# ‘They’re just who they’ve always been’

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# ‘They’re just who they’ve always been’: The Intersections of Dementia, Personhood, and Community in Scottish Care Homes.

**Abstract**

Issues stemming from differences in cultural identities affect residents and workforces in care homes in Scotland, as they do across the United Kingdom. Theoretical guidance and policy drivers emphasise the importance of considering cultural diversity when planning or enacting person-centred care processes, regardless of where health or social care takes place. Nevertheless, there is a recognised worldwide dearth of research concerning the intersections of cultural differences, dementia and long-term care. A recent research study found that certain poorly-understood aspects of culture and society could be seen to constrain person-centred care in some Scottish care homes. Conversely, other little-recognised sociocultural phenomena were observed to positively bolster it. Relevant to these assertions are;

- restricted understandings of the historically-located contexts of formative cultural identity in Scotland.
- a general failure to acknowledge the influence of inter-generational cultural change.
- limited understanding of the nature of interactions between staff and service users from different cultural backgrounds.
- lack of knowledge of the power of shared identity and community as a bulwark against the erosion of personhood often associated with dementia.

This paper describes findings from the aforementioned study, providing fresh insights into how cultural identity bears upon the interactions between workers and residents with dementia in

Scottish care homes. It goes on to suggest how the school of 'person-centred care' may be developed through further research into these phenomena.

Keywords: ***dementia, person-centred care, identity, culture, community, Scotland.***

**Introduction**

This paper presents the process and outcomes of an investigation into cultural identity as it affects the lives of people with dementia in Scottish long-term care settings. Throughout, a standpoint influenced by social constructionist conceptions of the nature of 'self' provided the philosophical backdrop, as elaborated in the work of Sabat (2001). Social constructionism holds that all knowledge is historically and culturally specific. In this sense, selfhood and social reality itself is 'constructed' via the discursive practices which occur between people. Perceptions of what and who we are exist within, and are defined by, the social interactions taking place throughout our lives. Dementia is often associated with the progressive erosion of self within individuals, although this commonly-held belief has been challenged (Sabat 2001). Nevertheless, people with dementia may be particularly vulnerable to loss of identity and damage to selfhood in long-stay care settings (Chaudhury 2008). This results from any number of factors: loss of long-familiar social/environmental anchors, the effects of organisational policies, constraints on revenue budgets, variations in staff training, the personal traits of staff and so on. The study took as its special focus the cultural component of the construction of self (Sabat 2001). It illuminated perceived weaknesses in the recognition and treatment of this in maintaining selfhood (as part of claimed 'person-centred' approaches) in individual care home residents in Scotland. The study adopted the view that cultural identity (most especially that which shapes us as human beings

early in our lives) as it affects the fields of health and social care is represented by a much more complex and dynamic set of phenomena than has hitherto been acknowledged. This assertion must be considered alongside the fact that *recognised* facets of cultural diversity and dementia have been poorly researched worldwide, and, moreover, a particular lack of investigation has characterised British health and social care contexts (Bowes and Wilkinson 2003). To this end, relevant theory, and health and social care policy as they are deemed to relate to these contexts are reviewed and discussed here. The research methods employed by the study are described, the findings outlined, and conclusions given. In summary, the contention will be made that the outcomes of the study cast light on potential weaknesses in the treatment of selfhood (and thus 'person-centredness') in Scottish care settings for people with dementia, while pointing in the direction of new research avenues which may offer some means to address this.

*Cultural diversity and the older person with dementia*

The necessity of considering the needs of people from diverse cultural backgrounds in health and social care settings is widely acknowledged in the literature, and is best known in the work of Madeleine Leininger (1997 pp.341-347). She conceived the theory of 'transcultural nursing', believing that nurses should possess knowledge of the 'symbols, expressions and meanings' of the cultures they are likely to encounter during their working lives. Adherents of this approach point out that an individual's cultural background will greatly influence how he or she makes sense of the world around them (as part of the socially-constructed self), including how they engage with health and social care services (Shenk and Groger 2006). 'Cultural competence' refers to the capacity of systems and staff to provide culturally--appropriate care to people with diverse values, beliefs, lifestyles and histories, and derives in the main from Leininger's work

(Betancourt, Green, Carillo and Ananeh-Firempong 2003). Kitwood's (1997) oft-quoted model of 'person-centred care', which was formulated specifically for people with dementia, calls for consideration of the diversity of people's backgrounds. The Scottish government imbue a similar focus to policy.

