Building a system-wide approach to community relationships with the findings of a scoping review in health and social care

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Abstract

Purpose – For leadership and management of Western health systems, good quality relationships are a fundamental cornerstone of organising health and social care (H&SC) delivery, delivering benefits across organisations and communities. The purpose of this paper is to explore the extant management, H&SC literature, grounded in older people care, reveal behaviours, processes and practices that if readily identified across a context will support healthy relationships across the "whole system" of stakeholders.

Design/methodology/approach – An academic/practitioner group designed and guided a scoping literature review of the H&SC and broader management literature to identify and extract important behaviours, processes and practices underlying the support of high-quality relationships. A search strategy was agreed and key health and management databases were interrogated and 51 papers selected for inclusion. Working with the practitioners, the selected papers were coded and then organised into emergent themes.

Findings – The paper outlines the relational behaviours, processes and practice elements that should be present within an older peoples care community, to support a healthy relational environment. These elements are presented under the five emergent literature themes of integrity, compassion, respect, fairness and trust. These five topics are examined in detail. A way forward for building statements using the review material, that may be applied to reveal relational patterns within older people care, is also explored and outlined.

Research limitations/implications – All literature reviews are subject to practical decisions around time, budget, scope and depth restraints. Therefore potentially relevant papers may have been missed in the review process. The scoping review process adapted here does not seek to make any major considerations with regards to the weighting of evidence behind the primary research.

Originality/value – This paper contributes to a growing need for designers of health systems to more fully understand, measure and draw on the value of relationships to help bridge the gap between diminishing resources and the expanding demand on H&SC services.

Keywords Relationships, Literature, Health and social care, Action-research, Western health systems, Older people care

Paper type Research paper

Introduction

Background

In Western economies there is a growing need for designers of health systems to bridge the gap between the expanding demand on health and social care (H&SC) services and diminishing resources (NHS, 2014). One aspect of the response to this challenge is the need to harness the system-wide potential of relationships across H&SC (Handley *et al.*, 2015). The World Health Organisation (2003) outlines the potential positive impact and determinants of social relationships on the health and well-being of communities. However, simultaneously within H&SC, UK reports have highlighted that the behaviours and values required to build and support healthy relationships within the system, such as

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compassion, are becoming more difficult to sustain, and their absence occasionally results in catastrophic failures (Cavendish, 2013; Francis, 2013). There is a large and wide ranging potential impact across the health "whole-system" comprising of employees, patients and wider communities for creating a more humanistic environment, grounded in relations that are underpinned by values such as respect (Gittell and Douglass, 2012), trust (Gilson, 2003), integrity and empathy (Patterson *et al.*, 2016).

The problems that cascade from poor relational environments represent a globally significant problem, as industrialised living drives more people to live in social isolation, so the number and quality of social contacts diminishes (Mcpherson *et al.*, 2006). The reduction of loneliness, particularly in older people, is now a recognised H&SC policy goal in the development of urban centres (World Health Organisation, 2007). Growing awareness and evidence indicates that relational factors play an important role in health & well-being outcomes across all demographics and influences illness prevention, deterioration, recovery and adjustment (Umberson and Montez, 2010).

For people over 65 years of age, social relationships represent a vital component of quality of life (Gabriel and Bowling, 2004) and social support is a major determinant of successful ageing (Rowe and Kahn, 1998). Increased support is expressed through frequency of contact with others, received help and/or levels of perceived help (Barrera, 1986). Improvements in health can be felt through this support which provides access to resources both psychological and material, and via social integration by nature of participation in a wide range of different relationships (Cohen, 2004). Holt-Lundstad's *et al.* (2010) meta-analysis across 148 studies (310,000 participants) examined the influence of social relationships on the risks of mortality and concluded that the absence of adequate social relationships has a negative impact on health outcomes for individuals at a similar scale as smoking cessation. The mere presence of others and a sense of relatedness appears to promote beneficial health effects (House *et al.*, 1988).

