Phase one findings v.1
Poster 1 of 2

University of Kent

Discovering a Concept of Care

Update of initial findings from '***Producing Culture and Care***' *(IRAS ID: 320196)*

The study so far...

From October 2023 to March 2024, 6 months of research was completed at two adult acute mental health inpatient services in the East of England. The aim was to explore what 'good care' means for people giving and receiving care on two wards.

A researcher visited the wards regularly, up to five times a week for up to five hours each visit, to observe everyday activities and talk to people about their experiences.

What has been completed so far:

- **360 hours** of participation, observations, and unstructured interviews
- **32 casefiles** with patients and staff
- **10 art workshops** with patients
- **2 focus groups** involving 13 staff

How has this been interpreted...

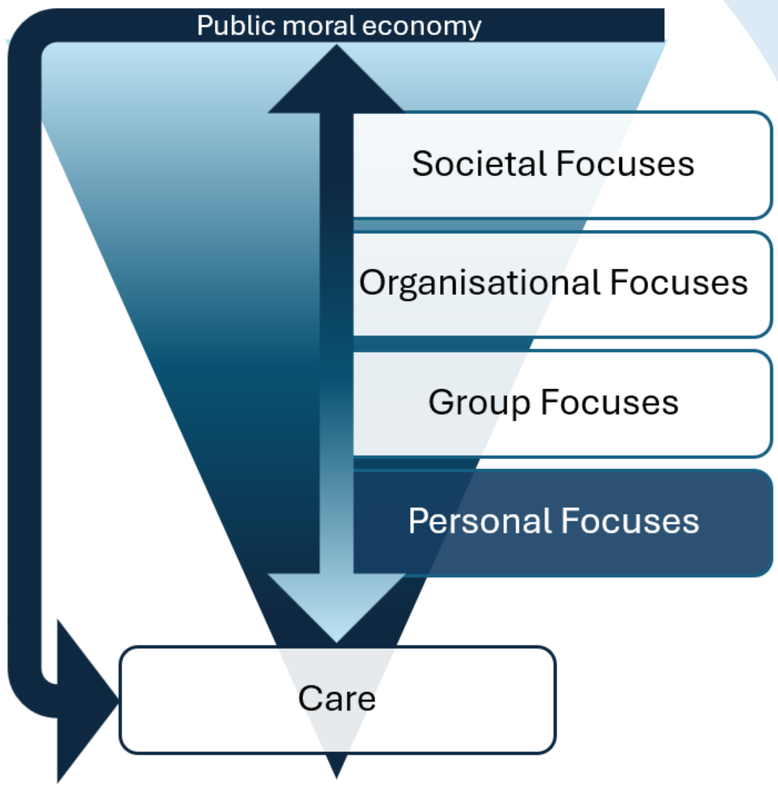
The focus group discussions framed an interpretation of findings through three steps of analysis:

Summarising: The 19,000-words of verbatim focus group transcriptions were summarised into 374 short phrase 'initial codes'.

Grouping: The codes were refined to 236 'axial codes' organised in 27 subcategories, and 4 general categories

Connecting: The categories were analysed using notes from participation, observations, interviews, casefiles, and relevant literature to create 50 new categories that connect the findings from the phase one activities to the research questions.

From these categories, 14 central organising themes in 3 sets were created



Theme 1: Care is Relational and Person-Centred

Care involves building connections and trust over time. While essential tasks like appropriate medication and health checks provide a foundation, long-term relationships can open spaces for deeper discussions about what truly matters to someone and what will ultimately further their restoration. Acts of care develop connections which allow patients to more securely express their needs and perspectives, fostering allyship and enabling person-centred planning. As a result, acts of care can shift the focus from broader group priorities to personal focuses.

Theme 2: Care is Embodied and Communicated Emotionally

Through investments in long-term relationships, staff can develop detailed understandings of individuals and their circumstances. This knowledge can become engrained in the staff, often triggering visceral responses and heightened sensitivities to changes that will affect patients. This knowledge enables staff to interpret and meet needs that may not be explicitly expressed, fosters the development of unique *languages of care* with each patient, and drives staff to advocate for patients during key clinical decisions.

