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Care Relationships Between Support Staff and Adults With a Learning Disability in Long-Term Social Care Residential Settings in the United Kingdom: A Systematic Literature Review

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RESEARCH

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ABSTRACT

Context: Research exploring care relationships between support staff (e.g., support workers) and adults with a learning disability in long-term social care residential settings in the United Kingdom is relatively neglected. This has potential theoretical and care practice implications.

Objectives: This study sought to synthesise relevant literature, expand knowledge, and identify directions for future research. We investigated five questions about care relationships and what makes them positive, exploring definitions of care relationships, relational practices and processes, barriers and facilitators to good care relationships, the impact of relationships, and restoration of disrupted relationships.

Methods: Following protocol registration in PROSPERO, a systematic literature review was conducted in June–July 2021. The review was informed by official guidelines and focused on the United Kingdom, covering 41 years of relevant work. Twelve databases and five websites were searched, and experts were contacted. Forty-five reports were included and synthesised using the narrative synthesis framework.

Findings: Definitions of care relationships revolved around friendship, equality, professionalism, and power. Practices and processes underlying positive relationships included knowing the person, setting boundaries, and shifting power dynamics. Barriers to positive care relationships included staff interactional patterns, attributions, and staff dilemmas, whilst facilitators included receiving training and using communication tools. Good care relationships were key to effective support and ways to restore disrupted relationships included receiving input from systemic therapy.

Limitations: Literature was limited for certain review questions and more extensive for others. Only a few reports addressed care relationships as such with the rest focusing on communication or interactions. Time constraints prevented us from including more kinds of reports. The voice of residents was limited.

Implications: We hope that this review contributes to and expands knowledge around care relationships and shapes directions for future research. Findings can be used by support staff, service managers, residents, trainers, advocates, regulators, and researchers.

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INTRODUCTION

Over one million adults in the United Kingdom (UK) have a learning disability (Mencap, no date, How common is learning disability?). Learning disabilities entail 'a reduced intellectual ability and difficulty with everyday activities – for example, household tasks, socialising or managing money – which affects someone for their whole life' (Mencap, no date, What is a learning disability?). In the UK, the term 'learning disability' is preferred to 'intellectual disability (Gates and Mafuba, 2016). Learning disabilities should not be confused with learning difficulties (e.g., dyslexia) which do not necessarily affect intellect (Mencap, no date, What is a learning disability?).

Working as support staff is very common in adult social care in the UK (e.g., 800,000 support staff roles in England; Skills for Care, 2021) with around half a million workers providing direct care to adults with a learning disability and/or autism (Skills for Care, 2018). Support staff have multiple responsibilities (Rycroft-Malone *et al*., 2014) and poorly defined roles (Manthorpe *et al*., 2010). The job titles describing this group may vary (Cavendish, 2013) with 'support worker', 'care worker', or 'personal assistant' being common. To avoid confusion, in this study, we use the umbrella term 'support staff' to include all those different job titles that essentially refer to the practitioners who are:

> providing face-to-face care and other support of a personal or confidential nature to service users in a variety of settings. However, crucially, they do not hold qualifications accredited by a professional association and are not typically formally regulated by a professional body (Saks, 2020: 1).

Social care residential services employ a large proportion of the support workforce, for example in England around 500,000 adults with a learning disability, including autistic adults, receive support in residential or domiciliary care settings (Skills for Care, 2021). Residential settings are community-based and include residential care (e.g., care homes), supported living, domiciliary care, and other arrangements. Long-term residential settings essentially describe spaces that people use for long periods and perceive as home, in contrast to short-term residential settings such as respite services. Considering the above, it becomes apparent that, across the UK, two large groups meet to provide and receive care and build potentially long-term relationships. It also appears that the primary context of this care provision and relationship building is residential spaces.

Relationships are dynamic and are situated at the core of human life (Reis, Collins and Berscheid, 2000). Positive staff-client relationships are central to person-centred practice (McCormack *et al*., 2012) and good care relationships, defined in this study as the interpersonal professional relationship between support staff and residents, are an important determinant of the quality of support provided in learning disability residential settings (Bradshaw and Goldbart, 2013; Windley and Chapman, 2010). Additionally, relationships are a key domain of the quality-of-life framework (Schalock *et al*., 2002) used widely in the UK to assess outcomes for people with a learning disability (Department of Health, 2001).

Staff constitute a significant proportion of the social networks of adults with a learning disability (Harrison *et al*., 2021) and building care relationships in residential settings is somewhat unique because care takes place in everyday life, a phenomenon that cannot be easily defined and has uncertain boundaries (Felski, 1999, as cited in Gjermestad *et al*., 2017). The material conditions of care work and relationship building are equally unique, with the UK adult social care suffering from chronic underfunding, high support staff turnover (34.4%; Skills for Care, 2021), low salaries (Skills for Care, 2019), and lack of recognition (National Association of Care and Support Workers, no date, Our Vocation).

Unlike other relationships (e.g., therapy, nursing), research exploring learning disability care relationships is a relatively neglected area (Hastings, 2010). This may have potential theoretical and care practice implications, especially when considering 1) the relevance of care relationships and their impact; 2) the vagueness of the support staff role and the size and working conditions of the support workforce; 3) the number of adults in learning disability residential settings; and 4) the uniqueness of building relationships in the realm of daily life in residential settings.

Among others, Dutch (e.g., Penninga *et al*., 2022) and Australian researchers (e.g., Johnson *et al*., 2012) have shown a particular interest in this area. Despite the undeniable importance of their work, it is perhaps worth noting that some of this research may vary in terms of scope (e.g., focus on children) or conceptually (e.g., treating professional and non-professional carer groups as one). Additionally, as this work is taking place in different social care systems (e.g., different regulations, policies, practices), findings might not always be relevant to the UK care experience.

AIM

This review sought to summarise the volume of research on learning disability care relationships focusing on the UK social care paradigm. We aimed to synthesise findings, expand knowledge, and identify directions for future research.

REVIEW QUESTIONS

1. How are (positive) care relationships between support staff and adults with a learning disability being understood and defined?

2. What processes and practices underlie them?
3. What factors serve as barriers and facilitators to good relationships?
4. What impact do positive relationships (or lack thereof) have on support staff and residents?
5. How can care relationships that have been disrupted or challenged, be restored?

METHODS

DESIGN

Systematic reviews 'seek to collate evidence that fits pre-specified eligibility criteria in order to answer a specific research question. They aim to minimize bias by using explicit, systematic methods documented in advance with a protocol' (Cumpston *et al*., 2023). Our review was informed by the Centre for Reviews and Dissemination (CRD; 2009) and the PRISMA 2020 (Page *et al*., 2021) guidelines.

SEARCH STRATEGY

The review explored questions beyond the effectiveness of interventions and included various study designs; therefore, we employed the SPIDER model (Sample, Phenomenon of Interest, Design, Evaluation, Research type; Cooke, Smith and Booth, 2012). Table 1 presents a sample of search terms and relevant techniques.

ELIGIBILITY CRITERIA

Student theses, books, and all types of reviews were excluded.[1] Literature discussing intentional communities and shared lives schemes was not eligible either. Literature that met the following criteria was included:

- English language.
- Empirical research or non-empirical reports (e.g., opinion pieces) published in academic journals, book chapters, or as grey literature.
- Focus on the UK, namely 'the country that consists of England, Scotland, Wales, and Northern Ireland' (Cambridge Dictionary, no date).
- Published between 1980–2021 (July), to reflect milestones in the UK community care policy and deinstitutionalisation.
- Literature exploring how others (e.g., family) view the staff-resident relationship was eligible.
- Literature exploring various populations and settings was eligible if relevant findings were presented separately.

PILOT REVIEW

The review was piloted in EBSCOHost resulting in a reduction of search term synonyms to make the search easier.

EXISTING OR ONGOING REVIEWS

The following databases were searched in June 2021: CRD database, Cochrane Database of Systematic Reviews, Epistemonikos, EBSCOHost, Scopus, PROSPERO, Social Care Online, and Campbell Systematic Reviews. No relevant existing or ongoing reviews were identified.

REVIEW PROTOCOL REGISTRATION

Registration number in PROSPERO (June 2021): CRD42021262379.