In a system view, the impact of relations at different levels will cascade throughout the health system. An example of this can be seen in the trend of decreasing trust in public institutions (Newman, 1998) and specifically in H&SC organisations (Mechanic, 1998). Such decreasing trust in institutions can directly affect personal well-being through influencing health seeking behaviours (Murayama *et al.*, 2012).

Across H&SC systems the continuing trend towards integration of healthcare providers is leading to the development of collaborative environments. These environments require high performing relationships between health and government agencies at the level of national, regional and local inter- and intra-agency (Hayes *et al.*, 2012) and increased inter-professional working to develop shared care models to reduce the H&SC service burden (Trivedi *et al.*, 2013). At the group and professional level, both the need to streamline and improve effectiveness of H&SC and the emergence of increasing complex health problems are creating a need for focus on extending inter-disciplinary working and integrated care to provide improved care coordination (Shaw *et al.*, 2011). There is also a growing emphasis on the changing structure of delivery, which includes more widely dispersed teams and shifting role responsibilities (Connell and Mannion, 2006, p. 429).

Relation between patients and providers is central in delivery and is the most researched context in H&SC (Calnan and Rowe, 2006). Improved relationships are connected to beneficial therapeutic effects for the patient (Mechanic, 1998), better GP-patient interactions (Safran *et al.*, 1998) and improved patient satisfaction (Thom and Ribisi, 1999). Continuity of care is important here (e.g. seeing the same GP over time, where appropriate) as it provides the potential for improvement of relationships and patient satisfaction outcomes (Freeman and Hughes, 2010).

Frameworks and tools

The frameworks and tools that currently exist to map the role of relationships in health systems often remain trapped in the biomedical and safety models which rely on "dead end" economic rationalist logic (Wiseman, 1998) and provide a partial understanding of human behaviour (Gilson, 2003). The dominating view of humans as autonomous, independent beings within western countries often leads to emulating rational industrialised production models in attempts to improve H&SC delivery (Aiken *et al.*, 2001). The growing pressures for time shortening and routinisation in H&SC delivery has created a shift from a system of relationships to one of encounters (Parker, 2002). In particular, there is a lack of consideration of the role that underlying attributes of relationships such as trust and justice can have in providing the basis for future cooperation, organisational performance and system-level legitimacy (Gilson, 2003). This is exacerbated by the situation that measuring values remains largely in the domain of individual competence, for example, in values-based recruitment (Health Education England, 2016) and situational judgment tests (Patterson *et al.*, 2016), rather than as they play out within the H&SC system across stakeholders.

There are a number of challenges to the dominant rational bureaucracy endemic in healthcare settings (Ashcraft, 2001) including: the broadening of concepts such as autonomy to include the wider relational, social and cultural context (Rockwell, 2012) and hence a need for the opportunity and space to express emotion and feeling (Mackenzie and Stoljar, 2000). Person centred care (Innes *et al.*, 2006) has also led to a variety of tools measuring components of relationships across health contexts (De Silva, 2014). Nolan *et al.* (2006) have developed a relational framework for nursing delivery in the care of older people. However, others have gone further and suggested relationships are the foundation from which effective H&SC flows. For example, relationship-centred care (RCC) (Tresolini, 1994) and relational leadership (Holm and Severinnson, 2014).

In general, it is possible to see an opportunity to shift towards a holistic, relational perspective that focusses on thinking about the content and quality of relations across "whole systems" rather than a fragmented set of organisations, teams and providers and recipients of care. This would represent a move away from notions such as connectivity, organisational efficiency and benevolent control towards relational health and inter-dependence.

It is important that any attempt to measure relationships should be contextualised. It is apparent in many measures focussing on relationships in H&SC (e.g. between patients and doctors) that there is a tacit assumption that it is possible to "max out" on areas such as trust (for a review of measures in H&SC, see De Silva, 2014). However, it is well established that too much trust can lead to negative consequences, for example, where this prevents organisational adaptation (Gargiulo and Benassi, 1999) or where power imbalance can lead to danger for the vulnerable trusting party (Skinner *et al.*, 2014), a key consideration in H&SC (Connell and Mannion, 2006).

Based on the perspective outlined above, the work discussed below attempts to explore the important underlying concepts that could form the foundation for a relational measure for use across the "whole system" of an older people H&SC community.

Design

Methodology

Scoping review approaches to literature searches offer a number of important advantages for action-research projects by: supporting broad research questions (Levac *et al.*, 2010), providing a rapid iterative process through exploration of the papers of interest, regardless of design or philosophical position (Arksey and O'Malley, 2005)

and focussing more on breadth than paper quality (Mays *et al.*, 2001; Levac *et al.*, 2010). The focus of this work was to establish the underpinning relational behaviours, practices and processes that enable good quality relationships within an older persons housing community. This paper adapted the following process suggested by Arksey and O'Malley (2005) as a guide to the review process: identify the question, identify relevant studies, select studies, and chart and summarise the data.

Research question

RQ1. "What behaviours, practices and processes support quality relationships within a care community for older people?"

The research question was arrived at and refined through the convening of a steering panel of H&SC practitioners and academics from healthcare ($n = 5$).

Whilst accepting the myriad of different views on conceptualising and theorising about relationships, the main focus here is on examining, across perspectives, the behaviours, practices and processes that might be present and influence the quality of the relationships across the system in an older people's community. This overlaps with but is distinct from similar perspectives, for example, those focussing on social capital (Pitkin *et al.*, 2009). We have not sought ontological or epistemological purity but extracted data in the form of behaviours, practices, and processes which were then refined into emergent themes by the academic/practitioner group.

Identifying relevant studies

The initial research question is purposely broad in its stance as the aim was to understand the topic from the system perspective, e.g. across different levels of analysis (inter-personal, group and organisational) and also to highlight current methods and tools for measuring the search terms and related concepts. The review followed the example of Pittaway *et al.* (2004, p. 139) and applied the search strings with increasing degrees of complexity to the chosen bibliographic databases. A defined search strategy focussed on the following search strings:

- Health OR Social OR car*
- AND elder* OR age* OR old* OR frail* OR extra$care
- AND care OR caring* OR compassion* OR wis* OR lov* OR benevolen* OR empathy* OR forgive* OR trust* OR respect* OR autonomy OR justice OR fortitude OR self-control* OR gratitude OR engage* OR integrity OR consistent* OR loyalty OR openness OR humility OR shar* OR coordinate* OR decision OR personal OR enable* OR commonality OR parity OR contin* OR inform* OR person OR relat*
- AND Improv** OR Effectiv* OR Increas* OR Positive OR Value* OR Well $being OR conflict OR safety OR impact OR Practice OR systems OR patient centre*
- AND measure OR tool OR assess* OR instrument*

Searches were restricted to English language databases (1990-2015inc.) and conducted between October 2014 and January 2015 using; PubMed, Medline, Social Services Abstract, Computer and Information Systems Abstracts, Applied Social Sciences Index and Abstracts (ASSIA), ABI Inform, Science Direct, Psych Info, Web of Science and Cochrane Database of Systematic Reviews. In addition, we also searched the reference

lists from returned papers and Google and Google scholar for additional material including grey reports. We ran a review of the search in November 2015 to take account of further papers published since project inception.

Selecting studies

A sample of returns were downloaded into Endnote and shared between the academic team to look for agreement on the usefulness of the papers in addressing the research question. The initial titles and abstracts of the returned 1,627 papers were read. To make the charting and management of the data manageable a sub-set of papers were selected and explored for potential organising themes by the academic/practitioner grouping ($n = 5$). The filtering process provided 51 representative papers. The papers were categorised into five sub groups; empirical papers (providing evidence of original research), review papers (substantial review of relevant topic), significant grey literature (relevant policy reports or related evidence, e.g. tools and assessments), methods for measuring the key concepts in relevant context) and commentary articles.