Theme 3: Care is Sacred and Legitimatising

To receive acts of care, patients disclose personal details about their life so that staff may understand and support them accordingly. This access into another's life was seen as a privilege and sacred to the staff. Providing personalised care through a detailed understanding of another held moral significance with substantial, emotional, time, and material investments being placed into relationships. Honouring and protecting these relationships is a top priority. Experiences delivering care shape staff, provide legitimacy to their practice, and are used purposefully to justifying perspectives and decisions.

Set 1: Themes 1-5 'A Concept of Care'

Theme 4: Care Always Has a Cost

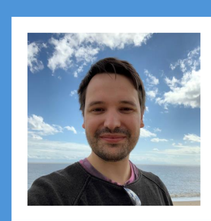
Staff must prioritise tasks during each shift, balancing available time, skills, and resources in a responsive manner. Often, staff feel obligated to work beyond their scheduled hours, sacrificing breaks and suppressing their own needs to provide additional care where shortfalls occur. Patients also contributed by supporting one another, adapting to ward routines, and expressing gratitude. Everyone gives and takes to some extent, creating an economy of time, needs, resources, and actions in relation to the competing focuses of care that are continually negotiated and re-conceptualised to align available resources to current needs.

Theme 5: Care entails tension and risks moral injury

Tensions arise between patient preferences and perceived best interests when negotiating personal focuses. Differing explanatory models on distress, illness, and treatment among groups can create tensions in group focuses. Organisational and societal focuses bring challenges around resources, standards, and priorities. When focuses are rejected, blocked, or misaligned within or between individuals and groups, those invested in them often experience frustration, isolation, distrust, and moral injury. This issue was often linked to processes and hierarchies.

A Concept of Care

Care can be conceptualised as dynamic, relational, and transactional. Care shapes how people can individually or collectively help a person in a specific context at wards. It is characterised by trust, emotional communication, and personal investment. Staff, patients, and carers contribute to a shared moral economy that creates an interplay between focuses, acts, and beliefs when agreeing on the contexts of distress and the nature of restoration. The production of care creates an experiential currency through relationships and acts that inform the negotiations of focuses as to where investments of time and resources should be made. Care involves navigating tensions in the negotiations of personal, group, and organisational focuses that entails a cost to acceptably broker the care needs of individuals with those of groups, organisations, and wider society.



Hello, my name is Matthew. I am the researcher completing this study. If you have any questions about this research, you are welcome to speak to me

Would you like to know more?

Study leaflets are available at the participating wards.

You can scan this QR code to view the study's website:

Phase one findings v.1
Poster 2 of 2

University of Kent

Processes and Outputs of Care

Set 2: Themes 6-10 ‘Processes of Care’

Theme 6: Multiphasic Interactions

Care involves interactions where focuses of care are shared, shaped, and negotiated in cycles and phases. These focuses guide the selection, prioritisation, and allocation of purposeful tasks, each creating opportunities for further interaction and collaboration, often in key situations that occur regularly in the service. Initially, staff begin with group focuses, but as they learn more about a patient’s unique circumstances, preferences, and experiences, they can shift towards negotiating personal focuses specific to the individual patient. This shift occurs through phases of acts and negotiations by patients, carers, and staff to create and test new shared personal focuses. Established focuses are developed through individuals’ past experiences, beliefs, and values. As trust and connections increase through the creation of new experiences and exchange of beliefs and values, people may adapt their perspectives. This mutual learning over time can produce new focuses that allow for shared conceptualisations of the context, enabling expectations and requirements for restoration to be designed and progressed. These cycles of negotiation, testing, and refocusing extend across services and admissions, as ward staff invest in both immediate contexts and the patient’s and carer’s foreseeable ongoing journey, laying the groundwork for future progress beyond the inpatient admission.