STUDY SELECTION

The following databases were searched in late June to mid-July 2021: Scopus (857 records), Social Care Online (2109 records), PubMed (1245 records), EBSCOHost (Abstracts in Social Gerontology; Academic Search Complete; Cinahl; Medline; APA PsycArticles; APA PsycInfo; Open Dissertations;[2] and SocINDEX, 126 records), Ethos[3] (60 records), Open grey (zero records), and Google Scholar (149 records). Records identified in preliminary searches were also included under the heading 'Other Literature' (46 records). Three commentaries to original reports and one original report to a commentary were also added.

The following websites were searched in late June to mid-July 2021: Mencap (five records), Dimensions UK (zero records), British Institute of Learning Disabilities (zero records), National Association of Care and Support Workers (zero records), and Skills for Care (four records). Experts were contacted with only one expert responding to suggest one record. The overall search yielded 4,606 records.

SCREENING AND INTER-RATER AGREEMENT

Figure 1 presents the PRISMA 2020 flow diagram (Page *et al*., 2021). The review software Rayyan© (Ouzzani *et al*., 2016) was used for screening. In Rayyan©, the labels 'include', 'exclude', and 'maybe' were used and reasons for exclusion were provided. To minimise bias and error,

CONCEPT 1: SUPPORT STAFF	*AND*	CONCEPT 2: LEARNING DISABILITY	*AND*	CONCEPT 3: CARE RELATIONSHIPS
Support AND (work* OR staff OR personnel OR assistant*) OR care AND (work* OR staff OR personnel OR assistant* OR aide* OR giver* OR taker* OR provider*)		Learning AND (disab* OR defici* OR disorder*) OR intellectual* AND (disab* OR developmental disorder* OR impairment* OR developmental disab*) OR "Down Syndrome"		Positive AND (relation* OR interaction* OR engag*) OR "therapeutic relation*" OR "professional-patient relation*" OR "interpersonal relation*" OR "rapport"

Table 1 Example of search terms, Boolean operators, and other techniques used.

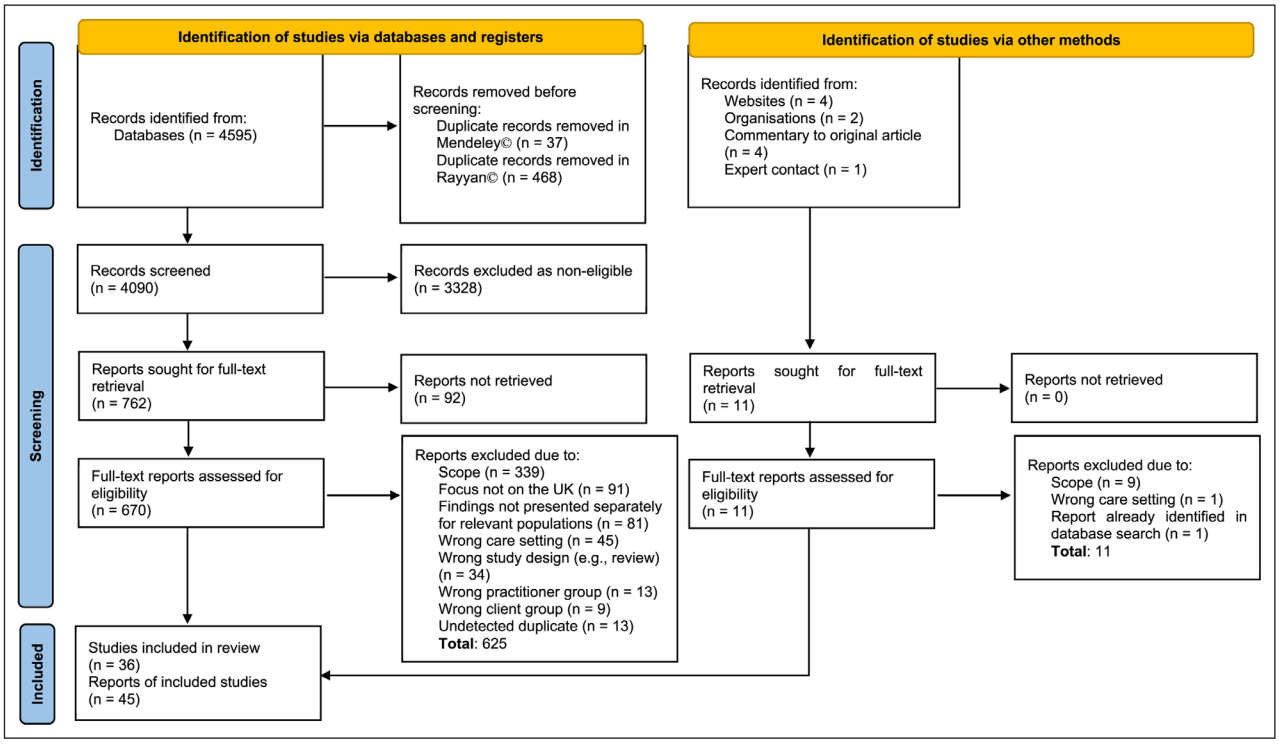

Figure 1 PRISMA 2020 flow diagram.

a second reviewer assisted at two stages for 10% of the records. Questions and clarifications were addressed in meetings. Cohen's kappa coefficient (κ; Cohen, 1960) for inter-rater agreement in the first stage was 0.81 (almost perfect agreement; Landis and Koch, 1977). There were no disagreements in the second stage. Of the initial 4,606 records, only 45 reports (i.e., 1%) were included in the review.

DATA SYNTHESIS

The narrative synthesis framework (Popay *et al*., 2006) is recommended for systematic reviews that go beyond the effectiveness of interventions, seek to answer a range of questions, and include reports with diverse designs (CRD, 2009; Popay *et al*., 2006). As our review met these criteria, this framework was employed (Figure 2). Narrative synthesis involves:

- Developing a theory
- Developing a preliminary synthesis of findings of included studies
- Exploring relationships in the data (interpretative synthesis)
- Assessing the robustness of the synthesis

RESULTS

DEVELOPING A THEORY

Building a theory beforehand to guide data synthesis or testing an existing theory can take place but is not mandatory in narrative synthesis (Popay *et al*., 2006). In this review, we chose to take an exploratory, inductive approach, rooted in the gathered data, rather than building a theory beforehand or testing an existing one. That is not to say that the review took place in a research or social vacuum. Our exposure to research exploring learning disability care relationships (e.g., Johnson *et al*., 2012) or care ethics (Rogers, 2016), our conversations with colleagues, and our own professional experience supporting people with a learning disability, are only a few examples of factors that guided the conception of this study and our review questions.

PRELIMINARY SYNTHESIS

A description of the included reports was conducted preparing the ground for further exploration (Popay *et al*., 2006).

Tabulation, grouping, and textual description

Relevant data from each report was extracted, described textually, and grouped according to research design and publication type. Tables 2 to 5 present the data.

Most research was conducted in England (62%) and published between 1998 and 2015 (80%). The total number of participants was estimated to be approximately 1,659. Staff's job titles were mostly 'support worker', 'personal assistant', or 'direct care staff', with a minority being team leaders or managers. The scale of learning disability tended to be either severe or not stated with a few reports discussing mild or moderate levels. The care home was the dominant residential setting.