In 'Fair for All: Improving the Health of Ethnic Minorities and the Wider Community in Scotland' (Scottish Executive 2002), and in 'All our Futures; Planning for a Scotland with an Ageing Population' (2007 p.20), the Scottish Government pledges to '...encourage all to understand the needs of older people in all their diversity '. In the National Dementia Strategy (2010), Holyrood assures a personalised approach to care, promising that the needs of minority groups will not be missed. These assertions are matched in policy documents emanating from Westminster. These statements occur in the rhetoric of governments of other developed countries, most notably those with substantial immigrant populations (Cox 2007). However, the aforementioned dearth of research into these phenomena inhibits the formulation of practical approaches to understanding the culturally-located needs of older people, especially in the United Kingdom. It must be emphasised here that a profound lack of awareness of the breadth of innate cultural difference (which is not necessarily dependent upon a person's membership of a 'recognised' or widely acknowledged minority ethnic or cultural group) compounds these deficiencies enormously. If such diversity as it affects the lives of people with dementia is not well understood, it is simply not possible to adequately consider it in service design and at the point of service provision. The following section will explain this assertion more thoroughly.

*Issues for investigation: the research questions*

A number of potential problems can be found in theoretical and political approaches to the

practical effects of cultural differences and dementia in Scotland, and in the UK as a whole. Culley (2006) describes a lingering failure in developed countries such as Britain to recognise and cater for the multifarious influences which impart a fluid, ever-changing and elusive nature to culture. He associates this with the influence of traditional transcultural models of care, which tend to depict cultural manifestations of diversity/identity as inevitably fixed, well-defined, easily visible, and easily addressed – quite literally, 'black and white'. Also, as seen in 'Fair for All' (2002) Scottish government policy invariably associates cultural diversity among service users with immigrant populations only. This standpoint assumes the cultural homogeneity of ancestral Scots. However, such a view flies in the face of history.

Trevor-Roper (2003 p.15) describes in detail the breadth of cultural diversity which existed in Scotland among long-established ancestral population groups, and which ceased to be recognised in the eighteenth century as the result of a wholly artificial process labelled by him as 'the creation of tradition'. Although one Scottish national culture now dominates, remnants of the older diverse mix still exist. In today's Scotland, there are still indigenous population groups who do not see themselves as Scots. Examples are many of the people of the Shetland and Orkney Islands, who have no history of Gaelic, speak dialects heavily suffused with Old Norwegian words, and look to Scandinavia for cultural links. Indeed, research reveals a definite rejection of Scots identity in these areas (Cartrite 2008). The Shetlanders and Orcadians represent the conscious vestiges of a historical Scotland which was inhabited by culturally diverse white population groups (Mitchison 2002 and Cartrite 2008). Hickman, Walter, Morgan and Bradley (2000), in discussing the UK as a whole, describe 'the myth of homogeneity of "white" British society'. According to the Office of National Statistics (2010) '...the UK today is more

culturally diverse than ever before', and explicitly link this to '4.6 million people from a variety of *non-white backgrounds'* (my italics). Confusingly, the same paper goes on to discuss 'white Irish' people as a discrete minority in the UK and also labels 'white Caribbean' as 'mixed ethnicity'. It has to be acknowledged, however, that the ONS now cover the concept of white ethnicity in more appropriate detail (2014).

In summary, Hickman et al (2000) argue that, in the UK, 'multi-culturalism is not reducible to skin colour', and conclude that current paradigms dealing with cultural diversity in care systems have a rigid, 'one-size-fits-all' nature. Mold, Fitzpatrick and Roberts (2005) argue that quality service provision includes acknowledging ethnic diversity in all older people, regardless of official 'minority ethnic' status. This requires an acceptance of potential ethnic/cultural diversity within non-immigrant groups whenever necessary. Exploring whether diversity in cultural identity among ancestral Scots population groups impacts on care processes in ways that have hitherto not been recognised was a key part of the study, and formed the first research question. A related consideration is that cultural differences *within* ethnic groups might actually outweigh cultural differences *between* ethnic groups (Duffy 2001).

