FLCH staff employed to defend (or protect), and to enhance (or nurture) their well-being at work. In other words, the themes represent 'tools' which FLCH staff employed. An unexpected finding was that the deployment of these tools was mainly triggered under seven contexts as discussed by participants. These contexts were recurrent in the focus group data and were related to relationships at work, workload, and feelings of low mood (see Chapter 6).

The second research question, 'can well-being self-efficacy be measured?' was chiefly addressed by Studies 2 and 3. To measure a change in WBSE, an appropriate measurement tool must be used (Bandura, 1997). Premised on the findings of Study 1, Study 2 set out to develop and validate an appropriate measurement tool, the WBSE scale. Having explored what FLCH staff did for well-being at work, the information generated was used to develop the items for the WBSE scale. A factor analysis resulted in a 29-item scale with a three-factor solution. The exploratory factor analysis showed reliability scores within the standard acceptable range, and the expected correlation with similar constructs (see Chapter 7). There was a high correlation between factor 1 and 3, and additional analysis was carried out to assess the distinctiveness of these factors. Although due to the limited sample size a confirmatory factor

analysis could not be performed on a new sample, this additional analysis conducted on the same sample showed a three-factor solution to be more favourable. The factors derived were 'maintaining/developing a tenacious attitude' (a resolute attitude in the face of challenges or difficulties), 'speaking up' (demonstrating proactivity about one's concerns and seeking support), and 'shielding' (dealing with the negative impact of other people). These preliminary results are promising and suggest the validity and reliability of the scale, although further analyses will be required. The results also demonstrate that the scale is distinct from other self-efficacy and emotional intelligence scales, and is correlated with job-related well-being. It was also anticipated that Study 3 would contribute to answering research question two. Whilst Study 2 involved the development of a scale, aimed at an objective measurement of WBSE, Study 3 aimed at demonstrating any change. However, due to a low sample size, the study could not conduct quantitative analyses to demonstrate objective change using the WBSE scale. However, qualitative analysis in Study 3 complemented this result.

Finally, the third research question was chiefly answered by Study 3 – 'can a participatory intervention, tailored to a care home setting, enhance WBSE, and uncover some mechanisms via which WBSE is enhanced?'. The findings from Study 3, which involved a participatory staff-led intervention, revealed a shift in participants' perception of their WBSE, uncovered mechanisms by which WBSE was improved, and suggest improvement in well-being. A realist evaluation of the intervention asked, what worked, for whom, in what contexts, and how? In addressing these questions, it revealed some mechanisms which were triggered by interactions between contextual and individual factors. Only three out of four initial context, mechanism, and outcome (CMO) configurations were confirmed by the findings:

1. In a work environment characterised by stress (C), by engaging in a participatory staff-led intervention which is aimed at improving well-being via self-efficacy, a frontline care home staff will have multiple opportunities to be exposed to the sources of self-

efficacy (M) which will enable them re-evaluate/re-appraise stressors at work (M). The individual will subsequently behave (M,O) in ways which demonstrate (improved) confidence in their ability to plan and take action (O) which consequently leads to improved, nurtured or protected well-being (O).

2. In a work environment like the care home, where there are numerous reasons for interpersonal conflict due to the close working culture and shared problem solving (C), participating in the current intervention (C) will improve trust and camaraderie (M,O). As perceived WBSE increases with participation (O), individuals will take more proactive steps towards resolving conflict (M), or do so more often (M), to improve, nurture or protect their well-being.

3. In a care home work environment where the expectations and demands of frontline care home staff are constantly increasing (C), improved WBSE (O) will enable staff to develop or maintain a tenacious attitude (M) which will enable them increasingly override stressors (M) and improve, nurture or protect well-being (O).

9.4 Traversing themes

The findings of each of the three studies have been discussed in the individual study chapters, however, this overall discussion aims to synthesise these findings and discuss them in the light of the conceptual framework, the literature, and their relevance to practice. In contemplating the findings of the studies, it was noted that three themes consistently run through them. These have been labelled: i) shifting focus ii) managing interpersonal conflict iii) absorbing stressor impact. They have been so labelled in order to capture what they portray. Shifting focus refers to changing one's perspective or frame of reference. Managing interpersonal conflict is related to the experience of conflict, often with colleagues. Absorbing stressor impact refers to an

ability to absorb the negative impact of a stressor for a period, after which a person restores themselves. Table 9.1 is an illustration of how these three themes cut across the studies. In considering the three themes which traverse the studies, the role of WBSE can be observed. These three themes are discussed in relation to WBSE; a key construct in the conceptual framework of the current research.

Table 9.1 Findings across the three studies

		Findings from the three studies	Shifting focus	Managing interpersonal conflict	Absorbing stressor impact
Study 1 *Focus groups*	1	Regulating emotions (in interpersonal conflict)	*	*	*
	2	Shifting focus	*		*
	3	Seeking support			*
	4	Taking control	*		*
	5	Self-care			*
					*
Study 2 *Survey*	1	Maintaining/developing a tenacious attitude	*	*	*
	2	Speaking up		*	*
	3	Shielding			*
					*
Study 3 *Intervention*	1	In a work environment characterised by stress (C), by engaging in a participatory staff-led intervention which is aimed at improving well-being via self-efficacy, a frontline care home staff will have multiple opportunities to be exposed to the sources of self-efficacy (M) which will enable them re-evaluate/re-appraise stressors at work (M). The individual will subsequently behave (M,O) in ways which demonstrate (improved) confidence in their ability to plan and take action (O) which consequently leads to improved, nurtured or protected well-being (O).	*		*
	2	In a work environment like the care home, where there are numerous reasons for interpersonal conflict due to the close working culture and shared problem solving (C), participating in the current intervention (C) will improve trust and camaraderie (M,O). As perceived WBSE increases with participation (O), individuals will take more proactive steps towards resolving conflict (M), or do so more often (M), to improve, nurture or protect their well-being.		*	*
	3	In a care home work environment where the expectations and demands of frontline care home staff are constantly increasing (C), improved WBSE (O) will enable staff to develop or maintain a tenacious attitude (M) which will enable them increasingly override stressors (M) and improve, nurture or protect their well-being (O).	*		*

9.4.1 Shifting focus and WBSE

The notion of shifting one's focus involves changing one's perspective or frame of reference. This theme was recurrent in the current research, but captured particularly strongly in the focus groups. As presented in the findings of the focus groups, participants shifted their focus in a variety of ways (see Chapter 6), the goal ultimately being to minimise the impact of a stressor and improve well-being.

The strong feature of this theme concurs with the conceptual framework and theoretical underpinnings of this research (Chapter 3). In Chapter 3, the role of cognitive appraisal was highlighted (Lazarus and Folkman, 1984). The chapter referred to reappraisal and defensive appraisal as cognitive activities which may be undertaken to deal with stress. Reappraisal refers to the cognitive action of changing one's initial interpretation of a goal-relevant situation (that is, a situation which is important to the actor). For example, a person might change their interpretation of a stressor, from being a threat to being a challenge. From the findings of the current research, reappraisals were not necessarily indicative of a negative situation, it was also about seeing things differently in order to improve one's well-being. For example, undertaking the National Vocation Qualification (NVQ) training, a recognised and recommended qualification for FLCH staff, could be reappraised from a threat (lack of academic prowess) to a challenge (of developing oneself). Indeed, the experience of the NVQ training was mentioned by some participants.

Unlike reappraisal, in defensive appraisal, an individual engages in a cognitive coping response to a previous encounter with a stressor. Here, the individual develops a cognitive strategy which involves reinterpreting the stressor or the stress experience in a positive light. This reinterpretation is usually aimed at attenuating the impact of a stressor, evaluating it as non-threatening or less damaging. This was especially important for participants when the situation seemed inevitable. In both reappraisal and defensive appraisal, participants in the current

research recounted their attitude of seeing things differently, and sometimes making an effort to do so intentionally. Additionally, engaging in reappraisal and defensive appraisal was not just a means of protecting one's well-being, but also served as a means of improving one's well-being. For example, being proactive by taking on a task which would previously have been judged as difficult and would not have been attempted.

It was anticipated, as presented in the conceptual framework of Chapter 3, that cognitive appraisal will feature strongly in this research. The findings indeed confirm this, however, the findings also show that of the various cognitive activities, defensive appraisal in particular, was key in the well-being experience of FLCH staff. It was not simply about the eradication of a stressor, but one's evaluation of it. For participants in this research, a defensive appraisal made the difference in the impact of a stressful day at work.