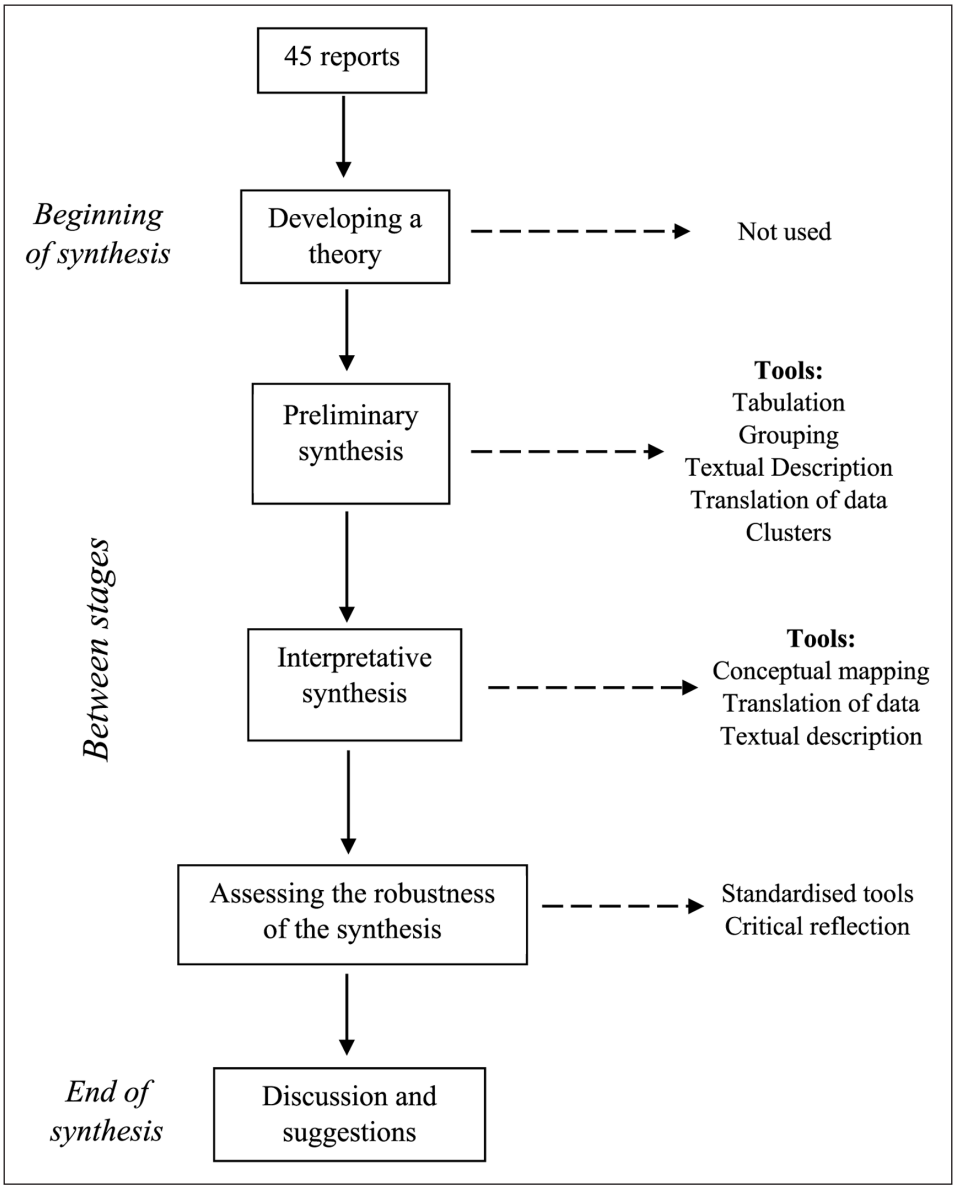

Figure 2 Narrative synthesis process and tools used.

Translation and conceptual clusters

Translation entails identifying main concepts across reports and 'seeking a common rubric for salient categories of meaning' (Popay *et al*., 2006: 20). Extracts containing information relevant to the review questions were taken from each report. We then summarised and synthesised findings and we generated main concepts. Consequently, we created five conceptual clusters reflecting our five review questions (Table 6). Each report was allocated to a conceptual cluster depending on its content. The same report could fall under different clusters.

INTERPRETATIVE SYNTHESIS

The findings for each review question (Figure 3) are discussed below.

Definitions of care relationships

Good care relationships involve mutuality and a sense of equality, with staff providing company and friendship (Norah Fry Research Centre, 2010). Being professional, setting, and respecting boundaries are key elements of positive relationships (Bowler and Nash, 2014). Power often accompanies relationships, with staff occupying a powerful position over residents (Antaki, Finlay and Walton, 2007a; Finlay, Antaki and Walton, 2008; Haydon-Laurelut and Nunkoosing, 2010; Jingree, Finlay and Antaki, 2006; Walton, Antaki and Finlay, 2020).

Processes and practices that underlie positive care relationships

Getting to know the person

Getting to know each other can lead to developing trust (Norah Fry Research Centre, 2010) and using creative (e.g., music) and life history methods can facilitate getting to know the person (Kennedy and Brewer, 2014). Shared activities and experiences (Williams, Ponting and Ford, 2009) can also help get to know each other.

REPORT (n = 15)	METHODS	CARE SETTING	LEVEL OF LEARNING DISABILITY	PARTICIPANTS AND PERSPECTIVE[4]	KEY FINDINGS
Antaki *et al*., 2017. England	Ethnography. Video footage, conversation analysis.	Residential care home.	Severe or profound.	Nine residents. Six support workers. Perspective: Interactions between staff-residents.	The limited interactional patterns of residents and the support workers' limited understanding of how to interpret such cues can result in staff responding in 'ordinary' ways and limit the quality of contact and interactions.
Antaki, Finlay and Walton, 2007a. England*	Recorded data (method not stated), conversation analysis.	Residential care home.	Not stated.	Two support workers and four residents. Perspective: Interactions between staff-residents.	Support workers' everyday subtle interactional practices can lead to ascribing disempowered identities to residents shaping care relationships accordingly.
Antaki, Finlay and Walton, 2007b. England.	Ethnography. Video footage, conversation analysis.	Residential care home.	Lower support needs, usable language skills	Four residents and four support workers. Perspective: Interactions between staff-residents.	Interactional practices to solicit talk from residents ranged from asking a direct question to teasing. Staff found themselves in a dilemma; namely, residents must be allowed to express themselves whilst staff act accordingly and manage other service demands.
Banks, 2012. England*	Ethnography. Observations, field notes, diary entries, interviews.	Residential care homes that became supported living settings.	Mild to moderate (not clearly stated).	The author reflects on their experiences as support staff. Perspective: Support worker.	Staff's various ways of interpreting social policy reforms may lead to tensions and impact negatively care relationships.
Bradshaw and Goldbart, 2013. England.	No specific qualitative approach was stated. Interviews.	Residential care homes.	Not stated.	14 members of staff. Perspective: Staff.	Support workers' personal experience of caring for residents and the process of setting boundaries were crucial to building good care relationships. Positive relationships are essential to providing effective support. Relying solely on experiential knowledge has limitations.
Firth *et al*., 2008. England.	Grounded theory. Interviews, field notes, observations.	Group homes.	Severe or profound.	29 members of staff Perspective: Staff.	Intensive interaction training can improve interactions and contribute to building positive relationships. Barriers included concerns about practising intensive interaction in public, negative staff attitudes, and domestic and care tasks re-asserting their priority over time.
Haydon-Laurelut and Nunkoosing, 2010. England.	Authors reflect on using systemic psychotherapy.	Residential care home.	Not stated.	One resident, one care home manager, one systemic psychotherapist, and one counsellor. Perspective: Resident and care home manager.	Awareness of how behaviour that challenges is discoursed by staff is key. Residents feeling listened to is crucial to building positive care relationships. Systematic psychotherapy can contribute to good care relationships.
Jingree, Finlay and Antaki, 2006. England.	Audio footage of meetings, conversation analysis.	Residential care home.	Mild to moderate.	Eight residents and five support staff. Perspective: Interactions between staff and residents.	Support staff's conversational and interactional practices can disempower residents and emphasise power imbalance.
Kennedy and Brewer, 2014. England.	Life story, creative methods, and participatory research elements.	Residential care home.	Substantial support is required. Various levels of verbal communication.	Four residents. Perspective: Residents; however, conclusions about how methods can be used are drawn by the researchers.	Effective communication is essential to understanding and getting to know residents. Communication can be enhanced through creative methods.

(Contd.)