As Sewell (2009 p.25) says, 'the language of "minority ethnic" groups does not fully acknowledge that many of the people being described as such were born in the UK, and regard themselves as Londoners, Glaswegians or British'. Little acknowledgement is given to the fact that younger and older people from the same ethnic background might possess different, while perhaps overlapping, cultural views of the world. It cannot be assumed that younger members of a given ethnic group are automatically culturally-competent as care workers for older members

of that group. The study aimed to examine this aspect of care, and this became the second research question.

The third research question was based on the fact that little research has covered the effects workers from non-UK backgrounds may have on culturally-effective service delivery in care homes. Froggatt, Davies and Meyer (2009 p.11) note that a 'high proportion of the workforce in care homes are non-nationals, raising challenges with respect to communication skills and mutual cultural awareness'. How do care workers from widely differing immigrant backgrounds practise 'culturally-competent care' with service users in Scottish care homes? Do care home staff who come from immigrant backgrounds always have enough situational cultural knowledge to contribute to the maintenance of self for care home residents? These questions have never been meaningfully investigated in a British context.

In short, it can be argued that existing appreciations of the broad phenomenon of 'culture' within health and social care may lack the flexibility and sensitivity to adequately address the complex, amorphous and difficult-to-perceive issues likely to be associated with cultural diversity, dementia and contemporary long-term care environments.

*Dementia and cultural identity; a special challenge for long-term care*

Stevenson (2010) describes how human beings have an inbuilt ability to adapt to changing social and cultural environments. However, certain individuals can progressively lose this facility, such as many older people with significant dementia. Indeed, these people may inhabit a psychological reality suffused with the cultural patterns of their formative years, which have

vanished or have significantly mutated, and which may have hugely reduced relevance in contemporary contexts. Edvardsson and Nordvall (2008 pp. 491-498) sum this up as being '*...lost in the present but confident of the past'* (my italics). As outlined by Sabat (2001), selfhood is inextricably linked to, and constructed via, life/lived contexts. In people who experience difficulty in adapting to the sudden and drastic changes of context represented by moving to live in a care home, an established sense of self can be greatly challenged. In plain language, they may not 'fit' in their new social environment, and might have limited cognitive capacity to personally tackle that as an individual. To this end, Orulv (2010 pp. 21-45) points out the importance of constructing care home situations which are 'in line with resident's previous experience' which allows them to 'find their place' in the here and now.

*Cultural diversity in Scottish care homes; an overview*

Little information exists concerning the number of people from traditionally-conceived minority ethnic (ME) backgrounds in Scottish care homes. The ethnic demography of care homes in England is similarly under-researched, although England has a much larger ME population than Scotland (people from ME groups comprising 9% of the total population of England, and only 2% of the Scottish population). Writing in 2005 (pp.1-7), Mold et al noted that data for ME people in English and Welsh care homes were not classified by age, although they give a figure of 'approximately 25, 166 ethnic adults in care homes in England and Wales'. Their review of the literature found only three UK journal articles dealing specifically with people from ME groups in care homes. If this is set alongside the contention already made in this paper (that cultural identity/diversity as it affects selfhood in people with cognitive decline is poorly understood, and extends to much more than that associated with traditional portrayals of

ethnicity) then the lack of insight into the intersections of cultural differences, dementia and long-term care could be taken as profound. This study provided initial inroads to understanding the potential influence of these ill-recognised phenomena. The following sections of this paper will detail how this took place.

## The research context

### *Places and people*

The original intention was to recruit care home residents from 'traditional' ME groups as well as from white Scottish backgrounds, to afford the opportunity to make comparisons. Unfortunately, approaches to over nine hundred care homes to ask if they would be interested in taking part were met with limited success, eliciting only twenty-five responses (and none of these homes accommodated people from traditional ME backgrounds). Ultimately, six care homes were selected; three in Scottish cities and three in a very remote and rural region (one of the aforementioned parts of Scotland in which local cultural identity does not always resonate with that of the rest of the country). Care home staff, and residents took part in the study, criteria for participation being the following;

- *Care home residents*

An existing diagnosis of dementia. Wherever possible, different in terms of personal formative culture from the greater proportion of the social care staff and nurses working in their care home (this was not always achievable, particularly in Shetland).

- *Care home workers*

'Hands -on' direct care staff (social care workers and registered nurses). Different in terms of personal formative culture from the majority of care home residents in their place of work, or significantly younger than the bulk of these residents (in order to search for evidence of 'inter-generational' cultural differences.