Shifting one's focus in this way is similar to cognitive reframing (Robson and Troutman-Jordan, 2014). Cognitive reframing involves changing one's thoughts about a situation, from being self-defeating and distressing, to thoughts which reduce anxiety and stress (Vernooij-Dassen et al. 2011). This concept is commonly used in therapy, but its benefits have also been demonstrated with informal care givers, where there were improvements in anxiety, depression and stress (Vernooij-Dassen et al. 2011). The findings of the current research provide some confirmation of the benefits of cognitive reframing, although further investigation may be required to ascertain this, since in the therapeutic context, more objective measures are used. However, when participants recounted their experience of focusing and thinking about something else amid a difficult situation, this shift in focus bolstered their ability to endure the experience, which was good for well-being. On other occasions, the attitude of shifting one's focus mentally prepared participants for what they anticipated to be a difficult situation. For instance, preparing to work with a 'difficult' person on a shift.

Well-being self-efficacy (WBSE) also played a role. We recall that the aim of the focus groups was to explore what FLCH staff did for well-being. Indeed, the findings on 'shifting focus' showed that they already engaged in reappraisal and defensive appraisal. This was also confirmed by the factors of the WBSE scale and the intervention study. The contribution of WBSE was that it acted as a 'trigger of awareness'. WBSE seemed to 'formalise' what FLCH staff often consider as 'ordinary'. It seemed to point participants to their abilities which were previously thought of as unimportant. Since WBSE denotes a belief in an ability, they had to consider what those abilities were.

FLCH staff usually downgrade their efforts. They often think of themselves as just 'ordinary'. When they do their work in thoughtful ways, sometimes in exceptional ways, or when they go out of their way to do outstanding things, or go the extra mile, they often downplay their efforts. An extract in Chapter 6 illustrates this, *"I remember once…I knocked on a resident's door and said it's only me, and she said, 'it's not only you, you do an important job.'"* (FG1). The attitude of downplaying one's effort perhaps lends explanation to why appreciation from others (especially from residents) plays an important role in the well-being of FLCH staff (see sub-theme *'self-appreciation and receiving appreciation'* in Chapter 6). From the researcher's experience on the field, FLCH were not always quick to talk about themselves, or boast about the good work they do. There seemed to be a focus on all other things except themselves. However, engaging with the intervention in Study 3, recording experiences in diaries, and sharing experiences provided the opportunity for participants to assess their actions and appreciate their efforts or abilities. This awareness in turn seemed to bolster confidence to act positively towards a desired outcome, that is improving well-being (see participants' evaluation of the intervention, Chapter 8: T6 Intervention site 3).

Therefore, since WBSE points to an ability, the 'trigger of awareness' occurs when an individual assesses (takes stock) of their ability to improve their well-being. Before an

individual evaluates their belief in an ability, firstly, they really must ask themselves, what is that ability, what are the steps which I take to improve or protect my well-being at work? On one hand, if there is a deficit in actions or steps taken, an awareness of this is raised. On the other hand, an individual may very well have a variety of 'tools', but still unable to use them if WBSE is low (see Chapter 4) (Bandura, 1997). Awareness is also raised in this situation as the individual better understands one possible process which hampers the use of their tools (that is, low WBSE), and how to improve it. In turn, this strengthens the agentic perspective, improving an individual's perception of control, and enabling them to effectively apply their 'tools'.

The findings of this research do not show any situation in which a FLCH staff took absolutely no actions (deployed no 'tools') to improve well-being. As seen in the focus group and survey studies, FLCH deploy a variety of 'tools' depending on the situation. The combination of 'tools' for one individual will likely differ to the next individual. Additionally, it is most likely that the belief in one's ability to deploy each of these 'tools' differs. Therefore, even for the same set of 'tools', belief in one's ability to apply them will differ from one individual to the next. In other words, this is a bespoke experience. Improving one's well-being at work is a bespoke experience. The task for an organization (a care home) to meet these myriad needs in the bid to improve staff well-being is almost impossible. However, by focusing on improving WBSE, FLCH staff can be supported to carve out their own niche experience towards well-being at work. As pointed out in the literature review, the European Network for Workplace Health Promotion (ENWHP, 2017) considers the effective promotion of health and well-being at work to be a combined effort, involving an organization and its staff. The findings of the current research on WBSE provides some evidence to demonstrate how both organization and staff may contribute to effective promotion of well-being at work.

In the bid to improve well-being at work for the FLCH, a focus on the individual may indeed be controversial, as some may argue that this approach may encourage organizations to abandon their duties or commitment to the health and well-being of their staff, especially since little is currently being done for well-being. This is an understandable point of argument, particularly in the light of the other pressures faced by care homes, and the minimal or non-existent attention to staff well-being in the care home industry. However, this research argues that creating the enabling environment, and a commitment to improving the WBSE of FLCH staff is in fact one way in which employers can demonstrate their commitment (later in this chapter, a practical means by which this can be done is suggested). These actions demonstrate a commitment to fulfilling their responsibilities to their staff. Moreover, it is in the best interest of care homes and relevant stakeholders to invest in the well-being of FLCH staff. As demonstrated in the review of literature, the improved well-being of FLCH staff holds much to be benefitted.

9.4.2 Managing interpersonal conflict and WBSE

Although interpersonal conflict could relate to the other two traversing themes, interpersonal conflict was such a strong feature in the research that it warrants a separate discussion. Across the studies of the current research, conflict was chiefly managed in three ways - by addressing it directly with the party involved, by addressing it with the aid of a mediator (often care home manager), or by completely avoiding it. All three strategies yielded different effects and had varying impacts on an individual's well-being. The least beneficial strategy to well-being was to completely avoid addressing the conflict. Although, sometimes this strategy of avoidance was employed temporarily, as some participants mentioned that following a long shift, they did not feel that they had the capacity for confrontation at that moment.

Perhaps one reason for interpersonal conflict featuring so strongly in the current research is the nature of frontline care home work. All FLCH staff on a shift as a necessity must work closely together in problem-solving, completing tasks and achieving the goals of the shift. Often, there is a need to work in very close physical proximity with each other, for instance, when two people need to support one resident (a 'double' - a word used to describe support of a resident which requires two care staff). The presence of interpersonal conflict can therefore hamper teamwork, create low moods, and a generally poor atmosphere and well-being (Wright et al., 2015). If this is persistent, it may lead to aggression, violence or individuals simply quitting their jobs (Barling et al., 2009; Frone, 2000). In contrast, good team spirit and effective teamwork can bolster work engagement and improve the quality of care (Wicke et al., 2004).

Participants alluded to the importance of good teamwork for personal well-being. This was discussed in all the focus groups and several items on the WBSE scale featured teamwork. In the intervention study, the accounts of participants pointed to the impact of interpersonal conflict on well-being. After applying the principles from the well-being workshop and building WBSE, one participant towards the end of Study 3 (intervention) recounts, *I've got better relationships with my colleagues…so right now at this moment, there's no tension I've got at work with my colleagues so I'm happy coming to work…It's like a massive weight off because I used to dread my shifts when that person was on.* (T6:24). Participants in the focus group and intervention studies frequently mentioned looking on the rota to know who they were working with. For others, their strategy to protect their well-being was to intentionally not look at the rota in advance, due to its impact on their mood when they realised they would be working with certain individuals. Some other participants mentioned engaging themselves in mental preparation before the shift in order to work with certain people.

Applying the avoidance strategy, some participants planned to avoid some colleagues throughout the shift. However, one may ask how this can be effectively done, or how such

festering bitterness may thrive without affecting one's ability to work, or potentially affecting the quality of care to residents. This is especially so when there are staffing pressures and two such embittered persons must care for the same resident as a 'double'. Often, this is the reality, as organizations cannot always accommodate 'not-working-with-Jane'.

Considering the impact of interpersonal conflict on FLCH staff well-being, and potentially on their quality of work, training on conflict management will be a useful provision to FLCH staff. As presented in Chapter 2, training has been applied in previous research to improve skills, build capacity, and shown to be an important determinant of staff well-being in health settings (Barry et al., 2005; Cohen and Gagin, 2005; Jeon et al., 2015; Watson et al., 2018). This research recommends including conflict management as a mandatory training, along the likes of moving and handling and infection control. More specifically, various studies (for example, Overton and Lowry, 2013), have demonstrated the benefits of conflict management training in healthcare settings. Dana (1999) point out that one of the biggest reducible cost to an organization is interpersonal conflict, and Buss (2011) concurs with this in making a business case of conflict management within organizations. In a later publication, Dana (2001) identified eight hidden costs to conflict namely, time wastage, bad quality decisions, loss of skilled employees, restructuring inefficiencies, lowered job motivation, disruption, absenteeism, and health costs. With interpersonal conflict featuring so prominently in the current research, it can be inferred that supporting FLCH staff in conflict management can be cost effective for care homes.