REPORT (n = 15)	METHODS	CARE SETTING	LEVEL OF LEARNING DISABILITY	PARTICIPANTS AND PERSPECTIVE[4]	KEY FINDINGS
Nagra *et al.*, 2017. England.	Interpretative phenomenological analysis. Interviews.	Residential care homes.	Profound or severe.	Eight staff in direct care roles. Perspective: Staff.	Intensive interaction training can empower staff, change their attitudes, and lead to improved interactions and better care relationships.
Waggett, 2012. England.	Reflections on consultation sessions.	Residential care home.	Severe and challenging.	Consultation sessions with the care home manager and three team leaders. Perspective: Consultant's perspective on care home dynamics.	Staff can act out the internal worlds of residents. Through the psychological mechanism of transference, staff may transfer negative emotions to residents or colleagues impacting care relationships.
Walton, Antaki and Finlay, 2020. England.	Video footage, conversation analysis.	Residential care home.	Severe or profound.	Nine residents. Nine support workers. Perspective: Interactions between staff and residents.	Support workers recognising the affective stance of residents and responding accordingly is essential to effective interactions. The power imbalance is key.
Williams, Ponting and Ford, 2009. England.	Video footage, conversation analysis.	Home settings.	Not stated.	14 pairs of residents and their personal assistants. The focus is on two pairs. Perspective: Interactions between staff-residents.	Various factors (e.g., showing respect) underlie positive interactions and care relationships. The care relationship is complex and cannot be simply described as a set of skills.
Williams *et al.*, 2009. England.	Video footage, conversation analysis.	Home settings.	Two residents were not verbal. Others were more able to express themselves verbally. Many residents had additional physical or sensory impairments.	14 pairs of residents and their personal assistants. Perspective: Interactions between staff and residents.	Various factors (e.g., showing respect) underlie positive interactions and care relationships. The care relationship is complex and cannot be simply described as a set of skills.
Windley and Chapman, 2010. England.	Phenomenological approach, flexible design. Focus groups and interviews.	Supported accommodation.	Not stated.	Eight support workers. Perspective: Staff.	Having the right temperament and being caring and empathetic are important staff qualities. The care relationship is crucial for providing effective support.

Table 2 Qualitative studies published in academic journals.

Note. The asterisk (*) indicates that the report did not provide explicit information about the exact UK country the study took place. UK location was determined based on the first author's affiliations.

REPORT (n = 21)	METHODS	CARE SETTING	LEVEL OF LEARNING DISABILITY	PARTICIPANTS AND PERSPECTIVE[4]	KEY FINDINGS
Beadle-Brown et al., 2015. England.	Quantitative descriptive study. One point in time observational/ cross-sectional study. Questionnaires, observations, interviews.	Supported living and residential care homes.	Severe or profound.	110 residents. Perspective: Staff.	Low levels of support and poor outcomes for residents (e.g., engagement in activities, contact with staff) in residential services. Implementing active support[5] is key to predicting good quality of life, skilled support, positive interactions, and engagement in meaningful activities and relationships.
Beadle-Brown, Hutchinson and Whelton, 2012. England.	Quantitative nonrandomised study. Pre–post-intervention. Observations, questionnaires.	Small community houses.	High support needs.	33 (baseline) and 31 (follow-up) residents. 29 residents at both time points. Perspective: Not applicable.	Training in and implementing active support increased the amount of assistance and the quality of support. Additionally, interactions and engagement were also increased.
Beadle-Brown, Hutchinson and Whelton, 2008. England.	Quantitative nonrandomised study. Pre–post-intervention design. Questionnaires, observations.	Residential care homes.	High support needs.	29 residents. Perspective: Not applicable.	Training in and implementing active support increased the amount of assistance and the quality of support. Additionally, interactions and engagement were also increased.
Bradshaw, 1998. England.*	Quantitative nonrandomised study. Case study, pre-post intervention. Observations.	Small community house.	Severe.	One resident with a learning disability and profound hearing impairment. Nine support staff. Perspective: Not applicable.	Training in communication skills (i.e., signed communication) and analysis of perceptions of the individual's behaviours increased the amount and improved the quality of interactions. Attitudinal changes also occurred.
Dagnan and Cairns, 2005. England.*	Quantitative descriptive study. Questionnaires.	Residential settings.	Not stated.	62 direct-care staff. Perspective: Staff.	Staff's attributions[6] and emotions are associated with their behaviour towards residents.
Gillete and Stenfert-Kroese, 2003. England.*	Quantitative nonrandomised study. Analytical cross-sectional pilot study. Questionnaires.	Residential units.	Ranged.	15 support staff. Perspective: Staff.	Different types of organisational culture can impact interactions and relationships between staff and residents affecting overall service performance.
Hastings *et al.*, 2018. England.	Quantitative cluster randomised controlled trial.	Residential services.	Not stated.	236 support staff. Half of the staff completed follow-up measures. Perspective: Staff.	'Who's challenging who' training did have a small positive, but not significant, effect on staff empathy. However, the training increased the staff's positive attitudes towards residents as well as their work-related wellbeing.
Hume, Khan and Reilly, 2021. Scotland.*	Quantitative nonrandomised study. Case study, pre-post intervention. Questionnaires, observations.	Residential homes.	Severe or profound.	A person with a learning disability and 16 support staff. Perspective: Staff.	Training using capable environments[7] and practice leadership frameworks improved staff interactions, assistance, and praise. The resident's engagement in meaningful activities was also increased whereas behaviour that challenges and use of medication decreased.

(Contd.)

REPORT (n = 21)	METHODS	CARE SETTING	LEVEL OF LEARNING DISABILITY	PARTICIPANTS AND PERSPECTIVE[4]	KEY FINDINGS
Jones *et al.*, 2001a. Wales.	Quantitative nonrandomised study. Replication study, pre-post intervention. Questionnaires, observations.	Staffed houses.	Ranged.	106 residents. Perspective: Not applicable.	Training in active support increased the assistance provided to individuals with a severe learning disability. Behaviour that challenges was unaffected. People with severe learning disability appear to benefit more from active support.
Jones *et al.*, 2001b. Wales.	Quantitative nonrandomised study. Replication study, pre-post intervention. Questionnaires, focus groups, observations. Qualitative elements with no clarification on analysis.	Staffed houses.	Ranged. Focused on severe or profound.	188 residents. Perspective: Not applicable; however, the opinions of some residents were discussed.	Training in active support increased the assistance provided to residents. People with severe learning disability appeared to benefit more from active support. Residents with a less severe learning disability also found active support useful and reported positive impacts on their relationships with staff. Training trainers (e.g., managers) was unsuccessful.
Jones *et al.*, 1999. Wales.	Quantitative nonrandomised study. Pre-post intervention. Questionnaires, observations.	Staffed houses.	Severe.	19 residents and 52 support staff. Perspective: Not applicable	Training in active support increased the assistance provided to residents. People with severe learning disability appear to benefit more from active support.
Mansell *et al.*, 2002. England.	Quantitative nonrandomised study. Experimental, pre-post comparison group. Questionnaire, observations.	Small residential care homes.	Not stated.	49 residents. Perspective: Interactions between staff and residents.	Active support led to increased engagement in meaningful activity and more interactions. The effect was small but significant and staff support was mixed.
McGill *et al.*, 2018. England.	Quantitative pragmatic cluster randomised controlled trial. Questionnaires, observations.	Residential settings.	Not stated.	81 residents. Perspective: Not applicable	Adopting a positive behaviour support[8] framework in residential settings led to a reduction in behaviour that challenges.
Phillips and Rose, 2010. England.	Quantitative nonrandomised study. Analytical cross-sectional. Questionnaires.	Various residential settings. Mostly residential care homes	The residents classed as 'breakdown group' had more developed language skills and were able to function more independently.	Support staff, (number not specified). The breakdown group consisted of 20 residents. The non-breakdown group consisted of 23 residents. Perspective: Staff.	The services' organisational features as well as staff's attributions and perceptions of ability were associated with interactions with residents and placement breakdown.
Rose and Rose, 2005. England.*	Quantitative descriptive study. Questionnaires.	Residential community homes.	Not stated.	107 direct-care staff. Perspective: Staff.	The level of stress was not associated with staff's attributions, emotions, and helping behaviour towards residents.

(Contd.)