Theme 7: Values and Attributes

Many staff shared personal experiences of distress, adversity, or mental health challenges, whether through caring for loved ones or facing these struggles themselves. These experiences seemed to shape their values on how care should be delivered and experienced, fostering a belief in recovery and strengthening their commitment to helping others. Practical and technical skills were also essential; after staff developed expertise in routine tasks, they were more able to focus on personalising care and became sensitive to subtle changes in patients. Diversity in skills, attributes, and backgrounds, including gender, age, and ethnicity, broadened the team’s perspectives, offered greater representation in relation to the diversity of patients accessing care, and ultimately produced more options to meet needs.

Theme 8: Acts of Care

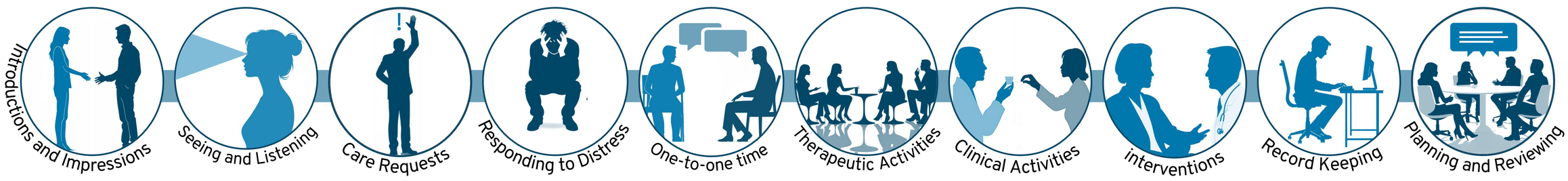
Ward staff identified essential interpersonal approaches for enacting acts of care: *attentiveness*, *non-judgemental understanding*, and *naturalising interactions*. They emphasised the importance of sensitivity in approaching patients and carers, active listening, and responding to requests while clearly communicating what they can do and when. Staff emphasised the importance of *being attentive* to signs of distress, responding with empathy, and with a careful consideration of available options. Being *non-judgemental* was seen as crucial, especially concerning patients’ histories and how they may present while acutely distressed on the ward; patients were often absolved from judgement under psychiatric or psychological explanations. Effective care also involved *naturalising* conversations where staff engaged in genuine casual conversations, and “banter” that fostered rapport and helped maintain patients' sense of self, connection to life outside of the ward, and senses of normality, belonging, and contribution through relationships and shared experiences.

Theme 9: Extensions of Care Focuses

Acts of care can extend beyond personal interactions to shape group and organisational focuses. This involves staff advocating for patients and carers in their absence, sharing essential information, requests, and preferences between shifts to maintain continuity and hold each other accountable for quality and consistency. These processes help sustain care stories, integrating them into persistent narratives through peer discussions, inclusion in decision-making, and record-keeping. Staff also participate in audits, reflective practice, and supervision to uphold shared standards. Although often unnoticed by patients and carers, these efforts preserve personal focuses, align them with group and organisational focuses, and foster continuous learning, supporting the adaptation of group focuses based on current patients’ needs. Staff expressed that disconnections and gaps within the team or between whole services can break continuity or create contradictions in care.

Theme 10: Accountability and Care

Focuses of care are affected by layers of clinical and organisational accountability. These structures weigh personal focuses with broader societal considerations to guide operational plans, policies, and resource allocation. However, these accountability structures create hierarchies within the organisation or over specific decisions, where communication, understanding, and trust are crucial. Effective communication and visible, engaged leadership were highlighted as essential for delivering responsive, flexible, person-centred care. When senior managers were accessible and supportive, staff believed their capacity to respond to patients’ needs improved. Conversely, when a senior presence was lacking or organisational structures felt detached from the daily realities of the ward, staff often felt pressured to prioritise misaligned procedural tasks over delivering personalised acts of care, leading to frustration, disconnection, and diminished trust.