*Methodology and methods*

The analysis was qualitative in nature, and took the form of an ethnography. Spradley's (1979 and 1980) ethnographic techniques of participant observation and interview were used to gather data in research venues, which was then analysed using his 'cultural domain analysis' approach. Parker's (1992) method of poststructural discourse analysis was used to interpret the cultural themes emerging from cultural domain analysis.

*Spradley's approach*

Data from observation was categorised into 'analytical cultural domains' which were deemed to represent interactions between workers/residents characterised by culturally-effective 'person-centred' care. A wide search of the literature provided baseline criteria for defining interactions which supported 'good' culturally –effective person-centred care (such as 'taking time to speak to residents', or 'knowing personal history of residents'). The same process was used to identify and categorise interactions which could be seen to inhibit culturally-effective person-centred care. The number of times each domain recurred was taken to indicate the prevalence of a particular pattern of 'supporting' or 'inhibiting' interaction. A pseudo-statistical means of tabulating and comparing these patterns of prevalence in types of interactions was adopted.

The results of this process are condensed and shown in the table below:

*<insert Table One here>*

Data from interviews was categorised into 'folk cultural domains', which here subjected to a similar process. This part of the data analysis differed only in that the size, rather than the number of domains were used to indicate strengths of 'supporting' and 'inhibiting' interactions (the size of folk domains stemming from individual interviews were taken to represent the focus and importance the interviewee ascribed to specific facets of life in the care home, which could be 'supporting' or 'inhibiting' of person –centredness). The patterns derived from this mirrored almost exactly those seen in analytical domain analysis, in terms of being supporting or inhibiting of person-centred care (examples from the two care homes with, respectively, the largest supporting and inhibiting domains are given below).

*Rosetree Care Centre, Shetland Isles*

1 Promoting (residents') happiness

2 Maintaining a sense of continuity in life (for residents)

3 'Knowing' the person

4 Maintaining links with the community

(the largest four folk domains out of 16 shared by all the interviewees there).

*Westmont Care Home, Aberdeen*

1 Pressures on time ( as they affect care processes)

2 'Knowing' the person.

3 Dynamics that inhibit 'knowing' the person (expressed as 'a lack of time' and 'communication problems').

4 'Problems with teamwork'

(the largest four folk domains out of 18 and shared by all the interviewees there).

Using folk domain analysis, the actions, beliefs and attitudes of individual workers could be aggregated to give understandings of the dominant patterns of person-centred/culturally-effective care in specific care home environments. Of course, this also gave insights into patterns of interaction which were ineffective, or which or actively inhibited these patterns. Along with the patterns discerned from analytical domain analysis, these were viewed as broad *cultural themes* bearing on person-centredness in these setting ('culture' in this statement being taken to refer to that occurring as (or affecting) 'ways of working' in the different care homes). It was recognised that, just as individuals working and living in care homes are affected by dynamics occurring within these specific contexts, care homes themselves exist within greater sociocultural contexts suffused with pressures which shape these dynamics. This being so, understandings of individual and local contexts will only come when the broader sociocultural context is also scrutinised. Parker's (1992) poststructural discourse analysis was used to give recognition of broader socially-located reasons why particular themes in specific care homes were prominent; for example, in accepting that short-staffing contributed significantly to a dominant theme in a care home, considering *why* not enough staff were working in that home at that time.

The main discursive themes deriving from cultural domain analysis were depicted as texts to facilitate consideration, as recommended by Parker (1992). For clarity, they were depicted thus;

*<Insert Figure One here>*

*<Insert Figure Two here>*

Following this, using Parker's approach, these themes were linked to the wider sociocultural discourses influencing the themes/texts portrayed in the above figures (these discourse diagrams could, if desired, be expanded upwards to encompass other influencing discourses originating outwith the care homes, all of which would ultimately bear upon good or bad culturally-effective, person –centred care). The outcomes of the research process as a whole are laid out below.