REPORT (n = 21)	METHODS	CARE SETTING	LEVEL OF LEARNING DISABILITY	PARTICIPANTS AND PERSPECTIVE[4]	KEY FINDINGS
Rose, Jones and Fletcher, 1998. Wales.*	Quantitative non-randomised study. Cross-sectional analytical. Questionnaires, observations.	Residential care homes.	Not stated. More stressed-out staff were supporting more independent individuals.	33 direct care staff. Also, various members of staff were observed. Perspective: Staff.	High stress was associated with higher demand and constraint and lower organisational support. Low stress was associated with greater assistance to residents and more positive interactions. Caution around causal relationships.
Samuel *et al.*, 2008. England.*	Quantitative nonrandomised study. Quasi-experimental interrupted time-series multiple-baseline. Video observations, assessment schedules, and questionnaires.	Supported living bungalows.	Profound.	Four female residents. 11 support workers and one team leader. Perspective: Staff and residents.	Intensive interaction training led to more positive interactions. Suggestions that Intensive Interaction can make care relationships more reciprocal.
Smith *et al.*, 2002. Wales.	Quantitative nonrandomised study. Replication study, pre-post intervention. Questionnaires, observations.	Staffed houses.	Ranged.	188 residents. Perspective: Not applicable.	Training in active support led to more efficient support and assistance. People with severe learning disability appeared to benefit more from active support.
Thomas and Rose, 2009. England.*	Quantitative descriptive study. Cross-sectional questionnaire.	Residential services.	Not stated.	95 direct care staff. Perspective: Staff.	Staff's lack of reciprocal relationships with their organisation, predicted emotional exhaustion, depersonalisation, and feelings of personal accomplishment. Those factors had a negative impact on the staff's behavioural responses to residents.
Toogood *et al.*, 2009. Wales.*	Quantitative nonrandomised study. Case study, pre-post intervention. Observations, charts.	Individual's own home.	Moderate.	One individual with a learning disability, epilepsy, and cerebral palsy. Six support staff. Perspective: Not applicable.	Active support procedures such as coaching on activity-based interactions and activity planning led to warmer and more frequent eye-level instructions by staff. Interactions were increased and engagement replaced behaviour that challenges.
Williams *et al.*, 2015. England.*	Quantitative nonrandomised study. Experimental study, repeated measures design. Vignettes, questionnaires.	Supported living and residential care homes.	Not stated.	50 support staff. Perspective: Staff.	Mitigating factors (e.g., level of communication difficulties) reduced staff's attributions of personal responsibility and led to increased sympathy.

Table 3 Quantitative studies published in academic journals.

Note. The asterisk (*) indicates that the report did not provide explicit information about which country in the UK the study took place. UK location was determined based on the first author's affiliations.

REPORT (n = 4)	METHODS	CARE SETTING	LEVEL OF LEARNING DISABILITY	PARTICIPANTS AND PERSPECTIVE[4]	KEY CONCLUSIONS
Bowler and Nash, 2014. England.	Not applicable.	Community and domiciliary care settings.	Not stated.	Refers to non-registered support staff. Perspective: Not applicable	Setting boundaries plays an important role in the care relationship.
Broussine, 2012. England.	Not applicable.	Health and social care settings.	Not stated.	Refers to health and social care practitioners. Perspective: Not applicable	Person-centred processes underlie good care relationships.
Finlay, Antaki and Walton, 2008. England.	Not applicable.	Residential care homes.	Ranged.	Refers to residents and support workers. Perspective: Not applicable	Staff watching video footage of everyday interactions with their residents can help them improve care practices and understand how (dis) empowerment may operate within care relationships.
Thurman, Jones and Tarleton, 2005. England.	Not applicable.	Not stated.	Higher communication needs.	Not stated. Perspective: Not applicable	Effective communication is key and various frameworks exist to address communication needs. A series of steps can be taken to achieve good communication.

Table 4 Text and opinion pieces and book chapters.

REPORT (n = 5)	METHODS	CARE SETTING	LEVEL OF LEARNING DISABILITY	PARTICIPANTS AND PERSPECTIVE[4]	KEY FINDINGS
Ashman and Beadle-Brown, 2006. England.	Quantitative nonrandomised study. Pre-post intervention. Questionnaires, observations.	Residential care and supported living.	Most services included people with a severe or profound learning disability.	Baseline: 343 residents. Post-intervention: 469 residents. Additionally, 425 staff completed questionnaires. Data was also gathered about the 649 residents the services supported. Perspective: Interactions between staff and residents.	Training in active support led to more efficient support and assistance. Residents with severe learning disability appeared to benefit more from active support.
Grove and Mcintosh, 2005. England.	Not applicable (guidelines).	Not stated.	Not stated.	Not stated. Perspective: Not applicable	A series of steps can be taken by staff to ensure effective communication.
Health and Social Care, 2016. Northern Ireland.	Not applicable (guidelines).	Any health or social care setting.	Not stated.	Produced for health and social care staff. Perspective: Not applicable.	A series of steps can be taken by staff to ensure effective communication.
National Institute for Health Research, School for Social Care, 2020. England.	Quantitative cluster randomised controlled trial.	Residential services.	Not stated.	236 support staff. Half of the staff completed measures at the follow-up. Perspective: Staff.	'Who's challenging who' training did have a small positive, but not significant, effect on staff empathy. However, the training increased the staff's positive attitudes towards residents as well as their work-related well-being.
Norah Fry Research Centre, 2010. England.*	Qualitative study (no specific qualitative approach). Group and individual interviews.	Primarily rented accommodation.	Levels ranged.	50 participants including residents and staff. Perspective: Primarily residents.	Trust, independence, mutuality, and other components of good care relationships were discussed alongside barriers and grey areas.

Table 5 Grey literature.

Note. The asterisk (*) indicates that the report did not provide explicit information about which country in the UK the study took place. UK location was determined based on the first author's affiliations.

DEFINITIONS OF CARE RELATIONSHIPS (n = 7)	PROCESSES AND PRACTICES UNDERLYING POSITIVE CARE RELATIONSHIPS (n = 11)	BARRIERS TO AND FACILITATORS OF POSITIVE CARE RELATIONSHIPS (n = 38)	IMPACT OF POSITIVE CARE RELATIONSHIPS (OR LACK THEREOF) (n = 4)	RESTORATION OF DISRUPTED CARE RELATIONSHIPS (n = 2)
Antaki, Finlay and Walton, 2007a. Finlay, Antaki and Walton, 2008. Bowler and Nash, 2014. Haydon-Laurelut and Nunkoosing, 2010. Jingree, Finlay and Antaki, 2006. Norah Fry Research Centre, 2010. Walton, Antaki and Finlay, 2020.	Bowler and Nash, 2014. Bradshaw and Goldbart, 2013. Broussine, 2012. Grove and Mcintosh, 2005. Haydon-Laurelut and Nunkoosing, 2010. Health and Social Care, 2016. Kennedy and Brewer, 2014. Norah Fry Research Centre, 2010. Walton, Antaki and Finlay, 2020. Williams, Ponting and Ford, 2009. Williams *et al*., 2009.	Antaki *et al*., 2017. Antaki, Finlay and Walton, 2007a. Antaki, Finlay and Walton, 2007b. Ashman and Beadle-Brown, 2006. Banks, 2012. Beadle-Brown *et al*., 2015 Beadle-Brown, Hutchinson and Whelton, 2012. Beadle-Brown, Hutchinson and Whelton, 2008. Bradshaw, 1998. Dagnan and Cairns, 2005. Finlay, Antaki and Walton, 2008. Firth *et al*., 2008. Gillete and Stenfert-Kroese, 2003. Grove and Mcintosh, 2005. Hastings *et al*., 2018. Health and Social Care, 2016. Hume, Khan and Reilly, 2021. Jingree, Finlay and Antaki, 2006. Jones *et al*., 2001a. Jones *et al*., 2001b. Jones *et al*., 1999. Kennedy and Brewer, 2014. Mansell *et al*., 2002. McGill *et al*., 2018. Nagra *et al*., 2017. National Institute for Health Research, School for Social Care, 2020. Norah Fry Research Centre, 2010. Phillips and Rose, 2010. Rose and Rose, 2005. Rose, Jones and Fletcher, 1998. Samuel *et al*., 2008. Smith *et al*., 2002. Thomas and Rose, 2009. Thurman, Jones and Tarleton, 2005. Toogood *et al*., 2009. Waggett, 2012. Windley and Chapman, 2010. Williams *et al*., 2015.	Bradshaw and Goldbart, 2013. Broussine, 2012. Phillips and Rose, 2010. Windley and Chapman, 2010.	Haydon-Laurelut and Nunkoosing, 2010. Toogood *et al*., 2009.

Table 6 Conceptual clusters.

Setting boundaries

Setting boundaries entails staff being clear about what they can and cannot do (Bradshaw and Goldbart, 2013) and avoiding over or under-involvement (Bowler and Nash, 2014). Boundary setting applies when building a relationship and when it has been established (Bradshaw and Goldbart, 2013).