WBSE also plays an important role in interpersonal conflict. We saw in Chapter 4, that one psychological process via which self-efficacy is mediated is affective state. One's affective state concerns the regulation of the nature and intensity of emotions experienced (Bandura, 1997). WBSE will influence a person's perception of control over their thoughts and emotions, and in interpersonal conflict, characterised by highly charged emotions, high WBSE will be a

beneficial personal resource. In interpersonal conflict, one individual may in fact be ready for positive change, but the other party may not. This is a situation in which a person may feel that they have no control, but a high perception of WBSE can mitigate the negative effects of this frustration. As pointed out in the WBSE chapter (Chapter 4), Yu et al. (2019) demonstrate that this kind of perception will inform how the situation is managed by ensuring that upsetting emotions are minimally aroused.

In light of the findings on interpersonal conflict, investment in training to improve WBSE is also recommended. As demonstrated by the current research, this may be in the form of providing an enabling environment for WBSE to be nurtured (potentially via an intervention). Indeed, considering the impact of interpersonal conflict on well-being, providing support to nurture the WBSE of FLCH staff should be a priority. As they work together so intricately, where one person's actions can have a direct effect on colleagues, there will inevitably be frequent occasions of conflict. Since attempting to eradicate these occasions may not be humanly feasible (or may not be beneficial if conflicts are opportunities for growth), it therefore seems logical to support FLCH staff to navigate these interpersonal conflicts.

9.4.3 Absorbing stressor impact and WBSE

Of the three themes which traverse all the studies of this current research, absorbing the impact of stressors was most prominent, as it related to many aspects of the three empirical studies. Absorbing and restoring were the key abilities captured by this theme. To absorb the impact of a stressor is to endure a measured exposure to the stressor, and then restore oneself after this exposure. A measured exposure means that the individual in question knows the limit to which they can bear with the stressor (see sub-theme *'understanding one's limit'* in Chapter 6). To restore or refresh oneself is to be able to return to a state where one's capacity to endure the

stressor is renewed, that is, the individual feels reinvigorated. This absorbing and restoring ability has a connotation of endurance and resilience, that is, taking on so much, then bouncing back afterwards.

I use an analogy to describe this theme. In analogy, this can be likened to having a 'stressor-absorbing sponge'. By the nature of FLCH work, frequent exposure to stressors is a characteristic (see Chapter 2, and confirmed in the current research). Exposure to stressors denotes an individual enduring the experience (sponge absorbing). However, the individual must be aware of their limit, which gives an indication of when they have endured enough (sponge becoming saturated). When a 'safe' limit of absorption is reached (as defined by the individual), the individual is able to engage a strategy which allows them to manage the situation (the action of squeezing the sponge, emptying as much of its content as possible). This action of squeezing the sponge may also indicate the preparation for another period of absorption.

A practical example of this analogy (a need to squeeze the sponge) is seen in the impact of long shifts (FLCH staff typically work 12-hour shifts). As demonstrated in the literature review (see Chapter 2), and confirmed by the current research, this is stressful role. Over a period, these long hours equate to more exposure to stressors (sponge absorbing). The words of a participant capture the notion of carrying on without a 'break' (that is sponge absorption without a squeeze). *"With this industry, I feel that if you don't take time for yourself…it's going to break you, and that's the most honest thing, it's going to break you"* (FG3). Another example which illustrates the need to 'squeeze the sponge' is the area of compassion fatigue. Compassion fatigue is experienced when (typically) a caregiver provides continuous compassion and empathy to others at the expense of one's care (Figley 1995, 2002). Figley (2002) points out that there is a cost for the very nature of being compassionate and empathic. Compassion

fatigue has a negative impact on the care giver and may even give rise to an inability to effectively perform one's role (Figley, 2002).

Compassion fatigue is also commonly discussed in relation to caring for others in a situation of trauma (for example, Burnett, 2017). Although a care home may not be described as a traumatising place, the experience of losing residents, the uncertainty of their health and the suddenness with which it can change, may represent a traumatising experience for staff. This is especially relevant in the current (2020) COVID-19 pandemic with the increased loss of residents in care homes. In essence, this cost for caring, compassion fatigue, demonstrates the need for a FLCH staff to refresh, to squeeze their 'stress-absorbing sponge'.

In the current research, an example of this action of squeezing the sponge was captured in the focus group discussions and themed 'self-care' (see Chapter 6). It referred to taking care of oneself in a role which demands so much. It involved taking time to appreciate oneself and to receive the appreciation of others, valuing one's work and grounding oneself in the knowledge or assurance that one was making a useful contribution to the lives of residents. The theme 'seeking support' (see Chapter 6) was another act of squeezing the sponge captured in the current research. It involved seeking out support which was judged to be important or useful. Sometimes this was support from a manager or a colleague. The usefulness of the support was not necessarily judged by the problem being solved, sometimes simply moaning to a colleague was just as 'effective'.

This finding is in line with the literature on social support at work, which Deelstra et al. (2003) describe as the actions of others with an intention to be helpful. Chou (2015) show that such support may be from colleagues or managers and can determine an employee's attitude and behaviour at work. Earlier work by Iverson (1996) pointed out that the bedrock of social support is usually trust, friendship, respect and having a deep concern for each other. In

addition, earlier work by Cohen and Wills (1985) and the more recent one by Chou (2015) point to a buffering effect of social support on workplace stress. Although the nature of frontline care home work can result in frequent interpersonal conflict, it also presents the opportunity to build and nurture friendships and social support, which will be beneficial in refreshing FLCH staff (sponge squeezing). Regarding developing this capacity, Daniels et al. (2018) investigated social support at work as a job characteristic which can impact on well-being. Like the previous studies, they highlighted its importance, but particularly, they demonstrated that via training, employees can be supported to enact this job characteristic for well-being. In this regard, training FLCH staff to seek support may be a useful strategy for sustaining well-being.

Actions (cognitive or overt) of squeezing the 'stressor-absorbing sponge' relate to improving one's well-being. Thus, building one's capacity to improve one's well-being can enable FLCH staff withstand the myriad and frequent stressors which they encounter at work. Here, WBSE again features. This ability to keep restoring oneself (squeezing the sponge) can be directly linked to one's perception of WBSE. This was demonstrated in the intervention study of the current research. A FLCH with a strong perception of WBSE will likely demonstrate mastery in restoring themselves. They are likely to have a variety of strategies to do so and will be motivated to acquire yet more useful strategies. This also links to the first traversing theme of this chapter (shifting focus). The findings of this research confirm that often, the first steps in developing and refining strategies for well-being, or the utilisation of these strategies, begins with the cognitive effort of shifting one's focus. As demonstrated by the current research, improved well-being is a likely result. As discussed earlier in this chapter, training which will improve the WBSE of FLCH staff is important (especially provided in the form of a participatory intervention). This training will enable FLCH staff more effectively deploy their

own strategies for improving their well-being. WBSE will also play an important role in strengthening one's resolve to act.

It however can be argued that this kind of training, which supports an individual in dealing with the impact of stress, is not ideal since it does not necessarily address the source of the stress. Indeed, addressing the source of the stress may likely provide a lasting solution to an issue, for example tackling stress related to job design or work practices (Daniels et al., 2017). Yet, not all stressors for the FLCH staff can be eradicated and understanding how to manage them is paramount. Moreover, Bandura (1986) argues that the development of resilient self-efficacy requires experience with difficulty and development of mastery through persistent effort. This implies that in supporting individuals to develop or improve WBSE, eradicating stressors will not be the chief focus. Bandura (1986) argues that if easy successes are experienced too often, there would be an expectation for quick results. This becomes detrimental since the experience of setbacks or failure will undermine self-efficacy. For instance, we consider interpersonal conflict which has featured prominently in the current research. In a care home which seeks to nurture WBSE, if there are issues regarding interpersonal conflict, the home may not simply work towards keeping the conflicting parties apart but provide opportunities to increase the belief in their abilities to resolve the conflict. This may involve providing appropriate support to the parties involved, perhaps during their usual personal appraisal meetings, alongside a whole-home intervention to improve WBSE. As mentioned previously, improving WBSE can strengthen a person's resolve to take action.

The argument of not necessarily eliminating all stressors is made with caution, as it must be understood that some stressors, especially problematic systemic issues, as a necessity should be eliminated and not interpreted as stressors which can strengthen WBSE. Besides, aiming to improve the WBSE of FLCH staff does not imply that no other well-being initiatives can be undertaken. A combination of efforts likely holds the most benefits. For instance, while a care

home and its stakeholders work on addressing identified organizational stressors, an initiative could run alongside which is aimed at supporting individuals to aim for and achieve a desired goal for well-being.

Additionally, well-being means different things to different people, and because this is so, simply addressing a stressor at an organizational level is not likely to address all individual stressors. Moreover, addressing the stressor for one group of individuals in an organization may be the introduction of a stressor to another group. Therefore, although it may be argued that an individual approach places the onus on the individual, this approach holds potential benefits in the care home setting. At an individual level (much the focus of the current research), the ability to squeeze one's 'stress-absorbing sponge' can be a beneficial quality.