Key Situations
of interaction

Set 3: Themes 11-14 ‘Outputs of Care’

Theme 11: Stories and Narratives of Care

Staff create stories of care through building relationships, negotiating personal focuses, and responding purposefully with chosen actions. Drawn from interactions, these stories contribute to learning about effective practices and may validate, expand, or reshape understandings of contexts and solutions. Stories shared within groups strengthen bonds, support discussions, and aid decision-making. They are valued as evidence of a deeper understanding of a patient’s needs, lending legitimacy to interpretations and recommendations. Stories involving multiple staff members carried greater legitimacy and fostered a sense of belonging among those sharing and listening, while stories that highlighted personalised care, significant effort, danger, or unique expertise were also notably more valuable; many staff recalled stories that, through repeated retelling, had gained allegorical value. As stories are shared, shaped, and applied, they coalesce into broader narratives of care that distinguish patterns and create theories. These narratives often aligned with explanatory models held by groups, leading to a sense of ownership over stories where their use supported either established or new focuses that had been invested in. Narratives of care inform group and organisational focuses

Theme 12: Connections and Networks of Care

Investments of time and resources in particular focuses connected individuals within the organisation, fostering belonging based on shared values, beliefs, and explanatory models that guide their practices and production of care. These connections allowed stories and narratives to extend into wider communities of practice beyond the confines of the wards. While generally inclusive, networks exchanged practices within the legal frameworks of the health sector and were influenced by hierarchical accountability structures that distinguish job roles in the NHS. *Care leaders* were recognised across multiple groups as ‘experts in contexts’ who could influence organisational focuses by using narratives to align group focuses and affect organisational focuses. However, being a care leaders is contextual, and such leaders did not always occupy formally accountable roles when their expertise was pertinent; networks enabled them to work with or bypass layers of accountability.

Theme 13: New Focuses of Care

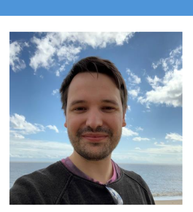
Those with clinical accountability interpreted and appraised colleagues' stories alongside clinical evidence and patient records. This allowed them to help staff navigate hierarchies by incorporating their insights into existing or new narratives and guiding further interactions. This adaptability enabled selected members of the multidisciplinary team or wider network to lead explorations or interventions based on their personal focuses negotiated at the point of care, transitioning these into group focuses where they demonstrated benefits to the patient’s restoration. The ability to transfer leadership while retaining accountability was evident among long-standing high-accountability professionals who were present in daily care delivery. Through delegation and feedback, new focuses were shaped by listening, enabling, and valuing the development of care leaders within their teams and networks. However, when pressures were high, staffing limited, or management inconsistent or absent, reliance on previously established focuses increased. Under such conditions, clinical staff often confined their objectives to the immediate scope of their shifts, with fewer opportunities to perform acts of care, share stories, negotiate focuses, build teamwork, and attribute expertise to care leaders.

Theme 14: Movement and Power

When patients receive or give care, they build trust and strengthen connections, fostering a renewed sense of self, independence, and purpose. Each act of care becomes a step toward empowerment, helping patients develop the motivation and ability to make meaningful changes in their lives. Staff who cultivate close and respectful relationships with patients become confidants, advocates, and therapeutic allies, balancing the need for interventions with engagement to support patients as they regain control over their admission and restoration. Among staff, sharing experiences builds respect and appreciation, enriching professional relationships and creating ongoing learning opportunities. By exchanging knowledge, stories, and skills, staff gain influence, empowering them to be care leader in particular contexts, foster improvements responsive to the dynamic needs of the patients and the team, and further their professional development; potentially also granting opportunities to advance their roles and accountability within the organisation.

Next phase of the research

The second phase will involve recommencing immersive visits at the two wards to map selected key situations through direct participation, observation, and semi-structured interviews. This approach aims to triangulate the concepts, processes, and outcomes of care to establish meaningful measures that can model how care is routinely produced in adult acute mental health inpatient services. With this clearer understanding, the final phase will invite patients, families, and staff to collaborate in identifying opportunities for improvement and designing and testing new processes to enhance the consistency, impact, and opportunities for care at the participating wards.



Hello, my name is Matthew. I am the researcher completing this study. If you have any questions about this research, you are welcome to speak to me

Would you like to know more?

Study leaflets are available at the participating wards.

You can scan this QR code to view the study’s website: