DESIGN4 HEALTH

Extract of the Proceedings of the 5th International Conference on Design4Health Sheffield 4th – 6th September 2018

Editors: Kirsty Christer, Claire Craig & Dan Wolstenholme

ISBN: 978-1-84387-421-8

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Funded and supported by NHS National Institute for Health Research

566. A Pictorial Interviewing Method Designed to Effectively Include the Voice of Residents of Care Homes for Older Adults.

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ABSTRACT We report on an ethnographic research method devised to examine the impact of the built environment of care homes on the health and wellbeing of their residents. Care home residents represent some of the most vulnerable people in our communities yet are key stakeholders in the life of residential care homes. We were therefore keen to capture their voices.

There are recognised problems associated with interviewing older adults and other vulnerable groups (Willcocks 1984). Thus, the views and experiences of care home residents remain under-represented in comparison to the voices of experts such as practitioners, academics and care deliverers (Burstow 2014; O'Dwyer 2013). Their choice-making strategies may be influenced by others (family, service providers) or affected by time and changing circumstances (Hillcoat-Nallétamby 2017). The tendency by care facilities to address management information needs in the guise of resident involvement has also been reported (Baur 2013).

This essay describes the visual method we used to engage residents in conversation. The method is flexible, a potential co-production method and transferable to different study topics. It was also designed for participants with low levels of cognitive decline. The ability of residents to not only participate but also offer solutions to problems they identify, was evidenced in the findings.

The negative impact of lengthy and academic consenting procedures on the inclusion of vulnerable populations in research, is also briefly described.

Keywords: Wellbeing, Interviewing, Ageing, Vulnerable Groups, Inclusion, Care Homes.

The Research Challenge

Our research approach was developed following regular relationship-building visits to six care homes over two years, getting acquainted with all stakeholders including management, staff and visitors. Becoming known to, and familiar with, the local environment and culture we noted the importance of activities to break up routine, creating other activities ourselves (Nevay and Lim 2015).

Our objective was to develop an accessible method to conduct supported conversations focusing on residents' knowledge and experience. We adapted a 1980s research method whereby residents were given cards illustrated with line drawings and text labels, similar to government information leaflets of the period. Each image represented a built environment element and they were used with cognitively able older adults (Willcocks 1984). However current care home residents are generally much older than in 1984, often 'in care' through circumstance, not choice, following a crisis, either health related or through the loss of a spouse or carer.

A pictorial approach to engage with individuals was devised. The intention was to emulate an inclusive 'game' interaction and neutralise the effect of an interview-like situation. The topics for the images (Figure 1) were based on care home observations, interviews with visitors and previous literature. The method was designed to encompass responses ranging from limited, to full engagement. This was to respect the sensibilities of people with low levels of cognitive decline and avoid participants' feeling failure, especially since ability could not be predicted until they participated. Our second pilot confirmed that we could use the 'game' without using the results (if necessary), and not undermine any participant.

Figure 1. Card Images used to stimulate discussions with residents

Following feedback from visitors to care homes we had produced a visual map of *'a journey through a mythical care home'* (Figure 2) resulting in the 'journey' framework which informed the narrative we employed giving structure, context and meaning to the cards as we used them with residents.