Charting and summarising the data

A thematic analysis of the 51 papers was conducted and the relational themes of integrity, compassion, respect, fairness and trust emerged as first-order categories. The behaviours, processes and practices associated with these themes are explored below with a refined summary of key points are shown in Table I.

Integrity

From an organisational systems perspective, integrity is often considered within leadership behaviours and the provision of consistency that leads to peer and/or subordinate modelling. This includes transparency in the decision-making process. A leader's integrity behaviour increases the likelihood of employee adherence to key organisational values through behaviour modelling (Grojean *et al.*, 2004). Leadership's ability to act with integrity (as measured on a scale of behavioural integrity) is linked in some circumstances to increased profitability (Simons and McLean-Parks, 2000) and influencing the moral intentions of the leader's "followers" (Peterson, 2004).

From a health leadership perspective, integrity has been conceptualised into four overlapping categories; wholeness, authenticity, words/action consistency and presence in adversity or extremis Palanski and Yammarino (2007). Wholeness refers to the literal meaning derived from "integer" which relates closely to a need for overall consistency in behaviour, with a particular emphasis on the constancy of words and deeds and other social behaviour. At the organisational level, this feeds into developing and rewarding a learning culture and for staff conduct in responding to problems and truth telling (Frith-Cozens, 2004). Organisational integrity can also be maintained by availability and drawing upon a wide mix of staff skills and experience (Nancarrow *et al.*, 2013). From the perspective of caring for older people there is a focus on behaviours that support the ability to recognise wisdom and to look at people as complete and worthy humans. (Erikson *et al.*, 1986). An important component of integrity is the notion of continuity and awareness of action and visions that needs to be in place in order to develop coherence to help establish trust-building behaviours. Teeri (2007, 2008) conceptualises three types of integrity: physical integrity (body inviolability, personal space and responding to needs), social integrity (family, culture, respect for lived life and knowledge of social life in and out of the institution, be alone and have others around), and psychological integrity (experiences, values, opinions,

Table I.
Key behaviours, practices and processes underpinning each identified relational theme with example statements and supporting papers

Relational theme	Visible behaviours	Visible practices	Organisational processes	Example statements	Key papers influencing themes and statement
Integrity	Consistency Authenticity Individual control of the social environment Transparency	Seeing the same faces Words matching deeds Truth telling	Leadership modelling in inn extremis Continuity of relations Learning routines Skills mixing Design and technology promoting movement and control	There are lots of questions and discussions about how to improve things	Dewar and Nolan (2013), Gittell and Douglass (2012) and Nancarrow *et al.* (2013)
Compassion	Noticing suffering and acting collectively Recognising the whole person	Giving and taking Time taking and listening Clarity in communication	Authentic teamwork Conflict resolution routines Future orientation talk Managing relational transitions	People have the time to talk and listen and share stories	Randers *et al.* (2003), Woolhead *et al.* (2006), Teeri *et al.* (2008) and Hupcey *et al.* (2001)
Respect	Mutuality Everyday courtesy self-enacting social exchange	Thoughtful communicating Opportunities to express unique skills	Personal space devolvement Minimising communication repetition	Everyone has the opportunity to contribute their skills and knowledge	Antonucci *et al.* (1990), Payne *et al.* (2002), Brown *et al.* (2003), Frith-Cozens (2004), Cheng (2009) and Wolff and Agree (2004)
Fairness	Citizenship acting (for the common good) Treating people equally	Employee commitment Dealing with difficult questions "elephants in the room"	Inclusive decision making Recognising disparities of outcome	People are involved in all decisions that affect them	Colquitt *et al.* (2001), Knight *et al.* (2010), Cheng (2009), Welford *et al.* (2011)
Trust	Task competency Managed risk taking Reciprocating	Openness Power asymmetries recognised Others best interests in mind	Team/community cohesion Recognising/ accounting for shared histories`	People will sometimes take risks to help each other	Dewar and Nolan (2013) and Morgan (2013)

beliefs, influence over daily life, listening, respect for dignity and respect for values and customs). The associated behaviours relate to truth telling, following through and doing the things that you are committed to doing. Another aspect of relational integrity is the need to manage personal interaction, i.e., having places to go to be alone and to be with others, and having the ability to manage this social flow. Randers *et al.* (2003) expanded social integrity to envelop social exchange theories that require individuals to be able to initiate shared activities, exchange confidences and have affinity with others. Randers *et al.* (2003) also considers the need for social experiences, socializing activities, reminiscing with others, recognition of personal knowledge and access to the outside world, e.g., through newspapers or TV.

Compassion

The definition of compassion relies on both a sympathetic disposition to another's difficult situation and also some form of action towards its alleviation. Effectively a compassionate act requires noticing, a generation of some form of emotion and then some form of legitimate action (Volkmann-Simpson *et al.*, 2014, p. 486). Action, in an organisational setting, should ideally be a collective response (Dutton *et al.*, 2006). Compassion is now recognised as a component of leadership (Holt and Marquez, 2012) related to: increases in employee satisfaction and organisational commitment (Dutton and Heaphy, 2003) and to leadership during crisis (Ciulla, 2010). Compassion enables faster activation and mobilisation of resources in a crisis situation and influences creativity and innovation by fostering good will (Natale and Sora, 2010), which aids the suspension of judgement and aiding the comprehension of difference (Pavlovich and Krahnke, 2012). Compassion as a cultural component of companionate love in long-term care organisations is shown to have a positive influence on teamwork and is negatively related to absenteeism and emotional exhaustion (Barsade and O'Neill, 2014). Dewar and Nolan (2013) have attempted to define compassion in the nursing context by building a more relational perspective that focusses on placing compassion within a relational frame (six senses framework). From a systems perspective this means having a culture where everyone works together to get things done and that there is a known process for resolving issues and conflicts when fallouts happen across the community. This also translates to an acceptance amongst all groups that there is a need for give and take to resolve issues and to prevent people suffering unnecessarily (Dewar and Nolan, 2013). A compassionate environment would also witness continued discussion, amongst all members and the need to share stories and listen (Hupcey *et al.*, 2001; Randers *et al.*, 2003; Woolhead *et al.*, 2006; Teeri *et al.*, 2008). Stories are particularly important in the organisational context as these provide a motive for compassionate acts, a large degree of learning amongst staff and promoting the culture in a positive or negative light (Dutton *et al.*, 2006, p. 80). Empathy is a discrete concept, at the core of therapeutic encounters, considered here under the umbrella of compassion. Empathy is expressed frequently as appearing via the treatment of the individual as a whole person, clarity of communication (Payne *et al.*, 2002) and helping with future orientation (Mercer *et al.*, 2004). Reference to the whole person relates to the consideration of individuals as people rather than a bed number or "condition" (Mercer *et al.*, 2004). In the care of older people, a key part of compassionate relating is the need to get pleasure from relationships within the community, which can also be expressed as celebratory elements within the context of the relationships (Dewar and Nolan, 2013). There is a particularly vulnerable point when people are making the transition into a new social system and this needs to be which requires careful management, with people

made aware of systems and "how things get done around here" in a timely and thoughtful way (Lee *et al.*, 2002; Six and Sorge, 2008). In the context of caring for older people, compassion is also often expressed over time as providing ways to ensure people feel "at home". For example, engaging people as groups in helping to take control of their own physical environment (Knight *et al.*, 2010).