So far, we have considered three themes which traverse the three empirical studies of the current research. They all relate to improving well-being and give insight into the role of WBSE. In addition, the benefits of improving WBSE in the contexts of these themes were highlighted, demonstrating the need to invest in improving the WBSE of FLCH staff. Some evidence of these benefits is demonstrated by Coates and Fossey's (2019) interpretative phenomenological analysis (IPA) study. Studying 12 highly self-efficacious care assistants in dementia care, Coates and Fossey (2019) demonstrate what it looks like when a care assistant performs their role with a strong perception of self-efficacy.

The overall findings of the current research concur with Coates and Fossey's (2019) IPA study. Coates and Fossey (2019), focusing on individuals with high perceived self-efficacy report similar characteristics to the current research. However, they point out that whilst their research highlights the important role of self-efficacy in the care of older people, it did not capture the voice of care assistants with lower levels of self-efficacy. Quite saliently, Coates and Fossey

(2019) point to the reality of insensitivity to the needs of FLCH staff, and they call for more research and interventions on the self-efficacy of FLCH staff. The current research has contributed to this effort and it is hoped that research and practice efforts to improve well-being via self-efficacy continue.

9.5 Research contributions

The current research brings some contributions to knowledge, which progress our understanding of the well-being experience of FLCH staff and how they may be supported.

Considering the possible impact of staff well-being on the safe and effective care of care home residents (Cooper et al., 2016; Goergen, 2001), this research identified that the well-being of FLCH staff has not been a priority in both research and practice. With other research demonstrating increased demand, high turnover and high stress levels in the frontline care home workforce (for example, Gordon et al., 2014; Nakrem, 2015; Skills for Care, 2019), this research thus contributes to the sparse literature on the well-being of FLCH staff. It presents the need to prioritise their well-being at work, and the potential benefits that may be gleaned in doing so.

The research identified that there have been previous attempts, albeit sparse, to focus on FLCH staff. These attempts predominantly focused on training aimed at improving job-related competencies, and not well-being per se. The findings of this research demonstrate that FLCH staff can indeed be trained to improve their skills, but more so, that employing a participatory intervention approach in a care home setting can have beneficial outcomes.

Additionally, the findings of this research contribute to the literature on how to support FLCH staff. Registered managers and other leaders within the care home sector highlighted a deficiency in their understanding of how to support the well-being of their staff (Care Workers

Charity, 2019). This research uncovers some mechanisms via which WBSE may increase, thus offering potential areas for stakeholder input. The self-efficacy theory chiefly focuses on the belief of an individual, and from a critical realist perspective, this belief can be influenced by causal powers and structures (in the real domain), which can produce observable events (in the empirical domain). The research has uncovered some mechanisms which act as forces that lead to maintenance or improvement in the well-being experience of FLCH staff.

The WBSE construct progresses our understanding of how a FLCH staff member may possess resources at work, may feel committed to their residents but still experience poor well-being. This research demonstrates that amidst the often-difficult work environment, and frequent exposure to stressors, FLCH staff deploy tools/strategies which enable them to cope with the stress at work. Particularly significant is that the research suggests that there was no participating FLCH staff who was without tools/strategies. This suggests that FLCH staff are not merely helpless victims at the mercy of stressors. However, the documented evidence of stress and high turnover seem to contrast the picture of individuals who possess tools to tackle stressors. The contribution of the research demonstrates that the moderating effect of WBSE as an individual resource may explain this contrast. The research also gives further insight into the significance of agency in this context.

Furthermore, this research contributes to the literature on self-efficacy and personal resources in relation to workplace stress and well-being. Burnout was identified to be particularly prevalent in the care sector, having its associated negative consequences, such as exhaustion, disengagement, and depersonalisation (Bakker and Heuven, 2006; Cooper et al., 2016; Demerouti et al., 2010). The findings of this research show that WBSE is a personal resource which can contribute to addressing burnout in the care sector. As a personal resource, the construct also takes into consideration the individualised nature of actions which may be taken towards improving or maintaining well-being. Additionally, this construct does not focus on

one specific task or a specific outcome, as is often done in the self-efficacy literature (for example, self-efficacy in the administration of medication). The definition of WBSE accommodates a variety of actions (steps to be taken) and a variety of outcomes (individualised definitions of well-being). As previously identified in this research, a consensus definition of well-being has been elusive, and previous research with care staff (Perry et al., 2017) indicated that there is no one-size-fits-all definition of well-being. WBSE caters for the lack of consensus, and the individualised nature of, the definition of well-being. This is a contribution which consents the exploration of self-efficacy in the context of well-being, without the need to first identify a specific definition of well-being. In addition, as previously pointed out, self-efficacy is domain-specific (Bandura, 1997). To the best of the researcher's knowledge, this is the first attempt to investigate self-efficacy and well-being in the care home context.

Another key aspect of the current research is its contribution to the literature on measurability of self-efficacy constructs (Bandura, 1997, 2006). In particular, the findings of this research progress our knowledge on the measurability of WBSE. Although further validation is required, a novel WBSE scale was developed to enable individuals and stakeholders assess the WBSE of FLCH staff. Developed from the experience of FLCH staff, the WBSE scale comprises of tools/strategies which FLCH staff commonly deploy to maintain or improve their well-being. The scale measures the strength of belief in one's ability to take action in various care-related contexts. Thus, the research also contributes to knowledge by identifying specific strategies which FLCH deploy for well-being.

Finally, the findings from the realist evaluation conducted in this research also contribute to the literature on intervention design and evaluation in care settings, and particularly in care homes. Evaluation was identified as a core aspect in demonstrating the quality of interventions in care settings, and the robustness of intervention evaluation in healthcare settings was identified as a gap. In their systematic reviews, Hill et al. (2016) and Williams et al. (2018)

called for well-designed and evaluated interventions. Although there is no standardised set of criteria to assess the quality of interventions, the realist approach taken in this research illustrates a means by which an intervention in a care setting can be substantively evaluated. The findings give insight into how well-being intervention designs may be tailored to a care home context, and how to manage multiple bespoke variations of the design within the same research.

Although not without limitations, the evaluation of the intervention in this research illustrates how a realist evaluation may be conducted in a care context, which often involves complex interventions. The evaluation contributes to how a research study in a care home may assess the extent to which an intervention worked, how it worked, why, for whom, and in what context. These parameters, especially in a complex social structure like a care home, may otherwise be challenging to evaluate using simplistic quantitative or qualitative methods of evaluation.

9.6 Practical implications: supporting the improvement of WBSE in practice

The findings of the current research suggest potential benefits to care home owners, managers, policy makers and other stakeholders. In particular, the findings point strongly to the need and benefits of addressing the gap identified in the literature, that is, the minimal attention given to the well-being of FLCH staff. One implication of the current research concerns the translation of the findings into practical support for stakeholders such as care home managers and owners, in the bid to bolster the well-being of FLCH staff. The next section presents this translation.

As demonstrated in Chapter 2, it is in the best interest of care homes and relevant stakeholders to invest in the well-being of FLCH staff, who are one of their greatest assets. Moreover,

workplace stress is now recognised to be a hazard, and in many countries, it has become a legal requirement that employers address it (Berridge and Cooper, 2000).

Having demonstrated the role and benefits of WBSE, a practical guide to improving WBSE is provided here. It is hoped that care home managers, care home owners, policy makers, or even FLCH staff will find this guide useful. This practical guide is a three-tier support which can simply be used as it is, or can serve as a template to be built upon. It may be especially beneficial to care home managers or owners, as it provides a template to create a bespoke experience in their care homes.

This practical guide has been developed from the findings of the current research and extant literature. Figure 9.1 illustrates the three-tier support in a pyramidal structure. Each level of the pyramid has been carefully designed to incorporate the four sources of self-efficacy – enactive mastery experience, vicarious experience, verbal persuasion, and (awareness of) physiological states. At each of the levels of support, the pyramid includes actions which may be taken, or systems that can be put in place, aimed at improving WBSE and consequently well-being.

The tiers of the pyramid denote increasing complexity of support, beginning from Level 1 to Level 3. For instance, Level 1 involves the most basic support which can be provided, and includes making some adjustments to on-going activities and systems already in place. At level 3, more sophisticated systems can be put in place, including having specialist support and adjusting job roles.