Tuning-in

Tuning-in involves being present physically and mentally (Egan, 2007, as cited in Broussine, 2012) with staff recognising and responding to the affective stances of residents, including verbal and non-verbal expressions (Walton, Antaki and Finlay, 2020). It involves synchronised body language (e.g., mutual smiling) and joint task orientation (e.g., finishing each other's sentences; Williams, Ponting and Ford, 2009; Williams *et al*., 2009).

Listening

Feeling listened to by staff is crucial (Haydon-Laurelut and Nunkoosing, 2010) and active listening involves staff acknowledging non-verbal behaviours and the social context of residents (Egan, 2007, as cited in Broussine, 2012). Staff's interactional styles (e.g., not using child-like talk) can influence whether residents feel listened to (Williams, Ponting and Ford, 2009).

Being person-centred

Three sub-processes were identified: 1) congruence, namely staff being true to their feelings, thoughts, and behaviours (Broussine, 2012) without overlooking that this

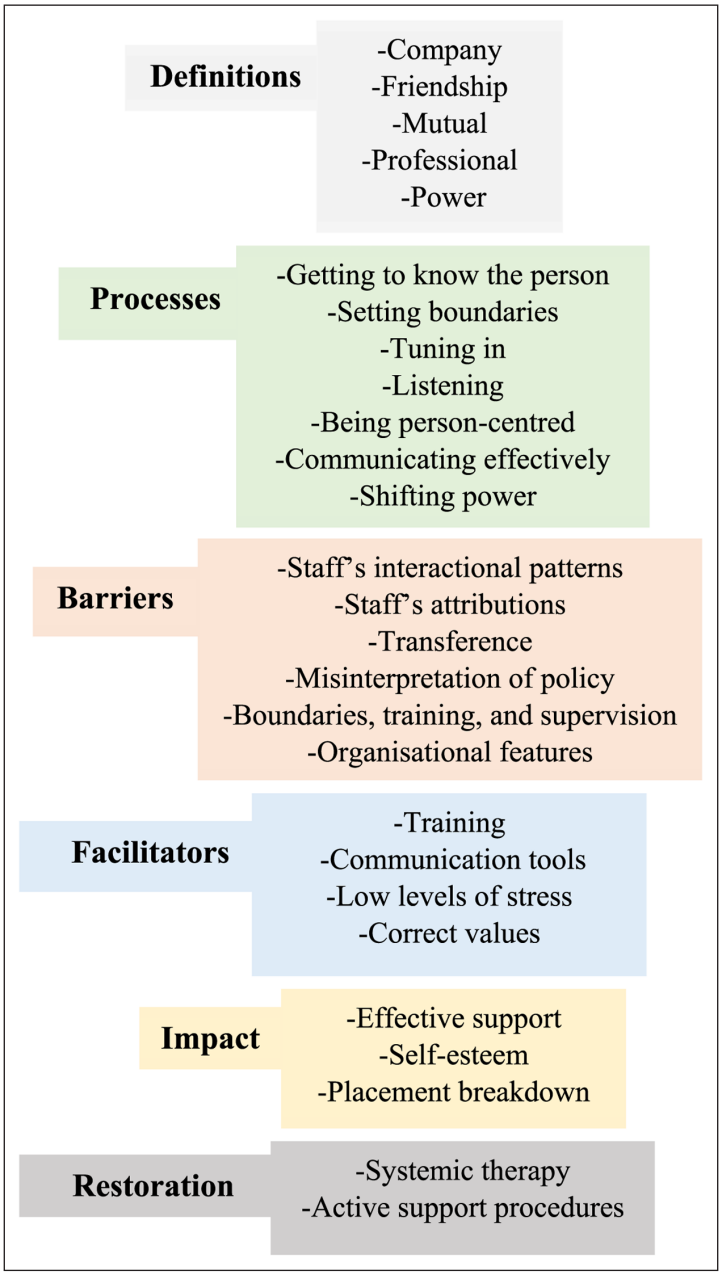

Figure 3 Review findings.

may prevent them from being objective (Cumbie, 2001, as cited in Broussine, 2012); 2) unconditional positive regard, with staff approaching residents with empathy, compassion, and without judgement (Broussine, 2012); and 3) self-awareness, namely staff being mindful of their emotions and how they can influence relationships as well as using the self therapeutically without overlooking associated emotional demands and potential incompatibility with routines in services (Broussine, 2012).

Communicating effectively

Effective communication involves using a respectful, friendly, and adult tone allowing room for choice and support to speak up (Williams, Ponting and Ford, 2009; Williams *et al*., 2009). In sensitive areas (e.g., money, risk), staff should communicate openly (Norah Fry Research Centre, 2010; Williams, Ponting and Ford, 2009). Humour can be a powerful tool to soften advice (Williams, Ponting and Ford, 2009; Williams *et al*., 2009). Getting the residents' attention, giving time, and considering environmental factors are also crucial (Grove and Mcintosh, 2005; Health and Social Care, 2016).

Shifting power dynamics

Staff stepping back allows residents to be in control and working as a team can facilitate a more equal relationship emphasising mutual responsibility (Norah Fry Research Centre, 2010; Williams, Ponting and Ford, 2009; Williams *et al*., 2009).

Barriers to positive care relationships

Interactional patterns

Subtle everyday staff interactional patterns (e.g., candidate answers, 'yes-no' questions) may disempower

residents and emphasise power imbalance in care relationships (Antaki, Finlay and Walton, 2007a; Antaki, Finlay and Walton, 2007b; Jingree, Finlay and Antaki, 2006). Staff responding ordinarily to residents with limited interactional capacity may impact engagement (Antaki *et al*., 2017). The way that staff discourse services and themselves (e.g., as friends) may result in ascribing deficient identities to residents and in disempowering relationships (Antaki, Finlay and Walton, 2007a; Jingree, Finlay and Antaki, 2006).

Attributions

Staff's attributions of internality, namely when the cause of the behaviour that challenges is perceived to lie within the individual, may be positively associated with staff anger and negatively with sympathy (Dagnan and Cairns, 2005). Attributions of stability, namely when the cause of the behaviour that challenges is perceived as having the potential to change over time, may correlate positively with staff sympathy (Dagnan and Cairns, 2005). Attributions of control over difficult behaviours may be associated with judging residents as personally responsible for their behaviour (Dagnan and Cairns, 2005). Attributions of control, but not challenging behaviour itself, seem to influence residential placement breakdowns (Phillips and Rose, 2010). When staff perceive residents as personally responsible for difficult behaviours, they are less likely to feel sympathetic towards the resident, whereas perceiving the resident as having some responsibility for finding solutions for behaviours that challenge, increases sympathy (Dagnan and Cairns, 2005). In turn, feeling or lacking sympathy seems to be linked to staff's helping behaviours (Dagnan and Cairns, 2005).

Staff may judge residents with communication difficulties as less responsible for difficult behaviours resulting in increased sympathy (Williams *et al*., 2015). Nonetheless, people with mild learning disability may be perceived as in control of their behaviour and receive fewer staff interactions (Phillips and Rose, 2010). Optimism, namely staff's expectations for dealing with difficult behaviours successfully, rather than attributions of control, could be a key factor influencing interactions (Rose and Rose, 2005). Attributions, behaviour, and levels of staff stress do not necessarily correlate as highly stressed staff still indicate a willingness to provide extra help (Rose and Rose, 2005).

Transference

Interpersonal dynamics are a key element of residential settings and staff often become exposed to the residents' negative emotions or traumatic experiences (Waggett, 2012). Exposure to these emotions and experiences can be intense and failure to process them can lead staff to somewhat perceive them as their own (Waggett, 2012). To cope with this disturbance, staff may seek to transfer such emotions and experiences back to residents, colleagues, or the organisation, which in turn can affect interactions and relationships (Waggett, 2012).

Policy interpretation

Policy reforms aimed at personalising residential services may be interpreted narrowly with staff only focusing on residents' responsibilities (Banks, 2012). Residents may resist such demands and tensions can arise resulting in staff blaming residents and emphasising professional agreements (e.g., tenant responsibilities) over relationships (Banks, 2012).

Lack of boundaries, training, and supervision

Difficulties around boundary setting (e.g., over-involvement) can threaten care relationships (Norah Fry Research Centre, 2010). Training and supervision on setting boundaries are important; however, personal assistants, especially those employed directly by residents, report limited opportunities to access it (Norah Fry Research Centre, 2010).

Organisational factors

Overworked teams, lacking resources and information, may experience residential placement breakdowns (Phillips and Rose, 2010). Less support for employees and higher levels of demand are linked to more stressed staff and limited engagement with residents (Rose, Jones and Fletcher, 1998). Lack of reciprocity between employees and organisations can predict exhaustion, depersonalisation, and personal accomplishment which may affect staff's interactions with residents (Thomas and Rose, 2009). Oppositional, competitive, or perfectionistic organisational cultural styles may lead to task-centred practices preventing interpersonal relationships (Gillete and Stenfert-Kroese, 2003).

Facilitators of positive care relationships

Training

Active support

Active support can lead to more positive and frequent interactions and staff assistance, increased engagement in meaningful activities, and overall better care relationships (Ashman and Beadle-Brown, 2006; Beadle-Brown *et al*., 2015; Beadle-Brown, Hutchinson and Whelton, 2012; Beadle-Brown, Hutchinson and Whelton, 2008; Jones *et al*., 2001a; Jones *et al*., 2001b; Jones *et al*., 1999; Mansell *et al*., 2002; Smith *et al*., 2002; Toogood *et al*., 2009).

Intensive interaction

Intensive interaction is associated with more positive and frequent interactions, improved communication, increased staff confidence, and overall more reciprocal relationships (Firth *et al*., 2008; Nagra *et al*., 2017; Samuel *et al*., 2008).

Other training

Training in signed communication and reflecting on the meaning of difficult behaviour can improve interactions and decrease judgemental attitudes among staff (Bradshaw, 1998). The 'Who's Challenging Who' training can increase staff's sense of accomplishment and motivation, and improve attitudes towards difficult behaviours (Hastings *et al*., 2018; National Institute for Health Research, School for Social Care, 2020). Capable environments and practice leadership frameworks can improve staff interactions and praise, increasing engagement and decreasing difficult behaviours (Hume, Khan and Reilly, 2021). Behaviour that challenges can disrupt relationships and positive behaviour support training can address this (McGill *et al*., 2018). Filming interactions may help staff reflect on their subtle everyday practices allowing them to explore power imbalance in relationships (Finlay, Antaki and Walton, 2008).

Communication tools

Creative methods (e.g., music) can enhance communication and help establish good relationships (Kennedy and Brewer, 2014). Interactive (e.g., proximal communication), profiling (e.g., communication passports), and consensus tools (e.g., circles of support) can also improve interactions (Thurman, Jones and Tarleton, 2005). Presenting accessible information (e.g., easy-read documents) is also key to positive interactions (Grove and Mcintosh, 2005; Health and Social Care, 2016).

Correct values

Having the right temperament and being caring and empathic are core values for good care relationships (Windley and Chapman, 2010).

Impact of positive care relationships (or lack thereof)

Positive relationships set the foundations for providing effective support (Bradshaw and Goldbart, 2013; Windley and Chapman, 2010) and can improve the self-esteem of people with a learning disability, challenging previous stigmatising experiences (Broussine, 2012). Poor relationships may be associated with residential placement breakdowns (Phillips and Rose, 2010).

Restoration of disrupted care relationships

Systemic therapy can help identify reasons behind poor care relationships, explore power imbalance, and suggest ways forward (Haydon-Laurelut and Nunkoosing, 2010). Active support procedures including coaching on activity-based interactions and activity planning can lead to warmer interactions replacing difficult behaviours (Toogood *et al*., 2009).

ASSESSING THE ROBUSTNESS OF THE SYNTHESIS

Discussions with colleagues as well as individual and team reflection on how the study was shaping and progressing took place regularly. To tackle publication bias, we included various types of published research, grey literature, and contacted experts. Involving a second reviewer has, at least partly, minimised bias and error during screening. English was the main language which may have introduced bias, nonetheless, this was somewhat inevitable due to the UK focus. Time constraints prevented us from searching further for the 92 non-retrieved reports or checking references of included reports. Moreover, time limitations and work-related commitments did not allow us to include books, reviews, or PhD theses in the review. Applying the findings to care contexts outside the UK must be done cautiously; however, care arrangements and levels of learning disability ranged which may increase applicability.

The Mixed Methods Appraisal Tool (MMAT; Hong *et al*., 2018) was used for empirical studies, the JBI Critical Appraisal Checklist (JBI; McArthur *et al*., 2015) for opinion pieces and book chapters, and the AACODS checklist (Authority, Accuracy, Coverage, Objectivity, Date, Significance; Tyndall, 2010) for grey literature. Reports were not excluded on grounds of poor methodological quality (Hong *et al*., 2018). In all MMAT tables, a column discussing ethics, consent, and limitations was added to complement critical appraisal. For a detailed appraisal of each report, we kindly refer the reader to the tables in the additional file that accompanies this article.

Most quantitative non-randomised studies, quantitative descriptive studies, and some qualitative studies met most MMAT criteria indicating higher quality. Similarly, all text and opinion and grey literature reports met most JBI and AACODS criteria respectively. All quantitative randomised control trials were deemed of poor methodological quality.

Less than half of qualitative studies, half of quantitative descriptive studies, and only a few quantitative non-randomised studies had ethics information. In contrast, most quantitative randomised control trials discussed ethics. Most qualitative studies and all quantitative randomised control trials had information about consent. However, less than half of quantitative non-randomised studies and only one quantitative descriptive study discussed consent. Most reports did address limitations.

Of the 45 reports, only 15 discussed care relationships as such, with fewer reports addressing positive relationships. Instead, most reports explored concepts at the periphery of relationships (e.g., interactions, communication). We aimed to be inclusive ensuring that relevant literature would not be excluded whilst considering the review questions and eligibility criteria.

DISCUSSION

This review synthesised literature on care relationships between support staff and adults with a learning disability in UK social care residential settings, covering 41 years of relevant work. Each area of relationships we explored and presented results for is discussed below through the lens of the wider literature. By doing so, we aim to contextualise and engage critically with our findings.

DEFINITIONS OF CARE RELATIONSHIPS

Definitions of good care relationships revolved around friendship, equality, professionalism, and power. These topics are not always compatible with each other. Residents often perceive staff as friends (Giesbers *et al*., 2019) whilst staff seek to maintain professional distance (Pockney, 2006). Uncertain relational boundaries, although to some degree unavoidable due to the nature of care work in residential settings, may lead to different expectations and hence damage relationships (Rogers, 2016). Staff describing themselves as friends can be interpreted as coaching residents about who their friends are, resulting in disempowerment (Antaki, Finlay and Walton, 2007a). Equality is an ongoing objective; however, staff's roles involve a degree of power which questions the feasibility of parity of status (Pockney, 2006). Nonetheless, research suggests that in learning disability intentional communities (e.g., Camphill), friendships, equality, and blurred boundaries are perhaps experienced more flexibly, as an integral part of the care relationship (Randel and Cumella, 2009).

PROCESSES AND PRACTICES UNDERLYING POSITIVE CARE RELATIONSHIPS

Knowing the person is key; however, staff relying solely on this can result in dismissing training as well as in poor care practices (Bradshaw and Goldbart, 2013). Tuning in reflects the wider literature exploring professional relationships (e.g., nursing; Riviere *et al*., 2019) and resembles 'connecting' in Johnson *et al*'s (2012) model. Tuning in and listening may happen simultaneously (Broussine, 2012); however, whether other processes are sequenced is unclear.

Interestingly, person-centred processes from therapeutic relationships (Rogers, 1957) also appeared in learning disability care relationships. Similar to the 'Definitions' section above, setting boundaries and shifting power were important processes, highlighting their relevance to care work. Using humour to build relationships corresponds with Johnson *et al*.'s (2012) model and reflects care relationships with other groups (e.g., older adults; Brown-Wilson and Davies, 2009).

BARRIERS TO POSITIVE CARE RELATIONSHIPS

Staff's attributions reflect the wider literature around attributions and behaviour, for example, attributions and mental health stigma (Corrigan *et al*., 2003). Residents' communication difficulties may mitigate staff's negative attributions, with staff judging residents with communication difficulties as less responsible for difficult behaviours (Williams et al., 2015). However, staff can often overestimate the communicative abilities of people with a learning disability (Purcell *et al*., 1999 as cited in Williams et al., 2015) leading to an increase in staff's attributions of difficult behaviour (Williams et al., 2015) with potential implications for staff's emotions (i.e., less sympathy towards the resident displaying behaviour that challenges).

Transference, a concept used widely in psychotherapy, also appeared in learning disability care relationships (Waggett, 2012). Boundaries were, once again, highlighted with an emphasis on how challenges around boundary setting can hinder good relationships (Norah Fry Research Centre, 2010). The review suggests that dilemma is part of the staff experience, shaping care relationships. Complying with policy reforms that emphasise autonomy versus making decisions on behalf of residents (Banks, 2012), providing emotional support versus pre-occupation with physical tasks (Nagra *et al*., 2017), or having multiple roles (e.g., enabler, advocate) versus handling organisational duties (Antaki, Finlay and Walton, 2007a), can lead to managing conflicting responsibilities and create dilemmas between care and control (Antaki, Finlay and Walton, 2007a).

Staff dilemmas correspond with the wider literature. Brown-Wilson and Davies (2009) discuss three types of relationships in care homes for adults without learning disabilities, namely pragmatic (i.e., focus on care tasks), personal (i.e., focus on what matters to resident), and reciprocal (i.e., focus on shared understanding). Staff dilemmas highlight that different priorities and processes, hence different types of relationships, may co-exist, without implying that this cohabitation is always balanced. After all, care work operates in the intersection of emotions, practical everyday care, and the socio-political context (Rogers, 2016).

FACILITATORS OF POSITIVE CARE RELATIONSHIPS

Several researchers (Hume, Khan and Reilly, 2021; Jones et al., 2001b; Smith *et al*., 2002) suggest that, regarding improving interactions and relationships, active support training is most effective when the full training is delivered, including the practical components. Active support can benefit adults with severe as well as milder learning disability in their relationships (Jones *et al*., 2001b). More recent research explores connections between active support and creating enabling staff-client relationships (Mansell and Beadle-Brown, 2012). The effects of active support may decrease, and practice leadership and management involvement are key to maintaining quality support (Ashman and Beadle-Brown, 2006; Toogood *et al*., 2009). Attitudes towards training are not

always positive, for example, support staff may dismiss intensive interaction as irrelevant (Firth *et al*., 2008). Staff responding with empathy and understanding towards residents with difficult behaviours is a complex situation and training designed to increase staff empathy, and consequently improve care relationships and overall care provision, does not always have significant effects (see Hastings *et al*., 2018, for discussion).

IMPACT OF POSITIVE CARE RELATIONSHIPS AND RESTORATION OF DISRUPTED RELATIONSHIPS

As discussed in the 'Interpretative synthesis' section, positive care relationships appear to play a key role in the provision of effective care and the improvement of the self-esteem of people with a learning disability. Nevertheless, the information we identified in the literature was somewhat limited and did not provide a well-rounded account of the impact of having or lacking good care relationships. For example, we remain uncertain about how relationships impact support staff or about the multifaceted impact that a lack of positive care relationships might have on residents. Equally, only limited information was found about ways to restore disrupted care relationships. Given the complexities of daily care and the presence of behaviours that challenge amongst a fair number of residents with a learning disability (e.g., see Hastings *et al*., 2018), surely there must be various day-to-day practices and care systems that support staff and residents engage with to restore care relationships that have been challenged. Future research could shed more light on these two domains of care relationships.

CONCLUSION

We hope that this review provides a well-rounded account of care relationships, expands knowledge, and serves as a starting point for future research. Certain review questions (e.g., barriers to and facilitators of positive care relationships) were answered more fully, whereas others (e.g., restoring relationships, relational practices and processes, the impact of care relationships) require further exploration. Through our review questions, we targeted key domains that, in our view, when pieced together, form the care relationship as a whole. This leads us to suggest that care relationships are complex and their various elements, sometimes operating in harmony and others in conflict, may co-exist. Consequently, we suggest that the results of this study are better understood in conjunction with each other; for example, what serves as a facilitator can, at the same time, be a care practice or process and also be used to define what we mean by care relationships.

The review included various study designs and report formats. Although we certainly believe that every research design and format has its own merits, we feel that qualitative research designs (e.g., interviews, ethnographic observations, diaries) are particularly useful for exploring care relationships. Such methods allow the exploration of meanings and lived experiences and seem appropriate for capturing the micro, meso, and macro aspects of care provision and relationships.

SUGGESTIONS FOR FUTURE RESEARCH

As discussed, only a limited number of included reports addressed care relationships explicitly and some findings were generated through a small number of reports. Future research could explicitly examine care relationships between support staff and adults with a learning disability in residential settings, investigating the areas for which evidence was limited. Furthermore, the voice of adults with a learning disability was not well represented in the included reports and future studies could address this. Although different levels of learning disability were included in the reports we reviewed, the studies did not explore whether or how such levels may influence care relationships (e.g., by serving as a barrier or facilitator) and future research could examine this. Staff dilemmas were highlighted, and future research could delve into this further.

Scheffelaar *et al*. (2019) argue that focusing on specific client groups is not required, as determinants of care relationships are often similar between groups. This is certainly an interesting point as similarities do appear to exist. Nevertheless, assuming such a degree of homogeneity perhaps underestimates the influence that different conditions and experiences as well as the social narratives and care practices associated with them have on developing relationships. Also, it perhaps does not take into account that different client groups have different needs, something that might clash with the ethos of person-centred care. Future research could explore similarities in building relationships between support staff and different client groups. This could be expanded to explore whether patterns in relationships exist across different staff-client groups and use findings to inform care practice.

SUGGESTIONS FOR CARE PRACTICE

This review can potentially improve how support staff, residents with a learning disability, and service providers understand care relationships in UK residential settings. Our findings could be used 1) by support staff and care managers to inform relationship building in daily care practice; 2) by trainers to inform the training that support staff often undertake when employed in social care services; 3) by adults with a learning disability and their advocates to highlight the importance of good care relationships and ways to achieve them; and 4) by regulators to inform care quality evaluations in residential settings.

SUGGESTIONS FOR POLICY

In this review, we situated care work in its UK material context (e.g., social care underfunding, staff's working conditions, low salaries, etc.), which can lead to questions

about how such context can influence building care relationships. Our findings could potentially contribute to conversations around the recognition of support staff, improved working conditions, and social care funding.

NOTES

1 When we started conducting the review, only Undergraduate and MSc/MRes/Mphil theses were excluded. However, during the study selection phase, we realised that including PhD theses, books, and other systematic/literature/scoping reviews was unrealistic due to time constraints and other pragmatic factors. Consequently, this exclusion criterion was added during study selection.

2 As per note 1, results from 'Open Dissertations' were immediately excluded.

3 As per note 1, results from 'Ethos' were immediately excluded.

4 Perspective refers to whose perspective the included article explores. For example, the article might explore care relationships from the perspective of staff or residents. Various articles explore topics from the perspective of the interaction between staff and residents. Where perspective is not applicable, this is either due to the article not providing relevant information or because of the nature of the article (e.g., guideline document).

5 Active support is a model of care for people with a learning disability that emphasises participation in everyday activities (Totsika *et al*., 2008).

6 Attributions refer to how staff perceive the causes of residents' difficult behaviours (e.g., as under or outside the resident's control) and how such understandings influence staff's emotional responses and behaviour (Dagnan and Cairns, 2005).

7 Capable environments is an approach that draws on positive behaviour support and seeks to reduce behaviour that challenges by providing high-quality, multifaceted care (Hume, Khan and Reilly, 2021).

8 Positive behaviour support is an approach that draws on applied behaviour analysis and focuses on understanding the context of behaviours that challenge (McGill *et al*., 2018).

ADDITIONAL FILE

The additional file for this article can be found as follows:

- **Additional file.** Critical appraisal tables using MMAT, JBI, and AACODS. DOI: https://doi.org/10.31389/jltc.189.s1

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COMPETING INTERESTS

The authors have no competing interests to declare.

DISCLAIMER

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