**Outcomes; analytical cultural domain analysis**

*Community, mutuality and identity*

Broadly, as evidenced in by the observational 'analytical cultural domain analysis', significantly better culturally effective/person-centred took place in the care homes in Shetland. In that very remote/rural setting, the local authority (which owned and ran all participating homes there) had followed a policy of constructing the units in local areas, and residents often came from these 'parent' districts. This had a number of benefits. Residents were still living in the communities in which they had spent much, if not all of their lives. In two of the three homes there, well-considered built design allowed residents to observe ongoing local crofting and maritime activity

(cultural staples for most of them). The care teams were mostly local people too, and had generally known the person before they had developed dementia (indeed, centuries-long inhabiting of the same community meant workers often had some form of material kinship with residents, be that by blood or by marriage). This meant that previously-mentioned potential difficulties stemming from the employment of workers of non- UK origins (Froggatt et al 2009) did not occur nearly as frequently as observed in the three care homes on the mainland. Also, these bonds of mutuality, based on shared personal and cultural understandings, and reinforced by the location of the care environment, meant that 'community' and 'place' played a huge part in reinforcing selfhood/personhood for residents with dementia (the term 'mutuality' was used by Kellaher (2000) to describe residents in care homes who shared a specific sociocultural template through which they viewed the world, based on religious belief. She pondered whether 'mutuality', and the benefits associated with that, could exist when religious affinity is not present). It was possible to conclude that, for the people in the districts where the care homes were located, affinity was found in the fact that individual identity was often inextricable from community identity (this assertion can be backed up by the conclusions of anthropologist Anthony Cohen (2007))**.** The fact that most care workers there shared cultural values and norms with the bulk of the residents was evidently of great value, although several instances were observed of much younger care workers who clearly found it difficult to tune in to the 'ways of seeing the world' displayed by residents (these care workers were of the same ethnic stock as residents, and often blood relatives). In workers, this was generally accompanied by a lack of ability to speak the local dialect, and was often compounded by loss of the ability to speak standard English among residents because of encroaching dementia.

*Ways of working, resources and intergenerational issues.*

'Ways of working' were also often strongly influenced by events in the community. For example, if a wedding took place in one local area it was customary for food from the meal to be sent to the home for residents to enjoy, so that they could 'take part'. 'Newsing' was a major activity, in which different local people would just drop in to the homes and relay community happenings, which very frequently developed into major discussions involving the visitors, residents and staff. It was very rare indeed to see workers approaching residents with dementia, and not interacting with them as they would a cognitively- intact person (even when residents were completely non-communicative). It was clear that their perception of 'who the resident was', was often deep, historical and based on shared community-mediated knowledge and identity. On more than one occasion staff said, while dementia 'certainly changed folk, they're still just who they've always been'.

Of course, this was helped in no small measure by the fact that this local authority is comparatively wealthy. The homes are well-staffed, certainly in comparison to the participating homes on the Scottish mainland. Without a doubt, good staff to resident ratios allowed all of the aforementioned patterns to exist and to flourish.

In all three homes on the Scottish mainland, the amount of time a care worker could spend with a resident was always more sparse. This affected the nature of care. 'Ways of working' in these homes were overwhelmingly dominated by a focus on just getting through daily tasks (and this was observed to be something of an ongoing challenge). While 'in-built' mutuality was generally absent because these homes were situated in urban contexts with greater catchment areas (and

many of the workers were from very different formative cultural backgrounds from residents, often of recent immigrant status), workers simply did not have the time to learn much about the people they were looking after. Also, it is probably unfair to criticise the physical location of these urban homes in comparison to those in Shetland, although other issues arose related to built environment which were seen to impact on the staff's opportunities to interact meaningfully with residents. The urban homes were much bigger, and two of them were designed to have large communal living/eating areas where the bulk of residents congregated. These comparatively large groups of people with dementia in 'warehouse' communal areas, with very few staff among them, were the locus of significant verbal and physical conflict between residents; much more than was seen in the smaller, more heavily staffed Shetland homes. Staff had to spend a significant part of their time addressing this, rather than being able to put that scarce resource to better use.

Similar intergenerational cultural differences were observed to those seen in the Shetland homes, with younger care workers sometimes struggling with the dialect of their ethnically-identical elders (this was most pronounced in the Aberdeen homes). The interview-based 'folk domain analysis' broadly mirrored these outcomes.