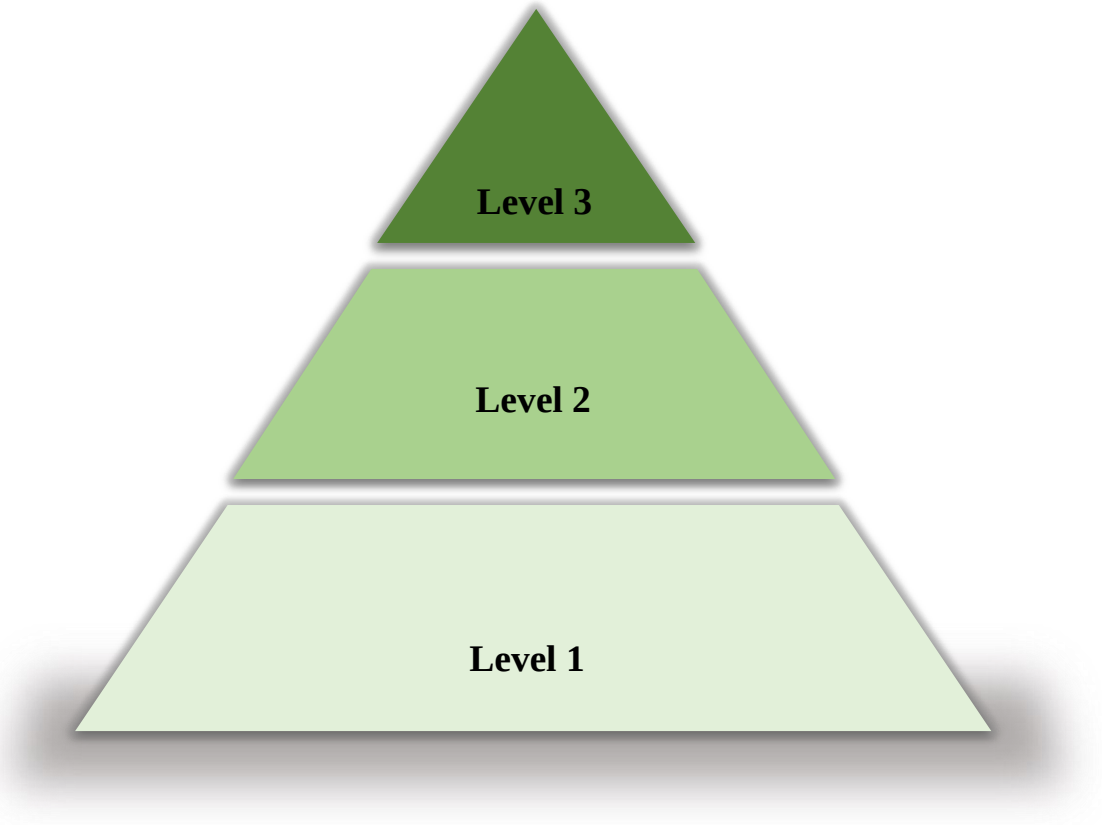

Figure 9.1 Improving WBSE, three levels of support

9.6.1 Level 1

Level 1 is the most basic form of support. It builds upon activities and systems which are already in place.

Level 1 support includes:

i. Include well-being conversation during individual staff appraisals and encourage individual well-being goals.

ii. Add a 10 to 20-minute invigorating well-being session to staff meetings (staff may suggest activities).

iii. Encourage more regular staff bonding activities to build camaraderie and social capital. Consider supporting at least two organised activities a year.

iv. Provide conflict management training to staff.

Aspects of the current research which inform level 1 support:

- Individuals have personal motivators which enable them to maintain their well-being when faced with difficult situations.
    - Theme 2, Study 1, Chapter 6, *"Focusing on personal motivation/drive"*
    - Programme theory (PT) 4, Study 3, Chapter 8, *"Personal motivators protecting well-being"*
- FLCH staff appreciate a demonstration of support from senior management
    - Study 1, Chapter 6
    - Study 3, Chapter 8
- Support from colleagues is considered an important aspect of one's well-being at work
    - Theme 3, Study 1, Chapter 6, *"Seeking support: from colleagues"*
    - Factor 2, Study 2, Chapter 7, "Speaking up"
    - PT 2, Study 3, Chapter 8, *"Improved trust and camaraderie aiding proactivity in conflict resolution"*

9.6.2 Level 2

Level 2 incorporates all activities at level 1, at a more engaging level. It is a build-up from the support provided at level 1.

i. Include well-being conversation during individual staff appraisals, set individual well-being goals which can be reviewed at the next meeting. However, this must be a natural non-pressured experience for both supervisee and supervisor.

ii. Add 30 to 40-minute well-being sessions to staff meetings. Alternatively, have separate well-being meetings and provide incentives for attendance. Incentive will be of high value (not necessarily expensive, as FLCH staff often made mention of the little things that count).

iii. Commit to support a bi-annual or quarterly staff bonding activity. This may not necessarily be high cost, for example subsidising an activity or providing the drinks/food for a staff-led activity.

iv. Encourage staff to develop a well-being action plan together as a team. Openly acknowledge/commend contributors and leaders.

v. By election or appointment, have a well-being champion or champions. Consider having a fixed 'tenure of office' (perhaps 6 months). Make this a coveted role, provide perks.

Aspects of the current research which inform level 2 support:

- Setting individual goals encourages proactivity and autonomy. It encourages an agentic perspective and creates opportunities for mastery experience (Bandura, 1986, 1997).

    - Theme 4, Study 1, Chapter 6, *"Taking control: exercising autonomy, being proactive"*

- Setting goals and reporting on them during appraisals with a supervisor or manager creates the opportunity for verbal persuasion (Bandura, 1997). Support from supervisor or manager was considered to be important.

    - Study 3, Chapter 8, "*... when you came in, you were speaking about, like, the stress levels and everything at work, there wasn't anything in place for us, but now after you came in that's when I started speaking to Fiona [manager]. Cause before I wouldn't go to the manager. It has helped, definitely has helped*"

- Dedicating more time to staff well-being during meetings and providing incentives to encourage attendance demonstrates commitment to and appreciation of FLCH staff. Support and appreciation from management was considered valuable.

    - Focus group 2, Study 1, Chapter 6, "*We are quite close to the directors and to the people who own the building…they are really appreciative. And when they say thank you, you know, it means something*"

    - Theme 5, Study 1, Chapter 6, *"Self-care: ...receiving appreciation"*

- Working together to co-create action plans for well-being provides opportunities to develop camaraderie and support. It also provides opportunities for vicarious experience (Bandura, 1997). Working together on a well-being project may also contribute to addressing issues around interpersonal conflict.

    - PT 2, Study 3, Chapter 8, *"Improved trust and camaraderie aiding proactivity in conflict resolution"*

- A (well-being) leadership role has the potential of encouraging sustained positive actions for well-being in the care home.

    - Theme 4, Study 1, Chapter 6, *"Taking control: exercising autonomy, being assertive, being proactive"*

9.6.3 Level 3

Level 3 incorporates all activities at levels 1 and 2 and includes some new items. This level requires more commitment from both staff and management. Consider delegation as a means of effectively implementing level 3 support.

i. Include well-being conversation during individual staff appraisals, set individual well-being goals which can be reviewed at the next meeting. However, this must be a natural non-pressured experience for both supervisee and supervisor.

ii. Consider the high value incentive at well-being meetings to be a raffle draw to win day off. That is one additional day of annual leave for the winner.

iii. Encourage staff to develop a well-being action plan together as a team. Openly acknowledge/commend contributors and leaders.

iv. Conduct a role swapping initiative as safety permits (or shadowing). For example, 'one day in the life of a senior', or 'one shift as a night staff'. The participants reflect upon and share their experiences at staff well-being meetings. Consider paying participants in their pseudo role. That is, a junior FLCH staff who experiences 'one day in the life of a senior' gets paid as a senior for one day.

v. Have a consultant come in for about 30 minutes during your staff meetings to take on the well-being sessions. Or ask if some staff would like to lead on something (although research shows that people may be more receptive to an external consultant).

vi. Offer staff an unexpected bonus.

Aspects of the current research which inform level 3 support:

- All the points made at levels 1 and 2 apply here.
- In addition, role swapping or shadowing can help improve communication and significantly address issues of interpersonal conflict.
- Having a consultant and offering an unexpected bonus intensifies management effort, and demonstrates a stronger commitment to FLCH staff well-being.

There are some critical points to make:

- Management must be seen to be interested and engaged
- Actions plans must be co-produced with all staff, or the majority (including non-direct care staff, like kitchen, domestic, or administrative staff).
- The suggestions on the pyramid are not one-size-fits-all. As previously suggested, it can be adapted. However, it is recommended that well-being initiatives be integrated into the work system of the organization such that it is not considered to be an additional burden for staff.
- The current research demonstrates that FLCH staff are capable of taking actions to improve well-being, encourage more a participatory staff-led approach.

It is hoped that this guidance will be a practical tool. The goal is sustained behaviour via simple positive intentional steps (Lyubomirsky & Layous, 2013). Bandura (1986, 1997) points out that firmly established self-efficacy beliefs are likely to remain so. He further states that these beliefs are resilient to adversity and will be persistently strong when an individual is experiencing a taxing situation and when they are not.