Respect

Respect is based on a Kantian notion that people should be regarded as ends in themselves and, that individuals have inalienable value (Woolhead *et al.*, 2006) and are not merely means (Jacobson, 2007). Respect and dignity have considerable overlap conceptually and are largely depicted as symbiotic (Jacobs, 2001). A lack of respect for health practitioners can feed into a poorer relationship with the health institution and is correlated with reduced health outcomes. (Blanchard and Lurie, 2004). Respect is considered an important component of high quality, purposeful connections between individuals and groups within organisations (Gittell and Douglass, 2012). Respect creates a positivity that can be utilised to improve employee relations and ultimately organisational performance. The point at which respect becomes more powerful in the relationship is when it becomes mutual (Gittell and Douglass, 2012). Gittell and Douglass (2012) suggest that mutual respect, within sympathetic contexts, will generate a level of attentiveness towards each other, which may be otherwise absent. In the older persons care context, respect can be expressed through consideration and self-management of personal space, upholding physical integrity, privacy (Teeri *et al.*, 2007), confidentiality in communication (Mechanic and Meyer, 2000; Widang and Frilund, 2003) and acting in ways that prevent embarrassment or shame or convey courteousness or politeness (Van der Geest, 2002, p. 25). In H&SC contexts, this can come under pressure due to the need to provide care in resource and time-poor environments where the focus is on the processing of individuals or the undertaking of discrete tasks (Calnan *et al.*, 2013). It is important that respect be considered towards the social self and in enabling others to contribute to social exchanges (Randers *et al.*, 2003).

Relationally, respect can be expressed in very small acts of consideration and taking care of the little things (Teeri *et al.*, 2007/2008), through the expression of "walking the talk" (Jacelon, 2003) and considering forms of address, e.g., Mrs X or "dear" (Woolhead *et al.*, 2006). From a caring perspective, the consideration of mutual respectful communicating is central, ensuring clarity of information through checking and minimising the need to repeat important information (Teeri *et al.*, 2007). Respect is conveyed relationally by upholding status based on achievement or merit (Nordenfelt, 2003) and a positive consideration of age in its association with increased knowledge (Van der Geest, 2002).

Fairness

Fairness within organisational life revolves around a small number of inter-related descriptions of justice. The main descriptors of fairness are: distributive, procedural and interactional (or inter-personal) (Cohen-Charash and Spector, 2001) and informational (Colquitt *et al.*, 2001). Procedural fairness is the process through which decisions of distribution are arrived at (Lind and Tyler, 1988), with the insight that in work situations it is not solely the perception of outcomes that people draw upon to make judgements around fairness. Procedural fairness is relevant to wider public perceptions of fairness. Interactional or inter-personal justice refers to two key points: first, the extent to which people receive appropriate levels of consideration within the

decision-making process, meaning appropriate inter-personal engagement is enacted, and second, considerations of clarity of communication around the decision-making process. General influence of justice at the organisational level includes: increasing general job satisfaction, management job satisfaction and evaluation of supervisors (Cohen-Charash and Spector, 2001), increasing emotional attachment and investment to the organisation (Allen and Meyer, 1990), reducing employee intentions to leave the organisation (Cohen-Charash and Spector, 2001; Dirks and Ferrin, 2001) and increasing the likelihood of "citizenship" behaviours (Organ and Moorman, 1993). Procedural fairness has been found to be particularly important when dealing with the fall out of large scale lay-offs and maintaining employee commitment and consequently performance (Van Dierendonck and Jacobs, 2012).