**Outcomes; folk domain analysis**

*Community, identity and 'person –centred care'.*

During interview, care staff in Shetland were more likely to speak at length (indeed, to focus) on the importance of strong mutual connections to the surrounding community and how that assisted them immeasurably in 'kennin' (knowing) residents, as a prerequisite for good care

processes. ‘Dir wir ain’ (‘they are our own people’) featured several times as a statement in interviews. Negative pressures on care processes were rarely described by workers, and were never the main focus of their answers. Interestingly, if asked specifically about ‘person-centred’ care, they tended to elaborate a truncated ‘textbook’ appreciation of ‘individualising’ care, rarely linking this to their actual practice or to what constituted ‘good’ care in their particular place of work. It could be inferred that, although their interactions with residents were very reflective of many tenets of theoretical person-centred care, they thought that ‘official’ person – centred care was simply ‘care of the individual’ (Brooker (2007) affirms that this is often the case in the minds of practitioners, managers and policymakers). These workers appeared to perceive person-centred care as something of an externally-originating ‘party line’, which they *should* know about, and were *meant* to subscribe to (while in their own words rarely linking person-centred care to what they described as most necessary for ‘good’ care, which, paradoxically *did* often coincide with the theory of person-centred care). It is interesting to speculate that, even if Kitwood had never penned his seminal body of work, care processes in these locations would probably have been person-centred anyway. Brooker (2007 p.12) argues that, in many settings, care is person-centred in name only (she considers that a major ‘challenge for this century’ is how to get person-centred theory into everyday practice). In these Shetland care homes, the opposite was broadly true; many aspects of care were very person-centred with little apparent awareness that this was the case. Less so in the mainland homes.

Most of the care staff in the mainland homes usually divulged something of what they thought ‘person-centred’ care *should* be (again, usually focusing on care of the ‘individual’). ‘Links to the community’ or the care home’s place in the community were almost completely absent from

their responses , and the focus of their stories was very often on what *prevented* good, person-centred, or culturally-effective care occurring in their place of work. Lack of staff/lack of time, ongoing budget cuts, and communication problems being chief among these, although sentiments which could have been based on racial prejudice were also represented ('the *(specific ethnic group named)* working here are very lazy)! 'Poor team spirit' was linked to this too by interviewees in the mainland homes, and a major part of that revolved around the reported poor pay, and poor terms and conditions associated with their jobs. The worth of a good unit manager was a point shared by staff in both remote/rural and mainland settings. This paper will be concluded in a summary of the most important points stemming from the research, after a section which looks at potential limitations of the research.

*Potential Limitations*

A number of dynamics exist which may have affected the study's findings.

Firstly, the small size of the study (involving only six care homes) means that claims to broad generalisability of the conclusions have to be viewed with caution. Rather, the study should be treated as a pilot, and the conclusions as questions for further research.

Additionally, in work which is by definition deeply interpretive, conclusions have been reached using a degree of intuition. Thus, the potential for outcomes to be skewed by the influence and perceptions of the researcher will always be present (beginning with the 'Hawthorne effect' on observed behaviour, and extending to the researchers own culturally-bound worldview). Perhaps the most significant potential limitation was that residents were not interviewed. The decision was taken to go down that route when it became clear that the residents involved in observation were all very significantly cognitively impaired. Having said this, it may have been possible to

interview some of these people using sensitively-considered approaches (after considerable work in how to go about doing this had taken place), and there is a definite chance that valuable insights were lost to the study.

**Conclusions**

There are few studies which investigate the connections between cultural differences and processes of care in Scottish care homes, and few which have examined claimed person-centred approaches being enacted. These factors should be coupled to the recognition that there is a general worldwide dearth of literature on the interplay between ethnicity, culture and dementia. There is very little empirical research evidence that person-centred care takes place at all in Scottish care homes. If it can be accepted that an individual's cultural make-up is a vital component of their sense of self, that maintaining a sense of self is fundamental to person-centred care, and that selfhood may be particularly vulnerable when people with dementia go to live in care homes, the significance of this lack of knowledge looms large. If this is coupled with contentions made in this paper that existing perceptions of the nature and effects of cultural diversity (as these actually bear on Scottish health and social care populations) are weak, then further ramifications begin to appear. In short, if current discourses which structure care delivery for people with dementia in long-term care in Scotland show little acknowledgement of the sociocultural processes which combine to make people *who they actually are*, many claims to person-centred approaches must be questionable. This statement can be set alongside the finding that 'person-centred' care in action (including the sociocultural component), varied enormously in quality between the six care homes. As described, numerous factors contributed to this, and issues stemming from cultural differences between individuals play no small part. Inter-