9.7 Limitations and future studies

The current research is not without limitations. In study 1, participation in the focus groups was voluntary, and this may have attracted individuals who were motivated and looking to improve their resources. This may potentially have introduced a bias towards those who were resource poor, according to the conservation of resources theory (Hobfoll, 1989, 2001, 2011), and unable to invest in gaining more resources. The employment of focus groups, in contrast to one-to-one interviews, may have emphasised this bias. Due to restrictions of time and other resources however, personal interviews could not be conducted in addition to the focus groups. Critical incident forms were used during the focus groups to encourage individual reflection and expression without the pressure of expressing oneself in a group setting. In Study 2, the sample size for the validation study was also not large enough to conduct confirmatory analysis on a new sample. Given this limitation, the current results offer a preliminary validation of the WBSE scale. Future national and international studies can further assess the psychometric properties of the scale. In all three studies, piloting of various aspects may have revealed practical/field restrictions which may have informed amendments to the design or implementation of the research. Furthermore, although the current research did not aim to explore the cultural nuances in the experience of well-being, future studies which explore the well-being experience of FLCH staff by race and ethnicity will provide further insight. This is

especially pertinent in the light of the current (2020) COVID-19 pandemic and the reported impact on minority ethnic groups.

In addition, although certain aspects of the research involved working with care home managers and administrators, the research primarily involved FLCH staff. Exploring the strategies which FLCH staff deploy for well-being at work, solely from the point of view of FLCH staff, the research may have missed the impact of other factors. For instance, further investigation into how organizational features (such as organizational culture and systems) can affect the deployment of these strategies will provide useful insight. Additionally, future investigation into the opportunities (or feasibility) of altering the features of one's job (job crafting) for well-being in the care home sector will be further insightful.

9.8 Conclusion

This chapter revisited the WBSE construct, presenting a proposed definition as related to frontline care home staff and workplace stress. The chapter synthesised the findings across the entire research. It did this by focusing on three themes which traversed the three empirical studies of this research, discussing them in relation to the literature, the conceptual framework, and practice. Highlighting relevant findings of the current research and their concurrence with extant literature, the need for investing in WBSE was also presented.

Making the current research accessible to practitioners in the care community was of keen interest in this research. Thus, this chapter provided practical guidance on how care homes and stakeholders may support the improvement of WBSE. This guide may be used as presented, or may serve as a template upon which bespoke experiences can be created to match the uniqueness of each care home.

The next chapter presents the conclusion of this research.

10 Conclusion

This thesis was about the well-being of frontline care home (FLCH) staff. This group of individuals play a significant role in the effective and efficient running of a care home, and extant literature establishes that they experience high levels of workplace stress. One gap identified in the literature was that, although it has been demonstrated that the well-being of FLCH staff plays a role in the safety of care home residents and in the quality care, there is no evidence to suggest that their well-being has been a priority in both research and practice. To contribute to the body of knowledge in this area, this thesis aimed to explore what FLCH staff do for well-being. The thesis also aimed to develop a participatory staff-led intervention as a means via which a personal resource based on self-efficacy could be improved. Another gap identified was related to the robust evaluation of interventions conducted within care settings. Thus, this thesis also aimed to conduct a detailed evaluation of the proposed intervention using a realist evaluation approach.

The thesis drew on Lazarus and Folkman's (1984) stress, appraisal and coping theory, and Bandura's (1997) self-efficacy theory, to argue that in spite of the level of workplace stress, a FLCH staff member can experience well-being, via increased belief in one's ability to improve well-being. Lazarus and Folkman (1984) conceptualise stress as a transactional process and state that coping actions are dependent on the individual's cognitive appraisal. To this end, Bandura's (1997) emphasis on the role of agency was critical to understanding how FLCH staff maintained their well-being, and particularly how to improve the belief in one's ability to take action for well-being. One main contribution of this thesis was the creation of the novel

construct, well-being self-efficacy (WBSE), related to the belief in one's ability to organise and take steps towards improving one's well-being.

Three questions were posed by the thesis: 1) What do FLCH staff do to improve and/or maintain their well-being at work? 2) Can well-being self-efficacy be measured? 3) Can a participatory intervention, tailored to a care home setting, enhance WBSE, and uncover some mechanisms via which WBSE is enhanced?

This thesis employed a multi-study sequential design, which involved three independent but interconnected studies. In response to question one, findings from a focus group discussion (Study 1) revealed that the well-being experience of FLCH staff is not optimal, concurring with the literature which depicts a stressful workplace experience. The findings of this thesis showed that FLCH staff deploy a variety of strategies ('tools') to protect and/or improve their well-being. These strategies were not static but changed depending on the situations encountered.

Findings from the development and validation of a novel WBSE scale (Study 2) answer research question two. The preliminary findings point to a three-factor scale, a means by which WBSE can be measured. The scale represents the actions taken by FLCH staff to improve or maintain their well-being at work. However, research with a different population of FLCH staff will provide confirmatory analysis of the scale. To the best of the researcher's knowledge, this is the first attempt to develop a self-efficacy construct based on well-being for FLCH staff, and to develop a measure to assess this construct. It is hoped that the WBSE scale may serve as a tool to aid care home managers and other stakeholders in taking measurable steps towards supporting the well-being of FLCH staff and addressing workplace stress.

Finally, the findings from Study 3 answer research question three. A participatory staff-led intervention with FLCH staff over a period of approximately nine months confirmed that the belief in one's ability to improve well-being can be improved via a tailored intervention. A

realist evaluation (Pawson and Tilley, 1997) of the intervention uncovered mechanisms by which WBSE was improved. These mechanisms lend further support to practical ways in which stakeholders can pay attention to, and prioritise the well-being of FLCH staff. The realist evaluation of the intervention enabled a detailed investigation of the extent to which it worked, how it worked, why, for whom and in what context. Additionally, the realist evaluation approach helped to address the issue of evaluation identified in the literature on interventions, by demonstrating how a complex intervention in a care home setting may be evaluated.

Although other studies have reported on the high stress levels, high turnover and other similar traits associated with care homes (Cooper et al., 2016; Skills for Care, 2019), there has not been a strong focus on how FLCH staff maintain their well-being, and much less focus on developing ways by which their well-being may be supported. The well-being experience of FLCH staff has largely remained under-explored, thus this thesis contributes to the literature and knowledge of what is known about FLCH staff. Overall, it suggests that their well-being can be improved amidst the challenging situations in which they work. It also demonstrates that the belief which a FLCH staff member has, in their ability to take steps towards well-being, can be bolstered. It is hoped that there will be future research and practice initiatives aimed at improving the WBSE and well-being of FLCH staff, and that the current research will serve a foundational purpose.

The benefits of improving WBSE and ultimately well-being, as presented throughout the chapters of this thesis, will hopefully incentivise care home managers or owners to invest in the well-being of their FLCH staff. It is also anticipated that the findings will be of benefit to policy makers, especially in consideration of the current (2020) COVID-19 pandemic where care homes need to be supported into recovery.

Besides demonstrating the benefits of improving WBSE and well-being, the current research has developed a practical guide for translating the findings of the research to a care home setting. This guide may be used directly or may serve as a template to create a bespoke experience in care homes. As presented in Chapter 1, registered managers and senior leaders stated that the mental well-being of care staff was their top concern, and they were interested in knowing how to offer good support to their teams (Care Workers Charity, 2019). It is hoped that this guide will be of benefit to care home managers and/or owners in addressing that need.

10.1 Contribution to knowledge

Overall, this thesis has taken the established theory of self-efficacy and applied it to the subject of well-being. Specifically, this has been applied to the context of care homes and their frontline staff, where well-being is known to be low, with associated negative consequences. The original contributions which this thesis has made to knowledge are outlined.

1. Re-interpretation of knowledge and established ideas
    - Using the established theory and ideas of self-efficacy to:
        - identify strategies which FLCH staff deploy to improve or sustain their well-being at work.
        - develop of a novel self-efficacy-based concept, WBSE, which describes a person's belief in their ability to improve their well-being. The WBSE concept may also give predictive insight into the level of FLCH staff well-being.
    - Using established principles of scale development and validation to:
        - develop a novel WBSE scale which enables the assessment of a person's belief in their ability to improve their well-being.

2. The discovery of knowledge:
    - Uncovered mechanisms by which WBSE improves, from investigating interactions between contextual and individual factors within care a home setting.
    - Provides insight into how WBSE may be improved via a tailored participatory staff-led intervention.

3. Practice guidance:
    - Developed guidance for care home managers, owners, and other stakeholders, on practical steps which can be taken to improve the WBSE, and potentially the well-being, of FLCH staff.