Fairness is linked strongly to principles of human rights. The perspectives are largely grounded in distributive fairness and considered as differences in health that are unnecessary, avoidable, unfair and unjust (Whitehead, 1992). This relates most readily to systemic disparities in health outcomes and/or access, the mechanism for the disparity being membership of a disadvantaged group, which is often based upon: socio-economics, ethnicity, gender, religion, geography, age, sexual orientation and relative power (Braveman and Gruskin, 2003). This link with disparity connects fairness explicitly to notions of social justice, i.e., people should not be denied rights based on perceptions of inferiority, and society has a duty to uphold conditions whereby people can be healthy (Levy and Sidel, 2005). There is a clear distinction between "equity" and "equality of outcomes" which may be unequal, e.g., the young are generally in better health than the old (Braveman and Gruskin, 2003). In the context of healthcare, it is important that the distribution of care resources is seen to be delivered with the lack of influence of financial incentives (Whitehead, 1993). In an older persons care setting, fairness connects the ability of individuals to have access to opportunities, to express and explore their social world (Cheng, 2009) and have the opportunity challenge rules and procedures; in certain health settings this might mean involving residents at the level of a group to express this fairness in a pragmatic fashion, for example, to decorate communal areas (Knight *et al.*, 2010).

Trust

Trust is a complex, multi-dimensional, multi-layered and dynamic relational concept which is viewed as necessary when an element of risk is derived from uncertainty around the future intentions, motives or actions of another upon which an individual is reliant (Mayer *et al.*, 1995). In healthcare research, the most common trust associated constructs are; communication (93 per cent), honesty including level of integrity and openness (91 per cent), confidence exemplified by reliability (91 per cent) and task competence (89 per cent) (Ozawa and Sripad, 2013). Trust scores can be significantly influenced by whether patients are taken seriously or given enough attention (Calnan and Rowe, 2006). Trust is heavily dependent upon perceptions of competency and feeling that others have one's best interests in mind Mayer *et al.* (1995). Trust is particularly salient for H&SC where there is potential for a high degree of patient vulnerability mediated by asymmetries in information and power (Calnan and Rowe, 2006; Connell and Mannion, 2006). Well-balanced trust can improve decision making by developing team cohesion whilst avoiding negative behaviours, e.g., groupthink (Lewicki *et al.*, 1998). Trust is also linked to improving knowledge sharing to provide organisational advantage (Nahapiet and Ghoshal, 1998) and maintaining effective inter-professional relations (Van Eyk and Baum, 2002). Frith-Cozens (2004) also

suggests organisational-level factors of; commitment to learning and accurate reporting, can influence trust in health settings. A decision to trust is influenced by the level of risk involved, the power balance between the parties and alternatives, and the potential or need for shared futures. In the care of older people, trust can be expressed in a number of ways. Dewar and Nolan (2013) outlined the need for challenge and potential risk taking which is a key component of developing trusting relations. This requires personal courage to take calculated, managed risks (Morgan, 2013) for the individual, whilst being cognizant of and balancing wider health and regulatory concerns. Trust between families and care institutions is central to good care. Families are a key source of information of residents' personal histories and should be involved where possible in decision making that affects the residents (Teeri *et al.*, 2007). Having a sense of shared background and values may also be an important factor in building trusting relations between residents (Randers *et al.*, 2003). An important consideration here is the need for social exchange that enables all people to reciprocate as far as possible in their relationships (Boerner and Reinhardt, 2003).

Conclusion

Through a review of the literature and co-production with experts in the H&SC field, this paper has looked to address the research question:

RQ1. "What behaviours, practices and processes support quality relationships within a care community for older people?"

It has identified five core themes of; compassion, trust, integrity, respect and fairness and outlined the supporting behaviours, practices and processes in a review. Future work would enable the themes and content provided here to form the development of a relational health survey comprising statements to explore the nature of relationships within an older people housing setting, across all stakeholders, e.g., residents, staff and visitors. Table I explores how the material might be used to create these statements. A more detailed development and use of a survey tool applied in a number of different older people settings, using this material, would provide the opportunity to explore whether; (a) common patterns emerge over time (b) establish if these patterns are connected to other measures such as well-being or staff/resident satisfaction instruments and (c) how the patterns of trust, respect, etc., compare between emerging forms of housing such as extra-care (Evans and Vallelly, 2007; Callaghan *et al.*, 2009) or more traditional older people care environments.

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