generational cultural differences between residents and care workers, and the impact of workers of recent immigrant origin on processes of care were chief among these. These are each worthy of further research in their own right. Of particularly significant interest, however, is the observation that 'natural' person-centred approaches are likely to be in ongoing action in Scottish communities, albeit in virtually unnoticed ways. This study suggests that 'mutuality' (and the benefits associated with that) can occur via a shared sense of 'community/place'. While a major 'challenge for this century' is how to get person-centred theory into everyday practice, this study suggests that it might be equally valid to seek and acknowledge 'natural' person-centred approaches where they occur, and draw lessons from these back into theory/practice guidelines for wider application. Thus, more focus must be given to looking for some of these answers between people, among groups, and in specific communities. In this way, 'community-centred care' might be developed with new emphasis as intrinsic to grounded, useable, and locally relevant person-centred care, in a true 'bottom –up' approach. Potentially, recognising, formalising and utilising existing 'community caring capacity' could be a much more efficient (as well as effective) way of delivering services. Furthermore, insights into the sociocultural phenomena which predispose particular affinity groups of people to better care for members with dementia, could be used in developing new approaches with utility to areas which lack this natural tendency. This study is one small, tentative step in that direction.

**Key points**

1 'Person-centred care', regardless of stated organisational philosophies and the understandings of front-line staff, is likely to occur in a very haphazard manner in different Scottish care homes.

2 The effects on such care processes of cultural differences between care workers and residents (and sometimes between care workers) is likely to be significant at times, and is currently ill-understood.

3 The effect on care processes of cultural *affinities* between care workers and residents within defined communities is very poorly acknowledged and understood. Nevertheless, this could represent a repository of insights which might be tapped to expand/enhance the 'person-centred' school, and increase the immediate applicability of person-centred care to specific communities.

**Statement of ethical approval**

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All named authors made a substantial contribution to the conception and design, the drafting of the article, its critical revision for intellectual content, and approval of the final version for publishing.

## Conflict of interests

None

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**Table One;** *frequencies of occurrence of supporting (in bold type) and inhibiting (in plain type) analytical domains per care home*

| *Rosetree Care Centre* **(Shetland)** | *Undertonbank Care Centre* **(Shetland)** | *Bonnyview Care Centre* **(Shetland)** | *Balmeddich Care Home* **(Glasgow)** | *Michaelpark Care Home* **(Aberdeen)** | *Westmont Care Home* **(Aberdeen)** |
|---|---|---|---|---|---|
| **615** | **252** | **188** | **179** | **84** | **482** |
| 5 | 18 | 55 | 796 | 386 | 520 |

**Figure One:** *Discourses derived from themes emerging from analytical domain analysis*

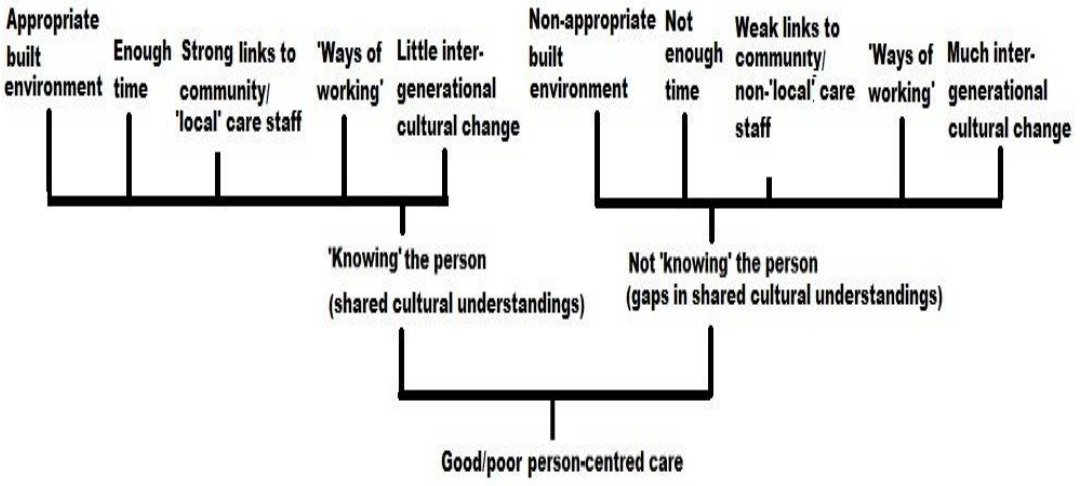

***Figure Two:*** *Discourses derived from themes emerging from folk domain analysis*