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Appendix A: Information sheet (Scale development and validation)

Participant Information Sheet

Research Title: Development and Validation of a 'Well-being Self-Efficacy' Scale for Staff in Care Homes

Dear Sir/ Madam,

I am a postgraduate PhD student at the University of East Anglia, Norwich Business School. The supervisors for this study are Dr Roberta Fida (Norwich Business School) and Dr Anne Killet (School of Health Sciences). You are being invited to participate in a study on well-being, and this information sheet will give you more details about the study.

Background of the research

There has been much research emphasis on care homes in terms of its residents, however, there is need to focus on ways to improve the well-being of staff also. Working in a care home can be a rewarding experience, however, what must not be overlooked is the fact that care homes can be challenging places to work, both physically and psychologically. Some stresses experienced by care homes staff have a direct impact on their well-being (Zimmerman et al. 2005). Paying close attention to the well-being of staff in this setting is paramount, because a better understanding can play a vital role in understanding the stresses experienced, and addressing any hindrances to nurturing staff well-being within these settings. Rose et al., (1998) and Firth-Cozens (2001) show that when staff feel better about their well-being, and are satisfied with their jobs, there is a positive influence on the quality of care they deliver. The current study offers an opportunity to explore the well-being experience of staff who work in care homes.

What would taking part involve?

You are being invited to attend a focus group discussion on well-being. During the focus group we will be discussing your experience of well-being, that is, what well-being means to

you, what impacts your well-being and any other points around well-being you would like to raise. In order to participate, you will be attending only one of four focus group discussions. The discussion will last a maximum of two hours. There will be approximately 8 people within the focus group. Light refreshments will be provided.

By participating in this research, you will be making a vital contribution to the body of knowledge on care homes. Your care home or agency will receive an abstract at the end of this research, which is a summary of the findings.

Your Confidentiality

Focus group discussions will be recorded in order for the researcher to refer to the information with clarity. Although you will be in a group with other individuals, strict confidentiality will be maintained during the focus group discussions, unless there is a safeguarding concern, in which case the County Council's safeguarding guidelines will be followed. In participating, neither you nor your organization will be identified in the analyses of the data or in reporting the findings of this study.

What you need to know

To participate, you will be required to give your consent by completing the attached form. Participation is voluntary. If you do not wish to participate but have scheduled to attend one of the focus groups, you can simply contact me to cancel. I will kindly request that this is done as early as reasonably possible for you in order for the place to be reallocated in good time.

Thank you very much for considering participating in this research. I look forward to working with you, your contribution is greatly valued!

If you would like further information at any stage, please do not hesitate to contact me via o.vaughn@uea.ac.uk

Oluwafunmilayo Vaughn

Lead Researcher
o.vaughn@uea.ac.uk

Supervisors
Dr Roberta Fida
Dr Anne Killett

Appendix B: Critical incident form

Your Experience

Your Role: ***(eg care staff, Nurse, etc)……..***

Sex: M/F ……. Age:…… Length of time in care work…….

Considering well-being based on the definition discussed at the beginning of this session, think of an occasion in which you had a **positive** experience of well-being as you carried out your work within the care home.

Now reflect on this situation based on the 4 categories below. Following your reflection, please complete the following:

1) The Situation

2) Your Action

3) Reasoning Behind Your Action

4) The Outcome

Please think of an occasion in which you had a **negative** experience of well-being as you carried out your work within the care home.

Now please reflect on this situation and following your reflection, please complete the following:

1) The Situation

2) Your Action

3) Reasoning Behind Your Action

4) The Outcome

Appendix C: Focus group schedule

Focus Group Schedule

(to guide the researcher)

The sessions will last 2 hours and they will follow the format outlined below.

1. Welcome, refreshments, introductions, and thanking participants [***10 mins***]
2. Agreeing on ground rules (e.g. confidentiality, not judging others) [***5 mins***]
3. Overview of the research (including the definition of well-being focused on the experience of satisfaction, positive affect and personal relationships) [***5 mins***]
4. Establishing the general aim of the discussion [***as item 3 above***]
5. Asking participants to complete the Critical Incident Form [***20 mins***]
6. Guiding the main discussions [***60 mins***]
   The discussions will be focused on incidents that staff consider to be positive and/or negative experiences of well-being. Some of the questions to be asked are:
   - What were the general circumstances leading up to this incident?
   - Exactly what did you do regarding the experience of well-being in this situation?
   - Why do you consider your action(s) (above) to be important and/or helpful when considering well-being (individual and/or collective well-being)?
   - Are there others that have a similar strategy or experience?
   - What other strategies would others have used?
   - How did the experience influence another incident?
   - Additional comments from the group
7. Anything else participants will like to say [***10 mins***]
8. Conclude
9. Debriefing [***10 mins***]

Note. Before commencement, the researcher will ensure that all signed consent forms have been received.

Participants will speak freely but if necessary, may be prompted to clarify points made or prompted to explain more. The researcher will seek to create a good rapport with the participants, facilitate the discussions, and will ensure that the sessions are timed carefully, abiding to the stipulated timing.

Appendix D: Gatekeeper letter

Manager/Service Lead,

……

……

Dear Sir/ Madam,

Invitation to Participate in Research on Well-Being

I am a postgraduate PhD student at the University of East Anglia, Norwich Business School. I am conducting a study to gain more understanding on successful ways in which care homes staff nurture their well-being. The supervisors for this study are Dr Roberta Fida (Norwich Business School) and Dr Anne Killett (School of Health Sciences).

This study is in two phases, and phase one has been completed. Phase one of this study involved the development of a questionnaire and a survey, following focus group discussions with care home staff. The study is currently in phase two, which involves an intervention. To carry out phase two, we are interested in recruiting care homes to participate in this staff-led participatory intervention.

Please find enclosed further information about the study, the same information would be given to potential participants of this study. These can be shared with your staff or placed at a suitable location within your care home, giving the opportunity for staff to see them.

If you are happy to consider your care home taking part in this research I am happy to meet with your staff to discuss this study and answer questions they may have. This for instance can be in the form of a brief presentation during one of you regular staff meetings.

Thank you very much for considering participating in this research, your contribution will be greatly valued. Please feel free to contact me to ask further questions about this study, or if you would like to participate. Thank you.

Oluwafunmilayo Vaughn

Lead Researcher
o.vaughn@uea.ac.uk
07448 593507

Supervisors Dr Roberta Fida
Dr Anne Killett

Appendix E: Gatekeeper consent form

Title of Research: Enhancing well-being, improving well-being self-efficacy: an intervention with care home staff

Lead Researcher: Oluwafunmilayo Vaughn

Permission to Undertake a Research on Well-Being, In Your Care Home

As the manager of _____, I give permission to the researcher, Oluwafunmilayo Vaughn, from the Norwich Business School, of the University of East Anglia to discuss the research project, conduct focus groups and administer questionnaires with staff who have consented to participate in this research.

Name of care home manager: _____

Signature of care home manager: _____

Date: _____

Thank you for giving us permission to discuss and conduct research in your care

Supervisors:

Dr Roberta Fida

Dr Anne Killett

Appendix F: Information sheet (intervention study)

University of East Anglia

Participant Information Sheet

Research Title: Improving well-being self-efficacy: an intervention with care home staff

I am a postgraduate PhD student at the University of East Anglia, Norwich Business School. The supervisors for this study are Dr Roberta Fida (Norwich Business School) and Dr Anne Killett (School of Health Sciences). You are being invited to participate in a study on well-being, and this information sheet will give you more details about the study.

Background of the research

There has been much research emphasis on care homes in terms of its residents, however, there is need to focus on ways to improve the well-being of staff also. Working in a care home can be a rewarding experience, however, what must not be overlooked is the fact that care homes can be challenging places to work, both physically and psychologically. Some stresses experienced by care homes staff have a direct impact on their well-being (Zimmerman *et al.* 2005). Paying close attention to the well-being of staff in this setting is paramount, because a better understanding can play a vital role in understanding the stresses experienced, and addressing any hindrances to nurturing staff well-being within these settings. Rose *et al.*, (1998) and Firth-Cozens (2001) show that when staff feel better about their well-being, and are satisfied with their jobs, there is a positive influence on the quality of care they deliver. The current study offers an opportunity to explore the well-being experience of staff who work in care homes.

What would taking part involve?

You are being invited to join in a participatory staff-led intervention on well-being within your care home. Taking part will involve first attending a well-being workshop at your care home. At this workshop, you will be introduced to information to support your well-being, and provided with the opportunity to practice the application of the information given. This practice will be in the form of a game. You will also have the opportunity to speak with me individually should you have any questions about the intervention. After this, you will work together with your colleagues on a well-being plan developed by yourselves. After the well-being workshop, you will be recording your experience using tools provided by us. The

intervention will last 6 months at your care home, giving the opportunity for you to both gain and apply information which will support your well-being. I will visit regularly to support your plan, and to answer questions which you may have.