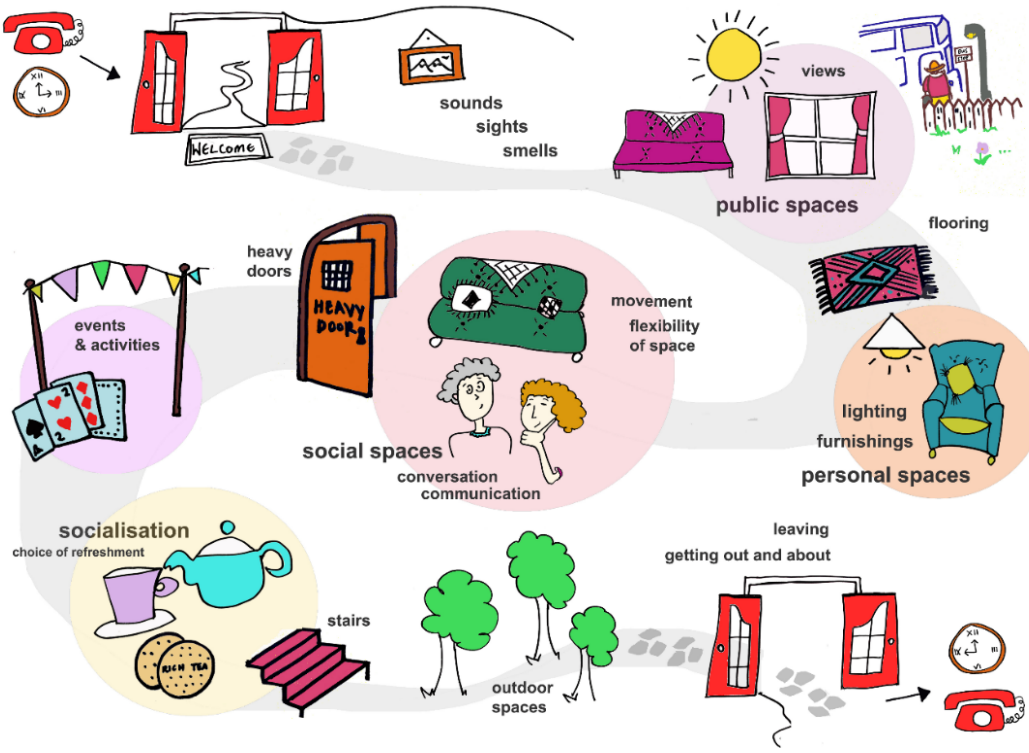

Figure 2. *'A journey through a mythical care home'*

Ethical Constraints

From previous work with older adults we perceived a further constraint to full engagement was an overly academic and long ethical consenting process (Dee and Hanson 2016). Initial adjustments to standard university processes received ethical approval but our first pilot participants still found the process too inaccessible. Normalising language use, and 'lightening' academic processes, without threatening research ethics, was important to create a 'level playing field' for these participants. In our second approved version the consent form was reduced to six verbally accessible bullet points which participants responded to with ease. We included images from the test stimuli on A5 information cards (Figure 3) with a photograph of the lead researcher and contact details. Designed to be large enough to be noticed and easy to read, they were widely available to changing shifts of staff, visitors and family members so all stakeholders were informed. Trust was maintained within the care home and the researcher easy to contact. It also proved useful as a prompt for conversations between participants and these other stakeholders. This approach proved successful in the second pilot study (including two residents with cognitive impairment) and with final study participants.

Figure 3. Information Cards for Residents' Ethical Consenting.

Ethical consenting procedures and the research method were tested and validated by an experienced care home activities organiser and approved by care home managers.

Method

Our use of images was based on the need to encourage conversation but also reduce the potential of social desirability bias. Previous work draws attention to ways that institutionalised people in particular want to please their interviewer, search for the right answer and are, understandably, reluctant to criticise the service they depend on for their everyday care (Peace 2002).

The use of objective images, bearing little resemblance to reality, was designed to allow negative feedback and counter the reluctance of a generation unwilling to complain (Pearson et al 1993). A symbol is neutral and simpler to comprehend, whereas photographs can be interpreted in an absolute way and lead to over thinking or fixation on a single aspect of an image, such as style or décor. Alternative communication practitioners report symbols as effective shorthand for those with cognitive conditions affecting communication or memory (Murphy 2015).

Thus, 39 A5 study cards displayed deliberately bright graphic images without text labels. The A5 cards were arranged into 13 topics to illustrate both the built environment (9 topics) and care home lifestyles (4 topics). The latter were included to encourage discussion around daily life which the built environment could impact upon. Each conversation was audio-recorded.

Sixteen residents across six care homes participated. Care home managers identified potential participants who met with researchers to check willingness to participate. Daily care home patterns were respected, interruptions expected and tea breaks or informal chatting were supported. All sessions took place in the care home at a time best suited to the resident and in an area identified by staff but influenced by the study needs; usually in a quiet space and always with a table to lay out the cards.

The cards were tested in pilot studies to ensure accessibility for people with low vision, hand tremors or wheelchair users. The A5 size addressed visual limitations and participants were happy using them on a table. The card sets acted as a prop to maintain the flow of conversation and the 'journey' provided a common framework and sequence.

One set of cards was shown at a time, each image described, and any questions addressed. Descriptions were literal -e.g., *'this is an outside bench next to a tree'*. Each image triggered a conversation and all responses were valid.. A window image for example provoked comments on indoor heating levels as well as light levels and views of the outside world.

After discussing each set participants were asked to place the cards in one of three boxes: '*important', 'not important' or 'don't like'*. This was a staged device to mark the intervals between sets, signalling the start of the next set of images and creating a participatory feeling. Box choices were not analysed, findings lay in detailed analysis of the recorded conversations in conjunction with the reaction maps.

Reaction maps were prepared forms on which participants' body language, facial expressions and strength of feeling were captured by a second researcher. Extreme enthusiasm or lacklustre responses were recorded, or participants pointing at examples,

when terminology failed, was captured. Only overt non-verbal responses were recorded. A Likert-type scale recorded strength of feeling, gauging positive and negative responses to 10 topic sets and 39 images. The scale also noted disinterest or doubtful responses as being 'on the fence'. Following this live coding the two researchers immediately debriefed, sharing their collective experience to check each reaction map.

Conclusions

Two researchers were important for the smooth operation of the game, observing residents' feedback and welfare, and good practice working with vulnerable participants.

The artefact 'trappings' (Figure 5), roused curiosity from other stakeholders making participation attractive and providing substance for later in-home discussions. Discovering that the re-designed Information Cards (Figure 3) became prompts for interactions between all stakeholders was a bonus.

The visual method proved effective in engaging in conversation. An established sequence enabled efficiency, held the correct discussion point, but allowed diversions. Exploiting face to face time was important as elders can tire but sociability was an important aspect of this activity. 'Talking while doing' is noted as therapeutic permitting diverse conversation whilst appearing to be active (Milligan et al. 2013, 12).

Participating then choosing a box replicated a game construct and recreated activity familiar in care homes. Residents found choice difficult and were torn between individual versus communal importance, with the latter tending to over-ride personal feelings.

Some images worked better than we imagined, e.g., 'seating' provoked a wealth of detail, while 'furniture layout' stimulated conversations about wider personal issues regarding the impact of communal living on socialising, privacy, choice and conflict.

The first set was deliberately small (Figure 1, Images 1 and 2) to ease participants into the method but proved unintentionally controversial, provoking early debate. The blue chair was criticised as lacking care home function, setting the scene for sharing personal expertise.

The rich detail from these single sessions suggest we tapped the surface of knowledge, elders in care homes, if enabled, could contribute to research and their communities.

The visual method required significant resources and time to develop, test and deliver in order to ensure a relaxed participatory experience.

Figure 5: Box Options

Acknowledgements

RCUK Lifelong Health and Well-Being Programme EP/K037293/1 - BESiDE: Built Environment for Social Inclusion in the Digital Economy.

Google Research Award 'Identifying and presenting trust-related features in health-directed search results for older users.'

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