By participating in this research, you will be making a vital contribution to the body of knowledge on care homes. Your care home or agency will receive an abstract at the end of this research, which is a summary of the findings.

Your confidentiality and remaining anonymous

Throughout the intervention, strict confidentiality will be maintained. Details you share about your experience during the intervention will remain confidential, except those you wish to share for the improvement of the intervention. Any such suggestions will be shared anonymously, except otherwise stated. During the intervention, there may or may not be groups discussions to discuss how the intervention is going. If there are group discussions, these will be recorded in order for the researcher to refer to the information with clarity.

In participating, neither you nor your organization will be identified in the analyses of the data or in reporting the findings of this study.

What you need to know

To participate, you will be required to give your consent by completing the attached form. Participation is voluntary. If you do not wish to participate in this study, you can simply not book into any of the well-being workshops and not participate in any of the activities following the workshops.

If you choose to participate in the study after the well-being workshops are completed, you can speak with any of your participating colleagues to share the details of the information you need to complete the leaves for the well-being tree. Alternatively, during one of my visits to your care home I can share these details with you. You can also inform me in advance of my visit, via the contact details below.

Thank you very much for considering participating in this research. I look forward to working with you, your contribution is greatly valued!

If you would like further information at any stage, please do not hesitate to contact me.

Oluwafunmilayo Vaughn

Lead Researcher
o.vaughn@uea.ac.uk
07448 593507

Supervisors
Dr Roberta Fida
Dr Anne Killett

Appendix G: Consent form (intervention study)

University of East Anglia

Participant Consent Form (Care Home Staff)

Title of Project: Improving well-being self-efficacy: an intervention with care home staff

Lead Researcher: Oluwafunmilayo Vaughn
Supervisors: Dr Roberta Fida, Dr Anne Killett

I confirm that I have read and understood the information sheet for the research project **Improving well-being self-efficacy: an intervention with care home staff, Dated 25/09/2017 version number V125/09/2017**	☐
I have had the opportunity to consider the information and ask questions and these have been answered satisfactorily.	☐
I know that I do not have to take part, it is my own choice. I know that I can withdraw from the study at any time without giving any reason and without consequence to me.	☐
I understand that all information will be anonymised and will remain confidential and only be used for research.	☐
I understand that any records will be kept in a password-protected computer and in a locked cabinet and will only be accessible to relevant research staff.	☐
I agree to take part in the research project titled **Improving well-being self-efficacy: an intervention with care home staff**	☐
• I agree to take part in a group discussion with other staff members	☐
• I understand that the group discussion will be recorded	☐

Appendix H: Diary template

My reflections

Please note: This diary is completed approximately every 2 weeks.

Date : ……

Please fill out the details on both sides. Completing this diary should take approximately 15 minutes. You may complete either column A or B or both.

A. Over the past two weeks, pick one experience at work which you consider to be a **positive** well-being experience.
Why was it positive?

Did you do anything to make it a positive experience? If yes, what did you do?

From your answer above, why did you take those actions?

B. Over the past two weeks, pick one experience at work which you consider to be a **negative** well-being experience.
Why was it negative?

Did you do anything to make it a negative experience? If yes, what did you do?

From your answer above, why did you take those actions?

Please complete the following

Based on your experience since your last diary entry

Please check **one** response for each item that best indicates how often you've experienced each emotion at work	Never	Rarely	Sometimes	Quite often	Extremely often
1. My job made me feel angry.					
2. My job made me feel anxious.					
3. My job made me feel at ease.					
4. My job made me feel bored.					
5. My job made me feel calm.					
6. My job made me feel content.					
7. My job made me feel depressed.					
8. My job made me feel discouraged.					
9. My job made me feel disgusted.					
10. My job made me feel ecstatic.					
11. My job made me feel energetic.					
12. My job made me feel enthusiastic.					
13. My job made me feel excited.					
14. My job made me feel fatigued.					
15. My job made me feel frightened.					
16. My job made me feel furious.					
17. My job made me feel gloomy.					
18. My job made me feel inspired.					
19. My job made me feel relaxed.					
20. My job made me feel satisfied.					

Thank you! Your contribution is greatly valued! If you have any questions,
please feel free to contact me via: Oluwafunmilayo Vaughn | o.vaughn@uea.ac.uk | 07448 593507

Appendix I: Well-being workshop schedule

	Item	Time allocation
1	Icebreaker	10 mins
2	Brief overview of the research Overview of the intervention	10 mins 15 mins
3*	About well-being About self-efficacy Well-being self-efficacy	30 mins
4	Play the game and action plan	50 mins
5	Well-being tree and Champion	15 mins
6	Further opportunity for questions	15 mins
6	Thank you and closure	5 mins
	Total	2.5 hours

**Content:*
-research evidence on workplace stress and its impacts, coping
-what is self-efficacy, why is it important (emphasis on individuals taking minimal or no action if perception of self-efficacy in low)
-applying self-efficacy (as WBSE) in their working context and the important role of the individual

Appendix J: Example of game card

Emma is 27. She's a carer at The Chestnut care home. A resident has recently complained about Emma shouting at him when she was trying to help transfer him to the toilet. This resident also displays challenging behaviours which Emma has to deal with all the time since she's his leading carer. Apparently, the resident had told another person, who mentioned it to the manager. Emma was asked to see the manager.

The way the conversation went, Emma felt like the manger was taking sides with whoever it was that reported. Emma didn't feel too happy because she expected that the manager will understand that the challenging behaviour of the resident could make him difficult to deal with. And that maybe as she was speaking to him and getting him to the toilet, he felt that she was shouting. The manager later gave her a written warning letter. She had never received or seen one ever before.

Some response cards for discussion:

Emma moans about it with her colleagues. They all know the resident and know that he's always thinking that people are shouting at him or treating him badly.

A relative of the resident was informed about the incident, and this relative actually took the time to speak with Emma about it. She encouraged Emma about the good job she has always done with her relative, and that she shouldn't let the incident trouble her.

Emma was feeling bad, and the whole day just seemed to drag. She even made a mistake later on that day as she took the wrong set of clothes from the laundry to a resident's room.

Appendix K: Interview Schedule

Interview and Debriefing Schedule

1. a. In general, how have you found the intervention so far?
   b. What has been your personal experience in putting it into practice so far?
2. How have you found the experience of completing the diary?
3. a. Do you feel that you your well-being affects your work? If yes, how?
   b. Do you feel that the intervention is making any difference to the home and to you? If yes, how?
4. a. Do you feel that your well-being has any impact in the quality of your work?
   b. Do you feel that the intervention and/or any new experience is making any difference in the quality of your work?
5. How does your well-being experience affect your relationship with:
   a. Residents
   b. Colleagues
   c. Relatives
   d. Supervisors/team leader/manager
   And how has the intervention made a difference, if any?
6. Do you feel that the intervention and/or your experience so far has made a difference in any other aspects of your care home apart from well-being? If yes, how?
7. Do you feel that the intervention has made a difference in your confidence to do things which improve your well-being, whether at work or outside work?
8. Do you feel that engaging in the intervention has had any influence on your well-being outside of work? If yes, how?
9. Finally, what do you feel about the sustainability of the intervention? That is, after the research is over, what are your thoughts about continuing it.

Notes:

Due to the realist evaluation being employed during the course of this study, the interview questions will differ based on the development/progress of the intervention in the different care homes. This schedule thus serves as an initial guide.

Before commencement, the researcher will ensure that a consent form has been signed.

Participants will speak freely but if necessary, may be prompted to clarify points made or prompted to explain more.

Appendix L: Conference papers and posters

Vaughn, O. (2017). Could improved staff well-being be the key to improved care? A Study of staff in care settings (peer-reviewed poster presentation). Employment, Systems and Institutions Conference: Work, learning and well-being conference - understanding what government, business, communities and individuals can do to improve well-being. Norwich, United Kingdom.

Vaughn, O. (2019). Could 'well-being self-efficacy' be the key to improved well-being? A study of frontline care home staff. Society for Studies in Organizing Healthcare (SHOC) symposium. Birmingham, United Kingdom.

Vaughn, O. (2020). Improving well-being via self-efficacy: A realist evaluation of what works for frontline care home staff. Organizational Behaviour in Health Care, International Conference - Managing Healthcare Organisations in Challenging Policy Contexts: Integration or Fragmentation?' Manchester, United Kingdom. [Paper confirmed. Conference cancelled due to COVID-19 pandemic].

Vaughn, O. (2020). Could well-being self-efficacy be the key to improved well-being? A study of frontline care home staff (poster presentation). South East Network for Social Sciences (SeNSS) Virtual Summer Conference.